

Board of Governors

PACKET

OCTOBER 9th, 2026

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, October 9th, 2026
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

PUBLIC COMMENTS: Public Comments can be submitted for any agendized item or for any item not listed on the agenda, by mailing your comment to: "Attn: Clerk of the Board," 1240 S. Loop Road, Alameda, CA 94502 or by emailing the Clerk of the Board at bgonzalez@alamedaalliance.org. You may attend meetings in person or by computer by logging in to the following link: Click here to join the meeting. You may also listen to the meeting by calling in to the following telephone number: 1-510-210-0967 conference id 88758315#. If you use the link and participate via computer, you may use the chat function, and request an opportunity to speak on any agendized item, including general public comment. Your request to speak must be received before the item is called on the agenda. If you participate by telephone, please submit your comments to the Clerk of the Board at the email address listed above or by providing your comments during the meeting at the end of each agenda item. Oral comments to address the Board of Governors are limited to two (2) minutes per person. Whenever possible, the board would appreciate it if public comment communication was provided prior to the commencement of the meeting.

PLEASE NOTE: The Alameda Alliance for Health is making every effort to follow the spirit and intent of the Brown Act and other applicable laws regulating the conduct of public meetings.

1. CALL TO ORDER

(A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on October 9th, 2026, at 12:00 p.m. in Alameda County, California, by Andrea Schwab-Galindo, Presiding Officer. This meeting is to take place in person and by video conference call)

2. ROLL CALL

3. AGENDA APPROVAL

4. INTRODUCTIONS

5. CONSENT CALENDAR

(All matters listed on the Consent Calendar are to be approved with one motion unless a member of the Board of Governors removes an item for separate action. Any consent calendar item for which separate action is requested shall be heard as the next agenda item.)

a) **SEPTEMBER 8th, 2026, FINANCE COMMITTEE MEETING MINUTES**

b) **SEPTEMBER 11th, 2026, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES**

c) **SEPTEMBER 11th, 2026, BOARD OF GOVERNORS MEETING MINUTES**

6. **BOARD MEMBER REPORTS**

   a) **BOARD CHAIR REPORT**

   b) **COMPLIANCE ADVISORY COMMITTEE**

   c) **FINANCE COMMITTEE**

   d) **STRATEGIC PLANNING COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

   a) **REVIEW AND APPROVE BAKERTILLY FINANCIAL AUDIT REVIEW**

   b) **INFORMATION TECHNOLOGY ANNUAL UPDATE**

   c) **REVIEW AND APPROVE AUGUST 2026 MONTHLY FINANCIAL STATEMENTS**

   d) **REVIEW AND APPROVE OLUSAN CONTRACT**

9. **STAFF UPDATES**

10. **UNFINISHED BUSINESS**

11. **STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS**

12. **PUBLIC COMMENT (NON-AGENDA ITEMS)**

13. **ADJOURNMENT**

NOTICE TO THE PUBLIC

The agenda may also be accessed through the Alameda Alliance for Health's Web page at: www.alamedaalliance.org

Board of Governors meetings are regularly held on the second Friday of each month at 12:00 p.m., unless otherwise noted. This meeting is held both in person and as a video conference call. Meeting agendas and approved minutes are kept current on the Alameda Alliance for Health's website at www.alamedaalliance.org.

Additions and Deletions to the Agenda: Additions to the agenda are limited by California Government Code Section 54954.2 and confined to items that arise after the posting of the agenda and must be acted upon prior to the next Board meeting. For special meeting agendas, only those items listed on the published agenda may be discussed. The items on the agenda are arranged in three categories. **Consent Calendar:** These items are relatively minor in nature, do not have any outstanding issues or concerns, and do not require a public hearing. All consent calendar items are considered by the Board as one item and a single vote is taken for their approval, unless an item is pulled from the consent calendar for individual discussion. There is no public discussion of consent calendar items unless requested by the Board of Governors. **Public Hearings:** This category is for matters that require, by law, a hearing open to public comment because of the particular nature of the request. Public hearings are formally conducted, and public input/testimony is requested at a specific time. This is your opportunity to speak on the item(s) that concern you. If in the future, you wish to challenge in court any of the matters on this agenda for which a public hearing is to be conducted, you may be limited to raising only those issues which you (or someone else) raised orally at the public hearing or in written correspondence received by the Board at or before the hearing. **Board Business:** Items in this category are general in nature and may require Board action. Public input will be received on each item of Board Business.

Supplemental Material Received After the Posting of the Agenda: Any supplemental materials or documents distributed to a majority of the Board regarding any item on this agenda after the posting of the agenda will be available for public review. To obtain a document, please call the Clerk of the Board at (510) 995-1207.

Submittal of Information by Members of the Public for Dissemination or Presentation at Public Meetings (Written Materials/handouts): Any member of the public who desires to submit documentation in hard copy form may do so prior to the meeting by sending it to "Attn: Clerk of the Board", 1240 S. Loop Road, Alameda, CA 94502. This information will be disseminated to the Board at the time testimony is given.

Americans With Disabilities Act (ADA): It is the intention of the Alameda Alliance for Health to comply with the Americans with Disabilities Act (ADA) in all respects. If, as an attendee or participant at this meeting, you will need special assistance beyond what is normally provided, the Alameda Alliance for Health will attempt to accommodate you in every reasonable manner. Please contact the Clerk of the Board, Brenda Gonzalez, at (510) 995-1207 at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodations to attend or participate in meetings on a regular basis.

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org by October 6th, 2026, by 12:00 p.m.



Brenda Gonzalez, Clerk of the Board

EXECUTIVE SUMMARY APPENDIX

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

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SUPPORTING MATERIALS APPENDIX

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

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PRESENTATIONS APPENDIX

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

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Consent Calendar

Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

September 8th, 2026
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting conducted in person and by Teleconference.

Committee Members in-person: Dr. Rollington Ferguson, Gil Riojas
Committee Members by Teleconference: Yeon Park, James Jackson
Committee Members Excused: Rebecca Gebhart
Board of Governors members in-person and on Conference Call: Andrea Schwab-Galindo

Alliance Staff in-person and on Conference Call: Matt Woodruff, Dr. Donna Carey, Tiffany Cheang, Beau Hennemann, Brenda Gonzalez, Tome Meyers, Felix Rodriguez, Danube Serri, Anastasia Swift, Sasi Karaiyan, Christine Corpus

CALL TO ORDER

Dr. Ferguson convened the Finance Committee meeting at 8:00 a.m.

ROLL CALL

Roll call was conducted and confirmed.

INTRODUCTIONS

Mr. Woodruff announced that Sarah Ream, currently General Counsel at DMHC, has accepted the Compliance Officer position. Her start date is planned for later in the month.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

There were no modifications to the Consent Calendar, and no items to approve.

COMMITTEE BUSINESS

a) CEO UPDATE

Mr. Woodruff provided an update noting July financial performance was on budget with an expected ~$5M loss and a recent slowdown in disenrollment trends, alongside continued monitoring of medical cost drivers. The update also highlighted a prior compliance sanction related to network issues from a historical review and outlined ongoing organizational IT workflow automation and AI tool implementation with a comprehensive IT update planned for October. Medicare enrollment was reported as below target following a prior strategic decision to remain smaller until August 1, with anticipated efforts to accelerate growth in the coming months. Additionally, Mr. Woodruff shared feedback from participation in an external board retreat covering enrollment trends, UIS population, and quality and medical management topics, including recognition of strong 2025 quality performance by AHS.

b) REVIEW AND APPROVE THE JULY 2026 MONTHLY FINANCIAL STATEMENTS

JULY 2026 Financial Statement Summary

Enrollment:

Total enrollment decreased by 2,999 members since June 2026.

Net Income:

For the month ended and fiscal YTD ended July 31st, 2026, the Alliance reported a Net Loss of $5.2 million (versus budgeted Net Loss of $5.2 million).

Premium Revenue:

For the month ended and fiscal YTD July 31st, 2026, actual Revenue was $180.0 million vs. our budgeted amount of $179.5 million.

Medical Expense:

Actual Medical Expenses for the month and fiscal YTD were $176.4 million, vs. budgeted amount of $175.3 million.

Medical Loss Ratio:

Our MLR ratio for this month and fiscal YTD was reported as 98.0%.

Administrative Expense:

Actual Administrative Expenses for the month and fiscal YTD ending July 31st, 2026, were $11.1 million vs. our budgeted amount of $11.8 million. Our Administrative Loss Ratio (ALR) is 6.2% of our Revenue for the month, and fiscal year-to-date.

Other Income / (Expense):

For fiscal year-to-date, our YTD interest income from investments show a gain of $2.3 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending July 31st, 2026, we reported $60.6 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $60.1 million. Our MCO Tax Expense was $60.6 million vs. budgeted MCO Tax Expense of $60.1 million.

Tangible Net Equity (TNE):

For July, the DMHC requires that we have $79.9 million in TNE, and we reported $226.5 million, leaving an excess of $146.6 million. As a percentage we are at 284%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $540.9 million in cash; $558.5 million is uncommitted. Our current ratio is above the minimum required at 1.16 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired $135,000 in Capital Assets year-to-date. Our annual capital budget is $1.3 million.

Question: Dr. Ferguson asked for clarification on pharmacy cost responsibility between the state and the plan. Mr. Riojas explained that the state covers retail pharmacy, while the plan covers most hospital-and physician-administered drugs.

Question: Dr. Ferguson inquired about which specific drugs are driving increased costs. Mr. Riojas said the main drivers include high-cost treatment such as transplant-related care and oncology-related therapies.

Motion: A motion was made by Gil Riojas, and seconded by James Jackson, to accept and approve the July 2026 Financial Statements.

Motion Passed

No opposition or abstentions.

b) REVIEW AND APPROVE THE 2026 SALARY SCHEDULE

Highlights:

- The salary schedule is a required CalPERS compliance document that must be maintained and board-approved, reflecting all organizational positions by grade.
- It includes all positions across the organization with corresponding grade levels, job creation dates, and salary ranges (hourly and annual), ensuring each role is mapped to a defined compensation band.
- The schedule is reviewed and updated through an external vendor salary survey process, with HR and finance validating recommended adjustments to salary ranges and incorporating newly added positions.
- Updates do not change job titles or reassign positions between grades; adjustments are limited to range updates and structural maintenance of the schedule.
- The document is intended to remain publicly available and is presented for governance review and approval through the finance committee and board consent process.
- A proposal was made to standardize the review cycle on an annual basis, with routine presentation to the finance committee followed by board approval.
- The committee confirmed alignment with maintaining the schedule as part of a regular annual governance cycle and continuing the approval workflow through the board consent calendar.
- It was clarified that the schedule includes all roles, including executive leadership positions, and reflects salary ranges rather than exact individual compensation amounts.

Question: Dr. Ferguson asked how individual executive salary discussions are reflected if the schedule only shows ranges. Mr. Riojas says the document does not display specific salaries for individuals; instead, it shows minimum-to-maximum pay ranges by grade, and each role, including executives, must fall within its assigned range.

Motion: A motion was made by James Jackson, and seconded by Dr. Rollington Ferguson, to approve the 2026 Salary Schedule.

Motion Passed

No opposition or abstentions.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 8:34 a.m.

Compliance Advisory Committee Meeting Minutes

COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes

September 11, 2026
10:30 a.m. – 11:30 a.m.

Video Conference Call or
1240 South Loop Road
Alameda, CA 94502

***Committee Members Attendance**:* Dr. Kelley Meade (Chair), Rebecca Gebhart, Byron Lopez, Stephen Smythe

Remote: None

Committee Members Excused: None

1. CALL TO ORDER

The regular meeting of the Compliance Advisory Committee was officially called to order by Dr. Kelley Meade at 10:30 a.m.

2. ROLL CALL

A roll call was conducted by the Clerk, and quorum was confirmed. Committee Member Rebecca Gebhart joined the meeting after the roll call.

3. AGENDA APPROVAL OR MODIFICATIONS

No modifications were requested; the agenda was approved as presented.

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

No public comments were received.

5. CONSENT CALENDAR

a) June 12, 2026 Compliance Advisory Committee Meeting Minutes and August 14, 2026 Compliance Advisory Committee Meeting Minutes.

Motion: A motion to approve the minutes was made by Byron Lopez.

Second: Stephen Smythe.

Vote: All voting members present approved the motion.

6. **COMPLIANCE MEMBER REPORTS**

a) Compliance Activity Report:
    i. Plan Audits and Regulatory Oversight:
        1. 2025 DMHC Routine Full Medical Survey
            - Working through remediation of the findings with goal of having them completed before DMHC returns to the Alliance in 2027.
            - Deficiency #9 is the highest profile issue.
                - Relates to how we work with providers when members are moving to a lower level of care, for example moving from inpatient to a skilled nursing facility (SNF), and documenting that the conversations have occurred with the providers.
                - Reviewing all authorizations through the look back period and uploading to TruCare – 1/3 of the way through this process.
                - Claims payment is underway.
                - Policies and procedures have already been adjusted and will be reviewed again in 2027 to ensure processes are still being followed.
        2. 2026 DHCS Annual Routine Medical Survey
            - The exit conference occurred on August 25th.
            - One (1) repeat finding regarding appeals.
            - Two findings that we are pushing back on in Utilization Management and letter translation because we followed our processes.
            - Responses to the preliminary findings were submitted on September 10th.
        3. 2026 HSAG Network Adequacy Validation (NAV) and Encounter Data Validation (EDV) Audits
            - Auditors did a deep dive into encounters.
            - Additional requests were received through August 5th.
            - All documents have been sent in as of September 4th.
        4. 2026 MY24 Heath Equity Quality Performance

- Twenty benchmark measures, with twelve that were found deficient.
    - Three (3) in Utilization Management
    - One (1) in Claims
    - Two (2) in Enhanced Case Management
    - Six (6) in Grievance and Appeals
- The corrective action plan is due at the end of September.
- A deeper look at specific measurements and measures will be reviewed at the full Board of Governors meetings.
- 2027 will be the first full measurement year.

ii. Sanctions

- MCAS
    - Provider Appointment Availability Survey (PAAS) regarding Telehealth
    - DMHC concluded the Alliance did not fully follow the required PAAS methodology.
    - Because Alliance policies stated that PAAS would be conducted in accordance with the DMHC methodology, DMHC considered the deviation a violation of Plan licensing documents.
- Enforcement Matter 24-693
    - The Alliance received a sanction of $25,000 for measurement year 2021.
    - Two cases where findings were not mitigated correctly related to timely access and compliance which results in a potential for member harm.
    - Mitigation includes tracking potential quality issues (PQIs) for timely access.
    - DMHC related fines tend to occur years after the incidents, as was the case here with the incidents in 2021.
    - This is the lowest possible sanction available to the Plan.

iii. Compliance Dashboard

- Total of two hundred and sixty-three (263) findings
    - Two hundred and thirty-six (236) completed

    - Twenty-seven (27) in progress
    - 90% completion rate
- 2026 DHCS preliminary findings received
    - Ten (10) DHCS audit findings
        a. Utilization management
        b. Enhanced case management
        c. Grievance and appeals and member rights
    - Five (5) self-identified findings
    - The response to the preliminary findings has been submitted and we are awaiting the final findings, however, are not expecting any changes.
- 2025 DMHC Audit
    - Ten (10) of twenty-two (22) findings complete, and twelve (12) in progress.
    - Continuing to work with departments to mitigate the open findings.
        a. Quality Assurance
            i. Enhanced PQI workflows
        b. Grievance and Appeals
            i. Grievance reporting process implementation
            ii. Expedited grievance notification training
        c. Access and Availability
            i. Nurse line monitoring process implementation
            ii. Provider Demographic Attestation process implementation
        d. Utilization Management
            i. UM policy revisions and staff training to support timely provider notifications
            ii. Concurrent review remediation ongoing
        e. Pharmacy
            i. Criteria language for formulary exception denial letter updates ongoing

ii. Formulary updates implemented

f. Behavioral Health

i. Group Care procedures updated and training completed

- Fifty-four (54) repeat findings from 2018 – 2026
  - Twenty (20) in member rights
  - Twelve (12) in utilization management
  - Ten (10) in access and availability

iv. Anti-Fraud Activity

- Working towards risk-based, proactive fraud, waste, and abuse detection
- Case management focus on closing cases to better focus efforts potential areas where there are issues.
- In August twenty-one (21) referrals were received, nine (9) met criteria for further investigation, and the remaining twelve (12) were logged for tracking and trending.
- Continuing to work with cross-functional and domain groups to strengthen our program and enhance case detection and mitigation efforts.

v. BOG and Annual Training

- Annual Compliance training kicked off in August.
- 50% of Alliance staff have completed training so far.
- Board Compliance training has rolled out as well, with nine (9) of eighteen (18) board members, or 50%, completing training so far.
- Three more live Board training sessions are coming up in September and October for those who chose not to take the self-paced training.
- All Alliance staff and Board members are given 90 days to complete the training, with completion due in November.

vi. Compliance Committee Overview

- The committee meets quarterly to discuss compliance strategic initiatives, with the most recent meeting completed on September 8th.
- The updated charter was approved to reduce the number of committee members while still allowing the committee to be a dedicated and focused meeting.

- Updated the risk-based Internal Audit Plan, which was approved by the committee.
- Updated the Enterprise Risk Methodology, which was approved by the committee.
- Discussed the Unsatisfactory Immigration Status (UIS) transition status.
    - Compliance is leading the initiative.
    - High level deliverables include exchanging data with DHCS and communication with the provider network to help facilitate the transition in the community.
    - Developing member call scripts and member notices.
- The committee also discussed Medi-Cal and Medicare program updates, and the PBM transition.

b) Medi-Cal and Medicare Program Updates

i. Pharmacy Benefit Manager Change
- Deferred for time but will be discussed at the October Compliance Advisory Committee meeting.

ii. State Medicaid Agency Contract (SMAC)
- Deferred for time but will be discussed at the October Compliance Advisory Committee meeting.

iii. Annual CMS BID Submission
- Deferred for time but will be discussed at the October Compliance Advisory Committee meeting.

iv. CHCN Delegation
- Deferred for time but will be discussed at the October Compliance Advisory Committee meeting.

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a) None

8. STAFF UPDATES

a) None

9. UNFINISHED BUSINESS

a) None

10. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

a) None

11. ADJOURNMENT

a) With no further business, the meeting was adjourned by Dr. Kelley Meade at 11:47 a.m.

Board of Governors Meeting Minutes

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, September 11th, 2026
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

Board of Governors Present: Andrea Schwab-Galindo (Chair), Aaron Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Rebecca Gebhart, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Marcus Watkins, Natalie Williams

Board of Governors Remote: Andrea Ford, Yeon Park, Dr. Noha Aboelata

Board of Governors Excused: Jody Moore

Alliance Staff Present: Matthew Woodruff, Dr. Donna Carey, Gil Riojas, Stephen Smythe, Sasi Karaiyan, Tiffany Cheang, Beau Hennemann

Chair Andrea Schwab-Galindo called the regular Board of Governors meeting to order at 12:04 p.m.

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL

There were no modifications to the agenda.

4. INTRODUCTIONS

There were no introductions.

5. CONSENT CALENDAR

a) AUGUST 11th, 2026, FINANCE COMMTTEE MEETING MINUTES

b) AUGUST 14th, 2026, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

c) AUGUST 14th, 2026, BOARD OF GOVERNORS MEETING MINUTES

d) APPROVE RESOLUTION APPOINTING MARCUS WATKINS TO THE FINANCE COMMITTEE

e) APPROVE RESOLUTION APPOINTING MEMBER(S) TO QUALITY IMPROVEMENT HEALTH EQUITY – UTILIZATION MANAGEMENT COMMITTEE

f) 2026 SALARY SCHEDULE REVIEW

Question: Ms. Gebhart asked how salary ranges are determined and benchmarked. Mr. Woodruff explained that a salary survey is conducted every other year by an external firm and benchmarked against comparable California health plans. The survey evaluates job titles, grades, and salary ranges. He noted that the most recent update resulted in an average increase of approximately 8.3% to the salary ranges.

Question: Ms. Gebhart requested that future reports include a year-over-year comparison of salary range changes. Mr. Woodruff agreed that a year-over-year change column by grade would be included in future reports.

Question: Ms. Gebhart asked whether employee benefits, including retirement benefits, could be reviewed by the Finance Committee for greater visibility. Mr. Woodruff agreed that employee benefits could be brought to the Finance Committee for review, with timing anticipated around December due to ongoing benefit cost negotiations.

Question: Chair Schwab-Galindo asked whether salary schedules are reviewed by the Finance Committee prior to approval by the Board. Mr. Woodruff explained that salary schedules previously went directly to the full Board through the consent calendar; however, the revised process provides for Finance Committee review prior to consideration by the full Board.

Motion: A motion was made by Natalie Williams and seconded by Supervisor Lena Tam to approve the Consent Calendar.

Vote: The motion was passed unanimously.

Ayes: Aaron Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, Rebecca Gebhart, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Andrea Schwab-Galindo.

Recuse: Marcus Watkins

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

The Compliance Advisory Committee reported strong progress on training completion, with the majority of required items completed and ongoing efforts to close remaining gaps. The committee reviewed regulatory and audit activity, including the 2026 DHCS audit results with state-identified and self-identified findings currently in progress, and noted completion of the 2025 fiscal examination and DHCS survey requirements, with DMHC items still open. Overall trends showed a reduction in repeat findings and continued improvement in compliance performance. The committee also reviewed regulatory sanctions and accountability items, including managed care accountability metrics where most requirements were met without financial penalty, and discussed a historical $25,000 sanction related to 2021 telehealth data reporting issues, which remains relevant for context in ongoing compliance oversight.

b) FINANCE COMMITTEE

The Finance Committee reviewed continued membership decline, reporting a reduction of approximately 3,000 members for the month and total enrollment of about 368,000, with projections indicating further declines potentially bringing membership below 300,000 over the fiscal year. Financial performance reflected pressure on margins, including a medical loss ratio of approximately 98% and a tangible net equity decline to 284%, alongside a reported loss in group care driven by high-cost utilization in the first month under updated rates. The committee also discussed salary schedule review processes, including an approximate 8.3% increase in salary ranges based on an external survey and the establishment of an annual July review cycle, as well as questions regarding the CEO contract review timeline through the executive committee. Additional discussion included rising pharmacy costs driven by physician-administered specialty drugs, a $2.3 million investment gain, strong liquidity with approximately $541 million in cash, and a generally break-even position on MCO tax impacts.

7. CEO UPDATE

The CEO update highlighted a $5 million net loss for the month of July, consistent with budget expectations, alongside continued enrollment decline trends that are beginning to moderate slightly over recent months. Key operational and environmental risks were discussed, including anticipated 20–30% reductions in Enhanced Care Management rates, uncertainty regarding community supports participation among health plans statewide, and the expected departure of approximately 60,000 undocumented members into fee-for-service Medi-Cal beginning in January, all of which are incorporated into current financial planning. The update also emphasized ongoing operational mitigation strategies, including expanded outreach initiatives, partnerships with county and provider partners, and the development of an AI-supported tool to improve redeterminations, gap closure, and member engagement.

The Board reviewed and evaluated the written Grievance and Appeals Report and Summary Log for August 2026, covering all lines of business – Medi-Cal, IHSS, and D-SNP. Management presented detailed written records of grievance and appeal volumes, categories, resolution outcomes, and regulatory timeliness metrics. The Board thoroughly discussed the trends, formally accepted the written record, and acknowledged receipt and review of the report and management’s ongoing monitoring of grievance and appeal performance.

Question: Ms. Peterson asked when clarity will be available regarding the new governor's stance and policy direction. Mr. Woodruff indicated formal clarity will likely come later in the budget cycle, but informal signals may emerge earlier through ongoing state discussions.

Question: Dr. Aboelata asked about the upcoming ECM changes, including whether eligibility criteria would be tightened and how the new payment structure would account for increased service intensity. Mr. Woodruff explained that the model is shifting toward fewer members receiving more intensive, in-person services with more frequent contact, and that payment will shift from flat monthly payments to a touch-based model. He noted that reimbursement may increase depending on service frequency. Gil added that overall costs are expected to remain similar or increase slightly depending on utilization.

Question: Dr. Ferguson asked for clarification regarding the approximately 60,000 members leaving the plan, the impact on projections and what actions are being taken to address membership decline and related financial and sustainability risks. Mr. Woodruff explained that these members are transitioning to fee-for-service Medi-Cal and are already reflected in budget assumptions, with overall membership expected to decline below 300,000. He noted that physician-administered drug costs are a key driver of current losses and that utilization trends, membership changes, and enrollment patterns will continue to be monitored.

8. BOARD BUSINESS

a) REVIEW AND APPROVE JULY 2026 MONTHLY FINANCIAL STATEMENTS

JULY 2026 Financial Statement Summary

Enrollment:

Total enrollment decreased by 2,999 members since June 2026.

Net Income:

For the month ended and fiscal YTD ended July 31st, 2026, the Alliance reported a Net Loss of $5.2 million (versus budgeted Net Loss of $5.2 million).

Premium Revenue:

For the month ended and fiscal YTD July 31st, 2026, actual Revenue was $180.0 million vs. our budgeted amount of $179.5 million.

Medical Expense:

Actual Medical Expenses for the month and fiscal YTD were $176.4 million, vs. budgeted amount of $175.3 million.

Medical Loss Ratio:

Our MLR ratio for this month and fiscal YTD was reported as 98.0%.

Administrative Expense:

Actual Administrative Expenses for the month and fiscal YTD ending July 31st, 2026, were $11.1 million vs. our budgeted amount of $11.8 million. Our Administrative Loss Ratio (ALR) is 6.2% of our Revenue for the month, and fiscal year-to-date.

Other Income / (Expense):

For fiscal year-to-date, our YTD interest income from investments show a gain of $2.3 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending July 31st, 2026, we reported $60.6 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $60.1 million. Our MCO Tax Expense was $60.6 million vs. budgeted MCO Tax Expense of $60.1 million.

Tangible Net Equity (TNE):

For July, the DMHC requires that we have $79.9 million in TNE, and we reported $226.5 million, leaving an excess of $146.6 million. As a percentage we are at 284%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $540.9 million in cash; $558.5 million is uncommitted. Our current ratio is above the minimum required at 1.16 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired $135,000 in Capital Assets year-to-date. Our annual capital budget is $1.3 million.

Motion: A motion was made by Natalie Williams and seconded by James Jackson to approve the July 2026 Monthly Financial Statements.

Vote: The motion was passed unanimously.

Ayes: Aaron Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, Rebecca Gebhart, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam, Marcus Watkins, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Andrea Schwab-Galindo.

No opposition or abstentions.

b) HEALTH CARE SERVICES: PROGRAM DATA UPDATE

Dr. Carey presented the Healthcare Services Program Data Update, providing an overview of outcomes and performance across care management, transitional care, Enhanced Care Management (ECM), population health initiatives, Community Health Worker (CHW) outreach, doula services, and inpatient utilization. Dr. Carey highlighted improvements in health risk assessment completion and several clinical measures, discussed ECM enrollment and member engagement, and reviewed outcomes associated with doula services and inpatient utilization initiatives.

Question: Dr. Lynch asked whether the Alliance can track emergency room and hospital utilization outcomes for ECM members at the member level. Dr. Carey explained that this information is not yet fully available. Claims and ECM enrollment data are available; however, dashboards linking the data are still being developed due to prior data accuracy issues.

Question: Ms. Gebhart asked how health risk assessment (HRAs) completion relates to STARS performance. Dr. Carey explained that HRAs are foundational to identifying member needs and help drive interventions related to STARS performance, although the relationship to STARS is indirect. Ms. Cheang added that HRA is currently a STARS measure but is expected to be retired in a future cycle.

Question: Ms. Schwab-Galindo asked how member outreach is conducted and whether methods other than telephone calls are used. Dr. Carey explained that outreach is primarily conducted by telephone and is supplemented by provider gap-in-care lists and coordination with primary care providers.

Informational Item only.

c) ANALYTICS: HEDIS/STARS UPDATE

Ms. Cheang provided an overview of HEDIS, STARS, MCAS, and DMHC quality measurement and regulatory requirements. She reported that MCAS performance improved from 83% to 94%, with most measures meeting required thresholds, and discussed expanded DMHC reporting requirements and related performance improvement efforts. Ms. Cheang also reviewed the Alliance's STARS performance, including its current 3.5-star rating, measures not meeting minimum performance thresholds, and upcoming changes to STARS measures. She highlighted ongoing efforts to improve clinical outcomes, provider and member engagement, data quality, and member experience.

Question: Chair Schwab-Galindo asked about the weighting of clinical outcomes versus member experience measures in STARS. Ms. Cheang explained that weighting varies by measure and that member experience measures generally carry greater weight, although clinical/HEDIS measures make up a larger number of the overall measures.

Question: Chair Schwab-Galindo asked what contributed to the improvement in MCAS performance from 83% to 94%. Ms. Cheang explained that the improvement resulted primarily from addressing previously missed measures, including diabetes, and from updated data, including corrected topical fluoride files.

Question: Dr. Meade asked whether the corrected dental data files may have been adjusted for patient age or other factors. Ms. Cheang stated that the specific reason for the correction was not provided by the State; however, rates changed significantly after the updated files were loaded.

Question: Dr. Lynch asked why the hypertension measure was still not met and what was being done to address it. Ms. Cheang and staff explained that the measure was missed by a small margin of approximately nine members and would be reviewed further, with a focus on disparities and improvement opportunities.

Question: Dr. Ferguson asked how grievances and appeals affect STARS performance. Ms. Cheang and Mr. Woodruff explained that grievances are reviewed and analyzed by the STARS workgroup to identify trends and improvement opportunities, and that member satisfaction and grievance patterns can affect STARS performance.

Question: Ms. Williams asked why the asthma medication-related measure was removed from HEQMS. Ms. Cheang explained that NCQA removed the measure due to concerns regarding its validity and that a replacement asthma-related measure is being developed.

Informational Item only.

9. STAFF UPDATES

There were no staff updates.

10. UNFINISHED BUSINESS

None.

11. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

12. PUBLIC COMMENT (NON-AGENDA ITEMS)

None.

13. ADJOURNMENT

Chair Schwab-Galindo adjourned the meeting at 2:04 p.m.

CEO Update

Matthew Woodruff

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

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

Date: **October 9th, 2026**

Subject: **CEO Report**

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

	August	YTD
Medi-Cal	($9.6M)	($11.0M)
Group Care	$251K	($2.7M)
Medicare	($864K)	($1.7M)
Total	($10.2M)	($15.4M)

  - **Revenue was $181.9 million in August and $361.9 million Year-to-Date (YTD)**.
    - Medical expenses were $184.0 million in August and $360.4 million for the fiscal year-to-date; the medical loss ratio is 101.1% for the month and 99.6% for the fiscal year-to-date.
    - Administrative expenses were $10.3 million in August and $21.3 million for the fiscal year-to-date; the administrative loss ratio is 5.6% for the month and 5.9% for the fiscal year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 268% of the required DMHC minimum, representing $135.6 million in excess TNE.
  - **Total enrollment in August was 366,605**, decreased by 570 Medi-Cal members compared to July 2026.

- **Alliance Compliance Update**
  - 2026 Rates should be out by the end of October
  - Do we want to have a November Finance Committee Meeting
  - August results:
    - PAD
    - Potential areas to review – Transportation, ECM, CS
  - UIS Transition – what has the Alliance accomplished

- **Key Performance Indicators – Grievances and Appeals:**
    - **Regulatory Metrics:**
        - Standard grievances were resolved within the goal of 95% of regulatory timeframes.
        - Expedited grievance cases were resolved within the 95% of regulatory timeframes (at 100%). Exempt grievances were resolved within the goal of 95% of regulatory timeframes at 100%.
        - Standard appeal cases were resolved within 95% of regulatory timeframes, and expedited appeal cases were resolved at 100% of regulatory timeframes.
        - There was a total of 1,866 unique grievance cases resolved during the reporting period, with a total of 2,443 grievances including 577 shadow cases. Out of 2,443 cases, 37% were related to Access to Care, 35% were related to Quality of Service, 18% were related to Coverage Dispute, 7% were related to "other" (enrollment and eligibility) and 3% were related to Quality of Care.
        - For the month of September 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.
- **Grievances – D-SNP:**
    - For the D-SNP line of business, there were 122 standard grievances resolved within the regulatory timeframe goal of 95% with a 100% compliance rate. First Call Resolution cases were resolved within the goal of 95% with a 100% compliance rate. There were no standard appeal cases within the regulatory timeframe. There were no expedited grievance cases or expedited appeal cases reported for D-SNP in the month of September 2026.
- **Legislative Updates:**
    - See Attachment
- **IT Workflow Automation – Next Quarterly Update December 2026**
- **Alliance in the Community**
    - **Community Engagement**: During the first quarter of fiscal year 2026-2027, Alliance staff have participated in 36 out of 44 invited community events, including major Bay Area and countywide gatherings. These include but are not limited to:
        - 2026 LifeSTEPS Spring Health Fair

- 2026 Alameda County Fair
- Oakland Unified School District (OUSD) Resource Fair
- The Eunice Law Annual Backpack Distribution, Resource Fair, and Car Show
- True Vine Ministries Back to School Event
- Piedmont Apartment National Night Out
- 4Cs Monthly Food Distribution
- Alameda County WIC World Breast Feeding Celebration
- Davis Street Annual Community Outreach and Resource Fair
- Hayward Unified School District (HUSD) Back to School Backpack Giveaway
- Allen Temple Baptist Church 46th Annual Holistic Health Fair
- Alameda County Behavioral Health's Office of Family Empowerment, Family Network Launch Event
- Alameda County Child Support Services Family Resource Fair
- 2026 Oakland Pride Festival
- 2026 Acts Full Gospel Church Health Fair
- 2026 Oakland Chinatown Chamber of Commerce (OCCC) 37th Oakland Chinatown StreetFest
- Laney College Welcome Back Week Resource Fair
- Tiburcio Vasquez Health Center Family Health Fiesta
- 2026 Building Opportunities for Self-Sufficiency (BOSS) Black August
- Asian Health Services (AHS) Wilma Chan Park Food Distribution
- 2026 Regional Center of the East Bay (RCEB) Community Based Organization Fair
- 2026 54th Annual Castro Valley Fall Festival
- Union City 5th Annual Polly's Heart Health Fair
- 2026 Kingdom Builders Christian Fellowship Community Health & Wellness Fair
- Alliance Community Advisory Committee Coffee & Conversation at St. Jarlath Catholic Church
- Glad Tidings International Church South Hayward Community Love Thy Neighbor Celebrations
- 2026 United Seniors of Oakland and Alameda County (USOAC) Healthy Living Festival
- 2026 Union City Family Center (UCFC) Toddler to Career Resource Fair
- Elder Justice Symposium
- Family Resource Center UTSAV South Asian Family Conference
- Friends of Children with Special Needs (FCFN) 5th Annual Disability Resource Fair
- City of Berkely Senior Wellness Fair

- **Community Relations Reinvestment Sponsorships**: The Alliance continues its community reinvestment sponsorships. These efforts through October include but are not limited to:

  - 2026 Sinkler Miller Medical Association (SMMA) 43rd Annual Scholarship gala

- 52nd Asian Health Services (AHS) Gala
- Culinary Angeles 10 Year Anniversary
- Physicians Medical Forum Doctors on Board Program
- Latino Coalition for a Healthy California (LCHC)
- Fremont Firefighters East Bay Innovations Crafts Fair Celebration

- **Looking Ahead**: Through November 2026, Alliance aims to participate in approximately 22 additional community engagement events and three community relations events. Notable upcoming activities include but are not limited to:

  - 2026 Alameda Contra Costa Medical Association (ACCMA) Annual Meeting
  - 2026 Roots Community Health Heal the Healer
  - Senior Services Coalition (SSC) Annual Make the Difference Conference

  The October BOG updates continue to highlight the Alliance's ongoing commitment, with new partnerships and expanded community engagement efforts scheduled for the coming months.

- **Medicare Overview**
  - **D-SNP Program Successfully Positioned for 2027 Annual Enrollment Period (AEP)**
    - Completed operational, benefit, vendor, and marketing readiness activities supporting the October 1st marketing launch and October 15th AEP start.
    - Finalized member-facing materials, FAQs, provider directory submissions, and Medicare Plan Finder (MPF) readiness across key supplemental benefit partners.

  - **Strategic Investments Strengthening Medicare Operations Infrastructure**
    - Implementation is on track for the new Pharmacy Benefit Manager (PBM), MedImpact, to support long-term operational efficiency and member experience.
    - Advanced CY2027 Online Enrollment Center (OEC) readiness, including enrollment workflow validation, integration activities, exception monitoring, and downstream processing controls.
    - Progressed technology enhancements supporting enrollment, retention, reporting, and sales operations.

  - **Expansion of Medicare Sales and Community Engagement Capacity**
    - Added two (2) Medicare Field Sales & Community Agents in September and secured approval for three (3) additional positions to support growth objectives.

- Approved eight (8) temporary positions to support Annual Enrollment Period (AEP) and Open Enrollment Period (OEP) activities.
- Expanded field-based outreach capabilities through enhanced onboarding, training, interpreter services, operational readiness planning, and health center engagement activities.

- **Strengthened Provider and Community Partnerships Through Second Annual D-SNP Town Hall**
  - Successfully hosted the Alliance's Second Annual D-SNP Town Hall on 9/24/2026, bringing together providers, community organizations, and healthcare leaders.
  - Highlighted D-SNP program achievements, care management initiatives, quality improvement efforts, member support programs, and future program enhancements.
  - Reinforced the Alliance's commitment to collaborative partnerships that improve health outcomes for Medicare and D-SNP members.

- **Medicare Growth Strategy and Member Experience Initiatives Advancing**
  - Continued phased member acquisition campaign in partnership with Anderson Marketing in preparation for AEP and year-end growth goals.
  - Completed enhancements to enrollment kits, onboarding materials, and member communications to improve the enrollment experience and support regulatory compliance.
  - Prepared launch of the centralized D-SNP website and updated digital resources to improve beneficiary access to information and enrollment support.

- **Delegation and Enterprise Readiness Efforts Continue to Progress**
  - Advanced the CHCN delegation initiative with project charter approval and ongoing development of delegation agreements and financial responsibility structures.
  - Continued enterprise-wide readiness activities supporting Medicare growth, operational sustainability, provider integration, and workforce development.
  - Initiated organizational training planning and learning infrastructure enhancements to support long-term Medicare program success.



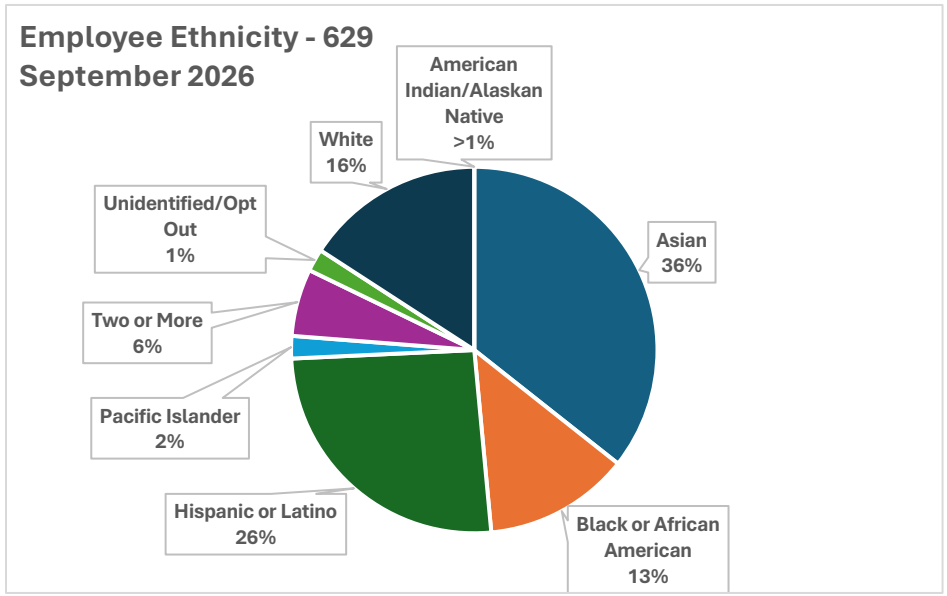
Demographics

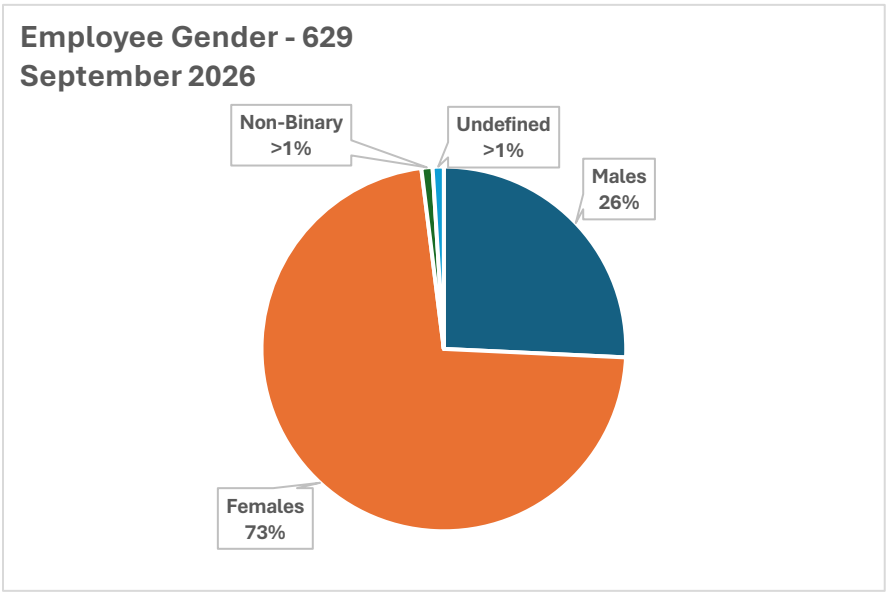
This report provides a comparative analysis of the demographic composition of Alameda Alliance for Health's workforce in relation to the population profile of Alameda County. The evaluation focuses on key demographic indicators, including race/ethnicity, gender, and age distribution. The objective is 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.

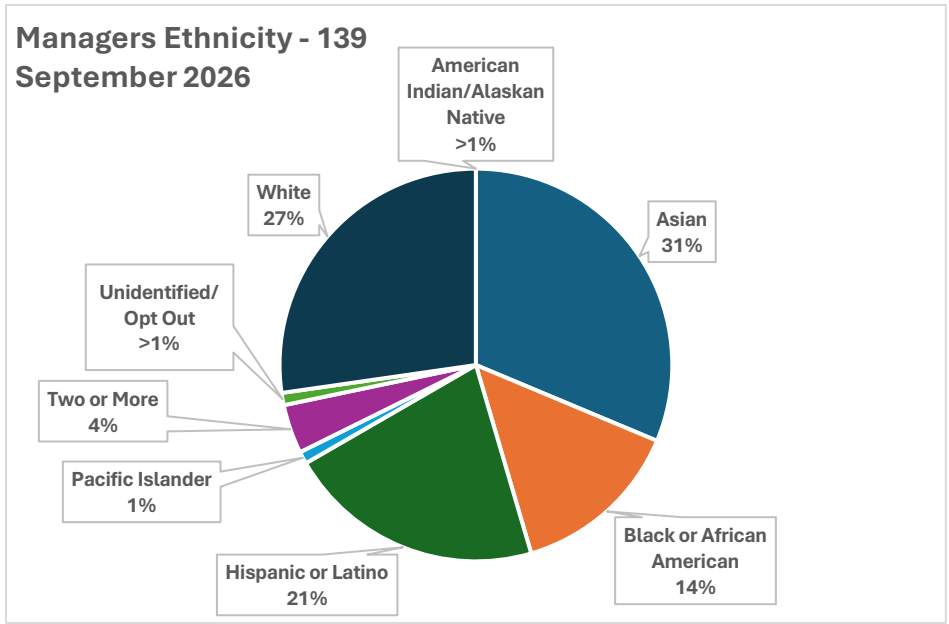
The demographic data for Alameda County, including total population figures and detailed demographic breakdowns, is sourced from Healthy Alameda County, a centralized data repository of information related to Alameda County, sponsored by the Alameda County Public Health Department. This platform provides 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 August 2026 and is collected and maintained internally, monthly, by the Human Resources Department.

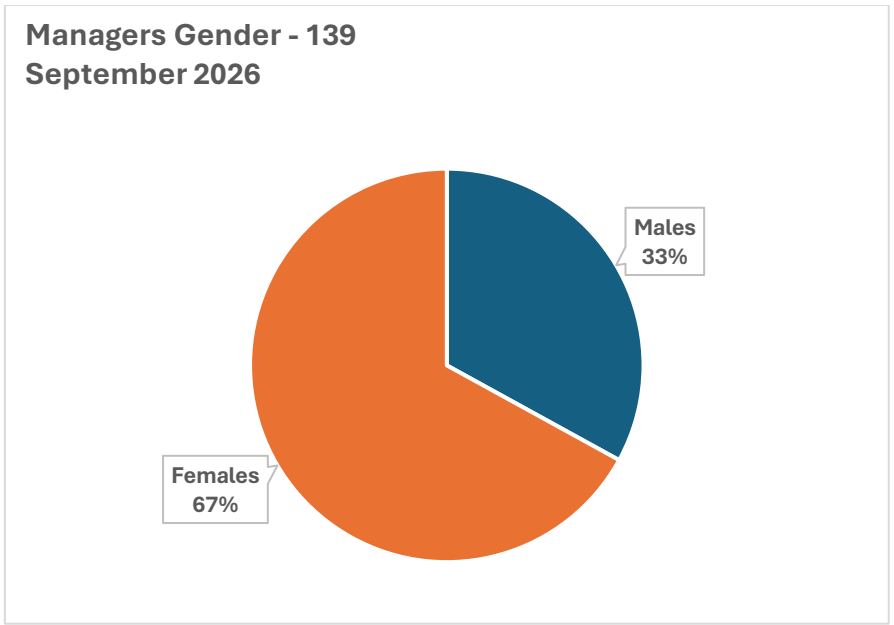
Category	**Alameda Alliance for Health** (Workforce information last updated September 2026)	**Alameda County** (Population information last updated in May 2026)
Population/Total Employees	629	1,647,132
Race & Ethnicity		
Asian	36%	35.62%
Hispanic	26%	23.53%
White	16%	24.90%
Black/African American	13%	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	73%	50.43%
Non-Binary	>1%	-
Undefined	>1%	-
Age Distribution		
Under 25	>1%	8.29%
25-34	17%	13.55%
35-44	38%	16.25%
45-54	29%	13.64%
55-Older	17%	29.35%

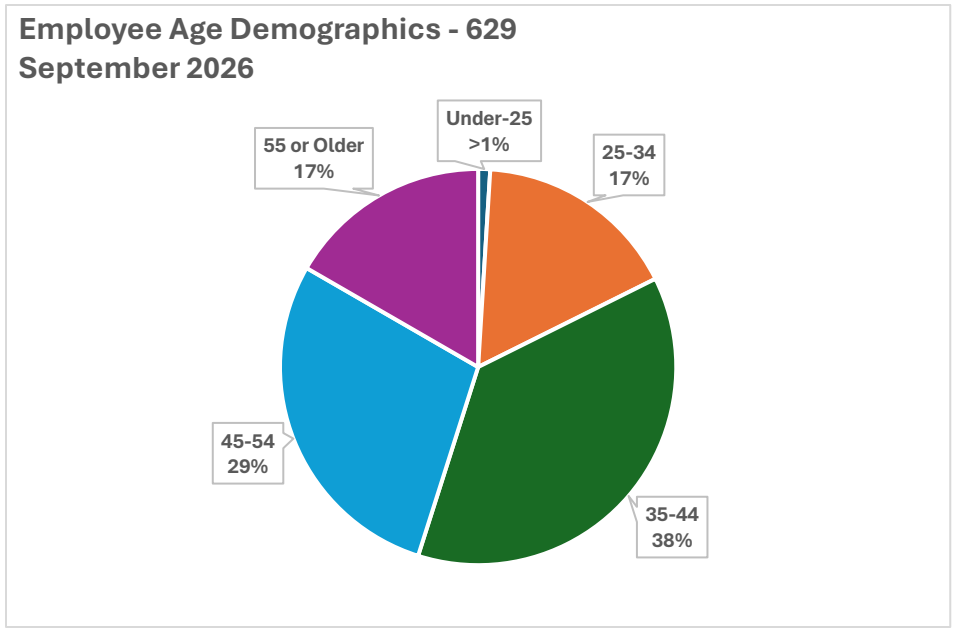
AAH Employee Demographics Data Report September 2026










Employee Age Demographics - 629
September 2026
Under-25
>1%
25-34
17%
55 or Older
17%
45-54
29%
35-44
38%



Legislative Tracking

October 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 September 3rd, CMS released additional guidance on the medical frailty exemption included in the community engagement/work requirements that will be required as part of H.R. 1 and will go into effect on January 1, 2027. The medical frailty exclusion was outlined in CMS' recent interim final rule and is defined 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 additional guidance from CMS on Medical Frailty outlines that:

- Using a list of conditions, States must confirm that individual's ability to comply is significantly impaired.
- If there is insufficient data or no data to assess medical frailty, a manual individualized review process necessitating additional documentation would be deployed.

We are awaiting additional communication from DHCS on whether the CMS guidance is aligned with the States work that is underway and any information on impacts to health plans.

On September 3, The House Democratic Doctors Caucus wrote to CMS Administrator Mehmet Oz regarding the medical frailty exemption – asking him to reserve course on the policy and stating that it will put the health of patients with the most complex medical conditions at risk and expressing concerns over the additional administrative burden it will place on providers.

The House decided to adjourn early, and September 16 was their last day in the chamber until after Election Day, giving lawmakers an opportunity to focus on campaigning in their districts. The Senate left town on the last day of September after weeks of unsuccessful efforts to vote on legislation they viewed would help vulnerable Republicans ahead of the election, including a bipartisan bill aimed at addressing concerns about data center energy costs. The House and Senate will be back on November 9th.

This summer, the Alliance submitted a Letter of Interest to the California Health Care Foundation (CHCF) and last month, we were selected among 20 regions to work to collaboratively address H.R. 1 and other Medi-Cal changes impacting enrollment, retention, and uninsured care through the Medi-Cal Regional Exchange for Access, Coverage, and Health (Medi-Cal REACH). The

Alliance will receive a grant of $85,000 to support local convenings and activities and will use these additional resources to continue the H.R. 1 safety net coordination work that we started last fall.

State Legislative Update

California's 2025-26 legislative cycle ended on September 30, 2026. Over the two-year 2025-26 regular session, there were over 4,000 proposed bills. In 2026, Governor Newsom signed approximately 1,040 bills and vetoed 120 which results in a 10 percent veto rate.

Budget Bill Junior (AB 113/SB 113), chaptered on September 18, 2026, addresses the transition of members with unsatisfactory immigration status (UIS) from Medi-Cal managed care to the fee-for-service (FFS) delivery system. AB 113 outlines how the $31 million funds appropriated in the finalized 2026-27 state budget will support UIS care and specifies how funding will provide navigation services, language access capabilities, integrated care planning, Member outreach, and coordination with FFS providers.

Passage of this bill ensures that the state cannot make overpayment-related recoveries from Medi-Cal managed care plans nor can managed care plans engage in overpayment retrievals from provider entities that meet the federal definition of a "prohibited entity," in relation to such payments. This protection is important as it reduces potential financial and administrative disruptions for managed care plans and helps support continuity of care during the transition to FFS.

On October 1, 2026, DHCS kickstarted a text message campaign to alert UIS Members that they will move into FFS on January 1, 2027, and to reassure Members that they will not lose Medi-Cal. DHCS is distributing two test versions to compare the effectiveness of both messages and ensure the clearest Member communication.

The Alliance is engaging in a multi-faceted approach to support the UIS transition. These efforts include developing internal resources and FAQs to assist our Member Services team and address anticipated questions from UIS Members as well as conducting a provider survey to identify and respond to concerns regarding the FFS delivery system and enrollment limitations. The Alliance is also implementing DHCS policy guide requirements and collaborating with sister plans to promote a smooth transition, support UIS Members, and preserve continuity of care for the most vulnerable.

California voters will decide who the next state Governor will be on November 3, 2026. In mid-September 2026, the Public Policy Institute of California released a poll that shows Xavier Becerra (D) leading Steve Hilton (R) by a wide margin (60% to 38%). Notably, the poll also indicates that support around Proposition 40 or the one-time wealth tax on state residents with a net worth exceeding $1 billion is highly divisive. According to the survey, approximately fifty-two percent of California voters would vote yes on Proposition 40.

There are currently 14 ballot measures that have qualified for the November 3 election, which include:

- Proposition 1: Authorizes Bonds for Housing Affordability Programs. Legislative Statute.
- Proposition 2: Increases State's Rainy-Day Fund. Legislative Constitutional Amendment.
- Proposition 3: Provides Permanent Funding for Schools and Health Care by Extending Existing Tax on High Incomes. Initiative Constitutional Amendment.
- Proposition 4: Repeals Prohibition Against Public Funding of Election Campaigns. Legislative Statute.
- Proposition 5: Changes to Recall Election Process for Statewide Officers. Legislative Constitutional Amendment.
- Proposition 37: Creates Loan Program for Middle-Income Buyers of Qualified New Homes. Initiative Statute.
- Proposition 38: Authorizes Bonds for Immunology Medical Research. Initiative Statute.
- Proposition 39: Prohibits Citizens from Voting Unless They Present Government-Issued Identification. Initiative Constitutional Amendment.
- Proposition 40: Imposes One-Time Tax on Certain Taxpayers. Initiative Constitutional Amendment and Statute.
- Proposition 41: Prohibits New State Taxes That Exclude Revenues from State Spending Limit. Requires Audits for New State Special Taxes. Initiative Constitutional Amendment.
- Proposition 42: Prohibits New State Personal Property Taxes and Certain Retroactive State Taxes. Initiative Constitutional Amendment.
- Proposition 43: Limits Voters' Ability to Raise Revenues for Local Government Services. Legislative Constitutional Amendment.
- Proposition 44: Requires Community Health Clinics Spend 90% Of Revenue on Program Services. Initiative Statute.
- Proposition 45: Modifies Environmental Review for Certain Projects. Initiative Statute.

Our team will continue to track the Governor's race and key ballot measures as well as attend relevant stakeholder meetings to ensure alignment with legislative and/or regulatory changes.

Priority Bill List

California's 2026-27 legislative cycle has ended. Since the beginning of the legislative season, our team tracked over 90 proposed bills and of those, only 20 bills were signed into law. Our legislative team will provide an in-depth summary of notable passed bills and anticipated plan impacts in next month's packet.

Bills Signed into Law			
Measure	***Author***	***Topic***	***Summary***
AB 280	Aguiar-Curry	Health Care Coverage:	This bill would require the Department of Managed Health Care to select a central utility and develop uniform provider directory standards requiring a

		Provider Directories	health care service plan to use the designated central utility to collect, manage, and verify the consistency and completeness of their provider directories. The bill would also require health insurers to use the designated central utility and follow the uniform provider directory standards. The bill would require plans and health insurers to submit their provider directories to the central utility for analysis, and would require the central utility to create a consistency report for each directory.
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.
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 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 related to health care service plans would be a crime, this bill would impose a state-mandated local program.
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 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 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 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 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 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 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 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 this 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 the legislative committee's 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 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 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.
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.
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: Antiretroviral Drugs, Drug	This bill would prohibit a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs, drug devices, or drug products that are medically

		Devices, and Drug Products	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 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 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.
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
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.
Bills Vetoed by Governor			
AB 539	Schiavo	Health Care Coverage: Prior Authorizations	This bill would require an approved prior authorization for a health care service requested by an in-network provider to remain valid for at least one year from the date of approval, or the period requested by the treating provider if less than one year. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.
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 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 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 form 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.
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 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 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.



Executive Dashboard

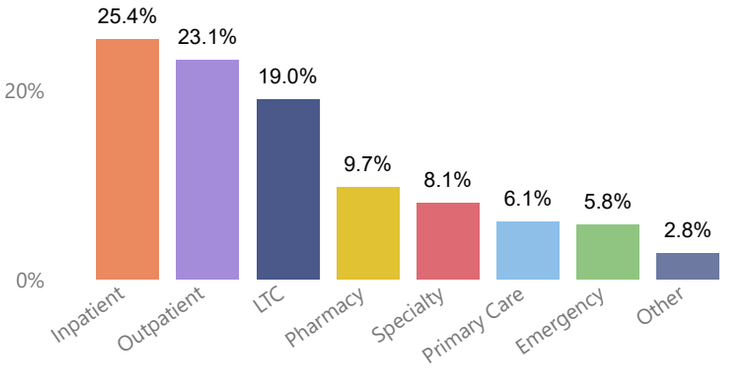
Financials

Income & Expenses

	AUGUST 2026	FISCAL YTD
REVENUE	$ 242.7 M	$ 483.3 M
MEDICAL EXPENSE	$ (184.0) M	$ (360.4) M
ADMIN EXPENSE	$ (10.3) M	$ (21.3) M
OTHER/TAX	$ (58.7) M	$ (117.0) M
NET INCOME	$ (10.2) M	$ (15.4) M

Medical Loss % (Fiscal YTD)
99.6%

Medical Expenses

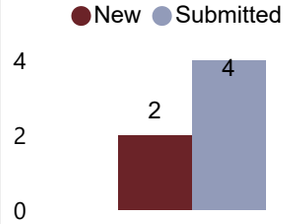


Liquid Reserves

TNE %
267.9%

TNE $
$216.3M

Reinsurance Cases



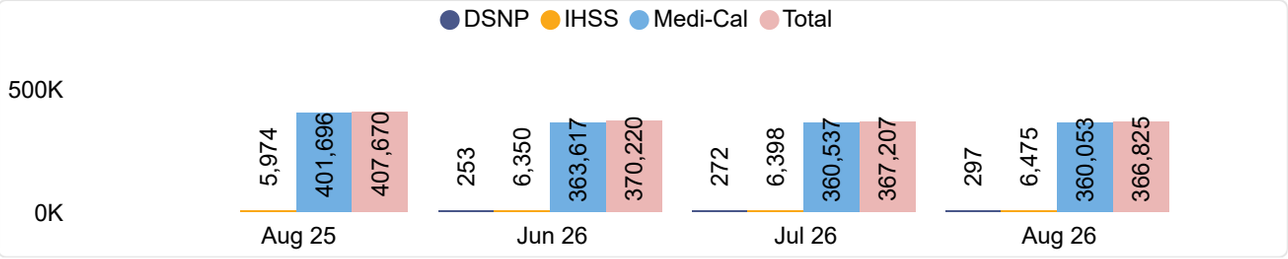
Balance Sheet

Cash Equivalents	$605.4M
Pass-Through Liabilities	$559.0M
Uncommitted Cash	$46.4M
Working Capital	$166.3M

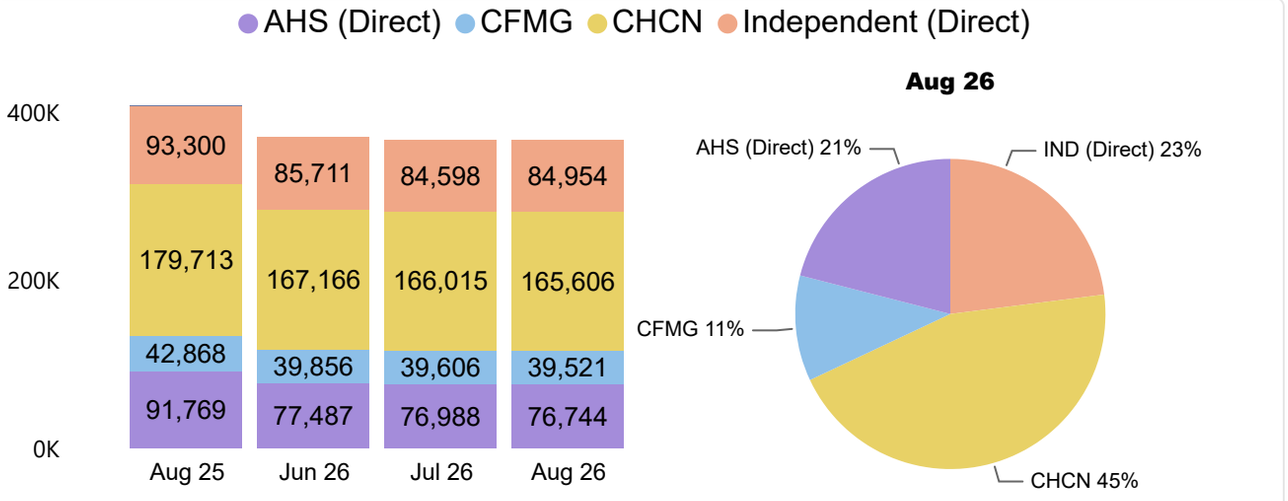
Current Ratio
1.14

Membership

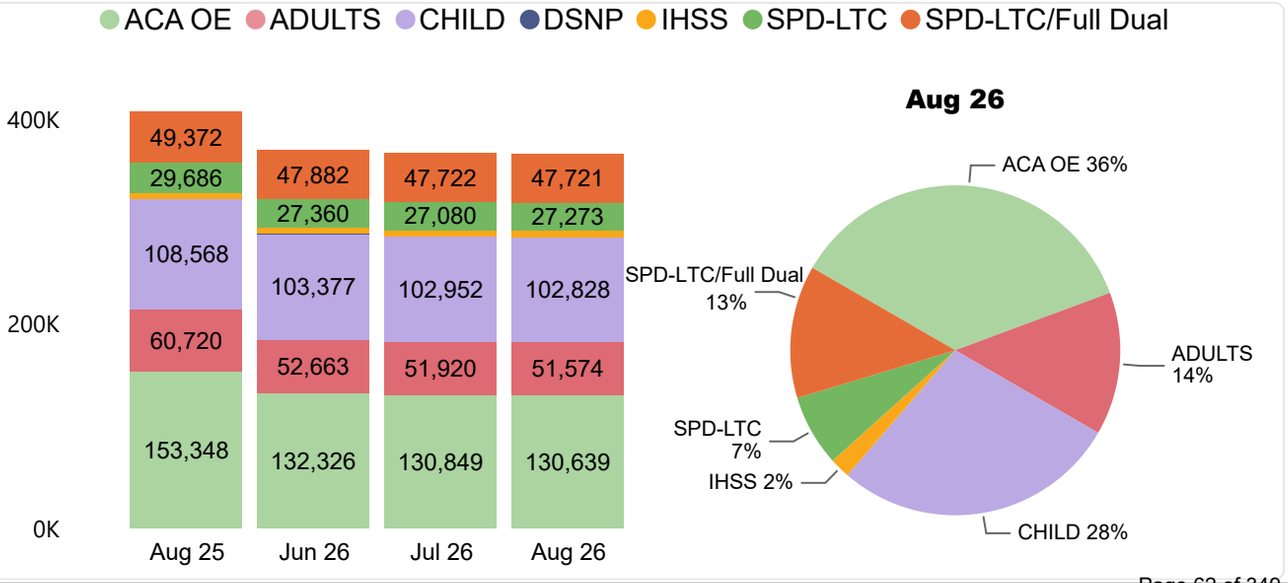
By Plan



By Network



By Category



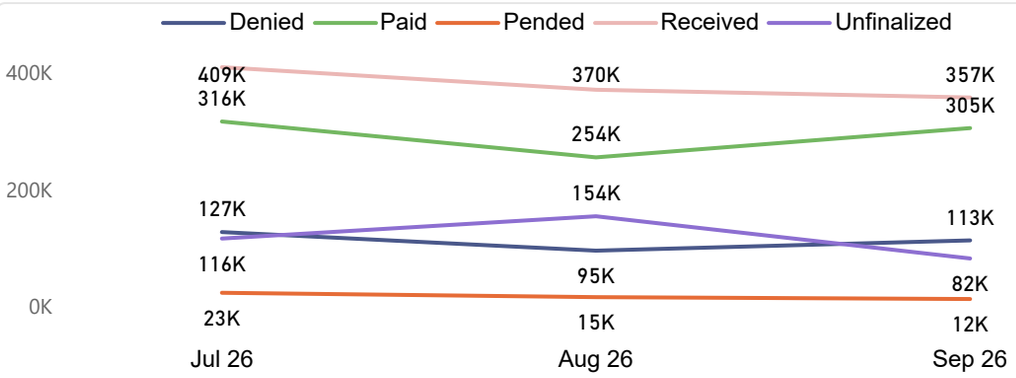
OPERATIONS DASHBOARD

OCTOBER 2026

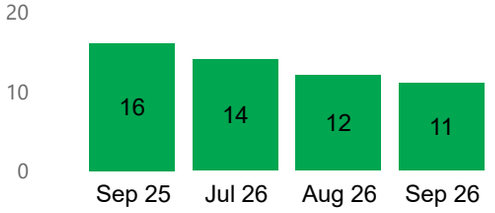
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Claims

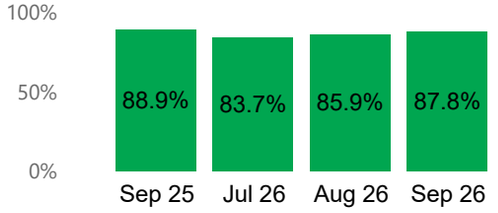
Claims Processing



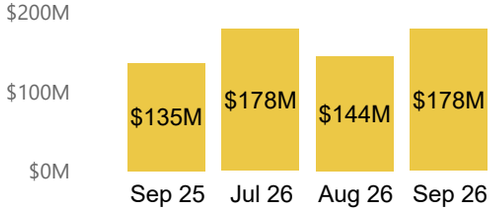
Average Payment TAT (Days)



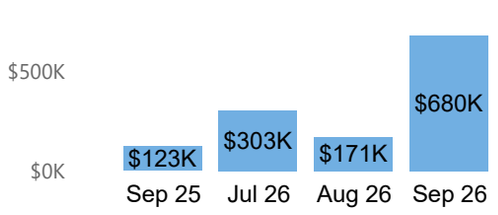
Auto Adjudication Rate (%)



Claims Paid ($)

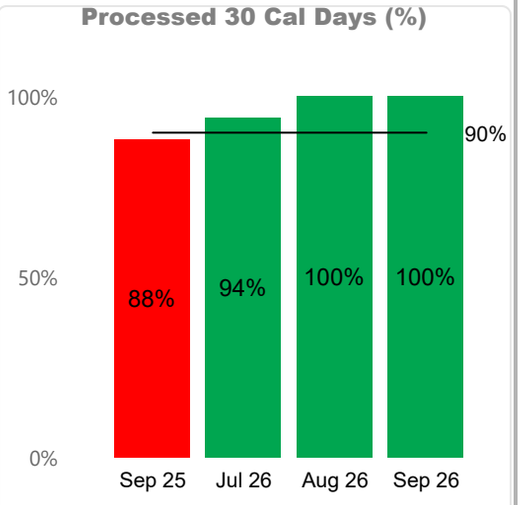


Interest Paid ($)

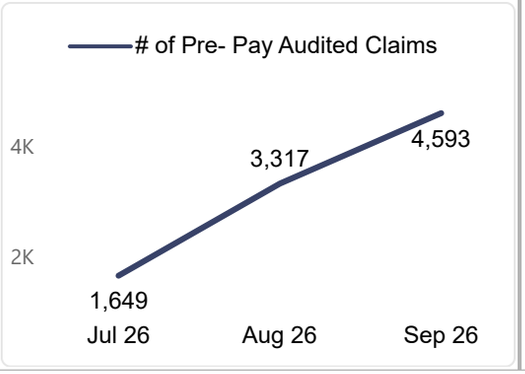


Claims Compliance

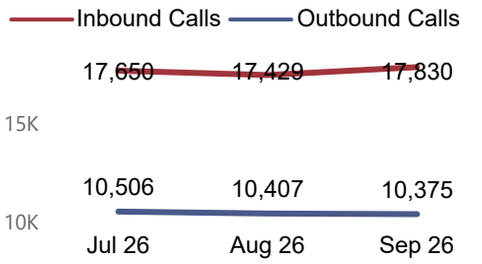
Processed 30 Cal Days (%)



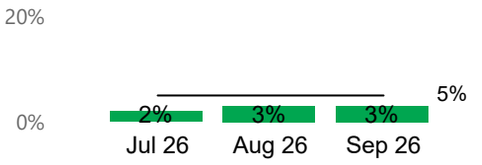
Claims Auditing



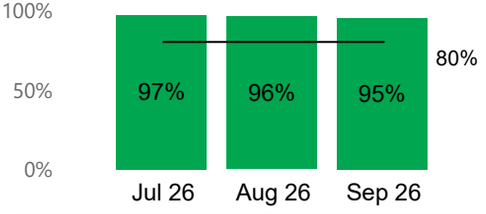
Member Services



Abandoned Call Rate (%)

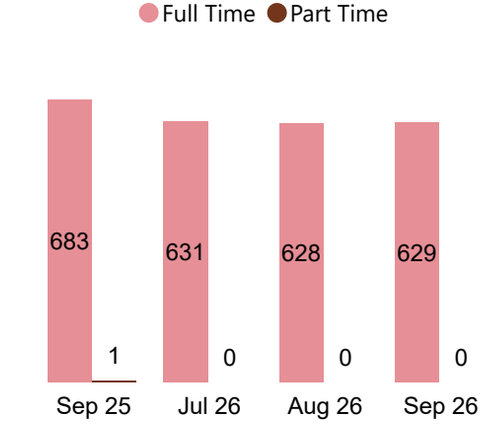


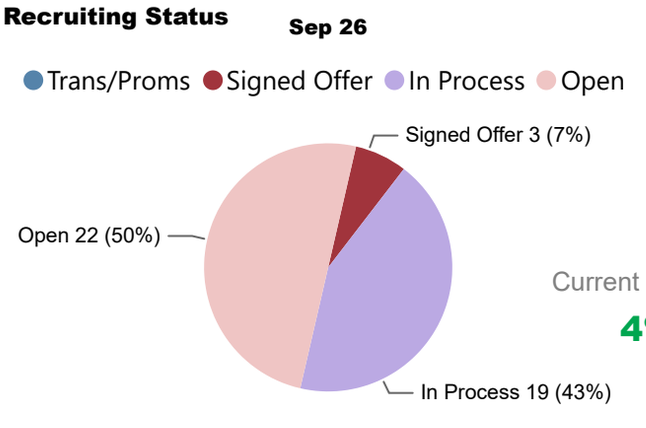
Calls Answered in 30 Seconds (%)



Average Call Times	Jul 26	Aug 26	Sep 26
Wait Time	00:07	00:09	00:09
Call Duration	07:31	07:26	07:18

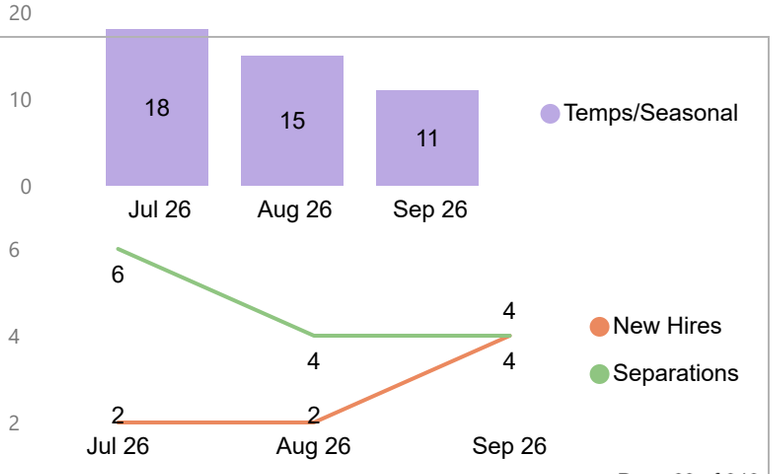
Human Resources





Current Vacancy

4%



Provider Services

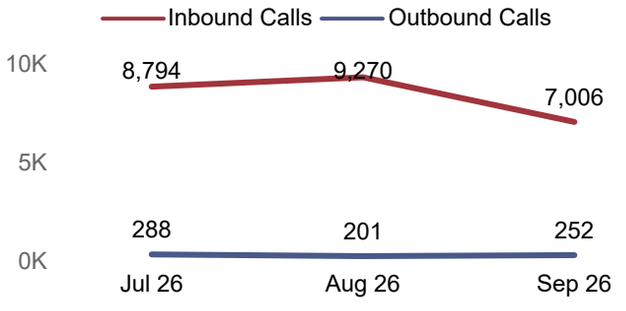
Provider Network

Hospital	17
Specialist	12,709
Primary Care Physician	726
Skilled Nursing Facility	106
Urgent Care	12
Health Centers (FQHCs and Non-FQHCs)	86
TOTAL	**13,656**

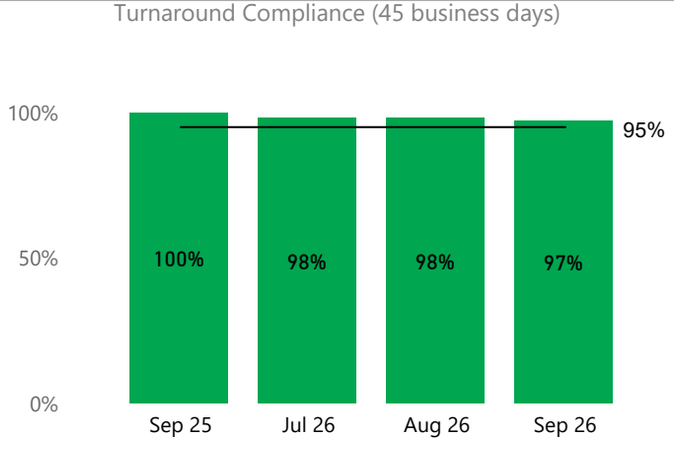
Provider Credentialing

6,232

Provider Call Center

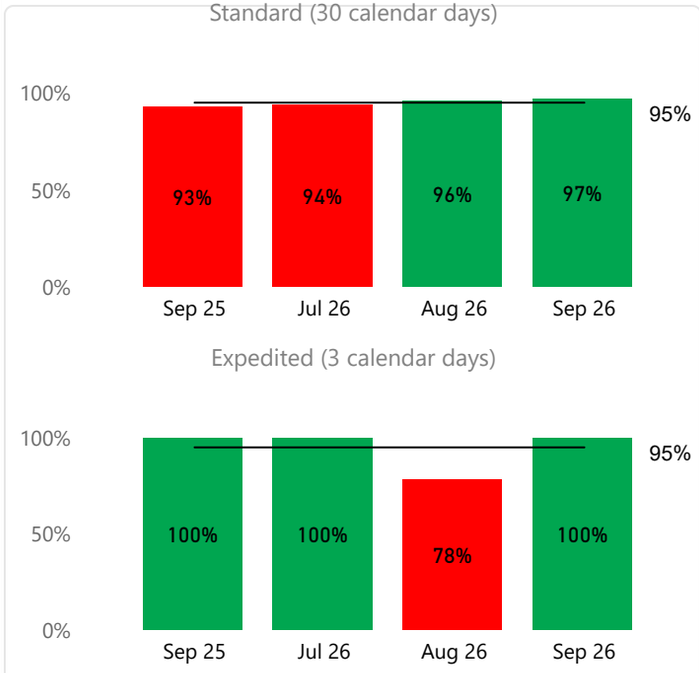


Provider Disputes & Resolutions

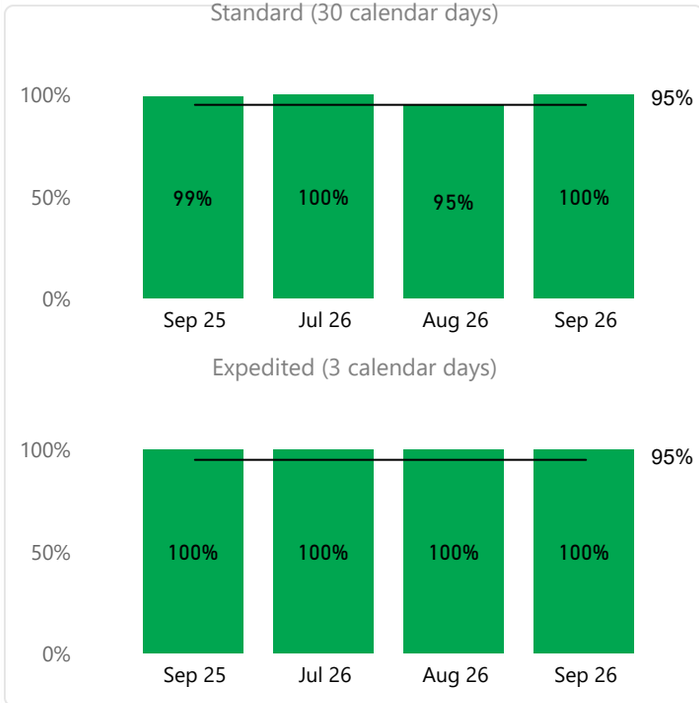


Compliance

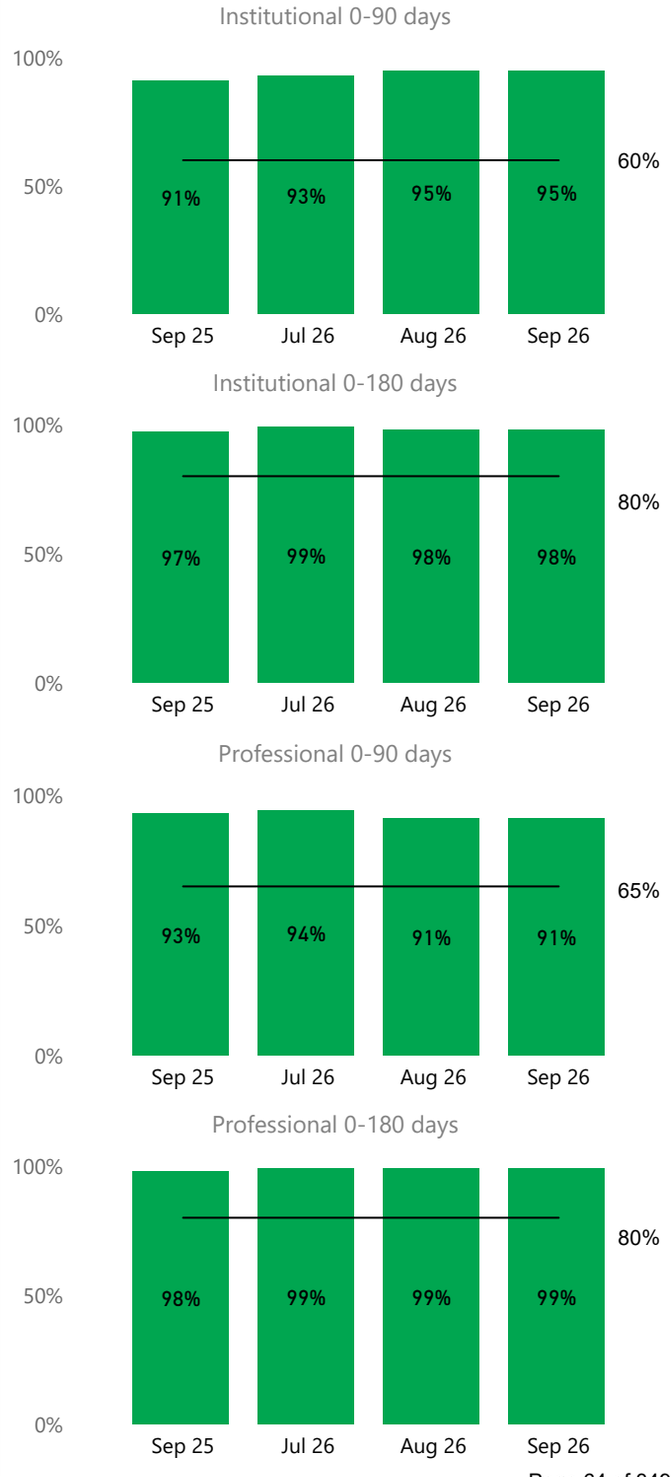
Member Grievances



Member Appeals

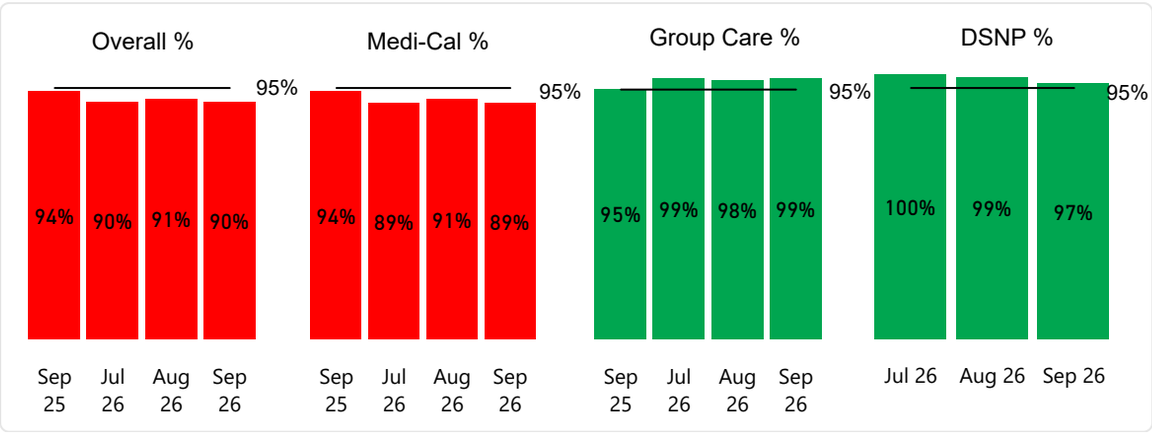


Encounter Data

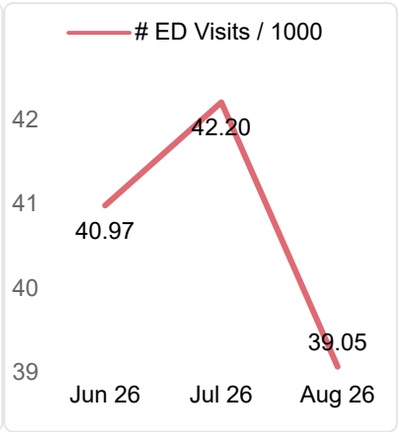


Health Care Services

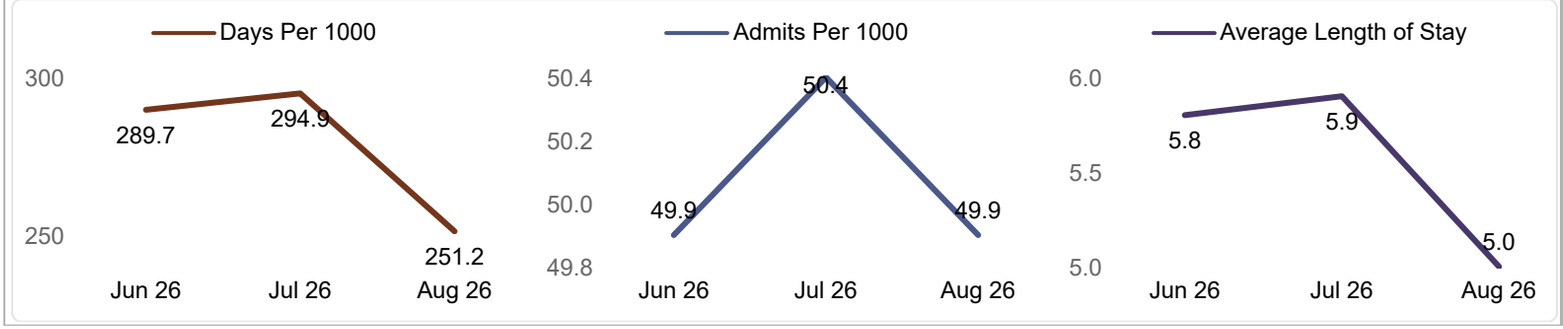
Authorization Turnaround



ED Utilization

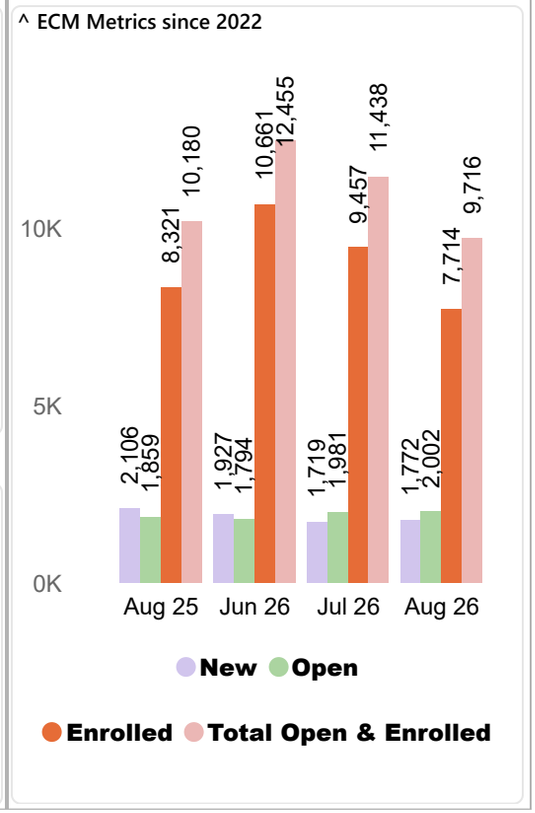


Inpatient Utilization

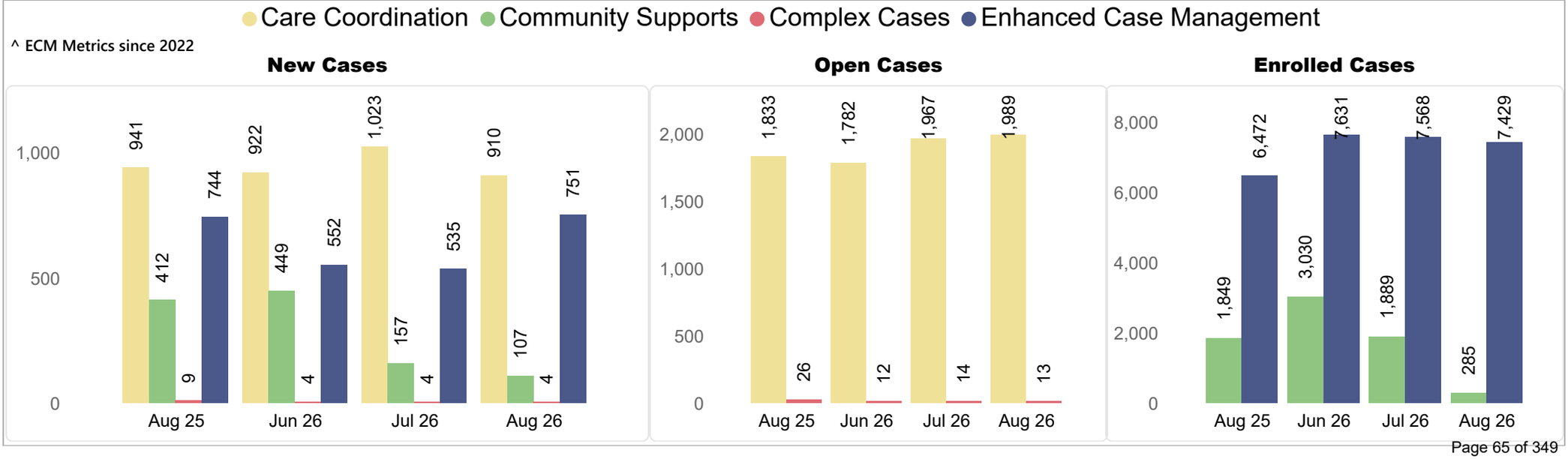


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Sep 25	Jul 26	Aug 26	Sep 26
HEALTHsuite System	100.0%	99.9%	99.5%	99.9%
Other Applications	100.0%	99.9%	99.5%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Sep 25	Jul 26	Aug 26	Sep 26
Denial Rate Excluding Partial Denials (%)	3.8%	5.7%	5.1%	4.3%
Overall Denial Rate (%)	4.2%	6.0%	5.5%	4.6%
Partial Denial Rate (%)	0.4%	0.4%	0.4%	0.3%

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

Pharmacy Authorizations

Authorizations	Sep 25	Jul 26	Aug 26	Sep 26
Approved Prior Authorizations	48	43	69	76
Closed Prior Authorizations	19	24	21	31
Denied Prior Authorizations	82	100	96	105
Total Prior Authorizations	149	167	186	212

Board Business

Bakertilly Financial Audit Review

bakertilly

2026 Audit Results: Alameda Alliance for Health

Report of Independent Auditors

Rianne Suico
Health Care and Insurance Services Principal

Chris Pritchard
Health Care and Insurance Services Principal

Gordon Lam
Health Care and Insurance Services Senior Manager

Statements of Net Position

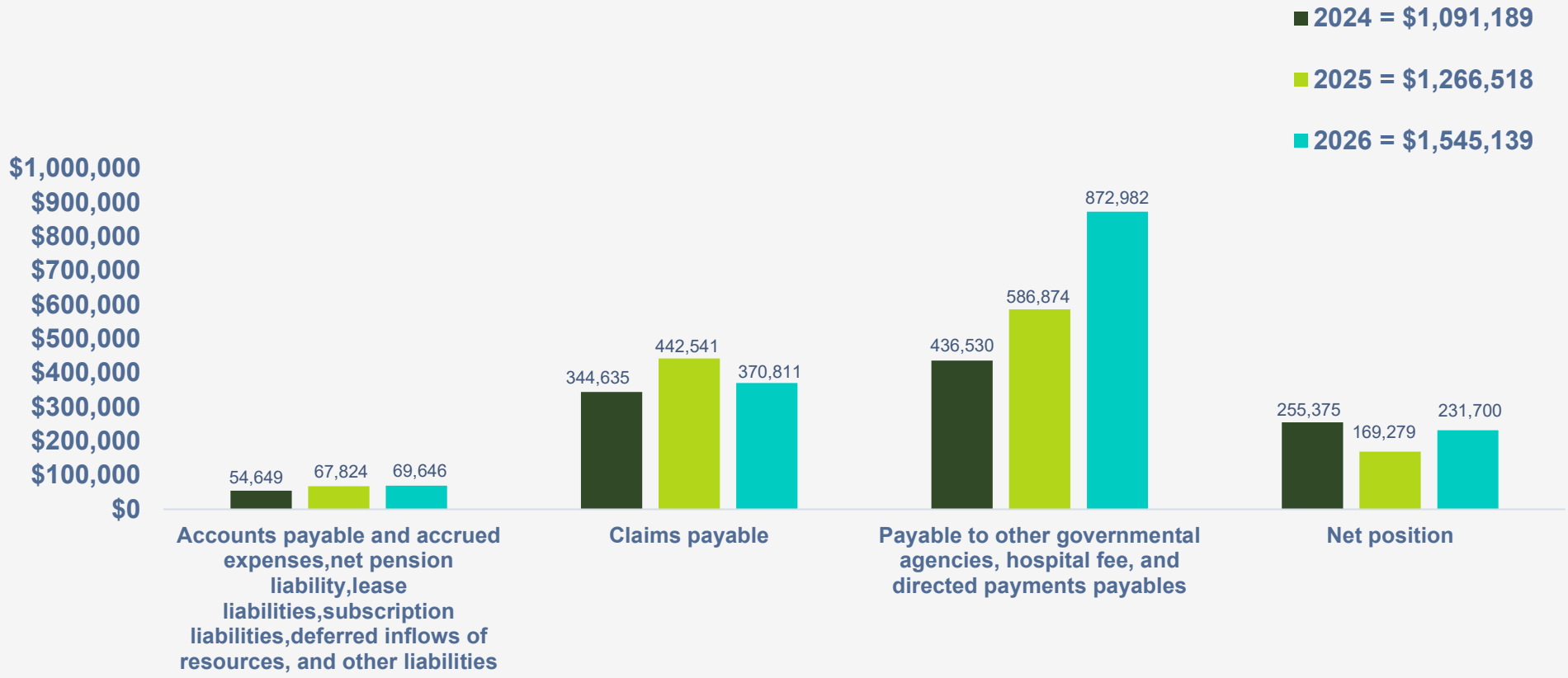


bakertilly

Assets and Deferred Outflows of Resources Composition (in thousands)



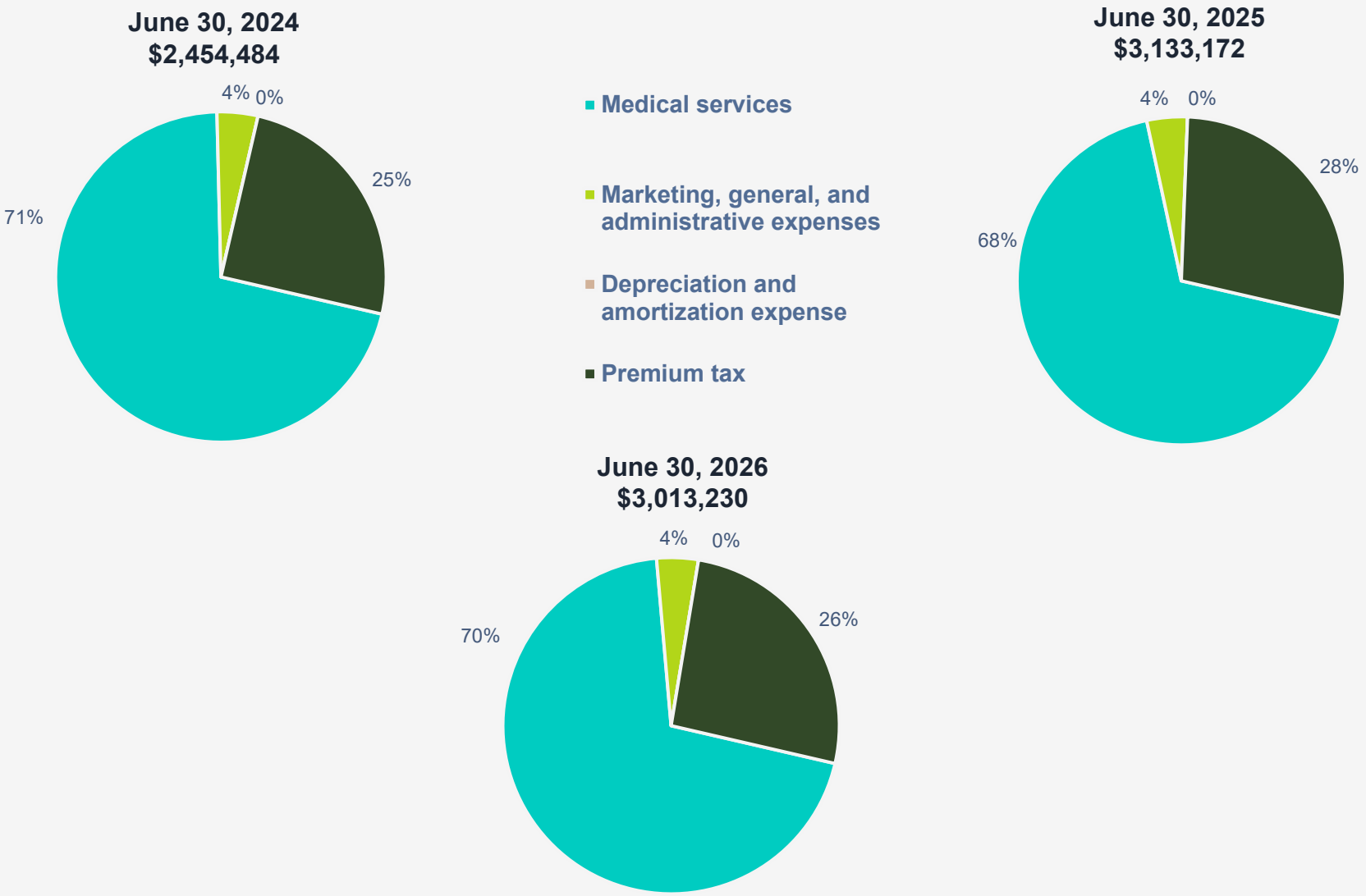
Liabilities, Deferred Inflows of Resources, and Net Position (in thousands)



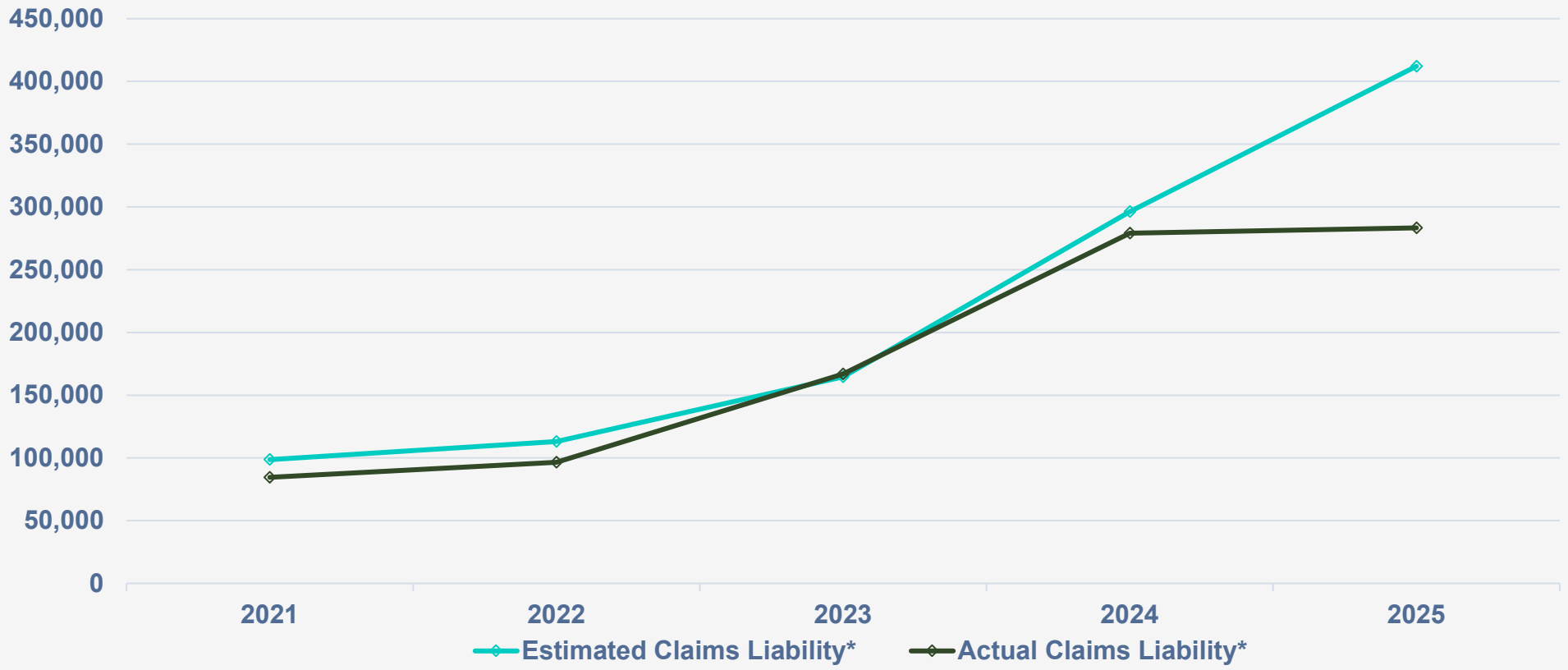
Operations

bakertilly

Operating Expenses (in thousands)



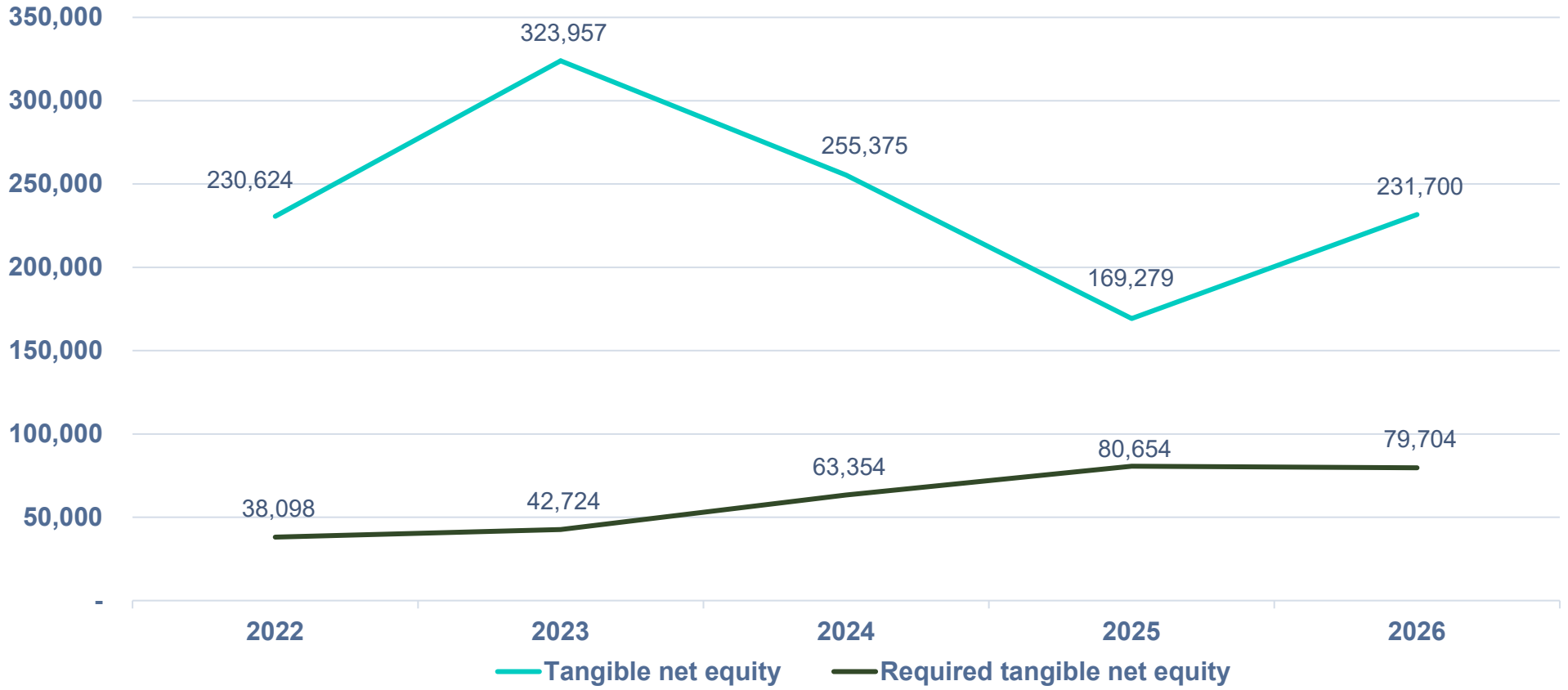
Historic Estimated Claims Liability and Historic Actual Claims Liability (in thousands)



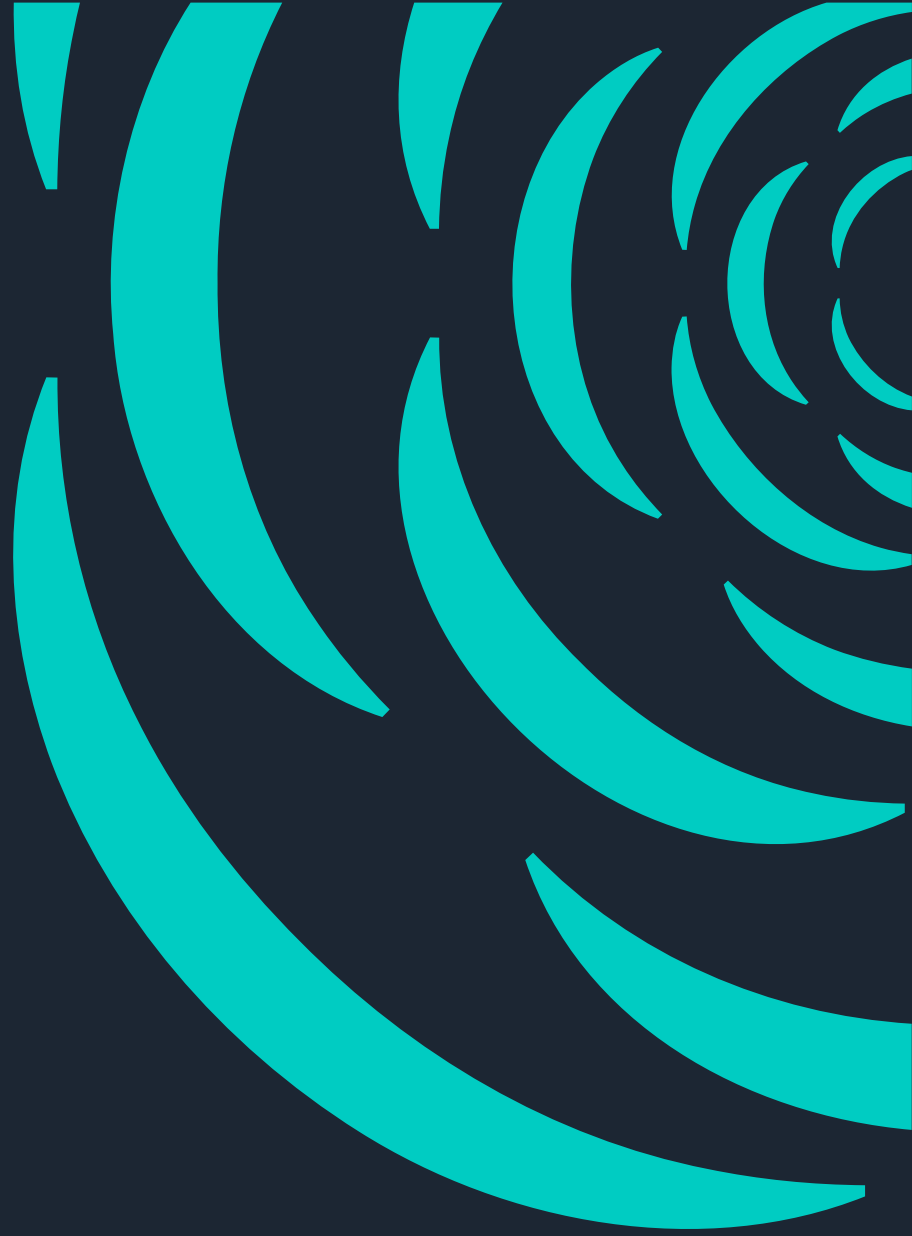
* Estimated claims liability and actual claims liability excludes non-hospital claims.

Source: Alliance's internal reports

Tangible Net Equity (in thousands)



Source: Annual Department of Managed Health Care Filing



Thank you.



bakertilly

The information provided here is of a general nature and is not intended to address the specific circumstances of any individual or entity. In specific circumstances, the services of a professional should be sought. Tax information, if any, contained in this communication was not intended or written to be used by any person for the purpose of avoiding penalties, nor should such information be construed as an opinion upon which any person may rely. The intended recipients of this communication and any attachments are not subject to any limitation on the disclosure of the tax treatment or tax structure of any transaction or matter that is the subject of this communication and any attachments. Baker Tilly Advisory Group, LP and Baker Tilly US, LLP, trading as Baker Tilly, operate under an alternative practice structure and are members of the global network of Baker Tilly International Ltd., the members of which are separate and independent legal entities. Baker Tilly US, LLP is a licensed CPA firm that provides assurance services to its clients. Baker Tilly Advisory Group, LP and its subsidiary entities provide tax and consulting services to their clients and are not licensed CPA firms. The name Baker Tilly and its associated logo is used under license from Baker Tilly International limited. ©2026 Baker Tilly Advisory Group, LP

Information Technology Annual Update

Information Technology

Sasi Karaiyan, Chief Information Officer & Chief Security Officer
October 2026

FY2026 Year at a Glance – Information Technology

AI to improve health outcomes, operational efficiency, consumer experiences, streamline healthcare operations, and transparent innovation.

99.5%
System Availability

96%
Regulatory Compliance

A-
IT Security Scorecard Grade

1,190
System Changes & Enhancements

14,819
IT Service Desk Tickets

System Interoperability and Data Exchange

- 100% On-time data submission.
- > 85% Encounter lag-time, 90% data completion, 95% data quality.
- > 96% Provider data quality.

IT Security & Governance

- Zero critical incidents reported.
- AI Governance and Policy implemented.
- Supported 64 production incident through Incident Command Center.

Member & Provider Channels KLO

- Supported consumer call center with more than 60K calls per month.
- Provider Portal utilization increased by 2% from FY25. Member Portal utilization decreased by 0.7%.

Operational Efficiency

- Claims auto-adjudication 87%.
- Closed 97% of IT Service Desk tickets on time.
- 100% On-time enrollment processing and delivery.

Key Technology Initiatives

- Infrastructure cloud migration.
- DSNP System expansion.
- HealthSuite/TruCare/Tier 0 Upgrades – 100% complete.

Workflow Automation

- 50K hours saved in FY2026.
- Completed Readily AI initiatives.
- 15+ workflow automations and rolled out Co-pilot to 160 staff.

Sasi Karaiyan, Chief Information Officer & Chief Security Officer | Alameda Alliance for Health | Oct ober2026

AI & Workflow Automation

Sasi Karaiyan, Chief Information Officer & Chief Security Officer
September 2026

AI Vision & Objective

AI to improve health outcomes, operational efficiency, consumer experiences, streamline healthcare operations, and transparent innovation.

Next 3 Years Objective

Automate & Optimize

Reduce friction, cut costs, and scale capacity without proportional headcount growth

Better Place to Work

Make Alliance a better place to work through improved work-life balance for all staff

Quality & Continuity

Improve service quality through workflow automation and AI advancement

Member & Provider Experience

Smarter, faster, personalized experiences driving lasting competitive differentiation

Cost Reduction & Sustainability

Drive financial sustainability through innovation and digital transformation

Analytics & AI-Driven Decisions

Embed AI into operations and leadership — turning raw data into clarity, speed, and advantage

AI-driven clinical decision-making is out of scope for Alliance AI initiatives.

Performance Highlight at a Glance – Last 10 months

AI to improve health outcomes, operational efficiency, consumer experiences, streamline healthcare operations, and transparent innovation.

ALAMEDA Alliance FOR HEALTH

10+
Automation Executed YTD

~55K
Staff Hours Saved YTD

90%
Compliance Workflow Live

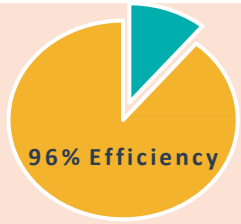
200
Staff using Co-Pilot

$150K
Eliminated Vendor Dependency/Year

Paper Fax to OCR AI Integration

Inpatient Auths, Outpatients Auths, DSNP Enrollment Forms, FaceSheet, Community Support/ Post Acute Auths, Health Ed & Wellness etc.

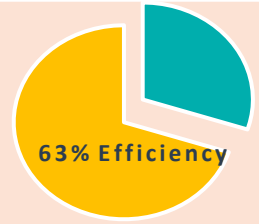
YTD Processed 45,000 forms/transactions
Saved ~12,400 hrs/YTD in FTE hrs
Eliminated vendor partners – $160K/Year



Core Administrative Task through AI

Co-pilots roll out, Letter Automation, JIRA and Confluence AI Integration, Readily AI for Compliance, Claude code for developers, Speech to Text.

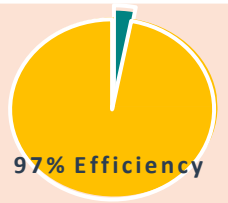
200 Staff using co-pilot,
Rovo AI integration with JIRA/Confluence
Saved ~4,800 hrs/month in FTE hrs



System Quality Testing Automation

HealthSuite, TruCare, Call Center, Consumer Portal, Provider Application, Core Feeds are end to end automated to support regression/smoke testing.

Approx. 6K uses cases are automated
650 hrs/month saving in FTE utilization
Proactive measurements applied



AI Governance and Maturity

A structured governance model ensures every AI deployment at Alliance is reviewed, risk-tiered, and accountable before reaching production.

01

Trust and Compliance

Establish AI governance framework to support and oversee AI strategy, tools intake, ethics, privacy, security and risk management across the enterprise.

02

Policies & Controls

Enforced across all AI deployments — with suspension authority for non-compliant tools.

DLP | IAM | HIPAA Compliance | Audit Trails | Suspension Authority

03

AI Tool Intake & Approval Workflow

Every AI tool request follows a structured approval path before provisioning.

- **Business Request**
- **IT / Security Review**
- **Vendor Management**
- **Governance Sign-off**

04

Risk Tiering

Use cases classified by data sensitivity, clinical decision-making impact, and compliance exposure.

Low | Medium | High | Critical

Human-in-the-loop mandates for high-risk use cases; PHI/PII safeguards enforced at intake to prevent unauthorized data exposure.

05

HIPAA-Aligned Data Handling

Strict controls govern what data AI tools can access, process, and retain — ensuring PHI remains protected at every stage of the AI lifecycle.

06

Monitoring and Audit

Continuous utilization monitoring, independent validation, and incident management integrated into the enterprise security response framework.

07

Data Governance Standards

Structured and unstructured repositories managed with quality checks, model validation, and data lineage tracking for reliable AI inputs.

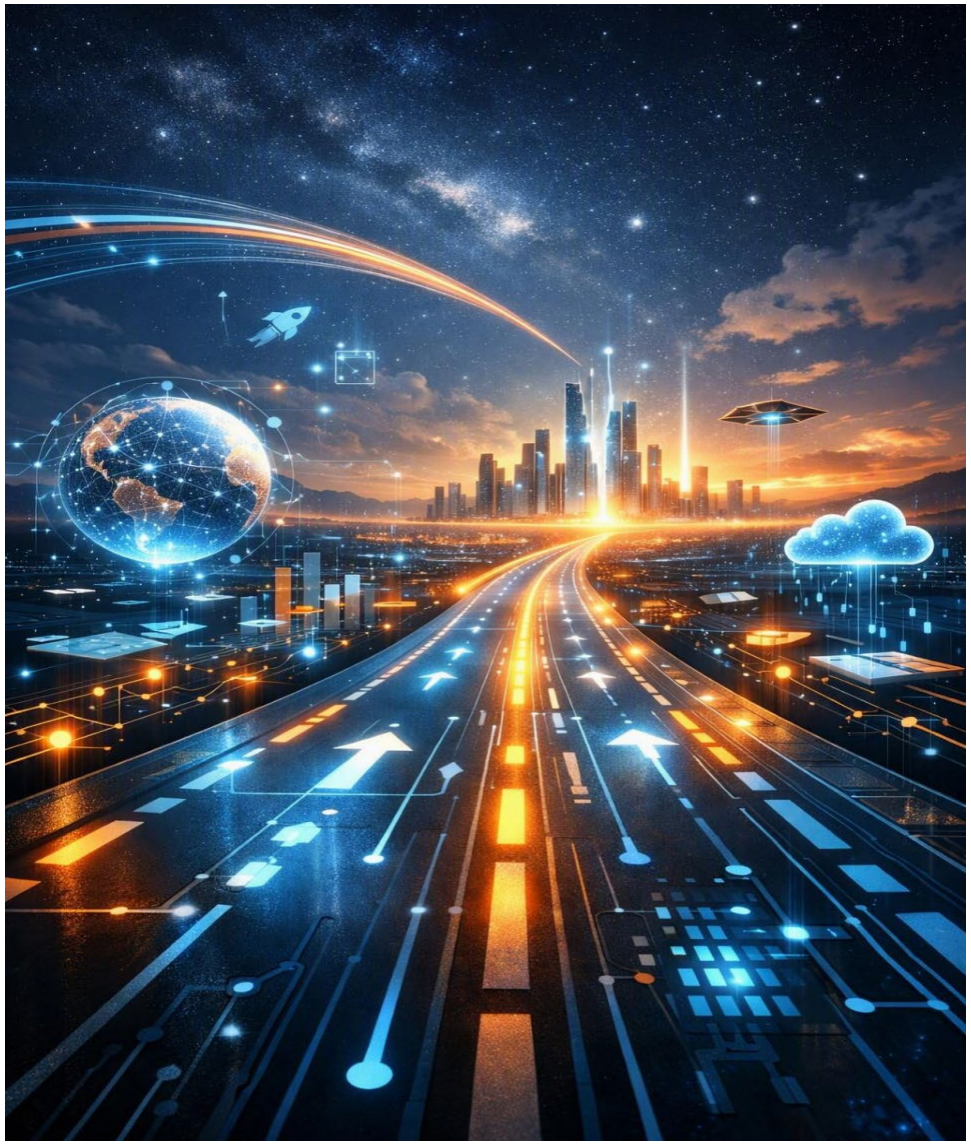
AI Data Lifecycle — Security Controls at Every Stage

Data Intake PHI/PII Gate → **AI Processing** Validated Model → **HITL Review** Human Check → **Output** Audit Trail

Sasi Karaiyan, Chief Information Officer & Chief Security Officer | Alameda Alliance for Health | October 2026

FY2027 AI Roadmaps & Priorities

- AI Employee adoption.
- 25+ Automations that includes
  - Claims Auto Adjudication from 85% to 94%.
  - Improve G&A and PDR TATs
  - Authorization Auto Adjudication from 40 to 50%
  - Self Servicing AI Chat Bot IT Service Desk and Human Resource Domain.
  - Implement a true omnichannel call center (voice, IVR, text, FSM, AI-assisted agents)
- AI Governance, Security and Privacy 2.0 to improve maturity.
- Automate through core technology transformation.
- Modernize DevOps, Data and infrastructure to support performance, scalability, and future analytics.
- Alliance a better place to work.



Cyber Security Operations

Sasi Karaiyan, Chief Information Officer & Chief Security Officer
September 2026

AAH Cyber Security Summary

0

Open Critical / High Incidents

Based on Arctic Wolf metrics (user impacting)

90%

Critical Asset Control Coverage

Based on Arctic Wolf Config, Monitoring, Incidents, and Ticketing #s

100%

Multi-Factor Auth. Coverage

DUO User Adoption

LOW RISK
Trend: Improving

Key Accomplishments

- ✓ Improved vulnerability management system to prioritize fixes based on risk.
- ✓ Used compartmentalizing software to secure crown jewel applications (Health Suite and True Care).
- ✓ Strengthened email checks, admin access, and improved tracking of sign-ins.
- ✓ Implemented AI block controls to prevent data leaks from unapproved use.
- ✓ Introduced AI security reviews / process and policies.
- ✓ Made technical security reviews a required project step to check all security layers.
- ✓ Phishing score improved 26% (less users being phished).

FY2027 Initiatives

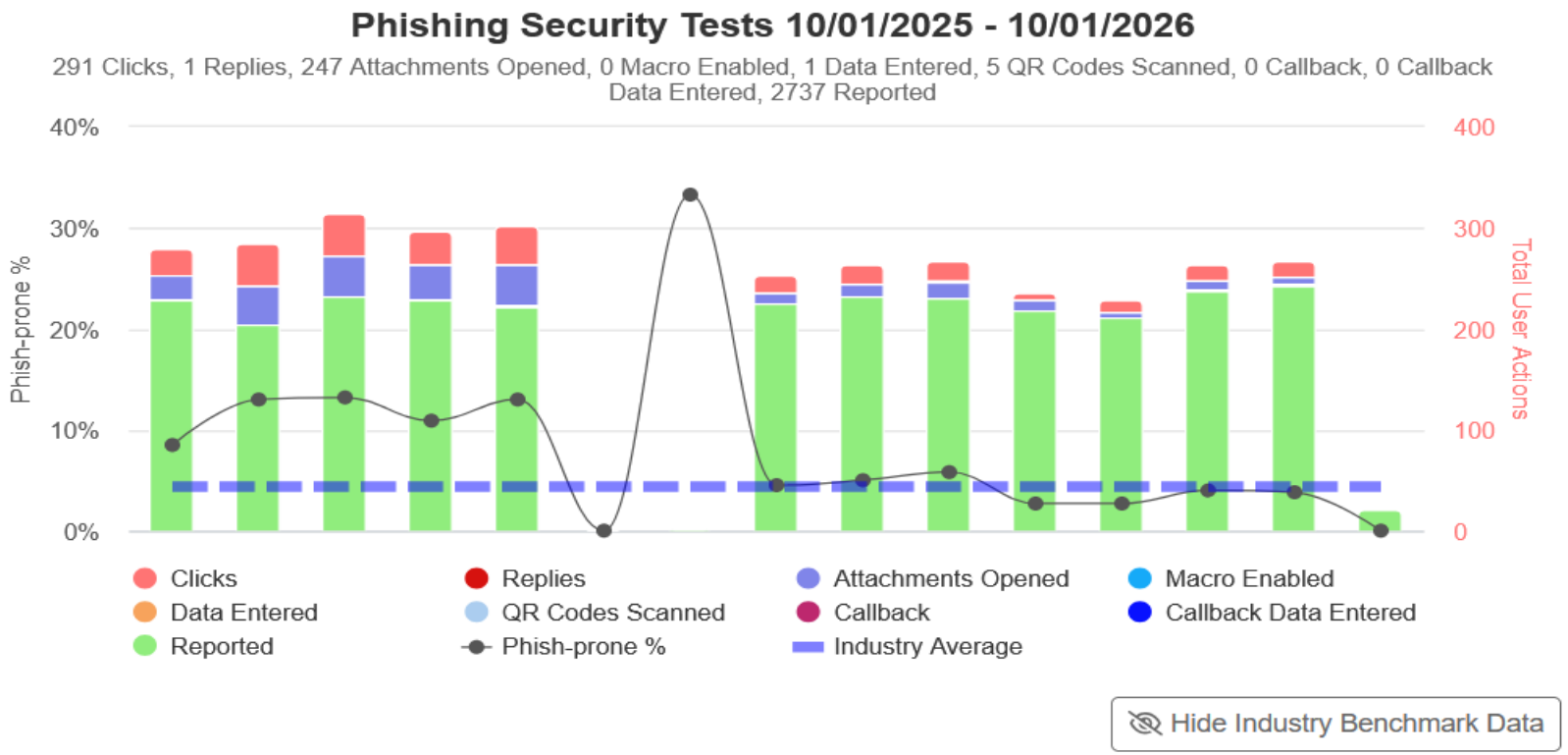
- ❖ Annual security risk assessment, penetration test and remediation.
- ❖ IT Cloud infrastructure and AI security modernization.
- ❖ Network segmentation phase 2: Workstations and databases.

Sasi Karaiyan, Chief Information Officer & Chief Security Officer | Alameda Alliance for Health | October 2026

Security Training and Awareness

- ✓ AAH employees, contractors, and temp resources are required training upon hire.
- ✓ Mandatory Security training consist of 8 exercises and videos, and these training will be revised each year.
  - ❖ 2026 KnowBe4 Security Awareness Training and Common Threats.
  - ❖ Cybersecurity Awareness: Core Security Principles.
  - ❖ Phishing Foundations and Data Privacy Basics
  - ❖ Artificial Intelligence Foundations.
  - ❖ Reporting Security Incidents.
  - ❖ Memo - 2026 Artificial Intelligence (AI) Governance and Acceptable Use Policy

IT Security– Phishing Effectiveness



Your Organization	
Account Average Phish-prone %	10.4%
Last Campaign Phish-prone %	0%

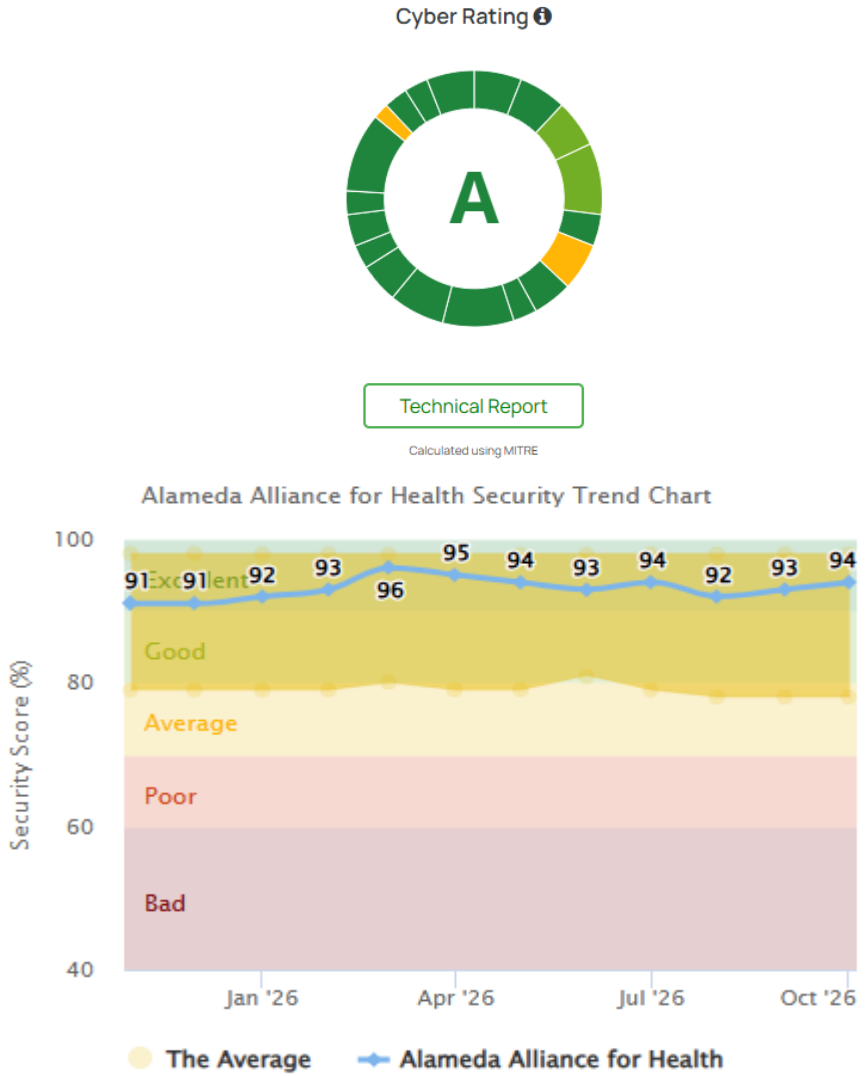
Industry Benchmark Data	Show in chart
Industry Phish-prone %	4.4%
Industry	Healthcare & Pha
Organization Size	Medium (250-999
Program Age	3 Years

Key Highlights

- At one point, % of users prone to clicking on phishing emails decreased >50% from last year.
- Within industry, we are at 96% percentile on clicking phishing emails.
- Sustained use of the Phishing Alert Report button (green bar)

AAH Security Scorecard

- The purpose of this score (from BlackKite) is to give organizations a **continuous, external-facing measurement of AAH's cybersecurity posture**. It works like a *credit score for cybersecurity*.
- In maintaining a healthy score, those who work or will work with AAH could rest assured the organization takes its cyber security very seriously.



THANK YOU!

ALAMEDA Alliance FOR HEALTH

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

Olusan Contract

The Operating System for Medicaid Continuity

ALAMEDA ALLIANCE FOR HEALTH

Statement of Work

AHS Operational Scope

Exhibit A to the Master Services Agreement between Alameda Alliance for Health and Olusan Platforms, Inc.

September 2026 | Confidential

1. Background and Purpose

Alameda Alliance for Health (“the Alliance”) is a public, not-for-profit managed care plan serving Alameda County. Per the Alliance’s July 2026 Board of Governors materials, Medi-Cal enrollment was 374,886 in May 2026, down approximately 36,497 members over twelve months, with the decline accelerating to a recent rate of roughly 5,500 members per month. The Alameda Health System (“AHS”) network has declined fastest, from 90,751 members in May 2025 to 78,604 in May 2026. The medical loss ratio reached 95.5 percent in April 2026 before easing to 93.7 percent in May, with the year-to-date ratio above target. A portion of the enrollment decline is policy-driven and unavoidable; a portion is procedural, meaning eligible members lose coverage because renewal steps fail, contact information is unreliable, or no one owns the case to completion. The Alliance’s board has asked which members are leaving and what that departure costs the plan.

The operating environment intensifies in 2027. H.R. 1 and the June 2026 CMS interim final rule introduce Medicaid community-engagement requirements, six-month redeterminations for the expansion group, and new documentation requirements, with a January 2027 implementation deadline. These changes increase the number of moments at which an eligible member can procedurally lose coverage.

The Alliance has eligibility files, care-management functions, member services, outreach channels, delegated providers, community partners, and enterprise systems. What it does not have is one operating system coordinating the work across them, from continuity risk signal to verified outcome. This Statement of Work engages Olusan Platforms, Inc. to deploy ContinuityOS to provide that coordination for the population defined below, so that eligible members keep their coverage, coverage turns into care, and every outcome the Alliance reports is backed by an auditable record.

2. Definitions

Term	Plain-language meaning
Olusan	Olusan Platforms, Inc., the vendor (“Olusan” under the Agreement).
Alliance	Alameda Alliance for Health (“Company” under the Agreement).
ContinuityOS	Olusan’s hosted software platform. It reads signals from the Alliance’s existing systems, assigns each member case a named owner and a deadline, routes the work through the Alliance’s existing teams and channels, verifies the outcome against an Alliance-approved source, and produces a Continuity Record. It is built on a common base platform configured for each customer; it does not replace any Alliance system and does not determine eligibility or compliance.
AHS Network	The Alameda Health System delegated network: the AHS hospital and its affiliated federally qualified health center clinics.

AHS Operational Scope	The AHS Operational Scope includes all individuals meeting the mutually agreed Alliance Medicaid eligibility, AHS attribution and exclusion criteria, as updated through the agreed data feeds. Medicare and dual-eligible members are excluded. Other excluded eligibility categories shall be expressly documented. Inclusion is determined by these criteria, not individual member designation. There is no numerical membership cap or fee adjustment based on membership changes. Previously included members may continue receiving authorized recovery assistance following procedural disenrollment during the applicable recovery period, subject to agreed recovery criteria and data-use permissions. Intervention prioritization and operating capacity are governed separately by the agreed delivery plan.

Additional Services	“Additional Services” means any services, capabilities, workflows, populations, outreach channels, integrations, deliverables, or other work not expressly included in this SOW. Additional Services shall not be performed, and the Alliance shall have no obligation to pay for them, unless they are included in a written amendment or order form executed by authorized representatives of the Alliance and Olusan that states the applicable scope, fees, deliverables, responsibilities, and schedule.
Start Date	“Effective Date” means the date of the last party’s signature. “Start Date” means the date Olusan receives the first quarterly payment. The Start Date establishes Day 1 of implementation and the fourteen -month Initial Term (as defined in Section 15). Data availability governs dependent activities under Assumptions and Dependencies and does not establish a separate commencement date.
Governed Case	One member continuity event managed in ContinuityOS from detection to a verified final outcome.
Continuity Record	The timestamped, audit-ready record produced for every Governed Case: the signal, the owner, the clock, the actions taken, the channel, the evidence, the verified outcome, and the reason code.
Population Intelligence	The platform capability that ranks the cohort by continuity risk so the highest-risk members are worked first. Included in the platform fee.
Pathway Match	The platform capability for H.R. 1 readiness. It first identifies members who do not need a work-requirement pathway because existing data shows they are exempt or excepted, then routes the remaining members to the correct pathway. The State remains the decision-maker.
Renewal	“Renewal” means the parties' mutual agreement to extend AHS Services beyond the Initial Term, as described inSection 11, evidenced by a signed amendment or separate SOW.
Written Deliverables	Reports, summaries, exports, and other written materials expressly identified as deliverables in Section 6.

3.General Terms

3.1 Personnel; No Subcontractors; U.S.-Based Operations. Olusan shall perform the Services directly using its own employees and personnel. As of the Effective Date, Olusan does not utilize subcontractors, offshore resources, or third-party service providers to perform the Services or access, process, maintain, transmit, or store Company Data.

All Services **shall** be performed exclusively within the United States by personnel physically located in the United States unless Company provides its prior written approval for an exception.

Olusan shall not engage any subcontractor or permit any third party to perform any portion of the Services, or access Company Data, without Company's prior written consent, which shall not be unreasonably withheld, conditioned, or delayed. Olusan shall provide Company at least thirty (30) days' prior written notice of any proposed subcontractor. Company may require information reasonably necessary to assess the subcontractor's qualifications, administrative capacity, compliance, and ability to perform the Services and meet regulatory requirements. Agreement, and Company may withdraw its approval if a subcontractor no longer meets Company's regulatory or oversight requirements. Company shall respond to any written request for approval of a subcontractor within fifteen (15) business days after receiving the subcontractor's identity, a description of the services to be performed, and the scope of any access to Company Data.

If Company approves the use of a subcontractor, Olusan shall remain fully responsible for the acts, omissions, performance, and compliance of such subcontractor and shall ensure that such subcontractor is bound by written obligations regarding confidentiality, privacy, data protection, information security, and regulatory compliance that are no less protective than those applicable to Olusan under this Agreement, the Business Associate Agreement, and applicable federal and California law.

Unless Company expressly agrees otherwise in writing, Company shall have no responsibility for any fees, expenses, costs, or compensation payable to any subcontractor, all of which shall remain the sole responsibility of Olusan.

Deployment Team, Vendor Readiness, or Regulatory Boundaries: Olusan represents and warrants that all personnel performing Services will possess and maintain all licenses, certifications, registrations, training, qualifications, and supervision required by applicable law and appropriate to their assigned functions. Personnel will not perform clinical, eligibility-determination, utilization-management, legal, or other professionally licensed functions unless expressly included in this SOW and authorized by the Alliance.

For the avoidance of doubt, generally available utilities and infrastructure services, including internet service providers, telecommunications providers, cloud hosting providers, and commercially available software platforms that do not independently perform the Services, shall not be considered subcontractors for purposes of this Section.

No Alliance Data shall be accessed, processed, stored, backed up, replicated, viewed, or otherwise made available outside of the United States without Alliance's prior written consent

3.2 Insurance and Indemnification. Olusan shall, at its sole cost and expense, fully comply with the terms and requirements of this Section. Olusan shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by Olusan, its agents, representatives, or employees. Olusan shall procure and maintain for the duration of the contract insurance against claims arising out of their professional services and including, but not limited to loss, damage, theft or other misuse of data, infringement of intellectual property, invasion of privacy and breach of data.

(a) Commercial General Liability (CGL). Olusan shall have a completed Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis, including products and completed operations, property damage, bodily injury and personal & advertising injury with limits no less than one million dollars ($1,000,000) per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.

(b) Automobile Liability. Olusan shall have completed Insurance Services Office Form Number CA 0001 covering, Code 1 (any auto), or if Olusanhas no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than one million dollars ($1,000,000) per accident for bodily injury and property damage.

(c) Workers' Compensation and Employers' Insurance. To the extent Olusan has employees, Olusan shall maintain workers' compensation insurance by the laws of the state of California, with Statutory Limits and employer's liability

insurance limits of liability of not less than one million dollars ($1,000,000) bodily injury by accident (each accident), one million dollars ($1,000,000) bodily injury by disease (policy limit), and one million dollars ($1,000,000) bodily injury by disease (each employee), or limits carried, whichever are higher.

(d) Professional Liability (Managed Care Errors and Omissions) Insurance. Insurance with limit no less than two million dollars ($2,000,000) per claim, five million dollars ($5,000,000) annual aggregate.

(e) Cyber Liability Insurance. Olusan shall maintain Cyber Liability Insurance with limits not less than two million dollars ($2,000,000) per occurrence or claim, two million dollars ($2,000,000) aggregate. Coverage shall be sufficiently broad to respond to the duties and obligations as is undertaken by Olusan in this agreement and shall include, but not be limited to, claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall provide coverage for breach response costs as well as regulatory fines and penalties as well as credit monitoring expenses with limits sufficient to respond to these obligations.

(f) Subcontractors. If Olusan has obtained prior written consent from Company per Section 3.1 to engage a Subcontractor for any portion of this Agreement, Olusan shall not allow any Subcontractor to perform any portion of the Services until Olusan obtains from such Subcontractor, and provides to Company, proof of insurance in form and substance appropriate to the nature and scope of the subcontracted service. Olusan shall in writing bind each such Subcontractor to the insurance requirements of this Section 3.2. Olusan shall also require that that Company is named as an additional insured on insurance requirements for subcontractors.

(g) Neither receipt nor acceptance of policies, endorsements, or certificates, whether indicating reduced or different coverages than required herein, nor any other forbearance or omission by Company with regard to these insurance requirements, shall be deemed a waiver of, or estoppel to assert, any right on the part of Company regarding these insurance requirements. The insurance requirements set forth herein are independent of Company's indemnification obligations and other obligations hereunder. Nothing herein shall be construed to limit or alter any of other obligations of Olusan, under this Agreement or otherwise, including, without limitation, Olusan's indemnification obligations.

(h) Other Insurance Provisions. The insurance policies are to contain, or be endorsed to contain, the following provisions:

(i) Additional Insured Status. Company, its officers, officials, employees, and volunteers are to be covered as additional insureds on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of Olusan including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to Olusan's insurance (at least as broad as ISO Form CG 20 10 11 85 or both CG 20 10, CG 20 26, CG 20 33, or CG 20 38; and CG 20 37 forms if later revisions used).

(j) Primary Coverage. Olusan's insurance coverage shall be primary coverage at least as broad as ISO CG 20 01 04 13 with respect to the Company, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by Company, its officers, officials, employees, or volunteers shall be excess of Olusan's insurance and shall not contribute with it.

(k) Notice of Cancellation. Each insurance policy required above shall state that coverage shall not be canceled, except with thirty (30) days' notice (ten (10) days' notice for nonpayment) to Company.

(l) Waiver of Subrogation. Olusan hereby grants to Company a waiver of any right to subrogation which any insurer of Olusan may acquire against Company by virtue of the payment of any loss under such insurance. Olusan agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not Company has received a waiver of subrogation endorsement from the insurer.

(m) Self-Insured Retentions. Self-insured retentions must be declared to and approved by Company. Company may require Olusan to provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention. The policy language shall provide, or be endorsed to provide, that the self-insured retention may be satisfied by either the named insured or Company.

(n) Acceptability of Insurers. Insurance is to be placed with insurers authorized to conduct business in the state with a current A.M. Best's rating of no less than A-:VII, unless otherwise acceptable to Company.

(o) Claims Made Policies. If any of the required policies provide coverage on a claims-made basis:

(A) The retroactive date must be shown and must be before the date of the contract or the beginning of contract work.

(B) Insurance must be maintained, and evidence of insurance must be provided for at least five (5) years after completion of the Agreement.

(C) If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a

retroactive date prior to the contract effective date, Olusan must purchase “extended reporting” coverage for a minimum of five (5) years after completion of contract work.

(D) Verification of Coverage. Olusan shall furnish Company with original Certificates of Insurance including all required amendatory endorsements (or copies of the applicable policy language effecting coverage required by this clause) and a copy of the Declarations and Endorsement Page of the CGL policy listing all policy endorsements to Company before work begins. However, failure to obtain the required documents prior to the work beginning shall not waive Olusan’s obligation to provide them. Company reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

(E) Special Risks or Circumstances. By mutual written agreement, Company may modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

3.3 Indemnification.

(a) Scope. Each Party (“Indemnitor”) will defend, indemnify, and hold the other Party (“Indemnitee”) harmless from and against all liability, damages, cost and expense (including reasonable attorneys’ fees and other costs of defense) arising from third party claims against Indemnitee in connection with this Agreement to the extent caused by the gross negligence, willful misconduct, or unlawful acts of the Indemnitor’s agents, contractors and/or employees during the term of this Agreement. The Indemnitor will have the right to control the defense and settlement (to the extent of such indemnification), and the Indemnitee will reasonably cooperate in such defense.

(b) Procedure. The Indemnitee shall provide Indemnitor with prompt written notice of any claims for which it seeks indemnification. No delay in notice shall excuse the Indemnitor’s obligations, except to the extent that the Indemnitor has been materially prejudiced by such delay. The Indemnitor shall defend the Indemnitee at Indemnitor’s sole expense with legal counsel reasonably acceptable to the Indemnitee. If the Indemnitor fails to provide a timely defense, then the Indemnitee may defend with counsel of its own choosing at the expense of the Indemnitor. Neither the Indemnitor nor the Indemnitee shall enter into any settlement without the prior written consent of the other, which shall not be unreasonably withheld or delayed.

(c) Indemnitee’s Rights. Indemnitee’s rights of indemnification under this Section 3.3 shall not in any way be limited by, reduced, altered, or diminished as a result of Olusan’s obligations to procure and maintain insurance as set forth in Section 3.3, or as the result of the existence or non-existence of any type of insurance coverage benefiting Olusan, or any of Indemnitee. The provisions of this Section 3.2 shall survive termination or expiration of this Agreement. The indemnification obligations under this Section are subject to any limitation of liability set forth in the Agreement and, with respect to the subject matter of this SOW, supersede any overlapping indemnification provisions of the Agreement.

3.4 Mediation. At either party’s election, any action, dispute, claim, or controversy between the parties, whether sounding in contract, tort, or otherwise, including all disputes arising out of or in connection with this Agreement and any related agreements or instruments and any transaction contemplated hereby (“Dispute” or “Disputes”) shall be attempted to be settled in good faith by nonbinding mediation as a condition precedent to arbitration by either party. The parties shall endeavor to resolve the Dispute by mediation which, unless the parties mutually agree otherwise, shall be in accordance with the Rules of the Judicial Arbitration and Mediation Service (“JAMS”) currently in effect. In the event of any inconsistency between such rules and these mediation provisions, these provisions shall supersede such rules. All statutes of limitation that would otherwise be applicable shall apply to any mediation proceeding under this Section. Request for mediation shall be filed in writing with the other party to the Agreement and with JAMS. The request may be made concurrently with the filing of a demand for arbitration but, in such event, mediation shall proceed in advance of arbitration or legal or equitable proceedings, which shall be stayed pending mediation for a period of 30 (thirty) days from the date of filing, unless stayed for a longer period by agreement of the parties or court order. Any mediator selected under this Section shall be knowledgeable in the subject matter of the Dispute. Qualified retired judges with at least five (5) years mediation experience shall be selected through panels maintained by JAMS or any private organization providing such services. The mediation shall be held within thirty (30) days of the date the demand for mediation is served on a party, unless the parties agree otherwise. The parties understand and agree that a representative from each side with full settlement authority will be present at the mediation conference. The mediation process is to be considered settlement negotiations for the purpose of all state and federal rules protecting disclosures made during such conferences from later discovery or use in evidence. All conduct, statements, promises, offers, views, and opinions, oral or written, made during the mediation by any party or a party’s agent, employee, or attorney shall not be subject to discovery or admissible for any purpose, including impeachment, in any litigation, arbitration, or other proceeding involving the parties. The parties shall share the mediator’s fee and any filing fees equally. The mediation shall be held in the County of Alameda, unless another location is mutually agreed upon. Agreements reached in mediation shall be enforceable as settlement agreements in any court having jurisdiction thereof.

3.5 Arbitration. If the Dispute is not resolved by agreement or mediation pursuant to Section 3.3 above, the Dispute shall be resolved by arbitration as set forth in this Section. Such disputes shall be resolved by binding arbitration in

accordance with Title 9 of the California Code of Civil Procedure, Section 1280 et seq. In the event of any inconsistency between such rules and these arbitration provisions, these provisions shall supersede such rules. All statutes of limitation that would otherwise be applicable, including any limitations periods under the Government Claims Act (Government Code, Section 810 et seq.), shall apply to any arbitration proceeding under this Section. No limitations periods shall be tolled for any reason absent a writing signed by both parties. In any arbitration proceeding subject to these provisions, the arbitrator is specifically empowered to decide (by documents only, or with a hearing, at the arbitrator's sole discretion) pre-hearing motions that are substantially similar to pre-hearing motions to dismiss and motions for summary adjudication. Judgment upon the award rendered may be entered in any court having jurisdiction. Qualified retired judges with at least five (5) years arbitration experience shall be selected through panels maintained by the JAMS or any private organization providing such services. If the parties are unable to mutually agree upon a retired judge to hear their arbitration, the arbitration service shall provide a list of three (3) available judges and each party may strike one (1). The remaining judge will serve as the arbitrator. Notices of demand for arbitration shall be served in writing by registered or certified mail to all parties to this Agreement. Demand will be made within a reasonable time after the dispute or other matter in question has arisen. In no event shall a demand for arbitration be made after the date when the institution of legal proceedings based on such dispute or other matter in question would be barred by the applicable statute of limitations. The applicable statute of limitation shall be tolled during the period such arbitration proceedings are pending. Except as otherwise provided herein, the California Code of Civil Procedure and California Evidence Code shall apply to and govern the conduct of discovery. The arbitrator shall issue a statement of decision not later than twenty (20) days after the testimony is closed. Judgment may be entered into in accordance with a statement of decision as provided in the California Code of Civil Procedure. Any memorandum of costs shall be submitted to the arbitrator and the arbitrator shall determine the amount of the costs to be awarded to any prevailing party. Any motion for attorneys' fees as an element of costs under California Civil Code section 1717 shall be served and filed with the arbitrator before or at the time the memorandum of costs is served and filed. The arbitrator's fees and charges shall be borne equally by the parties to the dispute. Notwithstanding anything contained herein to the contrary, if a third person or entity not a party to this Agreement brings an action in which Olusan and Company become a party, by cross-claim or otherwise, and said party or entity is not bound by the provisions of this Section regarding arbitration, the provisions of this Section shall not be applicable to such dispute.

3.6 Survival; Applicability. The provisions of this Article shall survive any termination, amendment, or expiration of this Agreement in which this Section is contained, unless the parties otherwise expressly agree in writing. Should an action, dispute, claim, or controversy be brought against Company and/or Olusan by a third party who is not bound by a mediation or binding arbitration provision similar to the mediation and arbitration provisions contained herein, the terms of this Article shall not apply to such action, dispute, claim, or controversy.

3.7 Conflict of Interest. Olusan shall promptly disclose to Company in writing any actual conflict of interest of which Olusan becomes aware that would materially impair Olusan's ability to perform its obligations under this SOW, and the parties shall cooperate in good faith to address any conflict so disclosed. Company acknowledges that Olusan provides products and services to other customers, including other health plans and health care organizations, some of which may compete with Company, and that nothing in this SOW or the Agreement restricts Olusan from doing so, provided that Olusan complies with its confidentiality, privacy, and data security obligations under the Agreement, the Business Associate Agreement, and this SOW, and does not use Company's Confidential Information or member data in performing services for any other customer. The performance of services for other customers shall not, by itself, constitute a conflict of interest under this Section.

3.8. Aggregated and De-Identified Data. Olusan may de-identify data received under this SOW in accordance with 45 C.F.R. § 164.514(b) and may use and retain such de-identified data, alone or aggregated with other data, to maintain, evaluate, and improve ContinuityOS and Olusan's products and services, including the algorithms and models used therein, and for benchmarking and research. Olusan shall not (i) re-identify or attempt to re-identify such data or permit any third party to do so, (ii) disclose de-identified data in any form that identifies Company as its source, or (iii) sell de-identified data. This Section survives termination or expiration of this SOW.

3.9 Limitation of Liability.

3.9.1 Exclusion of Indirect Damages. TO THE GREATEST EXTENT PERMITTED BY APPLICABLE LAW, AND EXCEPT AS PROVIDED IN SECTION 3.9.4, IN NO EVENT WILL EITHER PARTY BE LIABLE UNDER OR IN CONNECTION WITH THIS SOW OR ITS SUBJECT MATTER, UNDER ANY LEGAL OR EQUITABLE THEORY, INCLUDING BREACH OF CONTRACT, TORT (INCLUDING NEGLIGENCE), STRICT LIABILITY OR OTHERWISE, FOR ANY CONSEQUENTIAL, ENHANCED, EXEMPLARY, INCIDENTAL, INDIRECT, PUNITIVE, REMOTE OR SPECIAL DAMAGES, OR FOR ANY LOSS OF PROFITS, REVENUE, GOODWILL, BUSINESS OPPORTUNITY OR DATA, EVEN IF ADVISED OF THE POSSIBILITY OF SUCH DAMAGES OR IF SUCH DAMAGES WERE OTHERWISE FORESEEABLE.

3.9.2 Cap on Liability. EXCEPT AS PROVIDED IN SECTION 3.9.4, THE AGGREGATE LIABILITY OF EITHER PARTY ARISING OUT OF OR

RELATED TO THIS SOW, WHETHER ARISING UNDER OR RELATED TO BREACH OF CONTRACT, TORT (INCLUDING NEGLIGENCE), STRICT LIABILITY OR ANY OTHER LEGAL OR EQUITABLE THEORY, WILL NOT EXCEED THE TOTAL FEES PAID AND PAYABLE BY COMPANY UNDER THIS SOW IN THE TWELVE (12) MONTHS PRECEDING THE EVENT GIVING RISE TO THE CLAIM.

3.9.3 Application. THE EXCLUSIONS AND LIMITATIONS IN THIS SECTION 3.9 APPLY EVEN IF ANY REMEDY FAILS OF ITS ESSENTIAL PURPOSE, AND APPLY IN THE AGGREGATE ACROSS ALL CLAIMS ARISING UNDER OR RELATING TO THIS SOW.

3.9.4 Exceptions. THE EXCLUSIONS AND LIMITATIONS IN SECTIONS 3.9.1 AND 3.9.2 DO NOT APPLY WHERE PROHIBITED BY APPLICABLE LAW, OR TO LIABILITY FOR (A) BREACH OF A PARTY'S CONFIDENTIALITY OBLIGATIONS UNDER THIS SOW OR THE AGREEMENT, OR OF ITS PRIVACY OR DATA-SECURITY OBLIGATIONS UNDER THIS SOW OR THE BUSINESS ASSOCIATE AGREEMENT; (B) INFRINGEMENT, MISAPPROPRIATION OR OTHER VIOLATION OF THE OTHER PARTY'S INTELLECTUAL PROPERTY RIGHTS; (C) FRAUD OR FRAUDULENT MISREPRESENTATION; (D) GROSS NEGLIGENCE OR WILLFUL MISCONDUCT; (E) A PARTY'S INDEMNIFICATION OBLIGATIONS UNDER SECTIONS 3.2 AND 3.3; OR (F) COMPANY'S PAYMENT OBLIGATIONS UNDER THIS SOW. NOTWITHSTANDING THE FOREGOING, AND EXCEPT IN THE CASE OF FRAUD OR WILLFUL MISCONDUCT, EACH PARTY'S AGGREGATE LIABILITY UNDER CLAUSES (A), (B), (D) AND (E) OF THIS SECTION 3.9.4, WHEN AGGREGATED WITH ALL OTHER CLAIMS, WILL NOT EXCEED THE GREATER OF (i) TWO (2) TIMES THE CAP SET FORTH IN SECTION 3.9.2 AND (ii) THE LIMITS OF THE INSURANCE COVERAGE OLUSAN IS REQUIRED TO MAINTAIN UNDER SECTION 3.2.

3.10 Warranties; Disclaimer; AI Systems.

3.10.1 Limited Warranties. Olusan warrants that (a) the Services will be performed in a professional and workmanlike manner by qualified personnel, consistent with generally accepted industry standards; (b) ContinuityOS will materially conform to the descriptions in this SOW; and (c) Olusan will comply with applicable laws in its performance of the Services, including its obligations under the Business Associate Agreement. As Olusan's sole obligation and Company's exclusive remedy for breach of clauses (a) or (b) of this Section 3.10.1, Olusan will re-perform the affected Services or correct the non-conformity within a reasonable period and, if Olusan cannot do so, Company may terminate the affected Services and receive a refund of the fees allocable to the non-conforming Services for the period of non-conformity.

3.10.2 Nature of AI Systems. Company acknowledges that the Services and ContinuityOS incorporate artificial intelligence and machine learning technologies that are probabilistic in nature; that outputs generated by such technologies ("Output") may be inaccurate, incomplete, biased, or otherwise unsuitable for a given purpose; that identical inputs may produce different outputs; and that no such system can be guaranteed to be free of error. Olusan does not warrant the accuracy, completeness, reliability, or fitness of any Output. Company is responsible for evaluating Output before relying on it and for maintaining appropriate human review. The Services support outreach, prioritization, and workflow only; they do not provide medical advice and do not make coverage, eligibility, enrollment, or benefits determinations, all of which remain the sole responsibility of Company and its personnel under Company policies and applicable law. Company will not use the Services or any Output as the sole basis for any decision having legal, financial, medical, or similarly significant effects on any member.

3.10.2.1 AI and PHI Restrictions. Olusan may not use Alliance PHI or other confidential data to train, improve, test, validate, or develop any AI model, algorithm, large language model, or similar technology. PHI may only be used for the Services approved by the Alliance and may not be submitted to any public, shared, or third-party AI platform without the Alliance's prior written consent. Olusan shall maintain appropriate governance, oversight, and controls for any approved AI use.

3.10.3 Disclaimer. EXCEPT FOR THE EXPRESS WARRANTIES SET FORTH IN SECTION 3.10.1 AND ANY OTHER EXPRESS WARRANTIES SET FORTH IN THIS SOW, THE SERVICES, CONTINUITYOS, OUTPUT, WRITTEN DELIVERABLES, WORK PRODUCT AND DOCUMENTATION ARE PROVIDED "AS IS," AND OLUSAN HEREBY DISCLAIMS ALL WARRANTIES, WHETHER EXPRESS, IMPLIED, STATUTORY OR OTHERWISE, INCLUDING ALL IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, TITLE AND NON-INFRINGEMENT, AND ALL WARRANTIES ARISING FROM COURSE OF DEALING, USAGE OR TRADE PRACTICE, TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW. WITHOUT LIMITING THE FOREGOING, OLUSAN MAKES NO WARRANTY THAT THE SERVICES, CONTINUITYOS, OUTPUT, WRITTEN DELIVERABLES, WORK PRODUCT OR DOCUMENTATION WILL MEET COMPANY'S REQUIREMENTS, OPERATE WITHOUT INTERRUPTION, ACHIEVE ANY INTENDED RESULT, BE COMPATIBLE WITH ANY OTHER SOFTWARE OR SYSTEM, OR BE SECURE, ACCURATE, COMPLETE, FREE OF MALWARE OR ERROR-FREE. ALL OPEN-SOURCE COMPONENTS AND OTHER THIRD-PARTY MATERIALS ARE PROVIDED "AS IS," AND ANY REPRESENTATION OR WARRANTY CONCERNING THEM IS STRICTLY BETWEEN COMPANY AND THE APPLICABLE THIRD-PARTY OWNER OR DISTRIBUTOR.

4.The Solution

ContinuityOS is the Operating System for Medicaid Continuity. It operates above the plan's existing infrastructure, without replacing any system of record, and applies a named operational owner, a clock, and a confirmed outcome to every governed case across every channel touching the member. The platform converts activity, analytics outputs, community partner actions, and delegated network work into confirmed continuity outcomes the plan can defend.

DETECT	ASSIGN	EXECUTE	VERIFY	RECORD
Risk surfaced before the window closes: renewal, H.R. 1 exposure, outreach failure, care gap, social need, or partner handoff.	A named accountable owner and SLA clock are assigned. Ownership is preserved through every handoff and escalation.	Action is routed through the right channel: plan team, vendor, FQHC, CHW, CBO, ECM provider, or trusted partner.	Outcome is confirmed, not assumed. Terminal status, evidence, and source of truth are captured.	Continuity Record is produced with signal, owner, clock, action, evidence, outcome, and cause code.

ContinuityOS activates five operating domains for the Alliance:

Operating Domain	What ContinuityOS Governs
Renewal Governance	**Two operating motions. Coverage Preservation:** risk detection, owner assignment, renewal clocks, evidence readiness, escalation, and cause-coded closure. **Reinstatement Recovery:** the in-window recovery cohort, countdown clocks, outreach and evidence collection, and source-confirmed reinstatement.
Outreach Effectiveness	Contact reliability, channel choice, consent and suppression,duplicate-outreach prevention, and channel-to-outcome attribution.
Network Accountability	Provider assignment, acceptance, scheduling, completion tracking, closing the gap between ED and hospital discharge with ambulatory care
H.R. 1 Policy Compliance: Pathway Match	Exemption-first readiness, evidence organization, true-gap identification, and rule-correct pathway routing for H.R. 1, with the State as decision-maker.
Care Gap Closure	Coverage-to-care activation, primary-care connection, new-member baseline activation, and closed-loop referrals to Alliance-approved wraparound and community services, each with named ownership and verified closure, verified in encounter data or an Alliance-approved source.

5. Architecture

The architecture below is the common base platform configured for the Alliance during Stage 1 of implementation: the inputs ContinuityOS reads, the governance it applies, the execution channels it routes through, and the outcomes it confirms, together with the service commitment attached to each engine stage.

INPUTS	GOVERNANCE	EXECUTION	OUTCOMES
Enrollment and state files. Renewal dates, eligibility status, notices, reinstatement, and state and county outcomes. **Claims and encounters.** Utilization, medical frailty, BH and SUD, medication, and care-gap signals. **HRA and social needs.** Food, transportation, housing, documentation, and navigation barriers. **Cross-program data.** SNAP, TANF, WIOA, education, and wage signals where available.	**Population Intelligence.** Risk priors, pathway-readiness map, true-gap forecast. **Failure Mode Registry.** Classifies why continuity breaks and which queue applies. **Pathway Match.** Four-status triage, state logic, evidence map, owners, clocks. **Continuity Record.** Timestamped proof artifact with evidence and terminal status.	**Existing tools.** Care management, outreach, referral, eligibility, and reporting systems. **Partner pathways.** FQHCs, CBOs, ECM and Community Supports, CHWs, workforce partners. **Agent support.** Outreach, scheduling, document chase, verification follow-up, escalation. **Plan teams.** Member services, quality, compliance, network, operations.	**Confirmed results.** Coverage retained or cause-coded, not just attempts. **Network accountability.** Partner acceptance, SLA, terminal status, evidence. **Policy support.** Pathway readiness without plan compliance determination. **Audit-ready.** Continuity Record exportable on demand.

6. Scope of Services

Governed population

The AHS Operational Scope includes all individuals meeting the mutually agreed Alliance Medicaid eligibility, AHS attribution and exclusion criteria, as updated through the agreed data feeds. Medicare and dual-eligible members are excluded. Other excluded eligibility categories shall be expressly documented. Inclusion is determined by these criteria, not individual member designation. There is no numerical membership cap or fee adjustment based on membership changes. Previously included members may continue receiving authorized recovery assistance following procedural disenrollment during the applicable recovery period, subject to agreed recovery criteria and data-use permissions. Intervention prioritization and operating capacity are governed separately by the agreed delivery plan.

Services included in the platform fee

- Recover members who have fallen off coverage and are eligible to be reinstated: identify the members still inside their reinstatement window, assign each case an owner and a deadline, support outreach and evidence collection, and verify each reinstatement against Alliance-approved sources.

Improve outreach through Alliance-approved channels Included assistance comprises contact correction, duplicate suppression, approved channel coordination, outcome attribution, calls, document collection, scheduling support, provider coordination, escalation and verification, subject to agreed permissions, priorities, attempt limits and operating capacity.

- . Text messaging is governed exclusively by the Member Communications and Text Messaging Section.
- Close the loop with the provider network: track scheduling across the AHS FQHC clinics, confirm loop completion, and rank bottlenecks clinic by clinic so the Alliance can see where the provider loop breaks.
- Connect members to primary care: convert preserved coverage into a primary-care appointment, with medication and behavioral-health follow-up supported where indicated.
- Match members to work-requirement pathways, exemption first: before any member is burdened, identify members whose existing data indicates a potential exemption, exception, or evidence-supported pathway, for Alliance review under Alliance-approved rules, then route the remaining members to a rule-correct pathway. The State determines compliance; Olusan governs readiness and proof.
- Produce a Continuity Record for every Governed Case, and deliver the reporting described in Section 6, including the monthly board-cycle report on who is leaving and what can be recovered.
- Population Intelligence risk detection, prioritization, platform configuration, training, and standard implementation support, with a named engagement lead.

Excluded from scope unless separately agreed in writing

- Replacement of any Alliance system of record.
- EHR builds or direct scheduling integration inside provider systems.
- Any further members or hospital or Federally Qualified Health Center groups.
- Replacement of the Alliance's existing referral platforms.
- Eligibility determination, H.R. 1 compliance determination, official notices, or adverse-action communications.
- Custom software outside the ContinuityOS platform, and provider or clinic labor costs.
- Outreach labor and channel costs: the platform fee includes the governance, routing, attribution, reporting, and configuration of outreach workflows; it does not include call-center staffing, community health worker staffing, field outreach labor, or third-party messaging, voice, or print costs.

7.Deliverables and Milestones

The following deliverables cover two months of implementation and twelve months of live operations . All milestones are measured from the Start Date , subject to Assumptions and Dependencies. For a November 2, 2026 Start Date, implementation occurs during November–December 2026, live operations during January–December 2027, and assessment in October 2027. A detailed delivery and capacity plan , including responsible owners and dependencies, will be agreed and submitted at day 30. Alliance effort levels below are planning estimates.

Deliverable	What the Alliance receives	Milestone	Alliance effort
Design, configure and deploy ContinuityOS	Configuration of all five solutions for the agreed AHS Operational Scope, including eligibility and exclusion rules, data feeds, ownership, deadlines, permissions, Capacity Schedule and authoritative verification sources. Agree the nine metric specifications, available baselines and directional improvement objectives. Document owners and completion dates for unavailable baselines.	Months 1–2. Configuration, testing, training and production readiness completed by the end of implementation, subject to documented dependencies.	Medium
Platform go-live	Final configured platform, customized for the Alliance, live for Alliance users.Configured ContinuityOS available to authorized Alliance users,	within thirty (30) days of the Start DateCommencement of Month 3. Live operations continue through Month 14.	Low

Deliverable	What the Alliance receives	Milestone	Alliance effort
	with approved workflows, access controls, trained users and support arrangements.		
Launch member recovery queue and reinstatement reporting	Eligible members identified, reinstated,Identification and prioritization of eligible recovery cases, named owners and deadlines, approved assistance, stalled-case recovery and authoritative reinstatement verification. Report confirmed against Alliance-approved sources, with recovered members' recoveries and restored capitation reported monthly (Failure Mode Map and where supported by available evidence.	Live within 60 days of the Start Date; monthly thereafterQueue live at the commencement of Month 3. Monthly reporting throughout live operations; final reconciliation in Month 14.	Low
Deliver corrected member contact data and reach reporting	Corrected-contact file and Contact Reliability Register, with contact quality, reachability, permissions, suppression and channel results reported against agreed definitions and available baselines.	Workflow live at the commencement of Month 3. First reach report after the first live month; refreshed and reported monthly thereafter.	Low
Deploy primary-care loop tracking through AHS clinics	Member-level referral, provider acceptance, scheduling and verified completion tracking, including authorized coordination, missed-step recovery, unresolved barriers and clinic-level bottlenecks through the Provider Loop Map and Coverage-to-Care Queue.	Tracking live at the commencement of Month 3. Monthly reporting throughout live operations; eligible open-case completion and handoff in Month 15Month 14.	Medium

Deliverable	What the Alliance receives	Milestone	Alliance effort
Deliver the Monthly Operating Report	Results across the nine governing measures, including verified coverage and care outcomes, attribution, administrative burden, unresolved cases, reasons, accountable owners and next actions. Include potentially recoverable losses and supported financial value without double counting. Report Continuity Record completeness for audit integrity, separately from outcome improvement.	First report covers Month 3 and is due within fifteen business days after month-end. Monthly thereafter through Month 13, with final reporting in Month 14. Identify unavailable or lagged evidence in each report.	Low
Activate Policy Compliance and Pathway Match workflows	Exemption-first review under Alliance-approved rules, documentation of potential exemptions, exceptions and evidence-supported pathways, and routing of unresolved gaps for approved assistance. The Pathway Readiness Register records status, evidence, ownership and next actions; authorized entities retain official determinations.	Workflows configured and tested during Months 1–2; live at the commencement of Month 3 and maintained through each applicable cycle during live operations.	Medium
Produce audit-ready Continuity Records	A timestamped, exportable record for every Governed Case documenting the signal, owner, deadline, authorized actions, evidence, verification status and disposition. Unresolved cases remain identifiable with an accountable next owner and action.	Prototype during implementation. Production records maintained from the first live case onward, including authorized case activity during Month 14.	Low
Complete assessment and final reporting	Reconciliation of lagged evidence, final reporting on the nine governing	Month 14. Authorized actions on existing cases may continue, including	Agreed at kickoff

Deliverable	What the Alliance receives	Milestone	Alliance effort
	measures and value ledger, Alliance-specific Written Deliverables, and evidence to inform renewal. If the engagement ends, complete agreed transition, unresolved-case handoffs and data disposition under the governing agreements.	member contact, document collection, exception resolution and verification. New cases or campaigns require prior written Alliance approval.	

8. Implementation Plan

All phases are measured from the Start Date, subject to Assumptions and Dependencies.
Mobilize, Month 1

Executed SOW and BAA; security and insurance materials; minimum data specifications; dynamic AHS Operational Scope and exclusion rules; full-engagement RACI; dependency register; solution-level outreach, consent, suppression and permissions protocols; preliminary Capacity Schedule; nine metric specifications; and authoritative-source map.
Configure, Month 2
Validated data feeds and cohort lineage; solution rules and failure modes; case-owner and clock configuration; provider and community-partner workflow design; approved channel sequences and stop conditions; user acceptance testing; training; agreed Capacity Schedule; available matched historical AHS baselines ; and an agreed scorecard and directional improvement objectives by the end of implementation. Unavailable baselines shall have documented responsible owners and completion dates under Success Metrics. Complete production-readiness testing for go-live at the commencement of Month 3.
Operate, Assess and Complete, Months 3 through 12
Continuous population surveillance; qualified case creation; approved bounded execution; provider and community-partner coordination; handoffs, escalation and nonterminal recovery; authoritative verification; Continuity Records; monthly operating and metric reporting; outcome attribution; administrative-burden measurement; and protocol optimization. Members meeting the agreed inclusion criteria remain within the governed population regardless of whether they currently require intervention.
Complete eligible open cases; ingest and reconcile lagged eligibility, enrollment, encounter, claims, capitation and quality evidence; finalize reporting on the nine governing measures, identifying remaining evidence limitations; reconcile the no-double-counting value ledger; and provide final reports and Alliance-specific Written Deliverables to inform renewal. If the engagement ends, support the agreed transition and complete data disposition under the governing agreements. Authorized actions on existing cases, including member contact, document collection, exception resolution and verification, may continue. New cases or campaigns require prior written Alliance approval.

9.Success Metrics

WHAT AAH IS BUYING: One population-governance, execution, verification, and evidence layer for the dynamic eligible AHS network. Governance applies across the full eligible population because risk and attribution change. Intervention remains targeted, and active execution is separately bounded. The transaction is materially broader than renewal outreach.

The parties will govern the engagement to the measures below. Each measure is baselined from the Alliance's actual data Within sixty days after the Start Date, the parties shall agree the scorecard, measure definitions, eligible denominators, exclusions, measurement windows, responsible owners, authoritative sources and available baselines . Unavailable baselines shall be recorded with remediation responsibilities and completion dates without delaying agreement on the remaining scorecard. Outcomes are measured and reported against the Alliance-approved baselines. Following baseline approval, the parties will establish directional improvement objectives for each measure. No minimum numerical performance target or guaranteed financial outcome is assumed at signature. Reporting distinguishes message sent, member

contacted, action completed, and outcome verified, so activity is never counted as a completed outcome. As a standing leading indicator for every measure below, each validated case is assigned a named owner within 24 hours of signal, with escalation on breach, reported monthly. A Continuity Record stands behind every number reported.

SOLUTIONS	ECONOMIC VALUE	WHAT AAH RECEIVES
Renewal Governance	**Coverage preservation** **WHY IT MATTERS** Retains eligible members, covered months, capitation, and continuity of care. For AHS, continued coverage may also reduce uncompensated care when subsequent services occur.	Olusan-governed renewal-risk members maintained through redetermination, with each case, intervention, authoritative coverage result, and attribution trail recorded in the Continuity Record.
	Reinstatement recovery **WHY IT MATTERS** Restores eligible members and covered-month value not preserved through prevention, while reducing the duration and consequences of a coverage interruption.	Olusan-governed members procedurally disenrolled and returned to confirmed enrollment within the applicable reinstatement window, with ownership, actions, evidence, official confirmation, and timing recorded.
Network Accountability	**Acute Care Continuity** **WHY IT MATTERS** Closes the acute-care-to-primary-care gap and shows where AHS handoffs, acceptance, capacity, or follow-up break down.	One governed case from a qualifying ED encounter and/or discharge through an accepting AHS PCP and source-verified completed follow-up, with named ownership, clocks, recovery, and failure reporting.
Outreach Effectiveness	**Outcome attribution** **WHY IT MATTERS** Reduces duplicative outreach and member burden, establishes accountability across vendors and channels, and supports correct allocation of outreach spending and vendor payment.	Confirmed continuity and care-gap outcomes traced to the channel, vendor, owner, action sequence, and timing associated with the result, with the complete attribution chain preserved in the Continuity Record.
Care Gap Closure	**Primary-care connection** **WHY IT MATTERS** Converts enrollment into an attended primary-care relationship and supports applicable new-member access obligations.	AAH defines the population and window; Olusan governs assignment through attended visit; approved encounter or claims data confirms completion.
	Quality improvement **WHY IT MATTERS** Transforms plan-selected HEDIS or MCAS into verified performance improvement strategies with digital health engagement	AAH selects the measure, population, exclusions, closure window, and authoritative source. Olusan confirms the gap remains actionable, assigns an owner and clock, secures an accepting provider, governs member and provider actions, recovers failed steps, and returns evidence for official closure confirmation.
Policy Compliance	**Continuity Record** **WHY IT MATTERS** A CAP-defensible compliance artifact on every case and documentation supporting supplemental revenue. Reduces manual reconstruction.	One timestamped, source-attributed record of ownership, actions, evidence, authorized handoffs, verification, and disposition for every governed case.
	Pathway Match **WHY IT MATTERS** Isolates the true-gap population before outreach, reduces unnecessary documentation and member burden, focuses assistance on unresolved cases, and helps protect coverage before the applicable deadline.	Every potentially exposed member is screened against approved data and classified as an exclusion candidate, data-supported pathway, temporary exception, or unresolved pathway gap. Only the unresolved true-gap cohort proceeds to pathway assistance; authorized entities retain all official determinations.
All Solutions	**Administrative cost reduction** **WHY IT MATTERS** Releases staff capacity and lowers the cost of governing cases without reducing performance or shifting work elsewhere.	Automation and governed workflows that reduce manual routing, reconciliation, outreach duplication, case preparation, follow-up, rework, and error correction from detected risk through verified outcome and completed Continuity Record.

10. Service Levels

The following service levels apply to the platform and are measured and reported monthly at the governance meeting in Section 10.

Service level	Commitment	Measurement
Platform availability	99.5 percent monthly uptime for the ContinuityOS platform	Monitored continuously; reported monthly
Data-feed processing	Inbound files validated and ingested within one business day of receipt; exceptions flagged same day	Feed logs; monthly report
Incident response	Priority 1 production incidents acknowledged within one hour, with continuous work until stabilized and notification within the BAA-defined window; Priority 2 within four business hours; Priority 3 within one business day	Incident log; per incident and monthly
Scheduled maintenance	Normally outside Alliance business hours, with 72 hours advance notice where interruption is reasonably anticipated, except emergency maintenance	Maintenance log and notice
Recovery objectives	Target recovery time of eight hours and target recovery point of one hour, subject to the agreed production configuration	Annual testing; incident reporting

Customer volume and throughput schedule.

A schedule of Alliance-specific operating assumptions, governed cohort, estimated monthly recovery, renewal, care-gap, and provider-loop case volumes, outreach events by channel, and source-file cadence, will be completed with validated Alliance data during Stage 1 of implementation and maintained alongside these service levels. These are capacity-planning assumptions, not service levels.

Support model.

A named engagement lead is the Alliance's first point of contact. Support is provided during business hours Pacific time, with on-call escalation for Priority 1 issues, a defined escalation path, and the monthly governance meeting in Section 10 as the standing operational cadence. Olusan provides role-based training for Alliance users

during Stage 1 configuration, with written documentation, recorded sessions, and refresher training across the term so new Alliance staff can be brought current without a separate engagement.

11. Engagement Governance

The engagement is governed jointly, on a standing cadence, so results, risks, and decisions have one home. Olusan prepares the materials; the Alliance may fold these sessions into existing meetings.
Operating reports shall identify verified coverage and care outcomes, resolution times, unresolved cases, reasons for noncompletion, accountable owners and next actions. Olusan and Alliance shall coordinate existing services to avoid duplicative member outreach, overlapping assignments and duplicate attribution of outcomes or financial value.
Renewal and Expansion Review: Beginning October 4, 2027, the parties will review AHS renewal and potential expansion to CHCN, CFMG and/or independent networks against the performance criteria and readiness requirements established under the Joint Delivery and Capacity Plan, available funding, and required approvals. By October 29, 2027, the Alliance will provide a written decision, including reasons for any decline or deferral and anticipated timing for outstanding approvals. The parties will target execution of approved renewal or expansion agreements by November 30, 2027, and commencement on January 1, 2028. Renewal or expansion requires mutually agreed scope, pricing, implementation timing, and responsibilities, documented in a signed amendment or separate SOW, with required approvals. If the parties do not agree to a Renewal, the remainder of the Initial Term (through December 31, 2027) is reserved for agreed completion and transition activities.

Following joint validation of results, the parties may develop a case study addressing coverage continuity, completed care and implementation learning. Participation, permitted data use, publication and use of Alliance's name or results require separate written approval. Any findings shared must comply with the governing data-use agreements. Alliance may separately agree to serve as a customer reference.

Forum	Participants	Cadence	Purpose
Joint governance meeting	Alliance operational leads (member services, quality, IT or data, provider network) and the Olusan engagement lead	Weekly during Stages 1 and 2, monthly thereafter	Review the measures in Section 6, the service levels, open risks, and the queue and channel tuning decisions
Executive review	Alliance executive sponsor and CFO designee; Olusan executive sponsor	Quarterly, ahead of the board cycle	Executive scorecard, the board-question report, value accrued, and course corrections (Quarterly Executive Scorecard)
Conversion and expansion review	Both executive teams	Review beginning October 4, 2027; target renewal decision by October 29, 2027; transition/completion activities (if any) through December 31, 2027	Review observed outcomes against Alliance-approved baselines beginning October 4, 2027, and target a renewal decision by October 29, 2027, to support uninterrupted service. If the engagement does not renew, complete the final assessment by December 31, 2027, including verified outcomes, unresolved cases and, if the engagement ends, transition status.

12. Assumptions and Dependencies

The commitments in this SOW rest on the following. Because the Alliance provides each item below, ContinuityOS can deliver the corresponding milestones; where an item is delayed, affected timelines extend day for day.

- **Contract and security gate.** Executed SOW and Business Associate Agreement, and completion of the Alliance's security review, before any exchange of member data.
- **Data delivery.** The Alliance delivers the agreed data files on the agreed cadence: the 834 eligibility file (or agreed attribution file), renewal and redetermination status, reinstatement status, contact fields and preferred language, provider and clinic attribution, claims and encounter extracts, claims, the Alliance's care-gap list where maintained, and, where available, health-risk and social-needs signals, cross-program signals relevant to H.R. 1 exemptions (such as SNAP and TANF indicators), and the 820 payment roster. The minimum set required to begin Stage 1 is the eligibility, renewal-status, and contact files; the remaining files govern the dependent deliverables and their timing. No Medicare member data is transmitted.
- **Data exchange method.** The engagement runs on file-based data exchange: the 834 eligibility file is the preferred format, with pipe-delimited text or CSV over secure file transfer supported as fallbacks, and no API or single-sign-on dependency at launch. The Alliance provides scheduled extracts; Olusan returns governed queues, the corrected contact file, suppression and consent logs, attribution reporting, and Continuity Record exports as files to the Alliance's data environment. After the file-based first year, the parties may mature the exchange into secure API-based integration by mutual agreement, with source-of- truth boundaries preserved.
- **Alliance participation.** The Alliance names a project lead and a data contact, makes the relevant teams available for the Stage 1 configuration sessions and user acceptance testing, approves outreach rules and content, and confirms the approved verification sources. Alliance staff time is heaviest in Stage 1 (estimated at several hours per week for the named contacts) and light thereafter.
- **Provider data access.** The provider-loop and primary-care measures depend on AHS clinic scheduling and encounter data available through the Alliance's existing access. Where access is not yet in place, Olusan governs on the best available signal and marks dependent outcomes as contingent with a defined fallback.
- **Data availability.** If specific data elements are unavailable, incomplete, delayed, or not approved for use, Olusan performs the applicable services using available data, and the related measures or deliverables are adjusted by mutual agreement.

Vendor readiness. Olusan maintains commercial insurance coverage and will provide certificates of insurance evidencing the coverages and limits required under the Agreement prior to the Effective Date. Olusan runs continuous security and compliance monitoring on Vanta as part of its SOC 2 program and has completed an independent third-party security assessment; security documentation, including safeguards for PHI, is available to the Alliance's information security review on request. Olusan will execute the Alliance's Business Associate Agreement prior to any exchange of member data.

13. Deployment Team

Named	Accountability	Background
Founder and CEO	Executive sponsor: executive oversight, strategic alignment, escalation	Former COO, San Francisco General Hospital; former President, Sutter Health East Bay; former SVP, John Muir Health; former board member, Alameda Alliance for Health; IHI board member; NCQA Evaluation Programs Committee

Head of Operations	Engagement and operations lead: primary Alliance owner; implementation operations across plan, provider, and county workflows	Public health and program operations leader who has built and scaled care programs for vulnerable populations across California, including at UCSF and the San Francisco Department of Public Health
Chief Technology Officer	Technology and security: architecture, security, data integration, reliability	CTO, Syntex Data; former Enterprise Lead Architect, U.S. Department of Defense; health intelligence and secure enterprise systems
Head of Data Science	Population Intelligence: cohort analytics, failure-mode intelligence, prioritization, and metric integrity	Population health data scientist; led analytics for large public-sector health responses and delivery-system improvement programs
Head of Product	Product: console, workflow, and configuration design	Product designer and strategist who has built products serving over 80 million patients and 200,000 providers at Kroger Health, Kaiser Permanente, Brightline, and others

Olusan will notify the Alliance in writing of any change to named team members.

14. Policy, Eligibility, AI, and Regulatory Boundaries

Olusan does not determine Medicaid eligibility, H.R. 1 community-engagement compliance, exemption or exception status, medical necessity, utilization-review or utilization-management outcomes, claims payment, benefit coverage, or adverse coverage action under this SOW. The State, county, Alliance-approved process, or other authorized authority remains the source of truth for official determinations. Alliance systems of record remain authoritative; ContinuityOS coordinates workflow state, ownership, deadlines, evidence readiness, and outcome verification, and does not overwrite a source-of-truth determination.

Olusan uses artificial intelligence for administrative risk prioritization, next-action recommendations, evidence readiness, workflow prioritization, outreach and channel recommendations, escalation timing, and Continuity Record assembly, subject to human validation and Alliance-approved workflows. Olusan does not use artificial intelligence to make eligibility, compliance, medical-necessity, utilization-review, utilization-management, denial, delay, modification, or adverse-action decisions. To the extent any DMHC or state law requirements apply to artificial intelligence used for utilization review or utilization management, including California Health and Safety Code Section 1367.01(k), the parties acknowledge Olusan is not performing those functions under this SOW unless expressly agreed in a future written amendment.

Medicare FDR applicability. Because the AHS Operational Scope and the data exchange expressly exclude Medicare members, including dual-eligible members, and Olusan performs no Medicare administrative functions under this SOW, the parties do not intend Olusan to be a first-tier, downstream, or related entity under this SOW. If the Alliance determines Olusan is an FDR for a Medicare or D-SNP function in a future phase, Olusan will comply with applicable FDR obligations for the functions expressly delegated at that time. Nothing in the Medicare Addendum expands the scope of services or makes Olusan responsible for claims payment, utilization management, medical necessity, Part D administration, provider credentialing, official notices, eligibility determinations, or adverse actions unless separately agreed in writing.

Olusan shall not originate or send text messages to Alliance members. AHS shall remain the sender through its approved systems. Subject to Alliance's prior written approval of the applicable protocol, Olusan may route recommended outreach queues to AHS and receive delivery, response and authorized suppression information to coordinate and verify AHS-originated outreach. These activities do not constitute prohibited facilitation or direction and are included in the AHS Partnership Fee without a separate amendment or order form. Alliance shall secure documented AHS participation before activating the workflow, including an accountable owner, approval and sending turnaround times, delivery and response visibility, escalation procedures and fallback channels. Responsibility for sender and channel costs shall be expressly allocated in the written delivery plan before activation. Any additional fees payable to Olusan

require a written amendment or order form executed by Alliance and Olusan. Nothing in this SOW obligates AHS to provide texting or pay Olusan absent its separate agreement.

[No telephone number shall be considered authorized for text messaging solely because it appears in an eligibility, enrollment, provider, contact, care-management, claims, encounter, or other data file made available to Olusan.

Olusan shall not initiate, transmit, send, facilitate, direct, or cause the transmission of any text message to an Alliance member under this SOW. Olusan shall not use its own messaging platform, telephone number, short code, long code, sender identity, personnel, agent, subcontractor, or other resource to send text messages to Alliance members.

Any text messaging used in connection with the Services shall be performed solely by AHS, using AHS-controlled systems, personnel, sender identity, and communications processes. Before routing or recommending any member for text outreach by AHS, Olusan must receive the Alliance's prior written approval of the applicable member population, permitted purpose, content parameters, data elements to be provided to AHS, and operating protocol.

AHS shall remain responsible for determining and documenting the legal basis for its text messaging, including any required consent, sender identification, suppression, opt-out, frequency, recordkeeping, and other communications controls. Olusan shall not determine, validate, or represent that a member has consented to receive text messages.

No operating protocol, RACI, implementation plan, project plan, channel sequence, consent log, suppression list, workflow configuration, or other operational document may authorize Olusan-originated text messaging or modify the restrictions in this Member Communications and Text Messaging Section. Any amendment to these restrictions must be contained in a written amendment to this SOW executed by authorized representatives of the Alliance and Olusan.

Any texting workflow is outside the Services included in the AHS Partnership Fee and shall require a written amendment or order form executed by the Alliance and Olusan. Nothing in this SOW obligates AHS to provide text messaging or makes AHS responsible for any payment to Olusan.

Any AHS-originated texting used in connection with the Services must be conducted pursuant to an AHS-approved process under which AHS determines and documents the applicable legal basis, including any required consent, sender identification, suppression, opt-out, frequency, and recordkeeping controls. Olusan shall not determine, validate, or represent that a member has consented to receive text messages .][1]

15. Term

The i nitial t erm consists of two (2) months of implementation, twelve (12) months of live operations (the "Initial Term"). For a November 2 , 2026 Start Date, implementation runs through December 31, 2026 and live operations run January 1 through December 31, 2027. Any different Start Date requires corresponding dates to be documented in the implementation plan.

Implementation is addressed within this SOW; there is no separate implementation statement of work.

Operational Plan. Within thirty (30) days after the Start Date, the parties will document a Joint Delivery and Capacity Plan covering designated leads, AHS participation, data and approval timelines, communication workflows, staffing, execution capacity, prioritization, and escalation. The plan will establish mutually agreed evaluation criteria for Renewal and expansion, including baselines, measurement periods, verification sources, readiness requirements, and treatment of dependencies outside each party's control. Plan completion or approval

[1] NTD: Subject to discussion

will not delay SOW execution, the first payment, the Initial Term, or authorized implementation activities whose prerequisites are satisfied. Pending completion, the SOW's responsibilities and assumptions will govern. Unresolved items will be escalated to executive sponsors while unaffected work continues. The plan cannot change scope or fees, impose a numerical member ceiling, or override consent, security, or authorization requirements. Material changes to scope, fees, or committed resources require a mutually executed written amendment.

Minimum commitment. The initial fourteen (14) month term is an expected commitment. Each quarterly installment of the AHS Partnership Fee is fully earned as of the first day of the quarterly period to which it relates and is non-refundable and non-creditable. The Alliance may terminate this SOW, in whole or in part, for convenience upon ninety (90) days' prior written notice. The Alliance may deliver notice of termination for convenience no earlier than the date six (6) months after the commencement of live operations, so that any termination decision reflects a full operating cycle of live operations. Any termination for convenience shall be effective only on the last day of a quarterly installment period, and termination in part shall not reduce the quarterly installments. For purposes of this Section, the quarterly installment periods are: (i) November 2, 2026 through January 31, 2027; (ii) February 1, 2027 through May 2, 2027; (iii) May 3, 2027 through August 1, 2027; and (iv) August 2, 2027 through December 31, 2027 (the end of the Initial Term).

The Alliance will pay approved, non-cancellable third-party pass-through costs expressly identified in this SOW and actually incurred by Olusan prior to the effective termination date. Olusan shall provide reasonable documentation supporting any such costs upon request. Except as expressly provided in this Section, the Alliance shall have no obligation to reimburse implementation costs, transition costs, overhead, lost profits, anticipated future expenses, internal labor costs, allocations, reserves, or other estimated or unamortized amounts. Except as expressly provided in this Section, the Alliance will not owe accelerated license fees, minimum-commitment charges, early-termination fees, lost profits, or fees for periods after termination, other than fees for Transition Assistance as provided below. Olusan will promptly cease affected work, mitigate costs, deliver all Alliance data and work product, and securely return or destroy all Alliance data and Confidential Information in accordance with the Agreement and the BAA (the "Wind-Down Obligations"). The Wind-Down Obligations are Olusan's only post-termination obligations for which no additional fees apply. Any other transition-related services, including knowledge transfer, cooperation with or onboarding of a successor vendor, data extracts or conversions beyond Olusan's standard formats, or continued operation of any Services after the effective termination date, constitute "Transition Assistance," which Olusan will provide at the Alliance's written request for up to ninety (90) days following the effective termination date at Olusan's then-current rates under a mutually agreed transition plan. If any quarterly installment of the AHS Partnership Fee is not received within fifteen (15) days after written notice of non-payment, Olusan may suspend Services until payment is received, and affected deadlines and milestones will extend day-for-day.

16. Fees

The parties acknowledge that the AHS Partnership fee is a fixed commitment and is not priced on a per-member, per-case, per-workflow, per-intervention, or outcome-based basis.

The standard AHS Partnership fee is $2,625,000 for a fifteen (15)-month term (the "Standard Fee"). In recognition of the parties' shared Alameda County community, Olusan is applying a local partner discount, and the AHS Partnership Fee payable for the fourteen (14)-month Initial Term is $2,000,000. Any Renewal for an equivalent AHS Operational Scope shall be mutually agreed, with the AHS Partnership Fee for the term of the Renewal set at not less than the AHS Standard Fee, prorated for the length of the Renewal term. The AHS Partnership fee covers all Olusan technology, implementation, operational services, verification activities, reporting, support, and other deliverables described in this SOW for the AHS Operational Scope. Implementation is included in the AHS Partnership Fee. No separate activation, implementation, configuration, verification, runout, transition, or other fee applies.

The AHS Partnership is intended to provide continuous monitoring, analysis, prioritization, governance, execution support, and verification across the AHS Operational Scope. While only a subset of members may meet criteria for workflow entry or intervention at any given time, ContinuityOS continuously evaluates the AHS Operational Scope for approved triggers, risk indicators, eligibility events, care gaps, retention risks, and other operational conditions. Accordingly, the AHS Partnership fee reflects the ongoing capability to identify and manage opportunities across the AHS Operational Scope rather than the number of members actively receiving interventions during any specific period.

The AHS Partnership fee is paid by Alameda Alliance for Health to Olusan for the technology and services described in this SOW. No portion of the AHS Partnership fee constitutes compensation for access to Alliance members, and Olusan does not compensate the Alliance for member participation, member volume, referrals, interventions, outcomes, savings, or other member-related activities.

The AHS Partnership Fee is payable in four equal quarterly installments of $500,000 each, due November 2, 2026; February 1, 2027; May 3, 2027; and August 2, 2027 (approximately three, six, and nine calendar months after the Start Date). The first installment must be received by Olusan no later than November 2, 2026. If approval and execution cannot support that deadline, the parties shall agree to a revised commencement and payment schedule in writing before execution. Payment is not contingent on intervention volume, achieved outcomes or acceptance of Written Deliverables.

Supplemental Funding Support. The Alliance will designate a contact to help Olusan identify and pursue applicable supplemental funding, including any available IPP, community reinvestment, or other funding sources, and provide introductions, letters of support, and reasonable application assistance where appropriate. Funding remains subject to availability, eligibility, permitted uses, and required approvals, without duplicate payment for the same costs or services. These efforts will not delay or reduce the Alliance's payment obligations under this SOW, and neither party guarantees an award.

Acceptance of Written Deliverables

Acceptance applies only to written reports, summaries, exports, and other written materials expressly identified as Written Deliverables. Acceptance shall not condition, delay, or reduce payment of recurring platform license fees, ongoing ContinuityOS access, dashboard availability, workflow configuration, or case-governance services unless expressly stated in this SOW.

The Alliance shall provide written acceptance or written notice of deficiencies within thirty (30) business days after delivery of a Written Deliverable. If no notice is provided within that period, the Written Deliverable is deemed accepted. Olusan shall have thirty (30) days to correct noticed deficiencies and resubmit, and the same acceptance period applies to each resubmission.

Accepted and Agreed

The parties, by their authorized representatives, execute this Statement of Work as of the Effective Date.

ALAMEDA ALLIANCE FOR HEALTH	OLUSAN PLATFORMS, INC.
By: _____ Name: _____ Title: _____	By: _____ Name: Tosan Boyo Title: Founder and Chief Executive Officer
Name and title	Date

olusan

Exhibit A
Department of Managed Health Care Requirements

For purposes of this addendum "Subcontractor" shall mean Olusan and "Plan" shall mean Alameda Alliance for Health

This addendum sets forth requirements, in addition to those requirements set forth elsewhere in the [Agreement Reference from Contract], applicable to the performance of vendor services regulated by the California Department of Managed Health Care ("DMHC") unless otherwise pre-empted by the Medicare Modernization Act or other applicable law. The term "Member" used in this addendum shall refer to Plan's members who reside in California and are enrolled in a program regulated by the DMHC. If there is a conflict or inconsistency between the terms of the [Agreement Reference from Contract] and this addendum, the terms of this addendum shall control with respect to Subcontractor services regulated by DMHC.

1. Subcontractor shall comply with all applicable provisions of the California Health and Safety Code and related regulations in the California Code of Regulations. This includes, but is not limited to, the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code § 1340 et seq. and Chapter 2 of Title 28 of the California Code of Regulations ("Knox-Keene Act").

2. Books and Records. This Agreement will be construed and interpreted in a manner that permits confidential treatment by DMHC of payment rendered or to be rendered to Subcontractor.

2.1. Subcontractor shall prepare and maintain on a current and accurate basis all records, books, and papers related to this Agreement ("Records") possessed in any medium. Such Records shall be made available for inspection, including through electronic means, and copying by Plan and/or the DMHC, as may be necessary for Plan's compliance with the provisions of the Knox-Keene Act and the rules thereunder.

2.2. To the extent feasible, Records shall be located in the State and shall not be removed without DMHC's prior consent. If Records are located outside the State, Subcontractor shall make such Records available in the State or furnish true and accurate copies of such Records.

2.3. If Plan and/or DMHC requests to inspect Records, Subcontractor shall (i) furnish in electronic media Records that are possessed in electronic media, and (ii) conduct a diligent review of the Records and make every effort to furnish those responsive to the request for inspection.

2.4. To the greatest extent feasible, Records furnished for inspection shall be furnished in a digitally searchable format and must be maintained for at least five (5) years from the last date of service, except that if (i) DMHC requests, the Records must be preserved until furnished to DMHC, or (ii) other regulatory requirements require a longer retention period, that longer period will apply.

2.5. Subcontractor shall cooperate with Plan with respect to any DMHC examination of the fiscal and administrative affairs of Plan or Plan's subcontractors.

2.6. The obligation under this Section 2 shall survive termination of the Agreement for any reason.
[HSC §§ 1381, 1382, 1385; 28 CCR §§ 1300.67.1(d), 1300.67.8 (a)-(c), 1300.81, 1300.85, 1300.85.1]

3. Confidentiality of Medical Information Act.

3.1. Subcontractor will not disclose medical information regarding a Member unless such disclosure complies with the California Confidentiality of Medical Information Act, including the requirements in California Civil Code §§ 56.10, 56.104, 56.107, 56.108, and 56.110, as amended and applicable. [Health & Safety Code § 1348.5]

4. Liability.

4.1. Subcontractor and Plan are each responsible for their own acts or omissions and are not liable for the acts and omissions of, or the cost of defending, others. Nothing in this section shall preclude a finding of liability on the part of either Party based on doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases of liability. [Health & Safety Code § 1371.25]

5. Proper Licensure/Certification/Registration.

5.1. Personnel employed by or under contract to Subcontractor shall be licensed or certified by their respective board or agency, where licensure or certification is required by law. Equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law. [Health & Safety Code § 1367(b), (c)]

Artificial Intelligence. If Subcontractor or a downstream subcontractor utilizes an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, Subcontractor shall comply with HSC § 1367.01(k) and ensure the following:

6.1. The artificial intelligence, algorithm, or other software tool bases its determination on the following information, as applicable:
6.1.1. A Member's medical or other clinical history;
6.1.2. Individual clinical circumstances as presented by the requesting provider; and
6.1.3. Other relevant clinical information contained in the enrollee's medical record or other clinical record.
6.2. The artificial intelligence, algorithm, or other software tool does not base its determination solely on a group dataset.
6.3. The artificial intelligence, algorithm, or other software tool's criteria and guidelines comply with applicable laws.
6.4. The artificial intelligence, algorithm, or other software tool is fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by HHS.
6.5. The artificial intelligence, algorithm, or other software tool is open to inspection for audit or compliance reviews by the DMHC pursuant to HSC § 1381.
6.6. Disclosures pertaining to the use and oversight of the artificial intelligence, algorithm, or other software tool are contained in Subcontractor's written policies and procedures.

6.7. The artificial intelligence, algorithm, or other software tool's performance, use, and outcomes are periodically reviewed and revised to maximize accuracy and reliability.
6.8. Member data is not used beyond its intended and stated purpose, consistent with the California Confidentiality of Medical Information Act and HIPAA, as applicable.
6.9. The artificial intelligence, algorithm, or other software tool does not directly or indirectly cause harm to the Member.
6.10. The artificial intelligence, algorithm, or other software tool will not delay, deny, or modify health care services based, in whole or in part, on medical necessity.
6.11. The artificial intelligence, algorithm, or other software tool does not supplant health care provider decision making.
6.12. The use of the artificial intelligence, algorithm, or other software tool does not discriminate, directly or indirectly, against Members in violation of laws.

MASTER SERVICES AGREEMENT

THIS MASTER SERVICES AGREEMENT ("Agreement") is made and entered into as of November 1, 2026 ("Effective Date") by and between Alameda Alliance for Health, a managed care health plan ("Company"), and OLUSAN PLATFORMS INC ("Consultant") with reference to the following:

A. Consultant shall furnish services to Company for the project in accordance with the terms of this Agreement.

B. This Agreement is intended to and shall govern all services and work furnished by Consultant for the Project.

1. BASIC AGREEMENTS.

1.1 Basic Services. In compliance with all of the terms and conditions of this Agreement, Consultant shall provide those services specified in the "Statement of Work" attached hereto as Exhibit A, which services are referred to herein as the "Basic Services". Consultant shall meet with Company from time to time as requested by Company to discuss the progress of the Basic Services rendered to date and to ensure that Company is satisfied with the scope and quality of the Basic Services. Company may have a representative present at any meeting of Consultant concerning the Project.

1.2 Subconsultants. Consultant may retain subconsultants subject to the prior written approval of Company ("Subconsultants"). The retention of the Subconsultants shall not diminish or reduce the obligations and duties of Consultant hereunder. Company shall be listed as an intended third party beneficiary in each of Consultant's agreements with the Subconsultants to the extent applicable to the Project (the "Subconsultant Agreements"), and the Subconsultant Agreements shall provide that such Subconsultants shall be bound to the same terms and conditions of Consultant under this Agreement. In the event this Agreement is terminated by Company for cause, Company shall have the right, but not the responsibility, to assume the rights and responsibilities of Consultant under all or some of the Subconsultant Agreements that Company in its sole discretion chooses to assume. While this provision shall constitute a present assignment of Consultant's rights with respect to any and all such Subconsultant Agreements that Company so chooses to assume, Consultant, upon request from Company, shall promptly execute and deliver to Company written assignments of such Subconsultant Agreements that Company in its sole discretion so chooses to take by assignment. All Subconsultant Agreements shall provide for this assignment. Unless Company specifically approves in writing, in each instance, that the payment to any Subconsultant is a reimbursable expense, Company shall not have any liability for the cost and expenses of any Subconsultant, and Consultant solely shall be liable for any payment due to such Subconsultants. Consultant shall work with and coordinate its Basic Services with other consultants retained by Company in connection with the design of the Project as a Basic Service hereunder, but Consultant shall not be responsible for the content of their work or the errors or omissions of the Company's other consultants.

1.3 Standard of Performance. As a material inducement to Company to enter into this Agreement, Consultant hereby represents that Consultant has all applicable licenses to perform the

Basic Services and is experienced in performing work or services similar to the Basic Services and, in light of such experience, Consultant hereby covenants that it shall exercise the same degree of care, skill, and diligence as is ordinarily possessed and exercised by reputable members of the same profession currently practicing under similar circumstances in the same geographic area in performing the Basic Services and all services required hereunder and using only qualified personnel. Consultant shall comply with all applicable federal, state and local laws, ordinances, regulations and orders in performing the Basic Services and all services hereunder.

1.4 Additional Services. Company shall have the right at any time during the performance of the Basic Services, without invalidating this Agreement, to order extra services beyond that specified in the Statement of Work or make changes by altering, adding to, or deducting from said services ("Additional Services"). No Additional Services may be undertaken unless authorized by Company in advance and in writing, including via email. Additional Services shall be paid for by Company as provided in Section 2.2. All services performed in connection with this Agreement may be referred to herein as the "Services." All terms and conditions under this Agreement applicable to Basic Services shall be applicable to all Services except as otherwise agreed to in writing by Company and Consultant.

2. COMPENSATION. Company shall compensate Consultant for the Services to be performed in accordance with the terms and conditions of this Agreement as follows:

2.1 Basic Services. For Basic Services, as described in the Statement of Work, Company shall compensate Consultant for the Basic Services not to exceed the amount set forth in Exhibit A,without prior written authorization of Company. Said compensation shall be inclusive of all compensation costs, and expenses unless specifically set forth to the contrary in this Section 2.

2.2 Additional Services. For Additional Services, as described in Section 1.4 hereof, except as otherwise set forth in a separate written agreement between Company and Consultant, compensation shall be paid at the rates set forth in Exhibit A attached hereto, plus the actual cost for those out-of-pocket expenses for long-distance calls, fax transmission (not to exceed the cost of the call), photocopies, and delivery charges incurred in connection with the work hereunder. All other costs, expenses, or charges, including, but not limited to, daily working and commuting travel expenses and all compensation and benefits paid to Consultant's employees, incurred by Consultant in connection with the Additional Services, shall be paid by Consultant without reimbursement from Company. Notwithstanding anything in this Agreement to the contrary, Consultant shall not be entitled to reimbursement for such reimbursable expenses unless Company pre-approves such expenses in writing.

2.3 Payment. Payments for Basic Services shall be made monthly in proportion to services performed. Payments for Additional Services of Consultant, and for reimbursable expenses permitted hereunder, shall be made monthly upon presentation of Consultant's statement of services rendered with sufficient supporting data acceptable to Company. Consultant shall submit one complete application for payment per month, rendered on or before the fifth (5th) day of each month based on services completed to date. Each invoice from Consultant shall include an updated invoice tracking sheet describing the information required therein for all previous invoices related to the Basic Services and Additional Services, if any, and the information related

to the most current invoice. Each invoice must include detail of daily hours by individual. Company shall pay Consultant thirty days (30) after receipt of invoice.

(a) Should a bona fide dispute arise with respect to a payment application submitted by Consultant, or to the extent reasonably necessary to protect Company from loss for which Consultant is responsible, Company shall pay the undisputed amount within the time period set forth herein, but shall withhold the disputed amount until the matter is resolved. Notwithstanding anything contained in this Agreement to the contrary, no compensation shall be paid to or claimed by Consultant for services required to correct deficiencies in any documents or materials prepared by or on behalf of Consultant, or attributable to defaults, failures, errors, or omissions of Consultant, any Subconsultant, or anyone for whom Consultant may be liable, or changes in the Project requested by Consultant, any Subconsultant, or anyone for whom Consultant may be liable, unless previously approved in writing by Company. Consultant shall pay its own income taxes, federal, state, or city, and self-employment taxes. Consultant shall have the sole obligation to pay for any fees, assessments, and taxes, plus applicable penalties and interest, which may be imposed by law and arise from or are necessary for Consultant's performance of the Services required by this Agreement. Consultant will continue to perform its obligations hereunder and pursue prosecution of the Services during any claim, dispute, or proceeding between the parties hereto as if such claim, dispute, or proceeding had not been instituted, provided that Company continues to make payments to Consultant as required under this Agreement for Services that are not the subject of any dispute.

3. PROJECT SCHEDULE.

Consultant shall commence its Services hereunder within five (5) days of the receipt of an authorization to proceed from Company; provided, however, that no such Services shall be commenced until Company has approved the insurance required to be obtained by Consultant pursuant to Section 4.1. Consultant understands and agrees that time is of the essence with respect to Consultant's obligation to provide its Services under this Agreement in a timely manner; it being understood that delays by Consultant in the performance of its duties hereunder may cause substantial damages to Company.

4. INSURANCE AND INDEMNIFICATION.

4.1 Consultant shall, at its sole cost and expense, fully comply with the terms and requirements of this Section. Consultant shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by Consultant, its agents, representatives, or employees. Consultant shall procure and maintain for the duration of the contract insurance against claims arising out of their professional services and including, but not limited to loss, damage, theft or other misuse of data, infringement of intellectual property, invasion of privacy and breach of data.

(a) Commercial General Liability (CGL). Consultant shall have a completed Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis, including products and completed operations, property damage, bodily injury and personal & advertising injury with limits no less than one million dollars ($1,000,000) per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.

(b) Automobile Liability**.** Consultant shall have completed Insurance Services Office Form Number CA 0001 covering, Code 1 (any auto), or if Consultant has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than one million dollars ($1,000,000) per accident for bodily injury and property damage.

(c) Workers' Compensation and Employers' Insurance. To the extent Consultant has employees, Consultant shall maintain workers' compensation insurance as by the laws of the state of California, with Statutory Limits and employer's liability insurance limits of liability of not less than one million dollars ($1,000,000) bodily injury by accident (each accident), one million dollars ($1,000,000) bodily injury by disease (policy limit), and one million dollars ($1,000,000) bodily injury by disease (each employee), or limits carried, whichever are higher.

(d) Professional Liability (Managed Care Errors and Omissions) Insurance. Insurance with limit no less than two million dollars ($2,000,000) per claim, five million dollars ($5,000,000) annual aggregate.

(e) Cyber Liability Insurance. Consultant shall maintain Cyber Liability Insurance with limits not less than two million dollars ($2,000,000) per occurrence or claim, two million dollars ($2,000,000) aggregate. Coverage shall be sufficiently broad to respond to the duties and obligations as is undertaken by Consultant in this agreement and shall include, but not be limited to, claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall provide coverage for breach response costs as well as regulatory fines and penalties as well as credit monitoring expenses with limits sufficient to respond to these obligations.

(f) Subcontractors. If Consultant has obtained prior written consent from Company to subcontract any portion of this Agreement, Consultant shall not allow any subcontractor to perform any portion of the Services until Consultant obtains from such subcontractor, and provides to Company, proof of insurance in form and substance identical to that required to be carried by the Consultant pursuant to this Section 4.1 Consultant shall in writing bind each such subcontractor to all of the insurance requirements of this Section 4. Consultant shall also require that that Company is named as an additional insured on insurance requirements for subcontractors.

(g) Neither receipt nor acceptance of policies, endorsements, or certificates, whether indicating reduced or different coverages than required herein, nor any other forbearance or omission by Company with regard to these insurance requirements, shall be deemed a waiver of, or estoppel to assert, any right on the part of Company regarding these insurance requirements. The insurance requirements set forth herein are independent of Company's indemnification obligations and other obligations hereunder. Nothing herein shall be construed to limit or alter any of other obligations of Consultant, under this Agreement or otherwise, including, without limitation, Consultant's indemnification obligations.

(h) Other Insurance Provisions. The insurance policies are to contain, or be endorsed to contain, the following provisions:

(i) Additional Insured Status. Company, its officers, officials, employees, and volunteers are to be covered as additional insureds on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of the Consultant including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the Consultant's insurance (at least as broad as ISO Form CG 20 10 11 85 or both CG 20 10, CG 20 26, CG 20 33, or CG 20 38; and CG 20 37 forms if later revisions used).

(ii) Primary Coverage. The Consultant's insurance coverage shall be primary coverage at least as broad as ISO CG 20 01 04 13 with respect to the Company, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by Company, its officers, officials, employees, or volunteers shall be excess of the Consultant's insurance and shall not contribute with it.

(iii) Notice of Cancellation. Each insurance policy required above shall state that coverage shall not be canceled, except with notice to Company.

(iv) Waiver of Subrogation. Consultant hereby grants to Company a waiver of any right to subrogation which any insurer of Consultant may acquire against Company by virtue of the payment of any loss under such insurance. Consultant agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not Company has received a waiver of subrogation endorsement from the insurer.

(v) Self-Insured Retentions. Self-insured retentions must be declared to and approved by Company. Company may require the Consultant to provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention. The policy language shall provide, or be endorsed to provide, that the self-insured retention may be satisfied by either the named insured or Company.

(vi) Acceptability of Insurers. Insurance is to be placed with insurers authorized to conduct business in the state with a current A.M. Best's rating of no less than A-:VII, unless otherwise acceptable to Company.

(vii) Claims Made Policies. If any of the required policies provide coverage on a claims-made basis:

(A) The retroactive date must be shown and must be before the date of the contract or the beginning of contract work.

(B) Insurance must be maintained, and evidence of insurance must be provided for at least five (5) years after completion of the Agreement.

(C) If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date prior to the contract effective date, the Consultant must purchase "extended reporting" coverage for a minimum of five (5) years after completion of contract work.

(D) Verification of Coverage. Consultant shall furnish Company with original Certificates of Insurance including all required amendatory endorsements (or copies of the applicable policy language effecting coverage required by this clause) and a copy of the Declarations and Endorsement Page of the CGL policy listing all policy endorsements to Company before work begins. However, failure to obtain the required documents prior to the work beginning shall not waive the Consultant's obligation to provide them. Company reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

(E) Special Risks or Circumstances. Company reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

4.2 Indemnification.

(a) Scope. Each Party ("Indemnitor") will defend, indemnify, and hold the other Party ("Indemnitee") harmless from and against all liability, damages, cost and expense (including reasonable attorneys' fees and other costs of defense) arising from third party claims against Indemnitee in connection with this Agreement to the extent caused by the gross negligence, willful misconduct, or unlawful acts of the Indemnitor's agents, contractors and/or employees during the term of this Agreement. The Indemnitor will have the right to control the defense and settlement (to the extent of such indemnification), and the Indemnitee will reasonably cooperate in such defense.

(b) Procedure. The Indemnitee shall provide Indemnitor with prompt written notice of any claims for which it seeks indemnification. No delay in notice shall excuse the Indemnitor's obligations, except to the extent that the Indemnitor has been materially

prejudiced by such delay. The Indemnitor shall defend the Indemnitee at Indemnitor's sole expense with legal counsel reasonably acceptable to the Indemnitee. If the Indemnitor fails to provide a timely defense, then the Indemnitee may defend with counsel of its own choosing at the expense of the Indemnitor. Neither the Indemnitor nor the Indemnitee shall enter into any settlement without the prior written consent of the other, which shall not be unreasonably withheld or delayed.

(c) Indemnitee's Rights. Indemnitee's rights of indemnification under this Section 4.2 shall not in any way be limited by, reduced, altered, or diminished as a result of Consultant's obligations to procure and maintain insurance as set forth in Section 4.1, or as the result of the existence or non-existence of any type of insurance coverage benefiting Consultant, or any of Indemnitee. The provisions of this Section 4.2 shall survive termination or expiration of this Agreement.

5. RIGHTS AND REMEDIES.

5.1 Default by Consultant. In the event (i) Consultant fails to perform the Services in a skilled and expeditious manner; or (ii) Consultant, or any employee, Subconsultant, or agent of Consultant, shall wrongfully file or record a lien against any property of Company or any agent or employee of Company; or (iii) any representation or certification made by Consultant to Company shall prove to be false or misleading on the date said representation or certification is made; or (iv) Consultant commits a material breach of this Agreement in the observance or performance of any covenant, agreement, or condition contained in this Agreement required to be kept, performed or observed by Consultant; or (v) Consultant violates any laws, ordinances, rules, regulations, or orders of any governmental agencies or courts in the performance of its duties hereunder; or (vi) Consultant suffers bankruptcy; then, provided the event as described above is not cured within thirty (30) days after written notice from Company to Consultant, Company may declare Consultant to be in default hereunder. If Consultant commits any acts of default specified in this Section, Company may, by giving notice in writing to Consultant, without prejudice to any other rights or remedies given Company by law or by this Agreement, (i) terminate the services of Consultant under this Agreement; (ii) take possession of all materials and (iii) complete the Basic Services (and Additional Services, if any) by whatever method Company may deem expedient. "Bankruptcy" shall be deemed to occur when Consultant makes an assignment for the benefit of creditor, files a petition in bankruptcy court, voluntarily takes advantage of any bankruptcy or insolvency laws, or is adjudicated bankrupt or judicially insolvent, or if a petition or an answer is filed proposing the adjudication of such Consultant as bankrupt.

5.2 Default by Company. In the event Company shall fail to perform its obligations pursuant to this Agreement after thirty (30) days' written notice from Consultant to Company, Consultant may declare Company to be in default hereunder and exercise any remedies available to it. Should Company default in its obligations hereunder, Consultant may terminate this Agreement. Upon such a termination, Consultant may recover from Company full payment for all Services performed to the date of such termination and for all reimbursable amounts. Notwithstanding the foregoing, Company shall not be responsible for delays or damages or declared to be in default by reason of delays in performance or by reason of strikes, lockouts, accidents, acts of God, and other delays unavoidable or beyond Company's reasonable control,

delays in approval by governmental agencies, or delays in work of other consultants performing services on behalf of Company.

5.3 Termination by Company Without Fault of Consultant. Company shall have the right to cancel and terminate this Agreement upon providing thirty (30) days' written notice whether or not a default exists hereunder, and Company shall incur no liability to Consultant or any other person by reason of such cancellation. If the cancellation is for no fault of Consultant hereunder, Company shall pay to Consultant all amounts due under this Agreement for Services rendered by Consultant as of the date of termination, plus approved reimbursable expenses consistent with this Agreement.

5.4 Transfers on Termination. In the event of termination of this Agreement, Consultant and Company shall forthwith return to the other all papers, materials, and other properties of the other held by each for purposes of execution of this Agreement. In addition, each party will assist the other party in orderly termination of this Agreement and the transfer of all aspects hereof, tangible and intangible, as may be necessary for the orderly, non-disrupted business continuation of each party.

6. DISPUTE RESOLUTION.

6.1 Mediation. At Company's sole election, any action, dispute, claim, or controversy between the parties, whether sounding in contract, tort, or otherwise, including all disputes arising out of or in connection with this Agreement and any related agreements or instruments and any transaction contemplated hereby ("Dispute" or "Disputes") shall be attempted to be settled in good faith by nonbinding mediation as a condition precedent to arbitration by either party. The parties shall endeavor to resolve the Dispute by mediation which, unless the parties mutually agree otherwise, shall be in accordance with the Rules of the Judicial Arbitration and Mediation Service ("JAMS") currently in effect. In the event of any inconsistency between such rules and these mediation provisions, these provisions shall supersede such rules. All statutes of limitation that would otherwise be applicable shall apply to any mediation proceeding under this Section. Request for mediation shall be filed in writing with the other party to the Agreement and with JAMS. The request may be made concurrently with the filing of a demand for arbitration but, in such event, mediation shall proceed in advance of arbitration or legal or equitable proceedings, which shall be stayed pending mediation for a period of 30 (thirty) days from the date of filing, unless stayed for a longer period by agreement of the parties or court order. Any mediator selected under this Section shall be knowledgeable in the subject matter of the Dispute. Qualified retired judges with at least five (5) years mediation experience shall be selected through panels maintained by JAMS or any private organization providing such services. The mediation shall be held within thirty (30) days of the date the demand for mediation is served on a party, unless the parties agree otherwise. The parties understand and agree that a representative from each side with full settlement authority will be present at the mediation conference. The mediation process is to be considered settlement negotiations for the purpose of all state and federal rules protecting disclosures made during such conferences from later discovery or use in evidence. All conduct, statements, promises, offers, views, and opinions, oral or written, made during the mediation by any party or a party's agent, employee, or attorney shall not be subject to discovery or admissible for any purpose, including impeachment, in any litigation, arbitration, or other proceeding involving the parties. The parties shall share the mediator's fee and any filing fees equally. The

mediation shall be held in the County of Alameda, unless another location is mutually agreed upon. Agreements reached in mediation shall be enforceable as settlement agreements in any court having jurisdiction thereof. Where applicable to a mediation, the provisions of Section 6.2 below shall also apply to the mediation.

6.2 Arbitration. If the Dispute is not resolved by agreement or mediation pursuant to Section 6.1 above, the Dispute shall be resolved by arbitration as set forth in this Section. Such disputes shall be resolved by binding arbitration in accordance with Title 9 of the California Code of Civil Procedure, Section 1280 *et seq*. In the event of any inconsistency between such rules and these arbitration provisions, these provisions shall supersede such rules. All statutes of limitation that would otherwise be applicable, including any limitations periods under the Government Claims Act (Government Code, Section 810 *et seq.*), shall apply to any arbitration proceeding under this Section. No limitations periods shall be tolled for any reason absent a writing signed by both parties. In any arbitration proceeding subject to these provisions, the arbitrator is specifically empowered to decide (by documents only, or with a hearing, at the arbitrator's sole discretion) pre-hearing motions that are substantially similar to pre-hearing motions to dismiss and motions for summary adjudication. Judgment upon the award rendered may be entered in any court having jurisdiction. Qualified retired judges with at least five (5) years arbitration experience shall be selected through panels maintained by the JAMS or any private organization providing such services. If the parties are unable to mutually agree upon a retired judge to hear their arbitration, the arbitration service shall provide a list of three (3) available judges and each party may strike one (1). The remaining judge will serve as the arbitrator. Notices of demand for arbitration shall be served in writing by registered or certified mail to all parties to this Agreement. Demand will be made within a reasonable time after the dispute or other matter in question has arisen. In no event shall a demand for arbitration be made after the date when the institution of legal proceedings based on such dispute or other matter in question would be barred by the applicable statute of limitations. The applicable statute of limitation shall be tolled during the period such arbitration proceedings are pending. Except as otherwise provided herein, the California Code of Civil Procedure and California Evidence Code shall apply to and govern the conduct of discovery. The arbitrator shall issue a statement of decision not later than twenty (20) days after the testimony is closed. Judgment may be entered into in accordance with a statement of decision as provided in the California Code of Civil Procedure. Any memorandum of costs shall be submitted to the arbitrator and the arbitrator shall determine the amount of the costs to be awarded to any prevailing party. Any motion for attorneys' fees as an element of costs under California Civil Code section 1717 shall be served and filed with the arbitrator before or at the time the memorandum of costs is served and filed. Except as otherwise provided in Section 7.17 below, the arbitrator's fees and charges shall be born equally by the parties to the dispute. Notwithstanding anything contained herein to the contrary, if a third person or entity not a party to this Agreement brings an action in which Consultant and Company become a party, by cross-claim or otherwise, and said party or entity is not bound by the provisions of this Section regarding arbitration, the provisions of this Section shall not be applicable to such dispute.

6.3 Survival; Applicability. The provisions of this Article shall survive any termination, amendment, or expiration of this Agreement in which this Section is contained, unless the parties otherwise expressly agree in writing. Should an action, dispute, claim, or controversy be brought against Company and/or Consultant by a third party who is not bound by a mediation

or binding arbitration provision similar to the mediation and arbitration provisions contained herein, the terms of this Article shall not apply to such action, dispute, claim, or controversy.

7. MISCELLANEOUS.

7.1 Certifications. Consultant shall, from time to time, make such certifications and statements to Company and to others as Company shall reasonably request provided that Consultant determines that such certifications are true and correct based upon the Services performed by Consultant hereunder.

7.2 Liens. Provided Company has paid Consultant the amounts owing hereunder when such sums are owed to Consultant, should Consultant or any Subconsultant, employee, supplier, or vendor of Consultant make, record or file, or maintain any action on or respecting a claim of mechanic's or materialmen's lien, stop-notice, equitable lien, payment or performance bond, or *lis pendens*, Consultant shall immediately and at its own expense procure, furnish, and record appropriate statutory release bonds of bonding companies acceptable to Company which will extinguish or expunge said claim, stop-notice, or *lis pendens*. If Consultant fails to do so, Company will have the right to cause such lien to be removed and Consultant shall indemnify, defend, and hold harmless Company against all liability, cost, and expense incurred by Company in causing such lien to be removed. Company may retain out of any payment due Consultant amounts sufficient to reimburse Company for any such liability, cost, and expense.

7.3 Independent Contractor. Neither Company nor any of its employees shall have any control over the manner, mode, or means by which Consultant or its agents or employees, perform the services required herein, except as otherwise set forth herein. Consultant shall perform all services required herein as an independent contractor of Company and shall remain at all times as to Company a wholly independent contractor with only such obligations as are consistent with that role. Consultant shall not at any time or in any manner represent that it or any of its agents or employees are agents or employees of Company. Company shall not in any way or for any purpose become or be deemed to be a partner of Consultant in its business or otherwise or a joint venture or a member of any joint enterprise with Consultant. Consultant is free to pursue and accept other business opportunities so long as Consultant's business ventures do not conflict with the provisions of this Agreement.

7.4 Assignment. The experience, knowledge, capability, and reputation of Consultant, its principals and employees were a substantial inducement for Company to enter into this Agreement. Therefore, neither this Agreement nor any interest herein may be transferred, assigned, conveyed, hypothecated, or encumbered, voluntarily or by operation of law, whether for the benefit of creditors or otherwise, without the prior written approval of Company. Transfers restricted hereunder shall include the transfer to any person or group of persons acting in concert of more than twenty-five percent (25%) of the present ownership and/or control of Consultant, taking all transfers into account on a cumulative basis. In the event of any such unapproved transfer, this Agreement shall be void. No approved transfer shall release Consultant of any liability hereunder without the express consent of Company. Company, in its sole and absolute discretion, may assign this Agreement to any of its Affiliates. "Affiliates" means (a) Company's partners, co-members, or joint venturers, (b) any corporation or other entity that is a parent or subsidiary of Company, or (c) any corporation or other entity that is controlled by or under

common control of any of the parties listed in (a) or (b). Upon any such assignment by Company, Company shall be released from all obligations and liability under this Agreement that accrue after the effective date of such assignment.

7.5 Information. Company shall provide information regarding its requirements for the Services to be provided by Consultant. Consultant shall notify Company immediately in writing if Consultant is aware or becomes aware of any omissions or deficiencies in the data or information supplied to Consultant in its performance of its Services pursuant to this Agreement.

7.6 Company's Approval. Whenever provision is made herein for the approval or consent of Company, or that any matter be to Company's satisfaction, unless specifically stated to the contrary, such approval or consent shall be made by Company in its sole discretion and determination.

7.7 Notices. Any notice which either party may desire to give to the other party must be in writing and shall be effective (i) when personally delivered by the other party or messenger or courier thereof; (ii) three (3) business days after deposit in the United States mail, registered or certified; (iii) twenty-four (24) hours after deposit before the daily deadline time with a reputable overnight courier or service; or (iv) upon receipt of a telecopy or fax transmission, provided a hard copy of such transmission shall be thereafter delivered in one of the methods described in the foregoing (i) through (iii); in each case, postage fully prepaid and addressed to the respective parties as set forth on the first page of this Agreement or to such other address and to such other persons as the parties may hereafter designate by written notice to the other parties hereto.

If notice to Company:

Alameda Alliance for Health
Attn: Chief Executive Officer
1240 South Loop Rd.
Alameda, CA 94502

Copy to:

Alameda Alliance for Health
Attn: General Counsel
1240 South Loop Rd.
Alameda, CA 94502

Via Email: Legal@alamedaalliance.org

If notice to Consultant:

7.8 Books and Records. Consultant shall keep complete and detailed books and records relating to reimbursable expenses, and Services performed on the basis of a fixed rate on the basis of generally recognized accounting principles, consistently applied. These books and records shall be retained by Consultant at its head office for a period of at least ten (10) years after the date of completion of the performance of this Agreement. Company shall have the right at all reasonable times to audit the books and records. If such audit discloses that Consultant has charged and received more than it was entitled hereunder, Consultant shall immediately reimburse to Company

the excess amount received together with interest thereon at ten percent (10%) per annum from the date such excess amount was received until repayment thereof.

7.9 Confidentiality. Consultant, for itself and its employees and personnel, acknowledges, confirms, and agrees that all information learned in the course of the performance of Service under this Agreement and all data furnished by Company, all plans, drawings, computer programs, specifications, and other documents relating to the Project, Company's business, and the terms of this Agreement are and shall remain of a confidential nature. Any publicity or press releases with respect to the Project or the services hereunder shall be under the sole discretion and control of Company. Consultant shall not divulge to any unauthorized person any confidential information concerning observations, conversations, discussions, correspondence, personnel records, business records, or proprietary records. All matters concerning Company and its business operations, including, but not limited to, the identity of persons with whom it conducts business such as customers, vendors, manufacturers and suppliers, its research and development, its projects and contemplated projects, its financial affairs, its pricing structure and strategies and its procedures and practices shall be considered confidential. Such information remains the property of Company. Moreover, Consultant shall not employ confidential business information in performing Services for Company that it has obtained by virtue of its relationship with any other company or entity.

7.10 Conflict of Interest. Consultant shall not have any business or financial interest outside Company which in any way conflicts with the interests of Company or places Consultant in a position where it can use the association with Company for direct or indirect gain to the possible detriment or embarrassment of Company. A conflict of interest may arise in a wide variety of circumstances and may be direct or indirect. A conflict of interest arises whenever Consultant's outside interests might affect or might reasonably be thought by others to affect Consultant's judgment or conduct in matters which involve Company. Consultant agrees not to engage in such activity. Consultant assumes any and all liability should any allegation of conflict of interest arise from the conduct of Consultant and Consultant agrees to indemnify Company for any allegation of conflict of interest arising from the conduct of Consultant.

7.11 Waiver. No waiver of any default hereunder shall be construed as a waiver of any subsequent breach.

7.12 Successors and Assigns. Company and Consultant each binds itself, its partners, successors, permitted assigns, and legal representatives to the other party to this Agreement and to the partners, successors, assigns, and legal representatives of such other party with respect to all covenants of this Agreement.

7.13 Governing Law. This Agreement shall be construed in accordance with the laws of California.

7.14 Full Agreement. Each party acknowledges its full understanding of this Agreement and that there are no verbal promises, undertakings or agreements in connection herewith and that this Agreement may be modified only by a written agreement signed by all parties hereto. All previous negotiations and agreements between the parties hereto, with respect to the transaction set forth herein, are merged in this instrument which fully and completely express the parties'

rights and obligations, and the covenants herein shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, legal representatives, successors, and assigns.

7.15 Partial Invalidity; Counterparts. If any term or provision of this Agreement shall be found to be illegal, unenforceable or in violation of the laws, statutes, ordinances, or regulations of any governmental agency having jurisdiction thereof by a court of competent jurisdiction, then, notwithstanding such term or provision, this Agreement shall be and remain in full force and effect and such term shall be deemed stricken; provided, however, this Agreement shall be interpreted, when possible, so as to reflect the intentions of the parties as indicated by any such stricken term or provision. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall constitute one instrument. In order to facilitate the transaction contemplated herein, electronically mailed or facsimile signatures may be used in place of original signatures on this Agreement. Each party intends to be bound by the signatures on the electronically mailed or facsimiled document, are aware that the other party will rely on such signatures, and hereby waive any defenses to the enforcement of the terms of this Agreement based on the form of signature.

7.16 Survival. The terms, provisions, representations, and certification contained in this Agreement, or inferable therefrom, shall survive the termination of this Agreement and the payment of the remuneration hereinabove provided.

7.17 Attorneys' Fees and Expenses. In any action between the parties hereto seeking enforcement of any of the terms and provisions of this Agreement or in connection with the performance of the Services hereunder, the prevailing party in such action shall be entitled to have and to recover from the other party its reasonable attorneys' fees, expert witness fees, arbitrator's fees, statutory costs, court costs, and other expenses (including cost of collection) in connection with such action or proceeding.

7.18 Authority. Each individual executing this Agreement represents and warrants that he or she is duly authorized to execute and deliver this Agreement on behalf of the party to this Agreement.

7.19 Exhibits. Exhibit A and Exhibit B attached hereto, are incorporated herein by this reference. In the event of any conflict or inconsistency between the terms and conditions of the body of this Agreement and the Exhibit(s) attached hereto, the terms and conditions contained in the body of this Agreement shall prevail.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the Effective Date.

ALAMEDA ALLIANCE FOR HEALTH

By: _____ By: _____

Name:	Name:
Title:	Title:
Date:	Date:

EXHIBIT A
Statement of Work



Finance

Gil Riojas

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: October 9th, 2026

Subject: Chief Financial Officer Executive Summary

Executive Summary

- **1. Enrollment continues to decline, but the pace of decrease is slowing.** Total enrollment was 366,605 in August, a decrease of 469 members from July and 3,468 members from June. This indicates that the month-over-month decline moderated substantially in August after a larger decrease between June and July. Enrollment remains 6,822 members, or 1.9%, above budget. We continue to monitor enrollment changes. For September enrollment reflected a 1,700 member decrease and October preliminary enrollment is down another 2,300 members.

- **2. Pharmacy FFS expense is materially above budget and requires targeted corrective action.** Year-to-date adjusted Pharmacy FFS expense was $32.1 million compared with a $24.8 million budget, an unfavorable variance of $7.3 million, or 29.6%. On a PMPM basis, Pharmacy FFS was $43.77 versus $34.23 budgeted, an unfavorable variance of $9.54, or 27.9%. The variance is primarily driven by higher unit cost and is the largest adverse variance among the reported medical expense categories. We are working with our health care services team to identify cost drivers of Physician Administered Drugs (PAD). We have identified high cost providers and are implementing new strategies to address the issue.

- **3. The rising Medical Loss Ratio signals increasing pressure on operating performance.** MLR reached 101.1% for August and 99.6% fiscal year-to-date, meaning medical costs are consuming nearly all—or, for the month, more than all—premium revenue before administrative expenses. This trend is consistent with broad medical cost pressure, including pharmacy, inpatient, ancillary, outpatient, specialty, and emergency services. Our goal is to maintain an MLR between 90-95%. We are working with our heath care services team to address cost increases in Pharmacy and Ancillary categories of service. We are also preparing to share cost experience with DHCS to inform them of any emerging cost trends we are seeing to better align rates with medical expense experience.

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

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

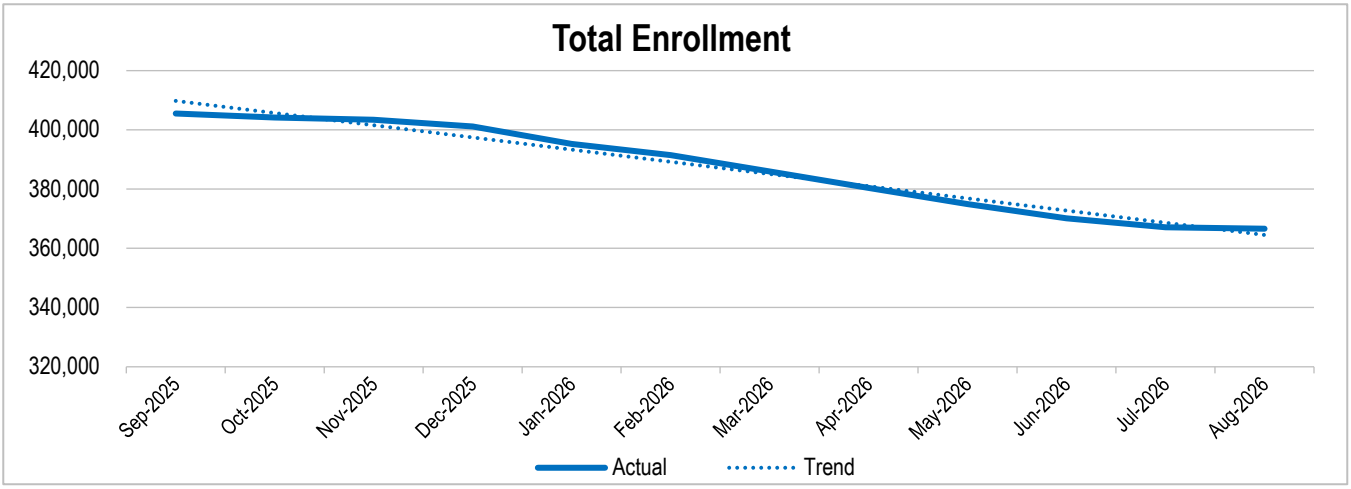
Date: **October 9th, 2026**

Subject: **Finance Report – August 2026 Financials**

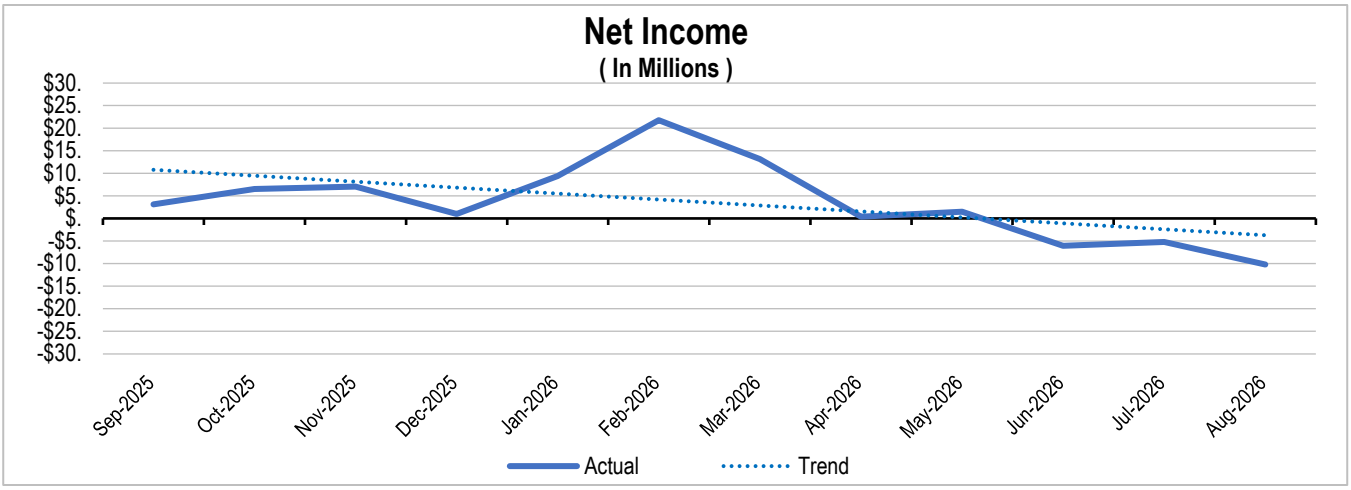
Executive Summary

For the month of August, the Alliance decreased in enrollment, down to 366,605 members. A Net Loss of $10.2 million was reported, and the Plan's Medical Expenses represented 101.1% of Premium Revenue. Alliance reserves decreased to 268% of required and continue to remain above minimum requirements.

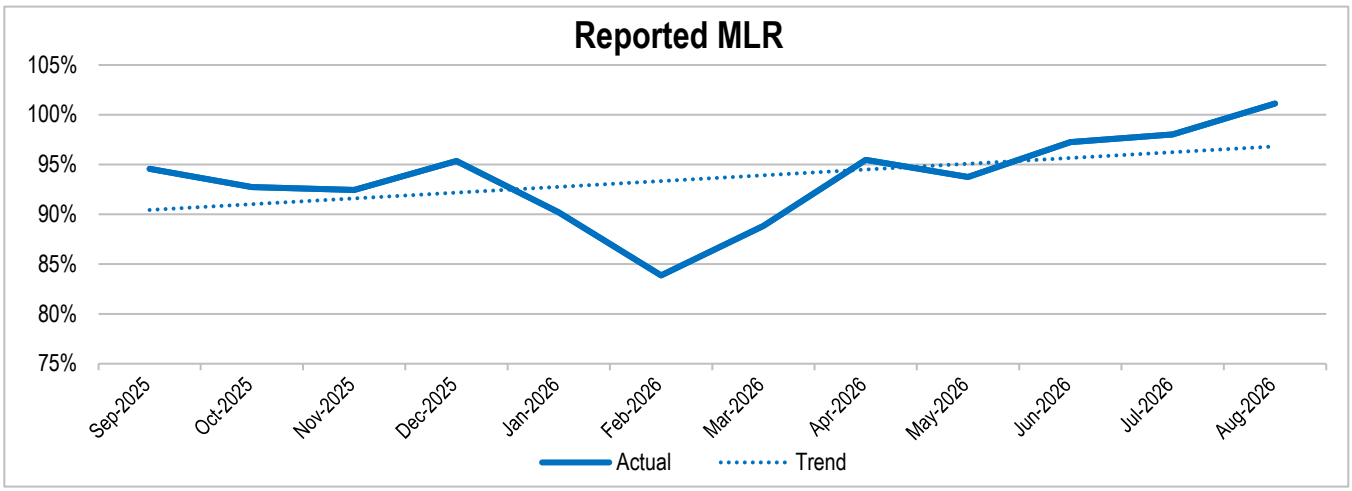
Enrollment – In August, Enrollment decreased by 469 members.



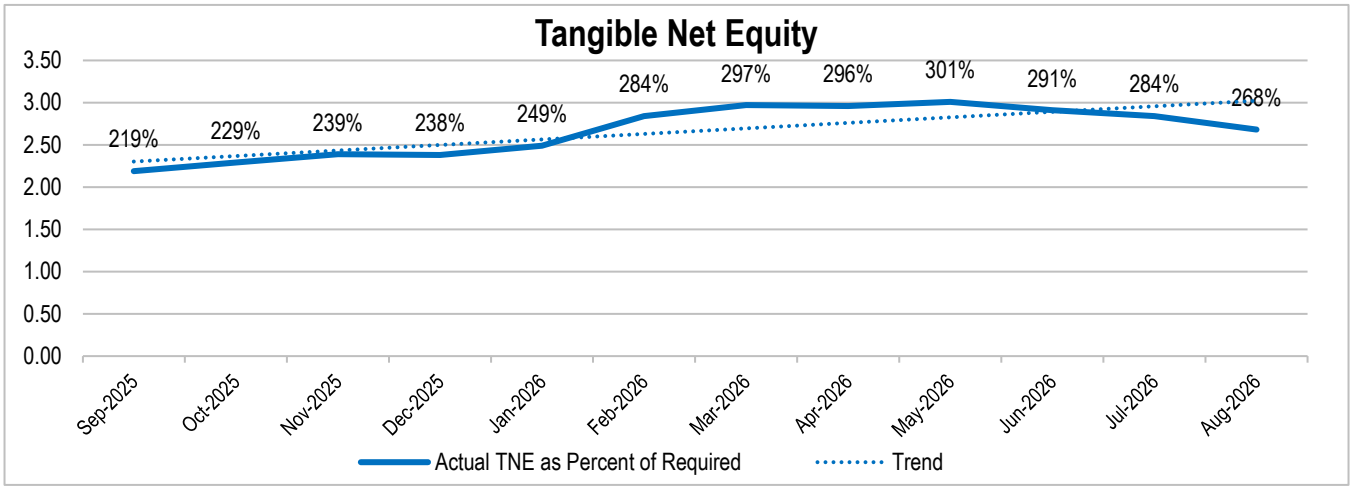
Net Income – For the month ended August, actual Net Loss was $10.2 million vs. budgeted Net Loss of $4.3 million. For the fiscal YTD, actual Net Loss was $15.4 million vs. budgeted Net Loss of $9.5 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $181.9 million vs. budgeted Revenue of $177.7 million. Premium Revenue favorable variance of $4.2 million is primarily due to current month Medi-Cal and IHSS volume variance.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 101.1% for the month, and 99.6% for fiscal YTD.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $121.1 million in reserves, we reported $216.3 million. Our overall TNE remains above DMHC requirements at 268%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, investments show a gain of $4.5 million and capital assets acquired are $135,000.

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

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

Date: **October 2nd, 2026**

Subject: **Finance Report – August 2026**

Executive Summary

- For the month ended August 31st, 2026, the Alliance had enrollment of 366,605 members, a Net Loss of $10.2 million, and Tangible Net Equity (TNE) equal to 268% of required.

Overall Results: (in Thousands)

	Month	YTD
Revenue	$242,740	$483,311
Medical Expense	183,986	360,377
Admin. Expense	10,253	21,337
MCO Tax Expense	60,809	121,426
Other Inc. / (Exp.)	2,114	4,435
Net Income	**($10,194)**	**($15,394)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	($9,580)	($10,966)
Group Care	251	(2,666)
Medicare	(864)	(1,762)
	($10,194)	**($15,394)**

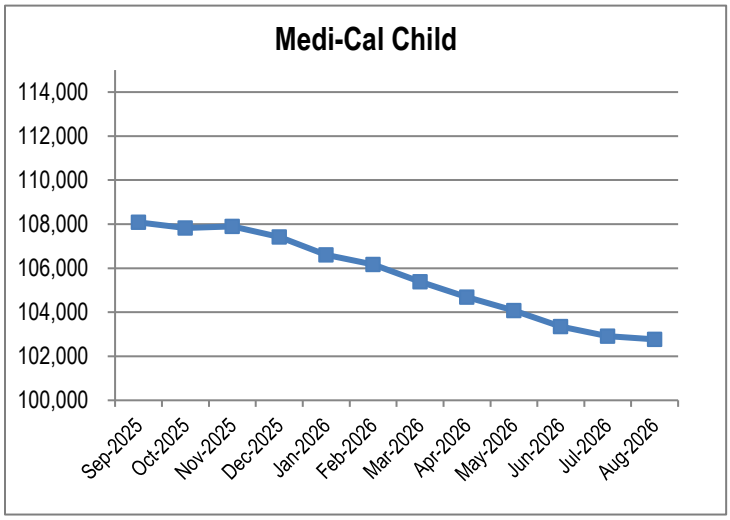
Enrollment

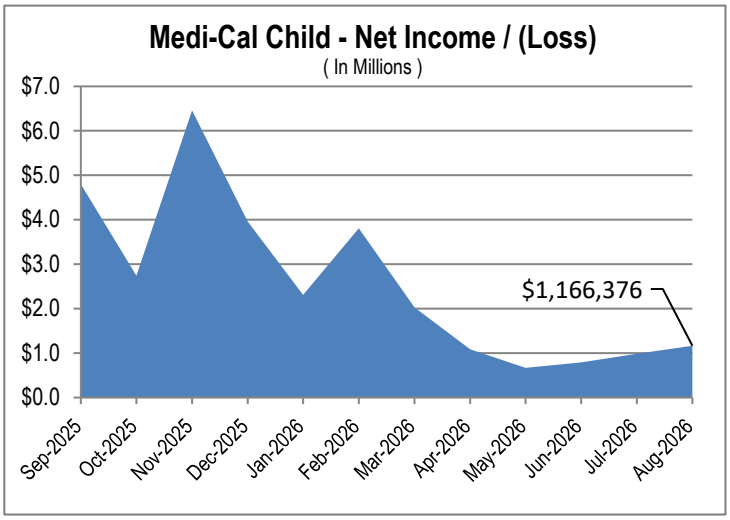
- Total enrollment decreased by 469 members since July 2026.
- Total enrollment decreased by 3,468 members since June 2026.

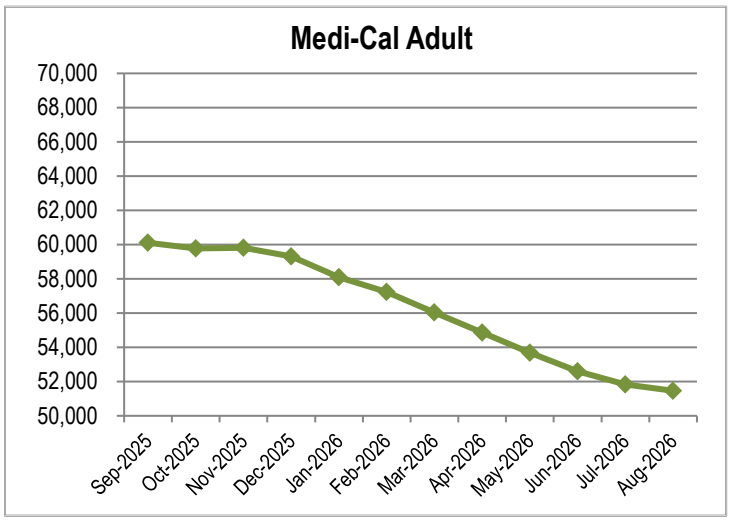
Monthly Membership and YTD Member Months
Actual vs. Budget

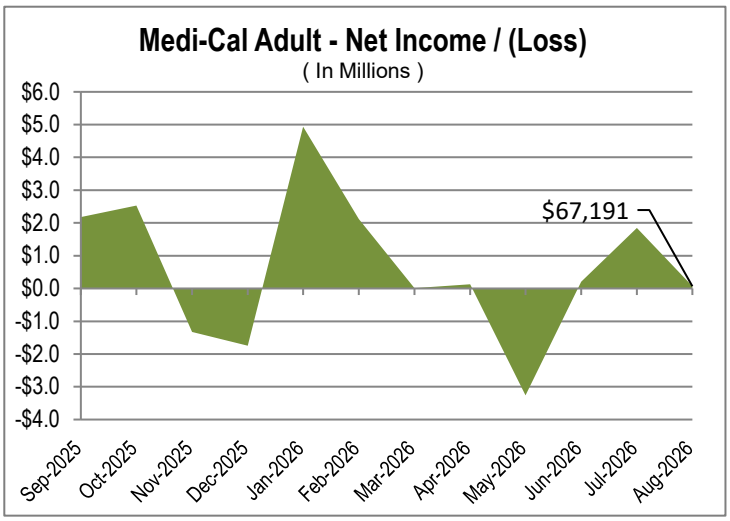
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
102,769	102,322	447	0.4%	Child	205,688	205,114	574	0.3%
51,463	51,378	85	0.2%	Adult	103,297	103,466	(169)	(0.2%)
130,627	124,672	5,955	4.8%	ACA OE	261,476	252,547	8,929	3.5%
27,259	27,085	174	0.6%	SPD with LTC	54,339	54,347	(8)	(0.0%)
47,716	47,409	307	0.6%	Duals with LTC	95,438	94,916	522	0.5%
359,834	**352,866**	**6,968**	**2.0%**	**Medi-Cal Total**	**720,238**	**710,390**	**9,848**	**1.4%**
6,475	6,331	144	2.3%	Group Care	12,873	12,656	217	1.7%
296	586	(290)	(49.5%)	Medicare	568	952	(384)	(40.3%)
366,605	**359,783**	**6,822**	**1.9%**	**Total**	**733,679**	**723,998**	**9,681**	**1.3%**

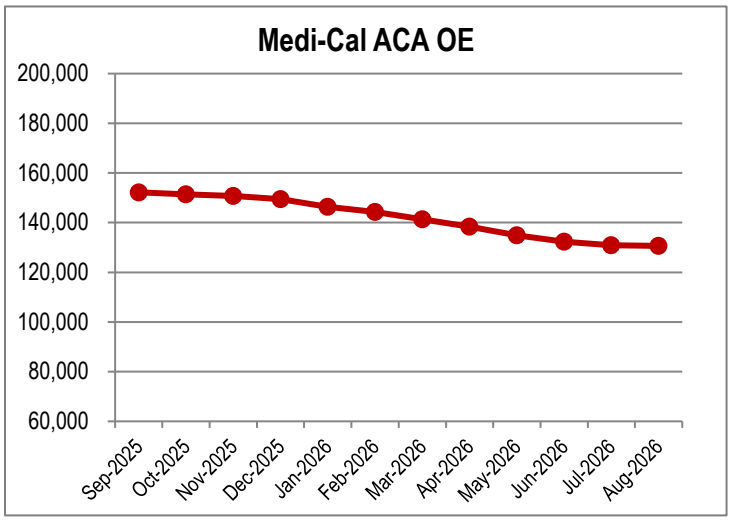
Enrollment and Profitability by Program and Category of Aid

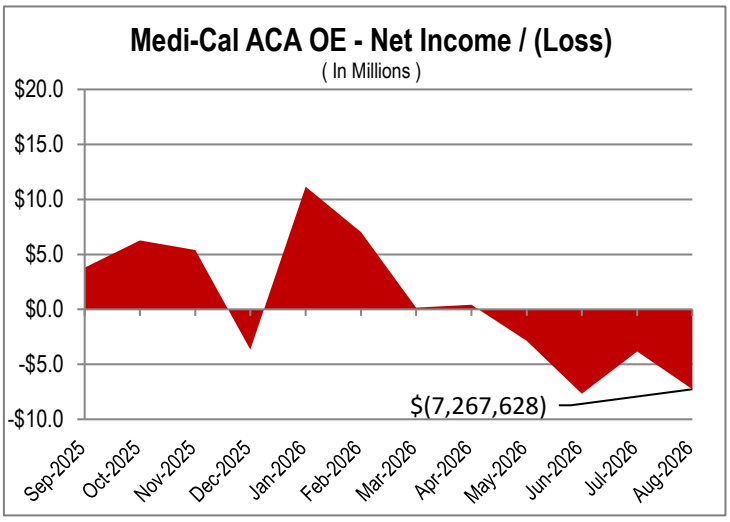




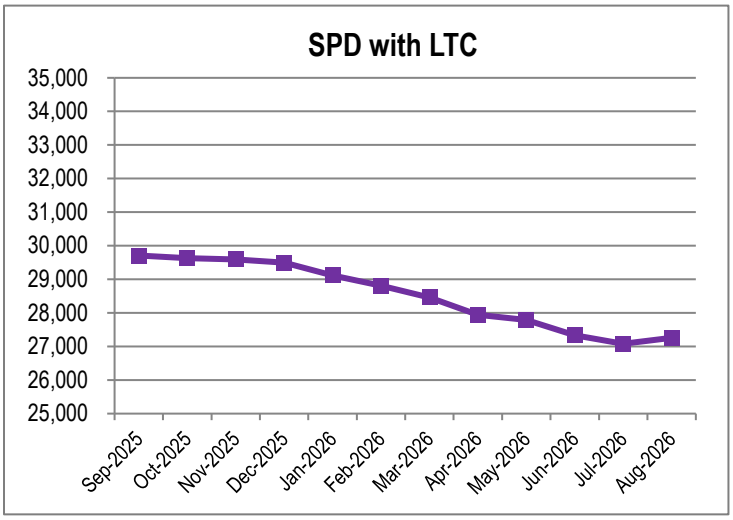


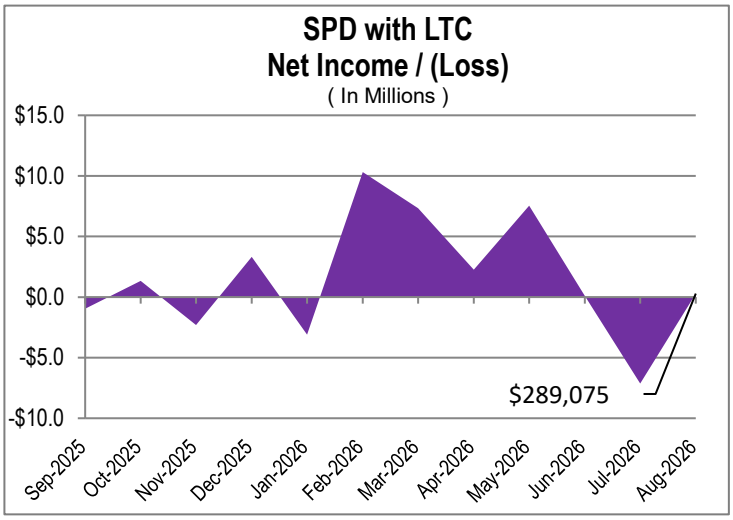


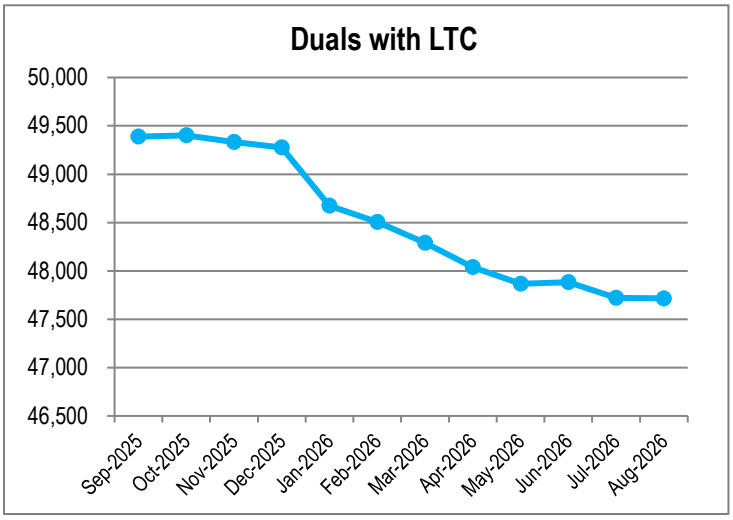


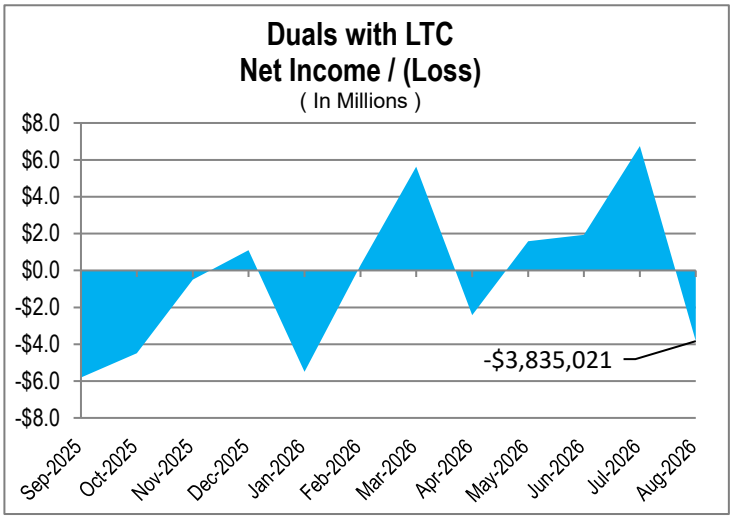


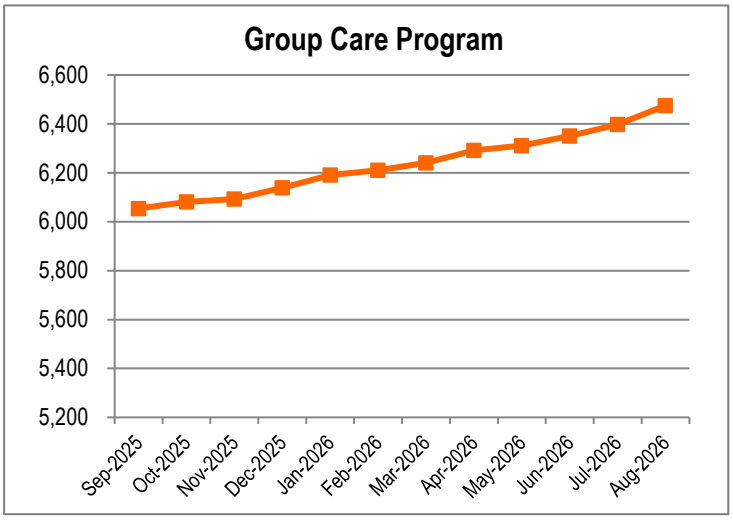
Enrollment and Profitability by Program and Category of Aid

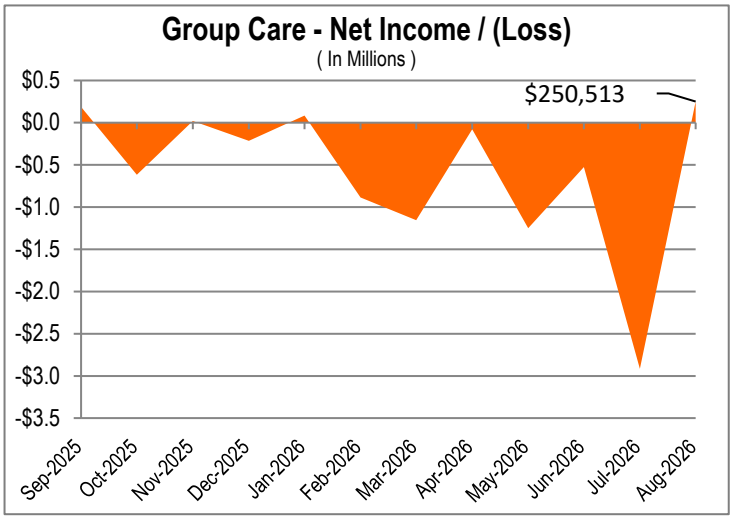




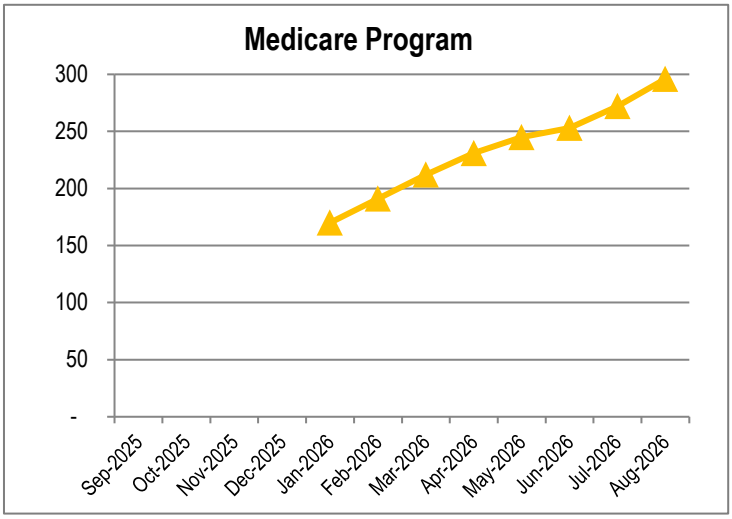


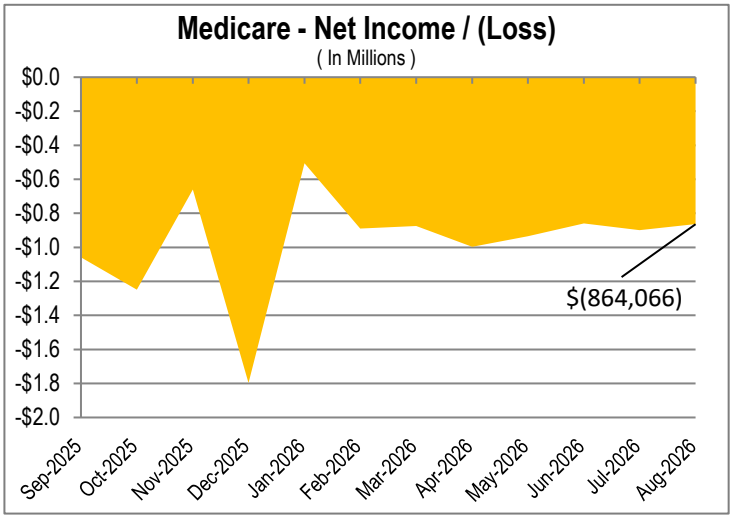


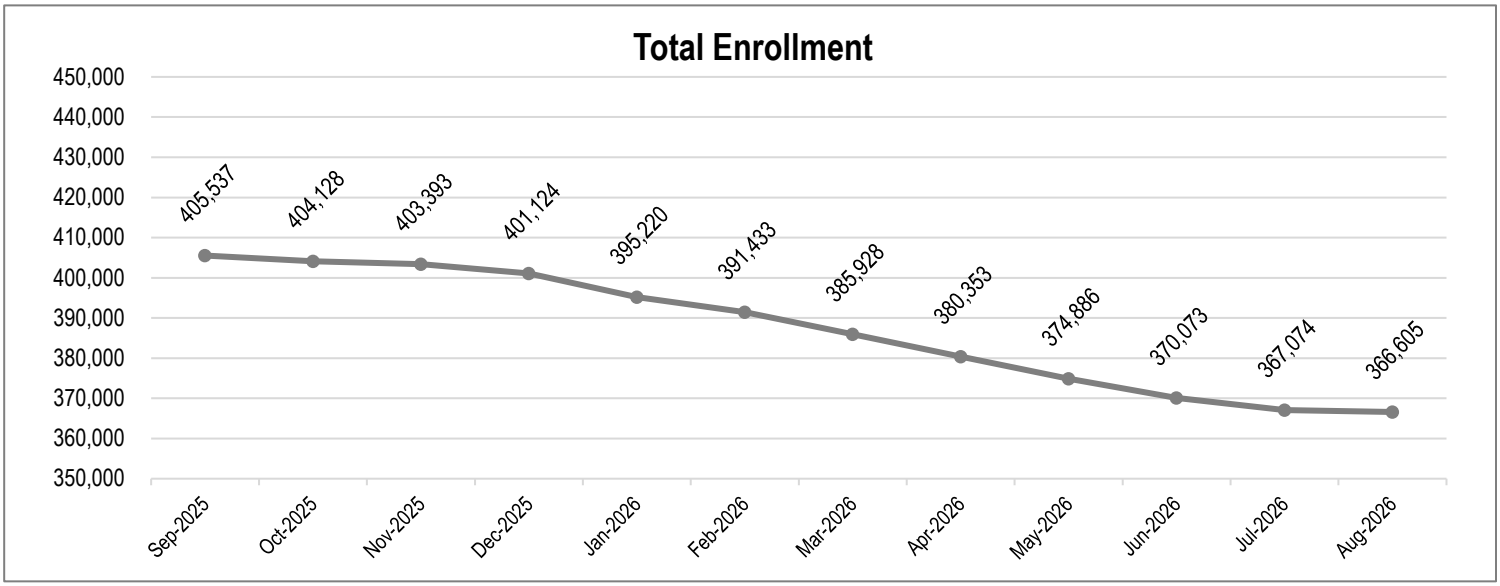


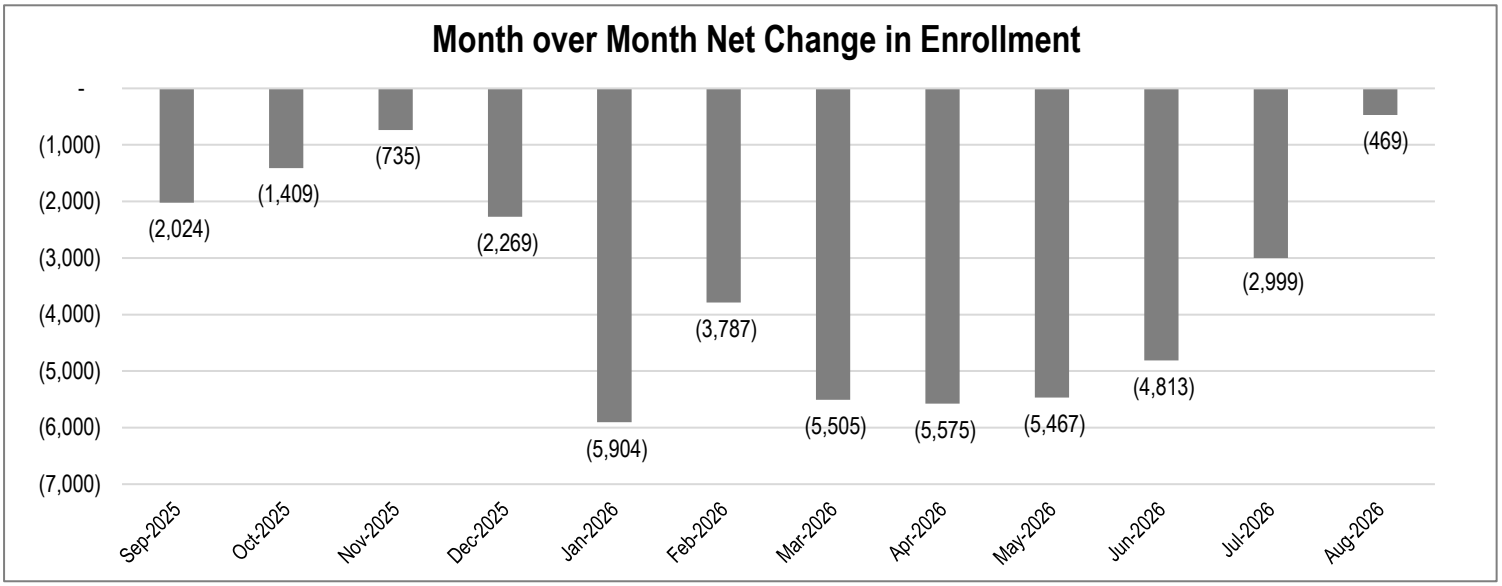


Enrollment and Profitability by Program and Category of Aid



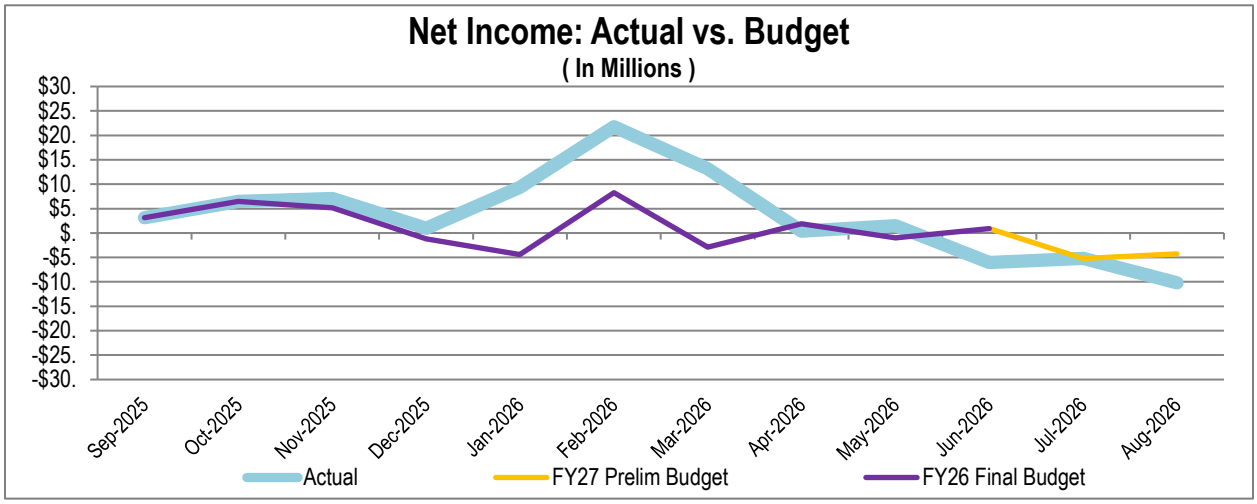






Net Income

- For the month ended August 31st, 2026:
  - Actual Net Loss: $10.2 million.
  - Budgeted Net Loss: $4.3 million.
- For the fiscal YTD ended August 31st, 2026:
  - Actual Net Loss: $15.4 million.
  - Budgeted Net Loss: $9.5 million.

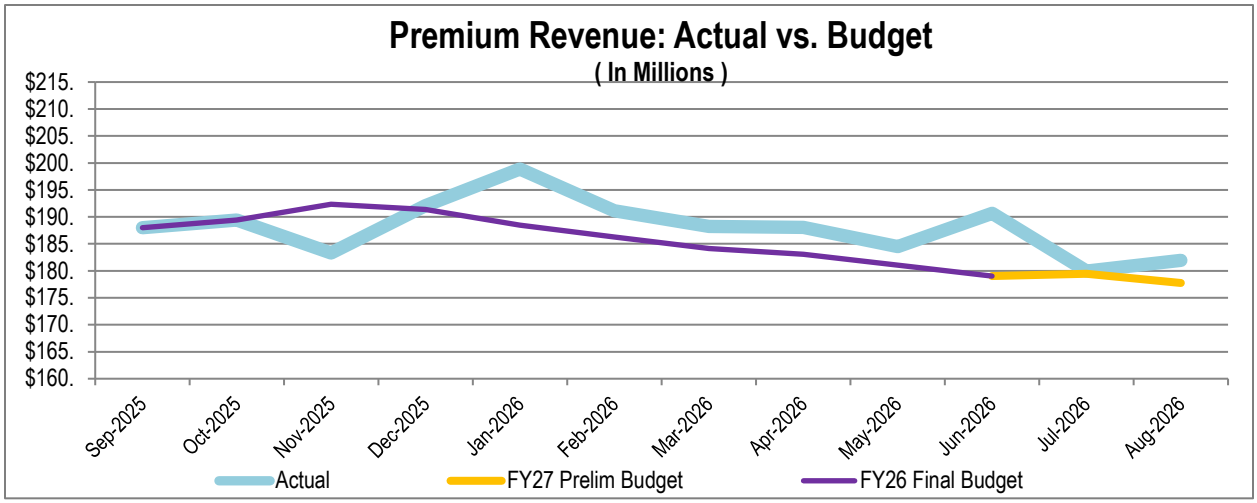


The unfavorable variance of $5.9 million in the current month is primarily due to:

- Medical Expense was $9.4 million higher than anticipated, resulting in an unfavorable variance.
- Premium Revenue was $4.2 million higher than anticipated, resulting in a favorable variance.

Premium Revenue

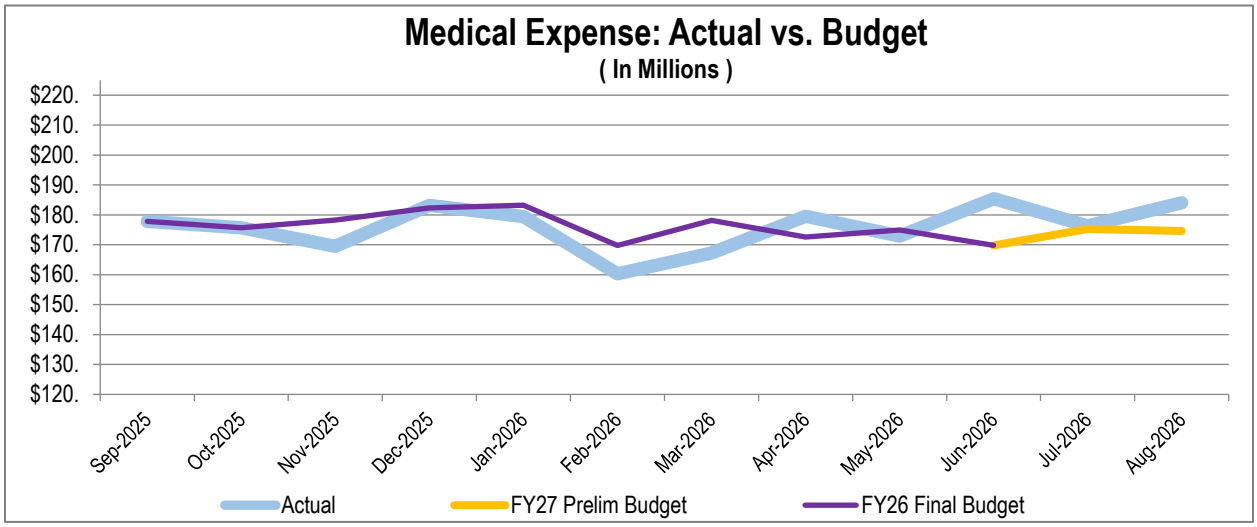
- For the month ended August 31st, 2026:
  - Actual Revenue: $181.9 million.
  - Budgeted Revenue: $177.7 million.
- For the fiscal YTD ended August 31st, 2026:
  - Actual Revenue: $361.9 million.
  - Budgeted Revenue: $357.2 million.



- For the month ended August 31st, 2026, the favorable Premium Revenue variance of $4.2 million is primarily due to favorable $3.4 million Medi-Cal and IHSS volume variance for August 2026, and favorable $1.8 million retroactive membership for July 2025 through June 2026. This was partially offset by several unfavorable variances totaling $1.1 million.

Medical Expense

- For the month ended August 31st, 2026:
  - Actual Medical Expense: $184.0 million.
  - Budgeted Medical Expense: $174.6 million.
- For the fiscal YTD ended August 31st, 2026:
  - Actual Medical Expense: $360.4 million.
  - Budgeted Medical Expense: $349.9 million.



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

- For August, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $49,000. Year to date, the estimate for prior years decreased by $6.0 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)

Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance: Actual Adjusted vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$32,013,420	$0	$32,013,420	$31,462,201	($551,219)	(1.8%)
Primary Care FFS	$7,519,766	($132,729)	$7,387,037	$9,169,797	$1,650,031	18.0%
Specialty Care FFS	$16,854,004	$745,257	$17,599,261	$15,445,544	($1,408,460)	(9.1%)
Outpatient FFS	$26,168,128	$2,031,187	$28,199,316	$24,604,099	($1,564,029)	(6.4%)
Ancillary FFS	$49,272,700	$109,863	$49,382,563	$46,036,361	($3,236,339)	(7.0%)
Pharmacy FFS	$32,111,296	$3,003,311	$35,114,607	$24,782,423	($7,328,873)	(29.6%)
ER Services FFS	$21,214,011	($267,566)	$20,946,445	$19,544,619	($1,669,392)	(8.5%)
Inpatient Hospital FFS	$101,917,578	($10,556,591)	$91,360,987	$97,368,535	($4,549,043)	(4.7%)
Long Term Care & SNF FFS	$69,384,863	($945,167)	$68,439,697	$70,669,392	$1,284,528	1.8%
Other Benefits & Services	$7,614,333	$0	$7,614,333	$8,224,099	$609,767	7.4%
Net Reinsurance	$1,152,481	$0	$1,152,481	$1,413,234	$260,753	18.5%
Provider Incentive	$1,166,667	$0	$1,166,667	$1,166,667	$0	0.0%
	$366,389,247	**($6,012,434)**	**$360,376,813**	**$349,886,971**	**($16,502,276)**	**-4.70%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

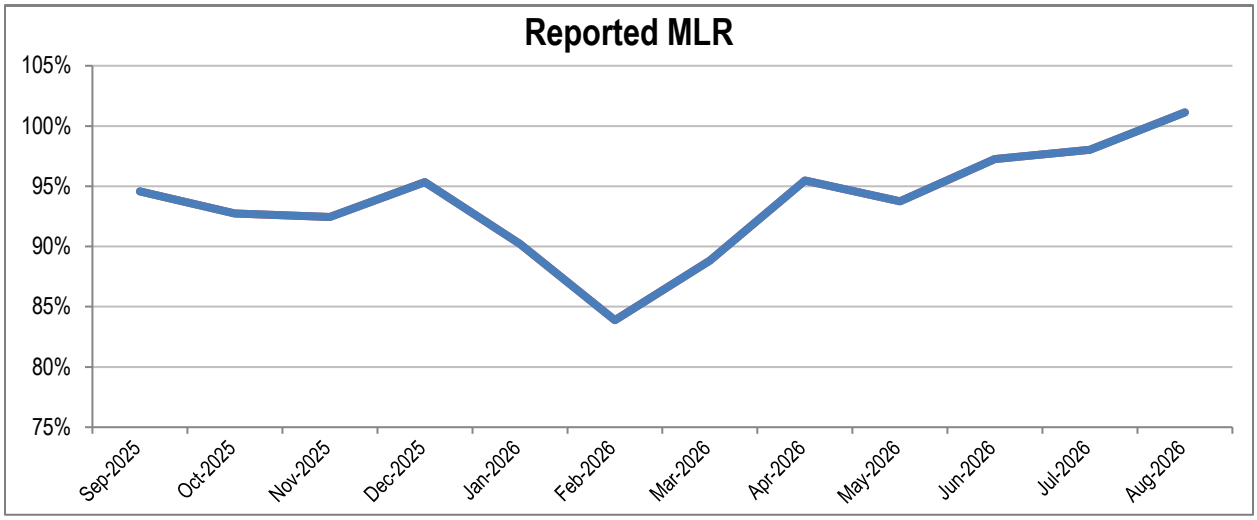
	Actual			Budget	Variance: Actual Adjusted vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$43.63	$0.00	$43.63	$43.46	($0.18)	(0.4%)
Primary Care FFS	$10.25	($0.18)	$10.07	$12.67	$2.42	19.1%
Specialty Care FFS	$22.97	$1.02	$23.99	$21.33	($1.64)	(7.7%)
Outpatient FFS	$35.67	$2.77	$38.44	$33.98	($1.68)	(5.0%)
Ancillary FFS	$67.16	$0.15	$67.31	$63.59	($3.57)	(5.6%)
Pharmacy FFS	$43.77	$4.09	$47.86	$34.23	($9.54)	(27.9%)
ER Services FFS	$28.91	($0.36)	$28.55	$27.00	($1.92)	(7.1%)
Inpatient Hospital & SNF FFS	$138.91	($14.39)	$124.52	$134.49	($4.43)	(3.3%)
Long Term Care & SNF FFS	$94.57	($1.29)	$93.28	$97.61	$3.04	3.1%
Other Benefits & Services	$10.38	$0.00	$10.38	$11.36	$0.98	8.6%
Net Reinsurance	$1.57	$0.00	$1.57	$1.95	$0.38	19.5%
Provider Incentive	$1.59	$0.00	$1.59	$1.61	$0.02	1.3%
	$499.39	**($8.19)**	**$491.19**	**$483.27**	**($16.12)**	**(3.3%)**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $16.5 million unfavorable to budget. On a PMPM basis, medical expense is 3.3% unfavorable to budget. Per-member-per-month expense variances are described below:
    - Capitated Expense is over budget, primarily driven by unfavorable Specialty 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 over budget, driven by unit cost and utilization.
- Outpatient Expense is over budget due to higher unit cost offset by lower utilization.
- Ancillary Expense is over budget, driven by behavioral health utilization in the Child and ACA OE aid code categories.
- Pharmacy Expense is over budget, driven by higher unit cost.
- Emergency Expense is over budget, driven by higher utilization in the ACA OE aid code category.
- Inpatient Expense is over budget, driven by high utilization in the Adult, ACA OE and SPD with LTC populations.
- Long Term Care Expense is under budget, driven by lower utilization in the Duals with LTC Duals aid code category.
- Other Benefits & Services is under budget due to lower-than-expected expenses for salaries and wages, employee benefits, temporary help services, professional medical services, interpreter services, licenses, and permits.
- Net Reinsurance is under budget because more recoveries were received than expected.
- Provider Incentive is neutral to budget, due to timing and accruals.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported Medical Expense divided by Premium Revenue) was 101.1% for the month and 99.6% for the fiscal year-to-date.



Administrative Expense

- For the month ended August 31st, 2026:
  - Actual Administrative Expense: $10.3 million.
  - Budgeted Administrative Expense: $10.3 million.
- For the fiscal YTD ended August 31st, 2026:
  - Actual Administrative Expense: $21.3 million.
  - Budgeted Administrative Expense: $22.1 million.

o

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 %
$6,675,234	$6,471,191	($204,044)	(3.2%)	Personnel Expense	$13,160,627	$12,763,930	($396,697)	(3.1%)
91,639	88,131	(3,507)	(4.0%)	Medical Benefits Admin Expense	180,080	176,052	(4,029)	(2.3%)
2,090,523	2,245,078	154,555	6.9%	Purchased & Professional Services	3,295,275	4,630,496	1,335,221	28.8%
1,395,415	1,545,159	149,744	9.7%	Other Admin Expense	4,700,920	4,561,408	(139,512)	(3.1%)
$10,252,811	$10,349,559	$96,748	0.9%	Total Administrative Expense	$21,336,902	$22,131,885	$794,983	3.6%

The year-to-date variances include:

- Favorable in Purchased & Professional Services, primarily due to Consultant Fees, Other Purchased Services, HMS Recovery fees, IT Software Licenses and Subscriptions, and Hardware Purchases.
- Favorable Supplies and Other expenses primarily due to Meals and Entertainment, Supplies, and Member Incentives. Partially offset by an increase in Provider Interests.
- Employee Expense is unfavorable primarily due to the workforce adjustment.
- Partially offset by unfavorable Benefit Administration Expense, primarily for the increases in Behavioral Health Administration Fees.
- Partially offset by unfavorable Printing/Postage/Promotions, primarily as a result of postage, printing, and mailing services.
- Partially offset by unfavorable Building Occupancy costs due to SBITA Amortization and timing in other areas.
- Partially offset by unfavorable Licenses, Insurance & Fees primarily due to unfavorable licenses and regulatory penalties, bank fees, insurance and subscriptions.

The Administrative Loss Ratio (ALR) is 5.6% of net revenue for the month and 5.9% 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 $474,000.

Other Income / (Expense)

Other Income & Expense consists primarily of investment income. Fiscal year-to-date net investments show a gain of $4.5 million.

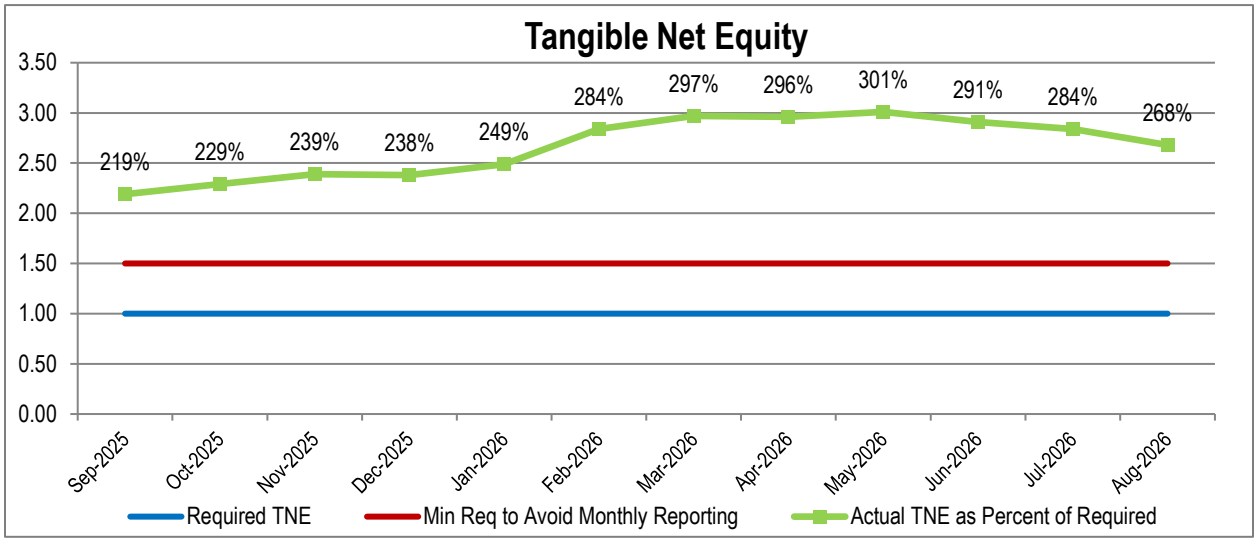
Managed Care Organization (MCO) Provider Tax

- Revenue:
  - For the month ended August 31st, 2026:
    - Actual: $60.8 million.
    - Budgeted: $59.3 million.
  - For the fiscal YTD ended August 31st, 2026:
    - Actual: $121.4 million.
    - Budgeted: $119.5 million.

- Expense:
    - For the month ended August 31st, 2026:
        - Actual: $60.8 million.
        - Budgeted: $59.3 million.
    - For the fiscal YTD ended August 31st, 2026:
        - Actual: $121.4 million.
        - Budgeted: $119.5 million.

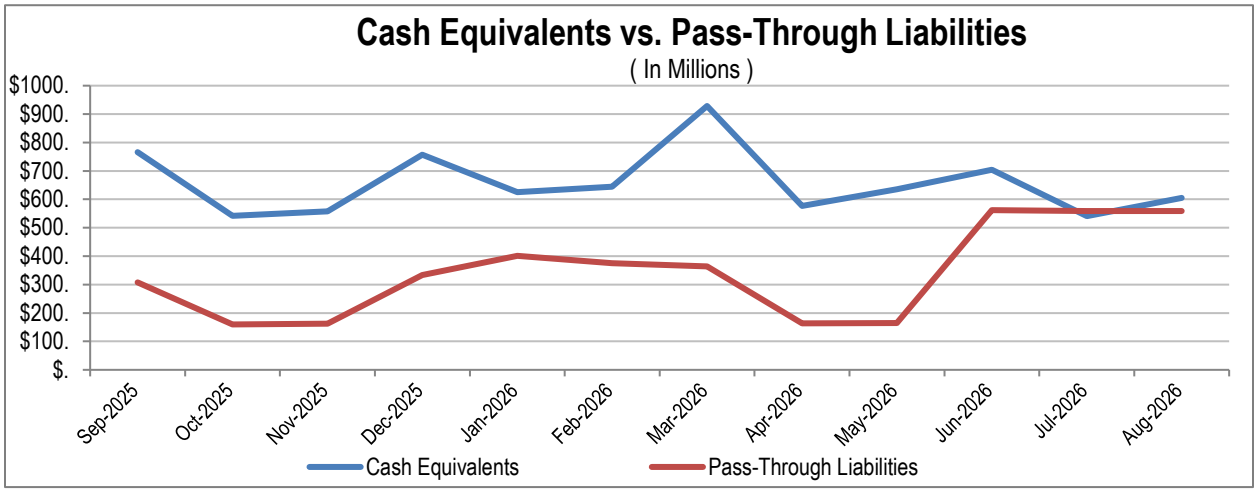
Tangible Net Equity (TNE)

- 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 $121.1 million
    - Actual TNE $216.3 million
    - Excess TNE $135.6 million
    - TNE % of Required TNE 268%



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

- Key Metrics:
    - Cash & Cash Equivalents $605.4 million
    - Pass-Through Liabilities $559.0 million



    - Uncommitted Cash $46.4 million
    - Working Capital $166.3 million
    - Current Ratio 1.14 (regulatory minimum is 1.00)

Capital Investment

- Fiscal year-to-date capital assets acquired: $135,000.
- Annual capital budget: $1.3 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 AUGUST, 2026

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
359,834	352,866	6,968	2.0%	1. Medi-Cal	720,238	710,390	9,848	1.4%
6,475	6,331	144	2.3%	2. GroupCare	12,873	12,656	217	1.7%
296	586	(290)	(49.5%)	3. Medicare SNP	568	952	(384)	(40.3%)
366,605	**359,783**	**6,822**	**1.9%**	**3. TOTAL MEMBER MONTHS**	**733,679**	**723,998**	**9,681**	**1.3%**
				REVENUE				
$181,931,032	$177,747,918	$4,183,113	2.4%	4. Premium Revenue	$361,884,894	$357,201,054	$4,683,840	1.3%
$60,809,286	$59,348,533	$1,460,754	2.5%	5. MCO Tax Revenue AB119	$121,425,635	$119,480,494	$1,945,141	1.6%
$242,740,318	**$237,096,451**	**$5,643,867**	**2.4%**	**6. TOTAL REVENUE**	**$483,310,528**	**$476,681,548**	**$6,628,981**	**1.4%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$15,861,673	$15,633,133	($228,540)	(1.5%)	7. Capitated Medical Expense	$32,013,420	$31,462,201	($551,219)	(1.8%)
				Fee for Service Medical Expenses				
$47,739,825	$48,463,732	$723,907	1.5%	8. Inpatient Hospital Expense	$91,360,987	$97,368,535	$6,007,548	6.2%
$3,545,395	$4,563,623	$1,018,228	22.3%	9. Primary Care Physician Expense	$7,387,037	$9,169,797	$1,782,761	19.4%
$8,692,738	$7,685,114	($1,007,623)	(13.1%)	10. Specialty Care Physician Expense	$17,599,261	$15,445,544	($2,153,718)	(13.9%)
$27,774,492	$23,051,163	($4,723,329)	(20.5%)	11. Ancillary Medical Expense	$49,382,563	$46,036,361	($3,346,202)	(7.3%)
$14,372,256	$12,268,605	($2,103,651)	(17.1%)	12. Outpatient Medical Expense	$28,199,316	$24,604,099	($3,595,217)	(14.6%)
$10,245,300	$9,738,760	($506,540)	(5.2%)	13. Emergency Expense	$20,946,445	$19,544,619	($1,401,826)	(7.2%)
$14,824,852	$12,362,632	($2,462,220)	(19.9%)	14. Pharmacy Expense	$35,114,607	$24,782,423	($10,332,184)	(41.7%)
$35,583,202	$35,309,213	($273,989)	(0.8%)	15. Long Term Care Expense	$68,439,697	$70,669,392	$2,229,695	3.2%
$162,778,059	$153,442,842	($9,335,217)	(6.1%)	16. Total Fee for Service Expense	$318,429,913	$307,620,770	($10,809,143)	(3.5%)
$4,185,424	$4,233,599	$48,175	1.1%	17. Other Benefits & Services	$7,614,333	$8,224,099	$609,767	7.4%
$577,503	$701,269	$123,766	17.6%	18. Reinsurance Expense	$1,152,481	$1,413,234	$260,753	18.5%
$583,333	$583,333	$0	0.0%	19. Risk Pool Distribution	$1,166,667	$1,166,667	$0	0.0%
$183,985,993	**$174,594,177**	**($9,391,816)**	**(5.4%)**	**20. TOTAL MEDICAL EXPENSES**	**$360,376,813**	**$349,886,971**	**($10,489,842)**	**(3.0%)**
$58,754,324	**$62,502,274**	**($3,747,949)**	**(6.0%)**	**21. GROSS MARGIN**	**$122,933,716**	**$126,794,577**	**($3,860,861)**	**(3.0%)**
				ADMINISTRATIVE EXPENSES				
$6,675,234	$6,471,191	($204,044)	(3.2%)	22. Personnel Expense	$13,160,627	$12,763,930	($396,697)	(3.1%)
$91,639	$88,131	($3,507)	(4.0%)	23. Benefits Administration Expense	$180,080	$176,052	($4,029)	(2.3%)
$2,090,523	$2,245,078	$154,555	6.9%	24. Purchased & Professional Services	$3,295,275	$4,630,496	$1,335,221	28.8%
$1,395,415	$1,545,159	$149,744	9.7%	25. Other Administrative Expense	$4,700,920	$4,561,408	($139,512)	(3.1%)
$10,252,811	**$10,349,559**	**$96,748**	**0.9%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$21,336,902**	**$22,131,885**	**$794,983**	**3.6%**
$60,809,286	**$59,348,533**	**($1,460,754)**	**(2.5%)**	**27. MCO TAX EXPENSES**	**$121,425,635**	**$119,480,494**	**($1,945,141)**	**(1.6%)**
($12,307,773)	**($7,195,818)**	**$5,111,955**	**(71.0%)**	**28. NET OPERATING INCOME / (LOSS)**	**($19,828,822)**	**($14,817,802)**	**$5,011,019**	**(33.8%)**
				OTHER INCOME / EXPENSES				
$2,114,213	**$2,930,639**	**($816,426)**	**(27.9%)**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$4,434,577**	**$5,331,218**	**($896,641)**	**(16.8%)**
($10,193,560)	**($4,265,179)**	**($5,928,381)**	**(139.0%)**	**30. NET SURPLUS (DEFICIT)**	**($15,394,244)**	**($9,486,584)**	**($5,907,660)**	**(62.3%)**
101.1%	98.2%	(2.9%)	(3.0%)	31. Medical Loss Ratio	99.6%	98.0%	(1.6%)	(1.6%)
5.6%	5.8%	0.2%	3.4%	32. Administrative Expense Ratio	5.9%	6.2%	0.3%	4.8%
(4.2%)	(1.8%)	(2.4%)	(133.3%)	33. Net Surplus (Deficit) Ratio	(3.2%)	(2.0%)	(1.2%)	(60.0%)

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

	8/31/2026	7/31/2026	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$27,377,737	$36,266,469	($8,888,732)	(24.5%)
Short-Term Investment	578,058,000	504,647,375	73,410,625	14.5%
Interest Receivable	4,493,018	3,780,754	712,264	18.8%
Premium Receivables	754,733,055	760,435,033	(5,701,979)	(0.7%)
Reinsurance Recovery Receivable	13,445,096	11,802,202	1,642,894	13.9%
Other Receivables	1,139,530	1,822,532	(683,001)	(37.5%)
Prepaid Expenses	945,093	1,016,123	(71,029)	(7.0%)
TOTAL CURRENT ASSETS	**1,380,191,530**	**1,319,770,488**	**60,421,042**	**4.6%**
OTHER ASSETS				
CNB Long-Term Investment	34,392,649	31,640,674	2,751,975	8.7%
CalPERS Net Pension Asset	(4,224,236)	(4,224,236)	0	0.0%
Deferred Outflow	15,559,551	15,559,551	0	0.0%
Restricted Asset-Bank Note	367,938	366,895	1,043	0.3%
GASB 87-Lease Assets (Net)	32,750	36,025	(3,275)	(9.1%)
GASB 96-SBITA Assets (Net)	6,446,274	6,724,607	(278,334)	(4.1%)
TOTAL OTHER ASSETS	**52,574,925**	**50,103,516**	**2,471,409**	**4.9%**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	10,028,605	10,028,605	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	39,155,362	39,155,362	0	0.0%
Less: Accumulated Depreciation	(34,249,791)	(34,189,471)	(60,321)	0.2%
PROPERTY AND EQUIPMENT (NET)	**4,905,571**	**4,965,891**	**(60,321)**	**(1.2%)**
TOTAL ASSETS	**1,437,672,026**	**1,374,839,895**	**62,832,130**	**4.6%**
CURRENT LIABILITIES				
Trade Accounts Payable	12,064,211	11,759,530	304,681	2.6%
Incurred But Not Reported Claims	290,919,872	284,133,963	6,785,909	2.4%
Other Medical Liabilities	161,273,883	156,181,595	5,092,288	3.3%
Pass-Through Liabilities	558,996,950	558,475,544	521,406	0.1%
MCO Tax Liabilities	176,092,547	115,283,261	60,809,286	52.7%
GASB 87 and 96 ST Liabilities	2,674,249	2,756,903	(82,654)	(3.0%)
Payroll Liabilities	11,835,555	11,526,281	309,275	2.7%
Deferred Revenues	0	639,530	(639,530)	(100.0%)
TOTAL CURRENT LIABILITIES	**1,213,857,267**	**1,140,756,606**	**73,100,661**	**6.4%**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	2,324,836	2,399,806	(74,970)	(3.1%)
Deferred Inflow	5,183,734	5,183,734	0	0.0%
TOTAL LONG TERM LIABILITIES	**7,508,569**	**7,583,539**	**(74,970)**	**(1.0%)**
TOTAL LIABILITIES	**1,221,365,836**	**1,148,340,145**	**73,025,691**	**6.4%**
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	230,860,201	230,860,201	0	0.0%
Year-To-Date Net Surplus (Deficit)	(15,394,244)	(5,200,684)	(10,193,560)	196.0%
TOTAL NET WORTH	**216,306,190**	**226,499,750**	**(10,193,560)**	**(4.5%)**
TOTAL LIABILITIES AND NET WORTH	**1,437,672,026**	**1,374,839,895**	**62,832,130**	**4.6%**
Cash Equivalents	605,435,737	540,913,844	64,521,893	11.9%
Pass-Through	558,996,950	558,475,544	521,406	0.1%
Uncommitted Cash	46,438,788	(17,561,700)	64,000,487	(364.4%)
Working Capital	166,334,263	179,013,882	(12,679,619)	(7.1%)
Current Ratio	113.7%	115.7%	(2.0%)	(1.7%)

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **August 31, 2026**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$4,077,555	$11,576,916	$21,870,184	$8,109,745
GroupCare Receivable	(3,068)	(3,781)	6,068	(5,421)
Total	4,074,487	11,573,135	21,876,252	8,104,324
Medicare Premiums				
Medicare Premiums	591,894	1,510,643	2,750,684	1,010,090
Deferred Premium Revenue	(639,530)	0	(405,514)	0
Medicare Receivable	(17,102)	1,756	(17,102)	(332)
Total	(64,738)	1,512,399	2,328,068	1,009,758
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	238,070,866	722,896,141	1,461,718,825	474,190,692
Premium Receivable	5,722,149	(391,724,251)	(153,041,531)	7,479,640
Total	243,793,015	331,171,890	1,308,677,294	481,670,332
Investment & Other Income Cash Flows				
Other Revenues	209,584	688,204	500,544	396,146
Interest Income	1,919,158	6,041,981	15,226,961	4,068,204
Interest Receivable	(712,264)	(1,188,347)	(2,011,907)	(887,410)
Total	1,416,478	5,541,838	13,715,598	3,576,940
Medical & Hospital Cash Flows				
Total Medical Expenses	(183,985,993)	(545,778,459)	(1,065,503,873)	(360,376,812)
Other Health Care Receivables	(965,276)	2,081,355	1,365,509	2,135,439
Capitation Payable	-	-	-	-
IBNP Payable	6,785,909	(19,585,158)	(76,466,501)	(24,319,985)
Other Medical Payable	5,030,359	402,254,665	196,937,344	1,218,160
Risk Share Payable	583,333	1,456,667	2,326,667	1,166,667
New Health Program Payable	-	-	-	-
Total	(172,551,668)	(159,570,930)	(941,340,854)	(380,176,531)
Administrative Cash Flows				
Total Administrative Expenses	(10,267,343)	(34,933,557)	(70,027,142)	(21,366,675)
Prepaid Expenses	71,029	(228,410)	143,459	(350,201)
Other Receivables	5,384	4,780	11,402	(563)
CalPERS Pension	-	(2,529,334)	(2,529,334)	-
Trade Accounts Payable	304,682	400,339	98,294	(1,299,457)
Payroll Liabilities	309,275	2,245,050	4,435,988	276,747
GASB Assets and Liabilities	123,985	425,237	1,193,224	420,836
Depreciation Expense	60,321	171,955	360,306	116,138
Total	(9,392,667)	(34,443,940)	(66,313,803)	(22,203,175)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(60,809,286)	(183,451,606)	(372,989,167)	(121,425,635)
MCO Tax Liabilities	60,809,286	(4,923,394)	(3,760,833)	(66,949,365)
Total	0	(188,375,000)	(376,750,000)	(188,375,000)
Net Cash Flows from Operating Activities	**67,274,907**	**(32,590,608)**	**(37,807,445)**	**(96,393,352)**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **August 31, 2026**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(2,751,971)	3,094,068	(1,109,608)	(2,640,711)
Total	(2,751,971)	3,094,068	(1,109,608)	(2,640,711)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(1,043)	(3,086)	(6,046)	(2,049)
Total	(1,043)	(3,086)	(6,046)	(2,049)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	(135,097)	(150,327)	(135,097)
Depreciation expense				
Change in A/D				
Purchases of Property and Equipment	-	(135,097)	(150,327)	(135,097)
Net Cash Flows from Investing Activities	**(2,753,014)**	**2,955,885**	**(1,265,981)**	**(2,777,857)**
Financing Cash Flows				
Subordinated Debt Proceeds	-	-	-	-
Net Change in Cash	**64,521,893**	**(29,634,723)**	**(39,073,426)**	**(99,171,209)**
Rounding	-	-	-	-
Cash @ Beginning of Period	540,913,845	635,070,461	644,509,164	704,606,947
Cash @ End of Period	**$605,435,738**	**$605,435,738**	**$605,435,738**	**$605,435,738**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **August 31, 2026**

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($10,193,565)	($21,449,738)	($6,452,984)	($15,394,245)
Add back: Depreciation & Amortization	60,321	171,955	360,306	116,138
Receivables				
Premiums Receivable	5,705,047	(391,722,495)	(153,058,633)	7,479,308
Interest Receivable	(712,264)	(1,188,347)	(2,011,907)	(887,410)
Other Health Care Receivables	(965,276)	2,081,355	1,365,509	2,135,439
Other Receivables	5,384	4,780	11,402	(563)
GroupCare Receivable	(3,068)	(3,781)	6,068	(5,421)
Total	4,029,823	(390,828,488)	(153,687,561)	8,721,353
Prepaid Expenses	71,029	(228,410)	143,459	(350,201)
Trade Payables	304,682	400,339	98,294	(1,299,457)
Claims Payable and Shared Risk Pool				
IBNP Payable	6,785,909	(19,585,158)	(76,466,501)	(24,319,985)
Capitation Payable & Other Medical Payable	5,030,359	402,254,665	196,937,344	1,218,160
Risk Share Payable	583,333.00	1,456,667.00	2,326,667	1,166,667
Claims Payable				
Total	12,399,601	384,126,174	122,797,510	(21,935,158)
Unearned Revenue				
Deferred Premium Revenue				
Deferred Revenue - IHSS				
Deferred Revenue - Medicare (DSNP)	(639,530)	0	(405,514)	0
Total	(639,530.00)	-	(405,514.00)	-
Other Liabilities				
CalPERS Pension	-	(2,529,334.00)	(2,529,334.00)	-
Payroll Liabilities	309,275	2,245,051	4,435,988	276,747
GASB Assets and Liabilities	123,985	425,237	1,193,224	420,836
New Health Program	-	-	-	-
MCO Tax Liabilities	60,809,286	(4,923,394)	(3,760,833)	(66,949,365)
Total	61,242,546	(4,782,440)	(660,955)	(66,251,782)
Rounding	-	-	-	-
Cash Flows from Operating Activities	**67,274,907**	**(32,590,608)**	**(37,807,445)**	**(96,393,352)**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **August 31, 2026**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$243,793,015	$331,171,890	$1,308,677,294	$481,670,332
Medicare Revenue	($64,738)	$1,512,399	$2,328,068	$1,009,758
GroupCare Premium Revenue	4,074,487	11,573,135	21,876,252	8,104,324
Other Income	209,584	688,204	500,544	396,146
Interest Income	1,206,894	4,853,634	13,215,054	3,180,794
Less Cash Paid				
Medical Expenses	(172,551,668)	(159,570,930)	(941,340,854)	(380,176,531)
Vendor & Employee Expenses	(9,392,667)	(34,443,940)	(66,313,803)	(22,203,175)
MCO Tax Expense AB119	0	(188,375,000)	(376,750,000)	(188,375,000)
Net Cash Flows from Operating Activities	**67,274,907**	**(32,590,608)**	**(37,807,445)**	**(96,393,352)**
Cash Flows from Investing Activities:				
Long Term Investments	(2,751,971)	3,094,068	(1,109,608)	(2,640,711)
Restricted Assets-Treasury Account	(1,043)	(3,086)	(6,046)	(2,049)
Purchases of Property and Equipment	0	(135,097)	(150,327)	(135,097)
Net Cash Flows from Investing Activities	**(2,753,014)**	**2,955,885**	**(1,265,981)**	**(2,777,857)**
Net Change in Cash	**64,521,893**	**(29,634,723)**	**(39,073,426)**	**(99,171,209)**
Rounding	-	-	-	-
Cash @ Beginning of Period	540,913,845	635,070,461	644,509,164	704,606,947
Cash @ End of Period	**$605,435,738**	**$605,435,738**	**$605,435,738**	**$605,435,738**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($10,193,565)	($21,449,737)	($6,452,985)	($15,394,245)
Add Back: Depreciation	60,321	171,955	360,306	116,138
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	4,029,823	(390,828,488)	(153,687,561)	8,721,353
Prepaid Expenses	71,029	(228,411)	143,460	(350,201)
Trade Payables	304,682	400,339	98,294	(1,299,457)
Claims Payable, IBNP and Risk Sharing	12,399,601	384,126,174	122,797,510	(21,935,158)
Deferred Revenue- Medicare (DSNP)	(639,530)	0	(405,514)	0
Other Liabilities	61,242,546	(4,782,440)	(660,955)	(66,251,782)
Total	67,274,907	(32,590,608)	(37,807,445)	(96,393,352)
Rounding	-	-	-	-
Cash Flows from Operating Activities	**$67,274,907**	**($32,590,608)**	**($37,807,445)**	**($96,393,352)**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF AUGUST 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	102,769	51,463	130,627	27,259	47,716	359,834	6,475	296	366,605
Revenue	$33,787,163	$29,072,242	$83,424,076	$48,415,517	$43,371,871	$238,070,869	$4,077,555	$591,894	$242,740,318
Medical Expense	$14,775,892	$19,533,015	$66,121,263	$41,745,217	$37,323,530	$179,498,916	$3,627,673	$859,404	$183,985,993
Gross Margin	$19,011,271	$9,539,227	$17,302,813	$6,670,301	$6,048,341	$58,571,952	$449,883	($267,511)	$58,754,324
Administrative Expense	$584,411	$1,041,899	$3,312,454	$2,343,001	$2,136,604	$9,418,369	$230,743	$603,700	$10,252,811
MCO Tax Expense	$17,362,710	$8,673,702	$21,951,055	$4,680,557	$8,141,262	$60,809,286	$0	$0	$60,809,286
Operating Income / (Expense)	$1,064,150	($176,374)	($7,960,696)	($353,258)	($4,229,525)	($11,655,703)	$219,140	($871,211)	($12,307,773)
Other Income / (Expense)	$102,226	$243,565	$693,068	$642,332	$394,504	$2,075,695	$31,373	$7,145	$2,114,213
Net Income / (Loss)	$1,166,376	$67,191	($7,267,628)	$289,075	($3,835,021)	($9,580,007)	$250,513	($864,066)	($10,193,560)
PMPM Metrics:									
Revenue PMPM	$328.77	$564.92	$638.64	$1,776.13	$908.96	$661.61	$629.74	$1,999.64	$662.13
Medical Expense PMPM	$143.78	$379.55	$506.18	$1,531.43	$782.20	$498.84	$560.26	$2,903.39	$501.86
Gross Margin PMPM	$184.99	$185.36	$132.46	$244.70	$126.76	$162.77	$69.48	($903.75)	$160.27
Administrative Expense PMPM	$5.69	$20.25	$25.36	$85.95	$44.78	$26.17	$35.64	$2,039.53	$27.97
MCO Tax Expense PMPM	$168.95	$168.54	$168.04	$171.71	$170.62	$168.99	$0.00	$0.00	$165.87
Operating Income / (Expense) PMPM	$10.35	($3.43)	($60.94)	($12.96)	($88.64)	($32.39)	$33.84	($2,943.28)	($33.57)
Other Income / (Expense) PMPM	$0.99	$4.73	$5.31	$23.56	$8.27	$5.77	$4.85	$24.14	$5.77
Net Income / (Loss) PMPM	$11.35	$1.31	($55.64)	$10.60	($80.37)	($26.62)	$38.69	($2,919.14)	($27.81)
Ratio:									
Medical Loss Ratio	90.0%	95.8%	107.6%	95.5%	105.9%	101.3%	89.0%	145.2%	101.1%
Administrative Expense Ratio	3.6%	5.1%	5.4%	5.4%	6.1%	5.3%	5.7%	102.0%	5.6%
Net Income Ratio	3.5%	0.2%	-8.7%	0.6%	-8.8%	-4.0%	6.1%	-146.0%	-4.2%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE AUGUST 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	205,688	103,297	261,476	54,339	95,438	720,238	12,873	568	733,679
Revenue	$67,559,456	$58,003,469	$166,998,665	$95,502,196	$86,126,908	$474,190,694	$8,109,745	$1,010,090	$483,310,528
Medical Expense	$29,720,684	$37,019,813	$128,667,508	$89,575,294	$63,451,340	$348,434,639	$10,324,773	$1,617,401	$360,376,813
Gross Margin	$37,838,772	$20,983,657	$38,331,157	$5,926,902	$22,675,568	$125,756,055	($2,215,028)	($607,311)	$122,933,716
Administrative Expense	$1,229,628	$2,188,108	$6,927,404	$4,885,056	$4,422,416	$19,652,612	$516,532	$1,167,757	$21,336,902
MCO Tax Expense	$34,672,657	$17,391,662	$43,958,548	$9,235,142	$16,167,626	$121,425,635	$0	$0	$121,425,635
Operating Income / (Expense)	$1,936,486	$1,403,886	($12,554,795)	($8,193,296)	$2,085,527	($15,322,192)	($2,731,561)	($1,775,069)	($19,828,822)
Other Income / (Expense)	$214,550	$510,859	$1,454,542	$1,347,991	$827,970	$4,355,912	$65,810	$12,855	$4,434,577
Net Income / (Loss)	$2,151,037	$1,914,745	($11,100,254)	($6,845,304)	$2,913,497	($10,966,280)	($2,665,750)	($1,762,214)	($15,394,244)
PMPM Metrics:									
Revenue PMPM	$328.46	$561.52	$638.68	$1,757.53	$902.44	$658.38	$629.98	$1,778.33	$658.75
Medical Expense PMPM	$144.49	$358.38	$492.08	$1,648.45	$664.84	$483.78	$802.05	$2,847.54	$491.19
Gross Margin PMPM	$183.96	$203.14	$146.60	$109.07	$237.59	$174.60	($172.07)	($1,069.21)	$167.56
Administrative Expense PMPM	$5.98	$21.18	$26.49	$89.90	$46.34	$27.29	$40.13	$2,055.91	$29.08
MCO Tax Expense PMPM	$168.57	$168.37	$168.12	$169.95	$169.40	$168.59	$0.00	$0.00	$165.50
Operating Income / (Expense) PMPM	$9.41	$13.59	($48.02)	($150.78)	$21.85	($21.27)	($212.19)	($3,125.12)	($27.03)
Other Income / (Expense) PMPM	$1.04	$4.95	$5.56	$24.81	$8.68	$6.05	$5.11	$22.63	$6.04
Net Income / (Loss) PMPM	$10.46	$18.54	($42.45)	($125.97)	$30.53	($15.23)	($207.08)	($3,102.49)	($20.98)
Ratio:									
Medical Loss Ratio	90.4%	91.2%	104.6%	103.8%	90.7%	98.8%	127.3%	160.1%	99.6%
Administrative Expense Ratio	3.7%	5.4%	5.6%	5.7%	6.3%	5.6%	6.4%	115.6%	5.9%
Net Income Ratio	3.2%	3.3%	-6.6%	-7.2%	3.4%	-2.3%	-32.9%	-174.5%	-3.2%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSES SUMMARY (ADMIN. DEPT. ONLY)				
$6,675,234	$6,471,191	($204,044)	(3.2%)	Personnel Expenses	$13,160,627	$12,763,930	($396,697)	(3.1%)
$91,639	$88,131	($3,507)	(4.0%)	Benefits Administration Expense	$180,080	$176,052	($4,029)	(2.3%)
$2,090,523	$2,245,078	$154,555	6.9%	Purchased & Professional Services	$3,295,275	$4,630,496	$1,335,221	28.8%
$471,692	$468,835	($2,857)	(0.6%)	Occupancy	$991,850	$943,658	($48,192)	(5.1%)
$160,557	$267,292	$106,735	39.9%	Printing Postage & Promotion	$514,101	$495,043	($19,058)	(3.8%)
$397,333	$314,488	($82,845)	(26.3%)	Licenses Insurance & Fees	$2,321,567	$2,228,083	($93,484)	(4.2%)
$365,834	$494,544	$128,711	26.0%	Other Administrative Expense	$873,402	$894,624	$21,222	2.4%
$3,577,577	$3,878,368	$300,791	7.8%	Total Other Administrative Expenses (excludes Personnel Expenses)	$8,176,275	$9,367,955	$1,191,680	12.7%
$10,252,811	$10,349,559	$96,748	0.9%	Total Administrative Expenses	$21,336,902	$22,131,885	$794,983	3.6%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
4,131,891	4,200,365	68,474	1.6%	Salaries & Wages	7,852,708	8,244,167	391,459	4.7%
630,410	368,134	(262,276)	(71.2%)	Paid Time Off	969,442	721,583	(247,858)	(34.3%)
150	1,000	850	85.0%	Compensated Incentives	237	2,000	1,763	88.2%
77,950	33,333	(44,617)	(133.8%)	Severence	779,532	66,667	(712,865)	(1,069.3%)
70,806	60,238	(10,569)	(17.5%)	Payroll Taxes	145,052	119,890	(25,162)	(21.0%)
63,544	60,712	(2,832)	(4.7%)	Overtime	144,018	119,424	(24,594)	(20.6%)
(841)	12,500	13,341	106.7%	Commission Pay	1,671	25,000	23,329	93.3%
364,713	312,118	(52,594)	(16.9%)	CalPERS ER Match	719,328	612,564	(106,764)	(17.4%)
1,110,330	1,154,493	44,163	3.8%	Employee Benefits	2,275,585	2,322,698	47,113	2.0%
(2,922)	0	2,922	0.0%	Personal Floating Holiday	(891)	0	891	0.0%
21,696	30,500	8,804	28.9%	Language Pay	44,346	61,000	16,654	27.3%
3,710	0	(3,710)	0.0%	Med Ins Opted Out Stipend	7,340	0	(7,340)	0.0%
65,901	0	(65,901)	0.0%	Sick Leave	39,688	0	(39,688)	0.0%
300	12,032	11,732	97.5%	Compensated Employee Relations	(617)	20,890	21,507	103.0%
19,960	23,740	3,780	15.9%	Work from Home Stipend	39,920	47,430	7,510	15.8%
999	4,172	3,173	76.0%	Mileage, Parking & LocalTravel	1,634	7,865	6,231	79.2%
6,038	9,431	3,393	36.0%	Travel & Lodging	9,516	20,513	10,997	53.6%
86,402	117,544	31,142	26.5%	Temporary Help Services	86,402	236,058	149,655	63.4%
22,484	40,792	18,308	44.9%	Staff Development/Training	43,256	85,268	42,013	49.3%
1,712	30,085	28,372	94.3%	Staff Recruitment/Advertisement	2,462	50,914	48,452	95.2%
6,675,234	**6,471,191**	**(204,044)**	**(3.2%)**	**Personnel Expense**	**13,160,627**	**12,763,930**	**(396,697)**	**(3.1%)**
41,474	31,084	(10,390)	(33.4%)	Pharmacy Administrative Fees	82,181	61,484	(20,696)	(33.7%)
0	10,000	10,000	100.0%	M3P Admin Fees	0	20,000	20,000	100.0%
2,537	352	(2,185)	(621.4%)	OTC Administrative	2,537	571	(1,965)	(344.1%)
346	0	(346)	0.0%	Capitation Admin Fees	650	0	(650)	0.0%
47,282	46,696	(587)	(1.3%)	Telemedicine Admin. Fees	94,713	93,996	(717)	(0.8%)
91,639	**88,131**	**(3,507)**	**(4.0%)**	**Benefits Administration Expense**	**180,080**	**176,052**	**(4,029)**	**(2.3%)**
359,444	619,075	259,631	41.9%	Consultant Fees - Non Medical	450,285	1,328,860	878,575	66.1%
344,271	257,537	(86,734)	(33.7%)	Computer Support Services	948,606	520,858	(427,749)	(82.1%)
40,793	15,000	(25,793)	(172.0%)	Audit Fees	73,815	30,000	(43,815)	(146.1%)
(26,900)	0	26,900	0.0%	Consultant Fees - Medical	0	0	0	0.0%
309,695	260,274	(49,421)	(19.0%)	Other Purchased Services	312,362	506,867	194,504	38.4%
1,480	1,879	399	21.3%	Maint.&Repair-Office Equipment	2,959	3,758	799	21.3%
70,463	63,833	(6,630)	(10.4%)	Legal Fees	95,463	127,667	32,203	25.2%
33,316	33,000	(316)	(1.0%)	Translation Services	33,316	66,000	32,684	49.5%
101,808	0	(101,808)	0.0%	Interpretive Services	0	0	0	0.0%
321,538	350,785	29,248	8.3%	Medical Refund Recovery Fees	202,695	711,571	508,876	71.5%
419,701	519,036	99,335	19.1%	Software - IT Licenses & Subsc	1,040,261	1,093,710	53,448	4.9%
0	55,604	55,604	100.0%	Hardware (Non-Capital)	20,296	106,248	85,953	80.9%
114,916	69,054	(45,862)	(66.4%)	Provider Credentialing	115,216	134,958	19,742	14.6%
2,090,523	**2,245,078**	**154,555**	**6.9%**	**Purchased & Professional Services**	**3,295,275**	**4,630,496**	**1,335,221**	**28.8%**
60,321	78,172	17,851	22.8%	Depreciation	116,138	156,344	40,206	25.7%
6,902	6,807	(95)	(1.4%)	Lease Rented Office Equipment	13,804	13,614	(190)	(1.4%)
17,875	18,750	875	4.7%	Utilities	52,856	34,700	(18,156)	(52.3%)
85,380	110,657	25,277	22.8%	Telephone	228,705	221,314	(7,391)	(3.3%)
22,880	27,620	4,740	17.2%	Building Maintenance	23,681	64,029	40,348	63.0%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
278,334	226,829	(51,505)	(22.7%)	GASB96 SBITA Amort. Expense	556,666	453,658	(103,008)	(22.7%)
471,692	**468,835**	**(2,857)**	**(0.6%)**	**Occupancy**	**991,850**	**943,658**	**(48,192)**	**(5.1%)**
48,164	65,530	17,366	26.5%	Postage	175,044	131,930	(43,115)	(32.7%)
3,740	7,167	3,427	47.8%	Design & Layout	3,740	14,333	10,593	73.9%
38,476	115,461	76,985	66.7%	Printing Services	239,054	230,922	(8,132)	(3.5%)
27,484	11,350	(16,134)	(142.1%)	Mailing Services	48,699	22,700	(25,999)	(114.5%)
8,240	8,805	565	6.4%	Courier/Delivery Service	10,889	15,749	4,860	30.9%
0	842	842	100.0%	Pre-Printed Materials & Public	80	1,683	1,603	95.2%
0	7,500	7,500	100.0%	Promotional Products	0	10,000	10,000	100.0%
0	150	150	100.0%	Promotional Services	0	300	300	100.0%
34,453	50,488	16,034	31.8%	Community Relations	36,595	67,425	30,830	45.7%
160,557	**267,292**	**106,735**	**39.9%**	**Printing Postage & Promotion**	**514,101**	**495,043**	**(19,058)**	**(3.8%)**
0	18,750	18,750	100.0%	Regulatory Penalties	0	37,500	37,500	100.0%
39,437	29,367	(10,070)	(34.3%)	Bank Fees	77,533	58,733	(18,800)	(32.0%)
0	175,000	175,000	100.0%	Insurance Premium	1,066,737	1,396,240	329,503	23.6%
25,471	64,747	39,277	60.7%	License,Permits, & Fee - NonIT	797,263	673,294	(123,969)	(18.4%)
332,425	26,624	(305,801)	(1,148.6%)	Subscriptions and Dues - NonIT	380,034	62,316	(317,718)	(509.9%)
397,333	**314,488**	**(82,845)**	**(26.3%)**	**License Insurance & Fees**	**2,321,567**	**2,228,083**	**(93,484)**	**(4.2%)**
804	4,009	3,205	80.0%	Office and Other Supplies	871	7,058	6,187	87.7%
0	500	500	100.0%	Furniture & Equipment	0	1,000	1,000	100.0%
9,171	10,296	1,125	10.9%	Ergonomic Supplies	10,546	14,285	3,738	26.2%
8,132	83,027	74,896	90.2%	Meals and Entertainment	28,540	92,604	64,065	69.2%
(3)	0	3	0.0%	Miscellaneous	(5)	0	5	0.0%
0	3,125	3,125	100.0%	Member Incentive	1,475	6,250	4,775	76.4%
171,068	206,921	35,853	17.3%	Provider Interest (All Depts)	473,649	415,093	(58,556)	(14.1%)
176,663	186,667	10,004	5.4%	Community Reinvestment Expense	358,326	358,333	7	0.0%
365,834	**494,544**	**128,711**	**26.0%**	**Other Administrative Expense**	**873,402**	**894,624**	**21,222**	**2.4%**
3,577,577	**3,878,368**	**300,791**	**7.8%**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**8,176,275**	**9,367,955**	**1,191,680**	**12.7%**
10,252,811	**10,349,559**	**96,748**	**0.9%**	**TOTAL ADMINISTRATIVE EXPENSES**	**21,336,902**	**22,131,885**	**794,983**	**3.6%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED JUNE 30, 2027

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Routers	IT-FY27-01	$ -	$ -	**$ -**	$ 100,000	$ 100,000
	Firewall, AAH Location	IT-FY27-02	$ -	$ -	**$ -**	$ 40,000	$ 40,000
	Cisco UCS Blades (x2)	IT-FY27-03	$ -	$ -	**$ -**	$ 548,000	$ 548,000
	Pure Storage	IT-FY27-04	$ -	$ -	**$ -**	$ 150,000	$ 150,000
Hardware Subtotal			**$ -**	**$ -**	**$ -**	**$ 838,000**	**$ 838,000**
3. Building Improvement:							
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	**$ 23,597**	$ -	**$ 23,597**	$ 25,000	$ 1,403
	Roof Overlay Warehouse	FA-FY26-05	**$ 111,500**	$ -	**$ 111,500**	$ 25,000	$ (86,500)
	Roof Replacement	FA-FY27-01	**$ -**	$ -	**$ -**	$ 338,500	$ 338,500
	Exterior Landscaping Conversion	FA-FY27-02	**$ -**	$ -	**$ -**	$ 60,000	$ 60,000
Building Improvement Subtotal			**$ 135,097**	**$ -**	**$ 135,097**	**$ 448,500**	**$ 313,403**
GRAND TOTAL			**$ 135,097**	**$ -**	**$ 135,097**	**$ 1,286,500**	**$ 1,151,403**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 8/31/26	**$ 39,155,362**
Fixed Assets @ Cost - 6/30/26	**$ 39,020,265**
Fixed Assets Acquired YTD	**$ 135,097**

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

TANGIBLE NET EQUITY (TNE)	**QRT. END Jun-26**	**Jul-26**	**Aug-26**
Current Month Net Income / (Loss)	$ (6,055,490)	$ (5,200,685)	$ (10,193,565)
YTD Net Income / (Loss)	$ 62,421,073	$ (5,200,684)	$ (15,394,244)
Net Assets	$ 231,700,433	$ 226,499,750	$ 216,306,190
Subordinated Debt & Interest	-	-	-
Total Actual TNE	**$ 231,700,433**	**$ 226,499,750**	**$ 216,306,190**
Increase/(Decrease) in Actual TNE	$ (6,055,490)	$ (5,200,685)	$ (10,193,565)
Required TNE (1)	**$ 79,704,419**	**$ 79,872,951**	**$ 80,728,096**
Min. Req'd to Avoid Monthly Reporting at 150% of Required TNE	$ 119,556,628	$ 119,809,427	$ 121,092,144
TNE Excess / (Deficiency)	$ 151,996,014	$ 146,626,799	$ 135,578,094
Actual TNE as a Multiple of Required	**2.91**	**2.84**	**2.68**
LIQUID TANGIBLE NET EQUITY			
Net Assets	$ 231,700,433	$ 226,499,750	$ 216,306,190
Less: Fixed Assets at Net Book Value	(4,886,612)	(4,965,891)	(4,905,570)
Net Lease Assets	(1,900,774)	(1,603,925)	(1,479,939)
CD Pledged to DMHC	(365,889)	(366,895)	(367,938)
Liquid TNE (Liquid Reserves)	**$ 224,547,158**	**$ 219,563,039**	**$ 209,552,743**
Liquid TNE as Multiple of Required	**2.82**	**2.75**	**2.60**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2027

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

	Actual Jul-26	Actual Aug-26	Actual Sep-26	Actual Oct-26	Actual Nov-26	Actual Dec-26	Actual Jan-27	Actual Feb-27	Actual Mar-27	Actual Apr-27	Actual May-27	Actual Jun-27	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	102,919	102,769											205,688
Adult	51,834	51,463											103,297
ACA OE	130,849	130,627											261,476
SPD with LTC	27,080	27,259											54,339
Duals with LTC	47,722	47,716											95,438
Medi-Cal Program	360,404	359,834											720,238
Group Care Program	6,398	6,475											12,873
Medicare Program	272	296											568
Total	**367,074**	**366,605**											**733,679**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change:													
Child	(424)	(150)											(574)
Adult	(758)	(371)											(1,129)
ACA OE	(1,466)	(222)											(1,688)
SPD with LTC	(257)	179											(78)
Duals with LTC	(161)	(6)											(167)
Medi-Cal Program	(3,066)	(570)											(3,636)
Group Care Program	48	77											125
Medicare Program	19	24											43
Total	**(2,999)**	**(469)**											**(3,468)**
Enrollment Percentages:													
Medi-Cal Program % of Total:													
Child % of Medi-Cal	28.6%	28.6%											28.6%
Adult % of Medi-Cal	14.4%	14.3%											14.3%
ACA OE % of Medi-Cal	36.3%	36.3%											36.3%
SPD with LTC % of Medi-Cal	7.5%	7.6%											7.5%
Duals with LTC % of Medi-Cal	13.2%	13.3%											13.3%
Medi-Cal Program % of Total	98.2%	98.2%											98.2%
Group Care Program % of Total	1.7%	1.8%											1.8%
Medicare Program % of Total	0.1%	0.1%											0.1%
Total	**100.0%**	**100.0%**											**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2027

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

	Actual Jul-26	Actual Aug-26	Actual Sep-26	Actual Oct-26	Actual Nov-26	Actual Dec-26	Actual Jan-27	Actual Feb-27	Actual Mar-27	Actual Apr-27	Actual May-27	Actual Jun-27	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted:													
Directly Contracted (DCP)	84,538	85,159											169,697
Alameda Health System	76,965	76,640											153,605
Directly-Contracted Subtotal	161,503	161,799											323,302
Delegated:													
CFMG	39,596	39,443											79,039
CHCN	165,975	165,363											331,338
Delegated Subtotal	205,571	204,806											410,377
Total	**367,074**	**366,605**											**733,679**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(1,585)	296											(1,289)
Delegated:													
CFMG	(251)	(153)											(404)
CHCN	(1,163)	(612)											(1,775)
Delegated Subtotal	(1,414)	(765)											(2,179)
Total	**(2,999)**	**(469)**											**(3,468)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.0%	44.1%											44.1%
Delegated:													
CFMG	10.8%	10.8%											10.8%
CHCN	45.2%	45.1%											45.2%
Delegated Subtotal	56.0%	55.9%											55.9%
Total	**100.0%**	**100.0%**											**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2027	PRELIMINARY BUDGET												
	Budget Jul-26	Budget Aug-26	Budget Sep-26	Budget Oct-26	Budget Nov-26	Budget Dec-26	Budget Jan-27	Budget Feb-27	Budget Mar-27	Budget Apr-27	Budget May-27	Budget Jun-27	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	102,792	102,322	101,855	101,389	100,927	100,468	90,854	90,491	90,129	89,769	89,410	89,052	1,149,458
Adult	52,088	51,378	50,677	49,986	49,306	48,637	28,605	28,147	27,696	27,253	26,817	26,387	466,977
ACA OE	127,875	124,672	121,559	118,535	115,597	112,742	82,003	79,544	77,158	74,843	72,597	70,418	1,177,543
SPD with LTC	27,262	27,085	26,910	26,735	26,560	26,388	20,972	20,889	20,806	20,723	20,640	20,557	285,527
Duals with LTC*	47,507	47,409	47,311	47,213	47,116	47,019	46,570	46,430	46,290	46,151	46,013	45,875	560,904
Medi-Cal Program	357,524	352,866	348,312	343,858	339,506	335,254	269,004	265,501	262,079	258,739	255,477	252,289	3,640,409
Group Care Program	6,325	6,331	6,337	6,343	6,349	6,355	6,349	6,355	6,361	6,367	6,373	6,379	76,224
Medicare Program	366	586	879	1,099	1,319	1,504	1,805	2,166	2,600	3,095	3,653	4,250	23,322
Total	**364,215**	**359,783**	**355,528**	**351,300**	**347,174**	**343,113**	**277,158**	**274,022**	**271,040**	**268,201**	**265,503**	**262,918**	**3,739,955**
Month Over Month Enrollment Change:													
Medi-Cal Program:													
Child	(647)	(470)	(467)	(466)	(462)	(459)	(9,614)	(363)	(362)	(360)	(359)	(358)	(14,387)
Adult	(2,079)	(710)	(701)	(691)	(680)	(669)	(20,032)	(458)	(451)	(443)	(436)	(430)	(27,780)
ACA OE	(965)	(3,203)	(3,113)	(3,024)	(2,938)	(2,855)	(30,739)	(2,459)	(2,386)	(2,315)	(2,246)	(2,179)	(58,422)
SPD with LTC	6,162	(177)	(175)	(175)	(175)	(172)	(5,416)	(83)	(83)	(83)	(83)	(83)	(543)
Duals with LTC	(8,343)	(98)	(98)	(98)	(97)	(97)	(449)	(140)	(140)	(139)	(138)	(138)	(9,975)
Medi-Cal Program	(5,872)	(4,658)	(4,554)	(4,454)	(4,352)	(4,252)	(66,250)	(3,503)	(3,422)	(3,340)	(3,262)	(3,188)	(111,107)
Group Care Program	216	6	6	6	6	6	(6)	6	6	6	6	6	270
Medicare Program	(459)	220	293	220	220	185	301	361	434	495	558	597	3,425
Total	**(6,115)**	**(4,432)**	**(4,255)**	**(4,228)**	**(4,126)**	**(4,061)**	**(65,955)**	**(3,136)**	**(2,982)**	**(2,839)**	**(2,698)**	**(2,585)**	**(107,412)**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	28.8%	29.0%	29.2%	29.5%	29.7%	30.0%	33.8%	34.1%	34.4%	34.7%	35.0%	35.3%	31.6%
Adult % of Medi-Cal	14.6%	14.6%	14.5%	14.5%	14.5%	14.5%	10.6%	10.6%	10.6%	10.5%	10.5%	10.5%	12.8%
ACA OE % of Medi-Cal	35.8%	35.3%	34.9%	34.5%	34.0%	33.6%	30.5%	30.0%	29.4%	28.9%	28.4%	27.9%	32.3%
SPD with LTC % of Medi-Cal	7.6%	7.7%	7.7%	7.8%	7.8%	7.9%	7.8%	7.9%	7.9%	8.0%	8.1%	8.1%	7.8%
Duals with LTC % of Medi-Cal	13.3%	13.4%	13.6%	13.7%	13.9%	14.0%	17.3%	17.5%	17.7%	17.8%	18.0%	18.2%	15.4%
Medi-Cal Program % of Total	98.2%	98.1%	98.0%	97.9%	97.8%	97.7%	97.1%	96.9%	96.7%	96.5%	96.2%	96.0%	97.3%
Group Care Program % of Total	1.7%	1.8%	1.8%	1.8%	1.8%	1.9%	2.3%	2.3%	2.3%	2.4%	2.4%	2.4%	2.0%
Medicare Program	0.1%	0.2%	0.2%	0.3%	0.4%	0.4%	0.7%	0.8%	1.0%	1.2%	1.4%	1.6%	0.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2027	PRELIMINARY BUDGET												
	Budget Jul-26	Budget Aug-26	Budget Sep-26	Budget Oct-26	Budget Nov-26	Budget Dec-26	Budget Jan-27	Budget Feb-27	Budget Mar-27	Budget Apr-27	Budget May-27	Budget Jun-27	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	84,404	83,549	82,737	81,921	81,126	80,341	70,022	69,397	68,810	68,259	67,744	67,255	905,565
Alameda Health System	75,718	74,467	73,254	72,066	70,907	69,774	52,485	51,573	50,694	49,845	49,025	48,232	738,040
Directly-Contracted Subtotal	160,122	158,016	155,991	153,987	152,033	150,115	122,507	120,970	119,504	118,104	116,769	115,487	1,643,605
Delegated:													
CFMG	39,818	39,610	39,404	39,199	38,997	38,796	36,620	36,446	36,273	36,102	35,931	35,762	452,958
CHCN	164,275	162,157	160,133	158,114	156,144	154,202	118,031	116,606	115,263	113,995	112,803	111,669	1,643,392
Delegated Subtotal	204,093	201,767	199,537	197,313	195,141	192,998	154,651	153,052	151,536	150,097	148,734	147,431	2,096,350
Total	**364,215**	**359,783**	**355,528**	**351,300**	**347,174**	**343,113**	**277,158**	**274,022**	**271,040**	**268,201**	**265,503**	**262,918**	**3,739,955**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	(5,773)	(855)	(812)	(816)	(795)	(785)	(10,319)	(625)	(587)	(551)	(515)	(489)	(22,922)
Alameda Health System	(4,463)	(1,251)	(1,213)	(1,188)	(1,159)	(1,133)	(17,289)	(912)	(879)	(849)	(820)	(793)	(31,949)
Directly-Contracted Subtotal	(10,236)	(2,106)	(2,025)	(2,004)	(1,954)	(1,918)	(27,608)	(1,537)	(1,466)	(1,400)	(1,335)	(1,282)	(54,871)
Delegated:													
CFMG	364	(208)	(206)	(205)	(202)	(201)	(2,176)	(174)	(173)	(171)	(171)	(169)	(3,692)
CHCN	3,757	(2,118)	(2,024)	(2,019)	(1,970)	(1,942)	(36,171)	(1,425)	(1,343)	(1,268)	(1,192)	(1,134)	(48,849)
Delegated Subtotal	4,121	(2,326)	(2,230)	(2,224)	(2,172)	(2,143)	(38,347)	(1,599)	(1,516)	(1,439)	(1,363)	(1,303)	(52,541)
Total	**(6,115)**	**(4,432)**	**(4,255)**	**(4,228)**	**(4,126)**	**(4,061)**	**(65,955)**	**(3,136)**	**(2,982)**	**(2,839)**	**(2,698)**	**(2,585)**	**(107,412)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	23.2%	23.2%	23.3%	23.3%	23.4%	23.4%	25.3%	25.3%	25.4%	25.5%	25.5%	25.6%	24.2%
Alameda Health System	20.8%	20.7%	20.6%	20.5%	20.4%	20.3%	18.9%	18.8%	18.7%	18.6%	18.5%	18.3%	19.7%
Directly-Contracted Subtotal	44.0%	43.9%	43.9%	43.8%	43.8%	43.8%	44.2%	44.1%	44.1%	44.0%	44.0%	43.9%	43.9%
Delegated:													
CFMG	10.9%	11.0%	11.1%	11.2%	11.2%	11.3%	13.2%	13.3%	13.4%	13.5%	13.5%	13.6%	12.1%
CHCN	45.1%	45.1%	45.0%	45.0%	45.0%	44.9%	42.6%	42.6%	42.5%	42.5%	42.5%	42.5%	43.9%
Delegated Subtotal	56.0%	56.1%	56.1%	56.2%	56.2%	56.2%	55.8%	55.9%	55.9%	56.0%	56.0%	56.1%	56.1%
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 2027

	Variance Jul-26	Variance Aug-26	Variance Sep-26	Variance Oct-26	Variance Nov-26	Variance Dec-26	Variance Jan-27	Variance Feb-27	Variance Mar-27	Variance Apr-27	Variance May-27	Variance Jun-27	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	127	447											574
Adult	(254)	85											(169)
ACA OE	2,974	5,955											8,929
Total	(182)	174											(8)
Duals with LTC*	215	307											522
Medi-Cal Program	2,880	6,968											9,848
Group Care Program	73	144											217
Medicare Program	(94)	(290)											(384)
Total	**2,859**	**6,822**											**9,681**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	134	1,610											1,744
Alameda Health System	1,247	2,173											3,420
Directly-Contracted Subtotal	1,381	3,783											5,164
Delegated:													
CFMG	(222)	(167)											(389)
CHCN	1,700	3,206											4,906
Delegated Subtotal	1,478	3,039											4,517
Total	**2,859**	**6,822**											**9,681**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2027

D-SNP

	Actual Jul-26	Actual Aug-26	Actual Sep-26	Actual Oct-26	Actual Nov-26	Actual Dec-26	Actual Jan-27	Actual Feb-27	Actual Mar-27	Actual Apr-27	Actual May-27	Actual Jun-27	YTD Member Months
Current Direct/Provider Network Enrollment:													
Directly-Contracted:													
Directly Contracted (DCP)	90	100	0	0	0	0	0	0	0	0	0	0	190
Alameda Health System	24	27	0	0	0	0	0	0	0	0	0	0	51
Directly-Contracted Subtotal	114	127	0	0	0	0	0	0	0	0	0	0	241
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	158	169	0	0	0	0	0	0	0	0	0	0	327
Provider Network Subtotal	158	169	0	0	0	0	0	0	0	0	0	0	327
Total	**272**	**296**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**568**
Direct/Provider Network Month Over Month Enrollment Change:													
Directly-Contracted	8	13	0	0	0	0	0	0	0	0	0	0	21
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	11	11	0	0	0	0	0	0	0	0	0	0	22
Provider Network Subtotal	11	11	0	0	0	0	0	0	0	0	0	0	22
Total	**19**	**24**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
Direct/Provider Network Enrollment Percentages:													
Directly-Contracted	41.9%	42.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	42.4%
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	58.1%	57.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	57.6%
Provider Network Subtotal	58.1%	57.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	57.6%
Total	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**

	Budget Jul-26	Budget Aug-26	Budget Sep-26	Budget Oct-26	Budget Nov-26	Budget Dec-26	Budget Jan-27	Budget Feb-27	Budget Mar-27	Budget Apr-27	Budget May-27	Budget Jun-27	YTD Member Months
Current Direct/Provider Network Enrollment:													
Directly-Contracted:													
Directly Contracted (DCP)	115	184	276	345	414	472	566	679	815	970	1,145	1,332	7,313
Alameda Health System	35	56	84	105	126	144	173	208	250	298	352	410	2,241
Directly-Contracted Subtotal	150	240	360	450	540	616	739	887	1,065	1,268	1,497	1,742	9,554
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	216	346	519	649	779	888	1,066	1,279	1,535	1,827	2,156	2,508	13,768
Provider Network Subtotal	216	346	519	649	779	888	1,066	1,279	1,535	1,827	2,156	2,508	13,768
Total	**366**	**586**	**879**	**1,099**	**1,319**	**1,504**	**1,805**	**2,166**	**2,600**	**3,095**	**3,653**	**4,250**	**23,322**
Direct/Provider Network Month Over Month Enrollment Change:													
Directly-Contracted	39	90	120	90	90	76	123	148	178	203	229	245	1,631
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	56	130	173	130	130	109	178	213	256	292	329	352	2,348
Provider Network Subtotal	56	130	173	130	130	109	178	213	256	292	329	352	2,348
Total	**95**	**220**	**293**	**220**	**220**	**185**	**301**	**361**	**434**	**495**	**558**	**597**	**3,979**
Direct/Provider Network Enrollment Percentages:													
Directly-Contracted	41.0%	41.0%	41.0%	40.9%	40.9%	41.0%	40.9%	41.0%	41.0%	41.0%	41.0%	41.0%	41.0%
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	59.0%	59.0%	59.0%	59.1%	59.1%	59.0%	59.1%	59.0%	59.0%	59.0%	59.0%	59.0%	59.0%
Provider Network Subtotal	59.0%	59.0%	59.0%	59.1%	59.1%	59.0%	59.1%	59.0%	59.0%	59.0%	59.0%	59.0%	59.0%
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%**	**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
Current Direct/Provider Network Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	(25)	(84)	0	0	0	0	0	0	0	0	0	0	(109)
Alameda Health System	(11)	(29)	0	0	0	0	0	0	0	0	0	0	(40)
Directly-Contracted Subtotal	(36)	(113)	0	0	0	0	0	0	0	0	0	0	(149)
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	(58)	(177)	0	0	0	0	0	0	0	0	0	0	(235)
Provider Network Subtotal	(58)	(177)	0	0	0	0	0	0	0	0	0	0	(235)
Total	**(94)**	**(290)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(384)**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
$1,458,455	$1,475,961	$17,506	1.2%	PCP Capitation	$2,982,003	$2,959,369	($22,634)	(0.8%)
5,730,886	5,925,237	194,351	3.3%	PCP Capitation FQHC	11,563,813	11,933,487	369,674	3.1%
429,118	434,836	5,718	1.3%	Specialty Capitation	877,836	871,923	(5,913)	(0.7%)
5,354,621	4,941,377	(413,245)	(8.4%)	Specialty Capitation FQHC	10,795,602	9,957,037	(838,565)	(8.4%)
760,752	717,010	(43,742)	(6.1%)	Laboratory Capitation	1,519,938	1,442,576	(77,363)	(5.4%)
316,464	307,924	(8,540)	(2.8%)	Vision Capitation	633,873	618,378	(15,495)	(2.5%)
97,603	98,903	1,300	1.3%	CFMG Capitation	199,660	198,318	(1,342)	(0.7%)
755,955	783,152	27,196	3.5%	ANC IPA Admin Capitation FQHC	1,525,007	1,578,345	53,337	3.4%
956,963	946,253	(10,710)	(1.1%)	DME Capitation	1,914,072	1,898,737	(15,335)	(0.8%)
856	2,481	1,626	65.5%	Dental Capitation	1,615	4,031	2,416	59.9%
15,861,673	**15,633,133**	**(228,540)**	**(1.5%)**	**7. TOTAL CAPITATED EXPENSES**	**32,013,420**	**31,462,201**	**(551,219)**	**(1.8%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
7,800,442	0	(7,800,442)	0.0%	IBNR Inpatient Services	(2,214,153)	0	2,214,153	0.0%
234,014	0	(234,014)	0.0%	IBNR Settlement (IP)	(66,422)	0	66,422	0.0%
624,035	0	(624,035)	0.0%	IBNR Claims Fluctuation (IP)	(177,132)	0	177,132	0.0%
34,683,618	44,056,862	9,373,244	21.3%	Inpatient Hospitalization FFS	83,661,648	88,499,088	4,837,440	5.5%
2,704,810	3,088,260	383,450	12.4%	IP OB - Mom & NB	6,382,580	6,215,074	(167,505)	(2.7%)
225,491	144,640	(80,851)	(55.9%)	IP Behavioral Health	797,940	290,334	(507,606)	(174.8%)
1,467,415	1,173,969	(293,446)	(25.0%)	Inpatient Facility Rehab FFS	2,976,527	2,364,039	(612,487)	(25.9%)
47,739,825	**48,463,732**	**723,907**	**1.5%**	**8. Inpatient Hospital Expense**	**91,360,987**	**97,368,535**	**6,007,548**	**6.2%**
(130,276)	0	130,276	0.0%	IBNR PCP	(632,086)	0	632,086	0.0%
(3,908)	0	3,908	0.0%	IBNR Settlement (PCP)	(18,963)	0	18,963	0.0%
(10,423)	0	10,423	0.0%	IBNR Claims Fluctuation (PCP)	(50,568)	0	50,568	0.0%
2,427,331	3,305,611	878,281	26.6%	PCP FFS	5,328,838	6,637,833	1,308,995	19.7%
447,141	433,162	(13,978)	(3.2%)	PCP FQHC FFS	1,127,245	870,947	(256,297)	(29.4%)
19,979	0	(19,979)	0.0%	Prop 56 Hyde	39,970	0	(39,970)	0.0%
99,602	0	(99,602)	0.0%	Prop 56 Trauma Screening	198,927	0	(198,927)	0.0%
106,112	0	(106,112)	0.0%	Prop 56 Developmentl Screening	211,796	0	(211,796)	0.0%
589,836	824,849	235,013	28.5%	Prop 56 Family Planning	1,181,877	1,661,017	479,140	28.8%
3,545,395	**4,563,623**	**1,018,228**	**22.3%**	**9. Primary Care Physician Expense**	**7,387,037**	**9,169,797**	**1,782,761**	**19.4%**
712,975	0	(712,975)	0.0%	IBNR Specialist	(58,196)	0	58,196	0.0%
21,390	0	(21,390)	0.0%	IBNR Settlement (SCP)	(1,745)	0	1,745	0.0%
57,038	0	(57,038)	0.0%	IBNR Claims Fluctuation (SCP)	(4,655)	0	4,655	0.0%
757,650	10,423	(747,228)	(7,169.3%)	Psychiatrist FFS	1,734,892	16,932	(1,717,960)	(10,146.1%)
3,108,589	7,542,630	4,434,041	58.8%	Specialty Care FFS	7,142,839	15,162,489	8,019,650	52.9%
304,659	0	(304,659)	0.0%	Specialty Anesthesiology	661,700	0	(661,700)	0.0%
1,584,506	0	(1,584,506)	0.0%	Specialty Imaging FFS	3,453,265	0	(3,453,265)	0.0%
61,055	0	(61,055)	0.0%	Obstetrics FFS	118,507	0	(118,507)	0.0%
346,695	0	(346,695)	0.0%	Specialty IP Surgery FFS	810,898	0	(810,898)	0.0%
933,500	0	(933,500)	0.0%	Specialty OP Surgery FFS	1,982,932	0	(1,982,932)	0.0%
555,330	0	(555,330)	0.0%	Speciality IP Physician	1,262,786	0	(1,262,786)	0.0%
249,351	132,062	(117,289)	(88.8%)	Specialist FQHC FFS	496,038	266,122	(229,915)	(86.4%)
8,692,738	**7,685,114**	**(1,007,623)**	**(13.1%)**	**10. Specialty Care Physician Expense**	**17,599,261**	**15,445,544**	**(2,153,718)**	**(13.9%)**
179,947	0	(179,947)	0.0%	IBNR Ancillary (ANC)	(4,437,949)	0	4,437,949	0.0%
5,399	0	(5,399)	0.0%	IBNR Settlement (ANC)	(133,137)	0	133,137	0.0%
14,396	0	(14,396)	0.0%	IBNR Claims Fluctuation (ANC)	(355,037)	0	355,037	0.0%
679,056	0	(679,056)	0.0%	IBNR Transportation FFS	319,328	0	(319,328)	0.0%
3,566,345	2,969,395	(596,950)	(20.1%)	Behavioral Health Therapy FFS	7,662,058	5,941,159	(1,720,899)	(29.0%)
3,221,325	0	(3,221,325)	0.0%	Psychologist & Other MH Prof	7,151,434	0	(7,151,434)	0.0%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
788,034	0	(788,034)	0.0%	Other Medical Professional	1,844,485	0	(1,844,485)	0.0%
187,429	2,634	(184,795)	(7,015.6%)	Hearing Devices	423,214	4,279	(418,935)	(9,789.9%)
22,242	0	(22,242)	0.0%	ANC Imaging	50,825	0	(50,825)	0.0%
3,908	0	(3,908)	0.0%	Vision FFS	4,894	0	(4,894)	0.0%
1,026,539	702,295	(324,244)	(46.2%)	Laboratory FFS	2,015,538	1,413,653	(601,885)	(42.6%)
263,008	0	(263,008)	0.0%	ANC Therapist	553,321	0	(553,321)	0.0%
0	25,491	25,491	100.0%	OTC Card	0	41,412	41,412	100.0%
1,815,238	1,814,985	(253)	0.0%	Transp/Ambulance FFS	4,078,387	3,642,649	(435,738)	(12.0%)
0	106	106	100.0%	Worldwide Emergency Benefit	0	173	173	100.0%
5,175,756	2,819,111	(2,356,645)	(83.6%)	Non-ER Transportation FFS	8,266,866	5,653,952	(2,612,914)	(46.2%)
1,667,078	1,811,503	144,426	8.0%	Hospice FFS	3,647,926	3,628,637	(19,289)	(0.5%)
2,779,349	3,194,237	414,888	13.0%	Home Health Services	6,148,585	6,412,654	264,070	4.1%
0	105,570	105,570	100.0%	Other Medical FFS	0	171,507	171,507	100.0%
223,137	0	(223,137)	0.0%	Medical Refunds through HMS	(135,844)	0	135,844	0.0%
37,338	2,592,946	2,555,608	98.6%	DME & Medical Supplies FFS	89,011	5,191,017	5,102,005	98.3%
0	441,000	441,000	100.0%	Transitional Care FFS	0	779,500	779,500	100.0%
3,316,662	3,174,950	(141,713)	(4.5%)	ECM Base/Outreach FFS ANC	6,604,891	6,387,203	(217,688)	(3.4%)
251,191	291,499	40,308	13.8%	CS Housing Deposits FFS ANC	537,344	582,998	45,654	7.8%
1,001,151	1,187,776	186,625	15.7%	CS Housing Tenancy FFS ANC	1,901,727	2,375,552	473,825	19.9%
549,392	493,345	(56,047)	(11.4%)	CS Housing Navi Servic FFS ANC	1,105,391	986,690	(118,701)	(12.0%)
240,900	364,749	123,849	34.0%	CS Medical Respite FFS ANC	465,929	729,498	263,569	36.1%
319,215	271,983	(47,232)	(17.4%)	CS Med. Tailored Meals FFS ANC	642,888	543,966	(98,922)	(18.2%)
9,532	24,345	14,813	60.8%	CS Asthma Remediation FFS ANC	11,157	48,690	37,533	77.1%
0	10,000	10,000	100.0%	MOT Wrap Around (Non Med MOT)	0	20,000	20,000	100.0%
539	2,589	2,050	79.2%	CS Home Modifications FFS ANC	959	5,178	4,219	81.5%
13,950	88,209	74,259	84.2%	CS P.Care & Hmker Svcs FFS ANC	68,583	176,418	107,835	61.1%
0	6,550	6,550	100.0%	CS Cgiver Respite Svcs FFS ANC	0	13,100	13,100	100.0%
950	1,630	680	41.7%	CS Housing Outreach	1,150	3,260	2,110	64.7%
0	143,000	143,000	100.0%	CS Transitional Rent FFS ANC	18,997	264,000	245,003	92.8%
0	27,226	27,226	100.0%	CS Transitional Rent Admin ANC Expense	5,078	51,701	46,622	90.2%
416,250	457,616	41,366	9.0%	CommunityBased Adult Svc(CBAS)	823,035	914,670	91,635	10.0%
(765)	18,923	19,687	104.0%	CS LTC to ALF Transition FFS ANC	1,529	37,846	36,317	96.0%
0	7,500	7,500	100.0%	CS LTC to Home Transition FFS ANC	0	15,000	15,000	100.0%
27,774,492	**23,051,163**	**(4,723,329)**	**(20.5%)**	**11. Ancillary Medical Expense**	**49,382,563**	**46,036,361**	**(3,346,202)**	**(7.3%)**
1,337,805	0	(1,337,805)	0.0%	IBNR Outpatient	(862,487)	0	862,487	0.0%
40,135	0	(40,135)	0.0%	IBNR Settlement (OP)	(25,874)	0	25,874	0.0%
107,025	0	(107,025)	0.0%	IBNR Claims Fluctuation (OP)	(69,000)	0	69,000	0.0%
3,561,026	5,926,636	2,365,609	39.9%	Outpatient FFS	7,544,109	11,915,688	4,371,580	36.7%
3,064,418	176,713	(2,887,705)	(1,634.1%)	OP Ambul Surgery FFS	7,749,852	287,084	(7,462,768)	(2,599.5%)
2,083,934	3,386,047	1,302,112	38.5%	Imaging Services FFS	4,577,705	6,813,247	2,235,542	32.8%
112,400	0	(112,400)	0.0%	Behavioral Health FFS	212,440	0	(212,440)	0.0%
882,913	0	(882,913)	0.0%	Outpatient Facility Lab FFS	1,898,049	0	(1,898,049)	0.0%
269,228	0	(269,228)	0.0%	Outpatient Facility Cardio FFS	706,550	0	(706,550)	0.0%
133,148	0	(133,148)	0.0%	OP Facility PT/OT/ST FFS	263,465	0	(263,465)	0.0%
2,780,225	2,779,209	(1,015)	0.0%	OP Facility Dialysis Ctr FFS	6,204,507	5,588,080	(616,427)	(11.0%)
14,372,256	**12,268,605**	**(2,103,651)**	**(17.1%)**	**12. Outpatient Medical Expense**	**28,199,316**	**24,604,099**	**(3,595,217)**	**(14.6%)**
(658,340)	0	658,340	0.0%	IBNR Emergency	(2,627,265)	0	2,627,265	0.0%
(19,751)	0	19,751	0.0%	IBNR Settlement (ER)	(78,818)	0	78,818	0.0%
(52,667)	0	52,667	0.0%	IBNR Claims Fluctuation (ER)	(210,181)	0	210,181	0.0%
9,861,200	9,738,760	(122,440)	(1.3%)	ER Facility	21,384,652	19,544,619	(1,840,033)	(9.4%)
1,114,858	0	(1,114,858)	0.0%	Specialty ER Physician FFS	2,478,057	0	(2,478,057)	0.0%
10,245,300	**9,738,760**	**(506,540)**	**(5.2%)**	**13. Emergency Expense**	**20,946,445**	**19,544,619**	**(1,401,826)**	**(7.2%)**
(2,852,425)	0	2,852,425	0.0%	IBNR Pharmacy (OP)	(3,220,188)	0	3,220,188	0.0%
(85,572)	0	85,572	0.0%	IBNR Settlement Rx (OP)	(96,605)	0	96,605	0.0%

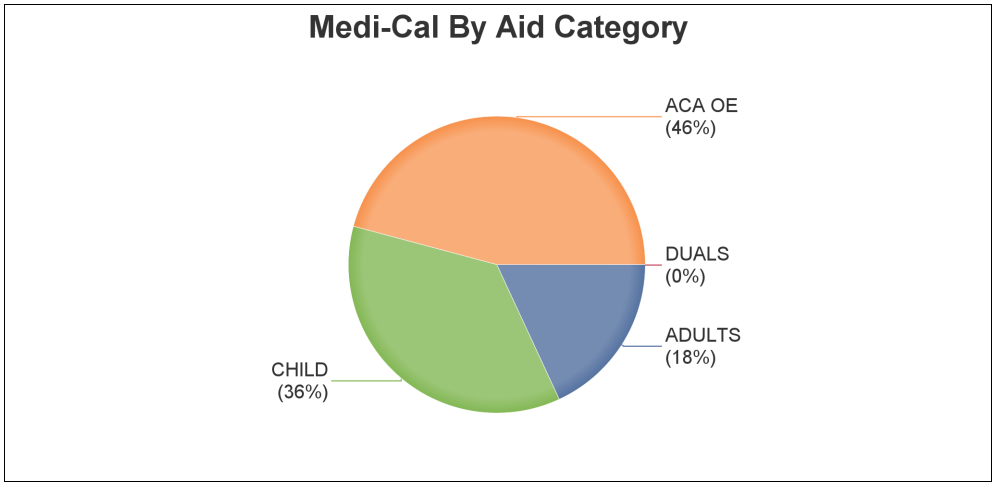
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 AUGUST, 2026

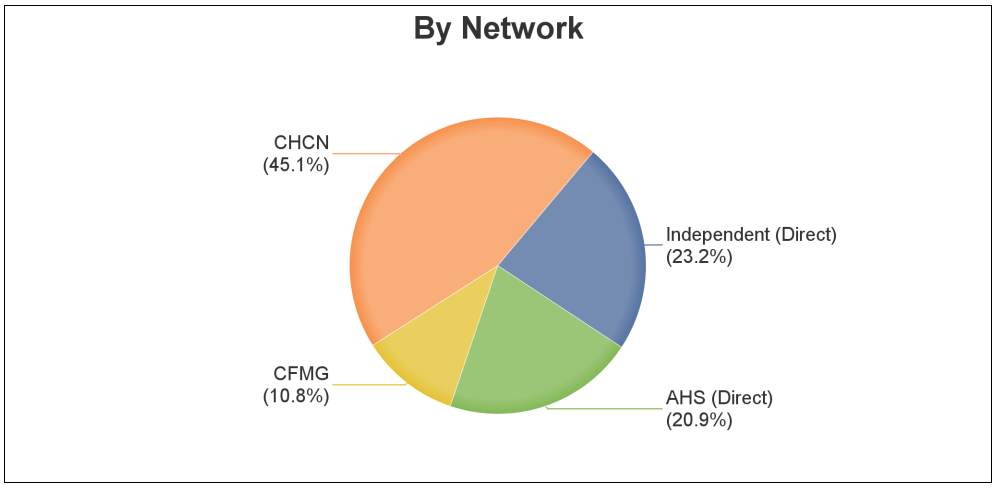
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(228,195)	0	228,195	0.0%	IBNR Claims Fluctuation Rx(OP)	(257,616)	0	257,616	0.0%
881,254	1,008,254	127,000	12.6%	Pharmacy FFS (OP)	1,765,645	1,941,142	175,497	9.0%
216,141	0	(216,141)	0.0%	Pharmacy Non PBM FFS Other-ANC	505,390	0	(505,390)	0.0%
12,894,929	11,433,770	(1,461,158)	(12.8%)	Pharmacy Non PBM FFS OP-FAC	26,960,650	22,999,991	(3,960,659)	(17.2%)
575,317	0	(575,317)	0.0%	Pharmacy Non PBM FFS PCP	1,276,889	0	(1,276,889)	0.0%
3,373,948	0	(3,373,948)	0.0%	Pharmacy Non PBM FFS SCP	8,289,829	0	(8,289,829)	0.0%
76,962	0	(76,962)	0.0%	Pharmacy Non PBM FFS FQHC	171,918	0	(171,918)	0.0%
12,493	0	(12,493)	0.0%	Pharmacy Non PBM FFS HH	24,569	0	(24,569)	0.0%
(40,000)	(79,393)	(39,393)	49.6%	Medical Expenses Pharm Rebate	(305,875)	(158,710)	147,164	(92.7%)
14,824,852	**12,362,632**	**(2,462,220)**	**(19.9%)**	**14. Pharmacy Expense**	**35,114,607**	**24,782,423**	**(10,332,184)**	**(41.7%)**
954,426	0	(954,426)	0.0%	IBNR LTC	(5,392,042)	0	5,392,042	0.0%
28,632	0	(28,632)	0.0%	IBNR Settlement (LTC)	(161,763)	0	161,763	0.0%
76,353	0	(76,353)	0.0%	IBNR Claims Fluctuation (LTC)	(431,363)	0	431,363	0.0%
1,617,805	1,810,021	192,217	10.6%	LTC - ICF/DD	3,814,733	3,623,355	(191,378)	(5.3%)
23,960,442	25,519,002	1,558,559	6.1%	LTC Custodial Care	51,832,722	51,079,770	(752,952)	(1.5%)
8,945,544	7,980,190	(965,354)	(12.1%)	LTC SNF	18,777,410	15,966,266	(2,811,143)	(17.6%)
35,583,202	**35,309,213**	**(273,989)**	**(0.8%)**	**15. Long Term Care Expense**	**68,439,697**	**70,669,392**	**2,229,695**	**3.2%**
162,778,059	**153,442,842**	**(9,335,217)**	**(6.1%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**318,429,913**	**307,620,770**	**(10,809,143)**	**(3.5%)**
0	(240,222)	(240,222)	100.0%	Clinical Vacancy #102	0	(419,656)	(419,656)	100.0%
88,749	258,684	169,935	65.7%	Quality Analytics #123	227,424	368,857	141,433	38.3%
407,930	486,830	78,900	16.2%	LongTerm Services and Support #139	754,714	873,875	119,161	13.6%
939,147	956,139	16,992	1.8%	Utilization Management #140	1,817,539	1,844,931	27,392	1.5%
677,579	684,677	7,098	1.0%	Case & Disease Management #185	1,259,338	1,351,802	92,463	6.8%
307,580	309,311	1,731	0.6%	Medical Management #230	513,091	618,306	105,215	17.0%
1,201,906	1,165,199	(36,706)	(3.2%)	Quality Improvement #235	2,016,604	2,355,951	339,347	14.4%
384,773	437,195	52,422	12.0%	HCS Behavioral Health #238	730,661	880,919	150,258	17.1%
177,761	175,787	(1,975)	(1.1%)	Pharmacy Services #245	294,962	349,116	54,154	15.5%
4,185,424	**4,233,599**	**48,175**	**1.1%**	**17. Other Benefits & Services**	**7,614,333**	**8,224,099**	**609,767**	**7.4%**
(2,279,000)	(2,103,808)	175,192	(8.3%)	Reinsurance Recoveries	(4,559,000)	(4,239,703)	319,298	(7.5%)
2,856,503	2,805,077	(51,426)	(1.8%)	Reinsurance Premium	5,711,481	5,652,937	(58,544)	(1.0%)
577,503	**701,269**	**123,766**	**17.6%**	**18. Reinsurance (Net)**	**1,152,481**	**1,413,234**	**260,753**	**18.5%**
583,333	583,333	0	0.0%	P4P Risk Pool Provider Incenti	1,166,667	1,166,667	0	0.0%
583,333	**583,333**	**0**	**0.0%**	**19. Risk Pool Distribution**	**1,166,667**	**1,166,667**	**0**	**0.0%**
183,985,993	**174,594,177**	**(9,391,816)**	**(5.4%)**	**20. TOTAL MEDICAL EXPENSES**	**360,376,813**	**349,886,971**	**(10,489,842)**	**(3.0%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

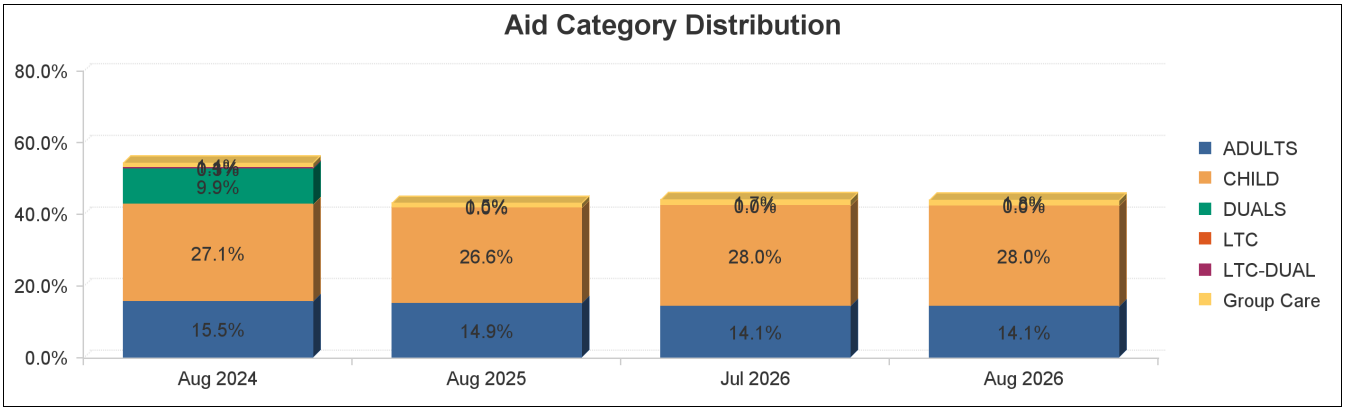
Category of Aid	Aug 2026	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	51,574	14%	10,464	12,400	1	28,709
CHILD	102,828	29%	9,214	13,631	36,604	43,379
SPD	0	0%	0	0	0	0
ACA OE	130,639	36%	24,326	41,114	1,403	63,796
DUALS	18	0%	18	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	27,273	8%	7,818	4,975	1,513	12,967
SPD-LTC/Full Dual	47,721	13%	30,693	3,384	0	13,644
Other	0		0	0	0	0
Medi-Cal	360,053		82,533	75,504	39,521	162,495
Group Care	6,475		2,320	1,213	0	2,942
D-SNP	297		101	27	0	169
Total	**366,825**	**100%**	**84,954**	**76,744**	**39,521**	**165,606**
Other %	0.0%		0.0%	0.0%	0.0%	0.0%
Medi-Cal %	98.2%		97.2%	98.4%	100.0%	98.1%
Group Care %	1.8%		2.7%	1.6%	0.0%	1.8%
D-SNP %	0.1%		0.1%	0.0%	0.0%	0.1%
	Network Distribution		**23.2%**	**20.9%**	**10.8%**	**45.1%**
			% Direct:	**44%**	**% Delegated:**	**56%**




By Network
CHCN
(45.1%)
Independent (Direct)
(23.2%)
CFMG
(10.8%)
AHS (Direct)
(20.9%)

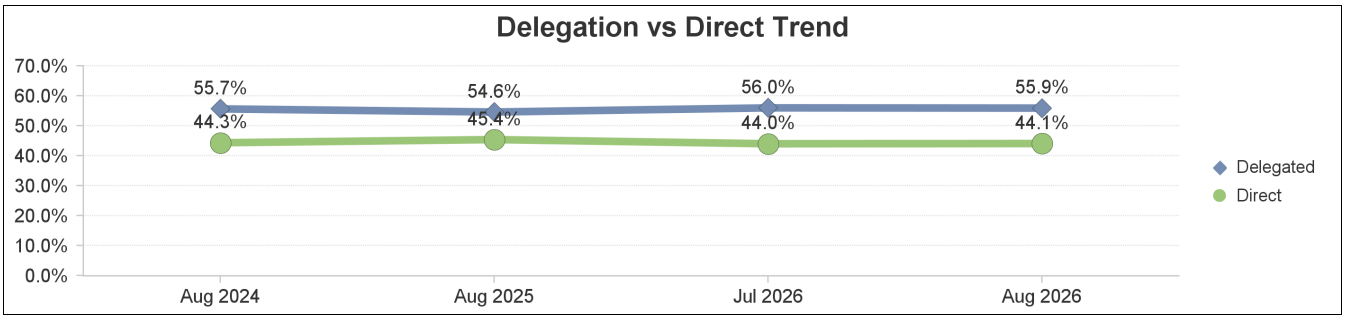
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
ADULTS	62,671	60,720	51,920	**51,574**	15.5%	14.9%	14.1%	14.1%	-3.2%	-17.7%	-0.7%
CHILD	109,803	108,568	102,952	**102,828**	27.1%	26.6%	28.0%	28.0%	-1.1%	-5.6%	-0.1%
SPD	35,177	0	0	**0**	8.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ACA OE	150,482	153,348	130,849	**130,639**	37.1%	37.6%	35.6%	35.6%	1.9%	-17.4%	-0.2%
DUALS	40,030	2	14	**18**	9.9%	0.0%	0.0%	0.0%	##########	88.9%	22.2%
LTC	226	0	0	**0**	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LTC-DUAL	1,247	0	0	**0**	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SPD-LTC	0	29,686	27,080	**27,273**	0.0%	7.3%	7.4%	7.4%	100.0%	-8.8%	0.7%
SPD-LTC/ Full Dual	0	49,372	47,722	**47,721**	0.0%	12.1%	13.0%	13.0%	100.0%	-3.5%	0.0%
Other	0	0	0	**0**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medi-Cal	399,636	401,696	360,537	**360,053**	98.6%	98.5%	98.2%	98.2%	0.5%	-11.6%	-0.1%
Group Care	5,686	5,974	6,398	**6,475**	1.4%	1.5%	1.7%	1.8%	4.8%	7.7%	1.2%
D-SNP	0	0	272	**297**	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
Total	**405,322**	**407,670**	**367,207**	**366,825**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.6%**	**-11.2%**	**-0.1%**



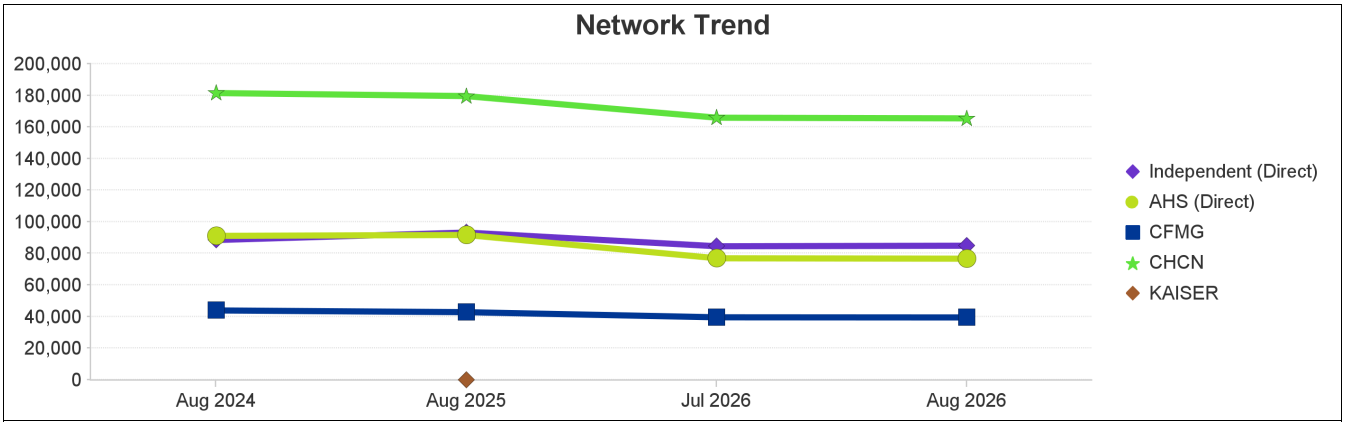
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
Delegated	225,590	222,601	205,621	**205,127**	55.7%	54.6%	56.0%	55.9%	-1.3%	-8.6%	-0.2%
Direct	179,732	185,069	161,586	**161,698**	44.3%	45.4%	44.0%	44.1%	2.9%	-14.5%	0.1%
Total	**405,322**	**407,670**	**367,207**	**366,825**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.6%**	**-11.2%**	**-0.1%**



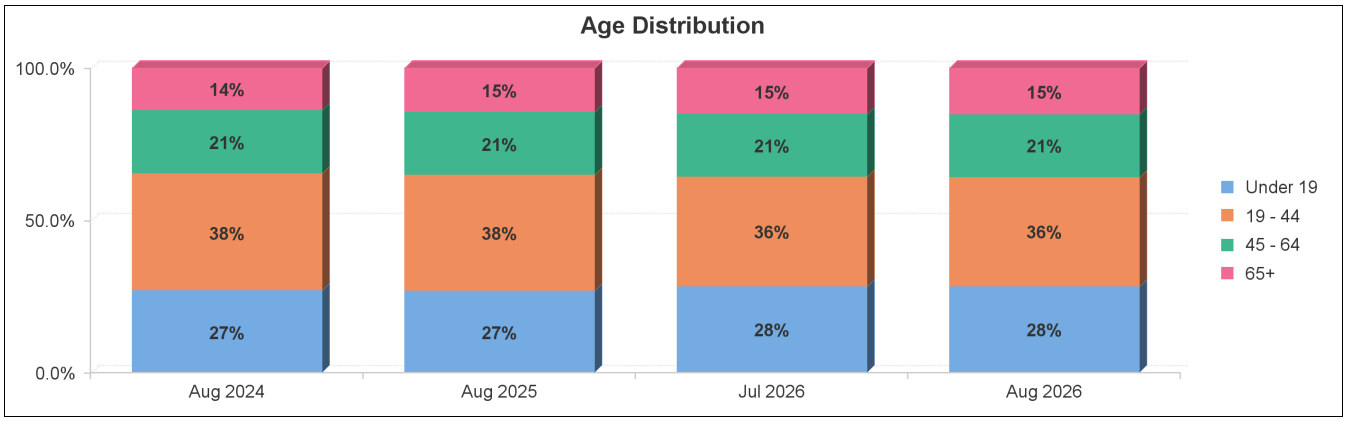
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
Independent (Direct)	88,550	93,300	84,598	**84,954**	21.8%	22.9%	23.0%	23.2%	5.1%	-10.0%	0.4%
AHS (Direct)	91,182	91,769	76,988	**76,744**	22.5%	22.5%	21.0%	20.9%	0.6%	-19.6%	-0.3%
CFMG	43,959	42,868	39,606	**39,521**	10.8%	10.5%	10.8%	10.8%	-2.5%	-8.5%	-0.2%
CHCN	181,631	179,713	166,015	**165,606**	44.8%	44.1%	45.2%	45.1%	-1.1%	-8.6%	-0.3%
KAISER	0	20	0	**0**	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Total	**405,322**	**407,670**	**367,207**	**366,825**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.6%**	**-11.2%**	**-0.1%**



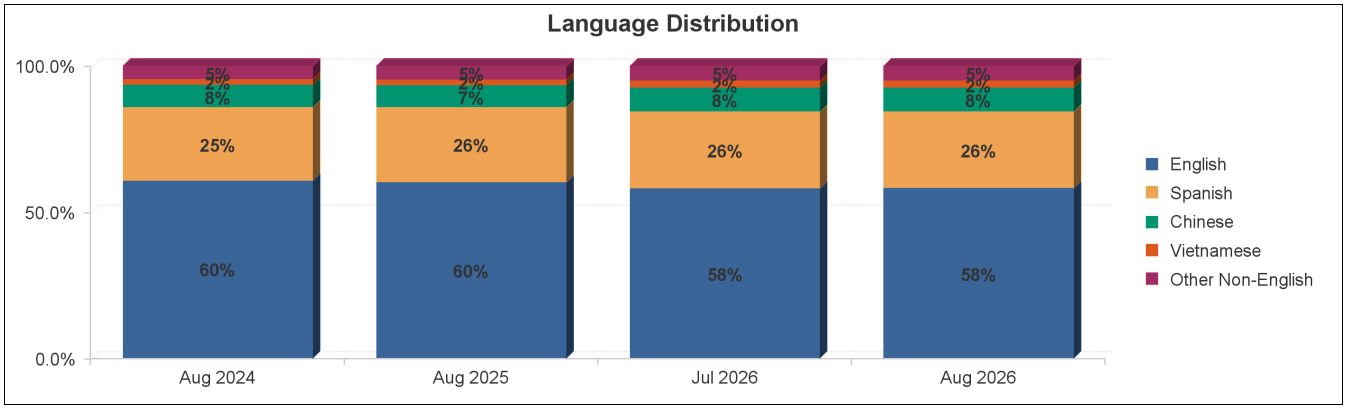
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
Under 19	108,349	108,381	102,657	**102,540**	27%	27%	28%	28%	0%	-6%	0%
19 - 44	155,686	155,276	132,299	**131,867**	38%	38%	36%	36%	0%	-18%	0%
45 - 64	84,199	84,220	75,549	**75,514**	21%	21%	21%	21%	0%	-12%	0%
65+	57,088	59,793	56,430	**56,607**	14%	15%	15%	15%	5%	-6%	0%
Total	**405,322**	**407,670**	**366,935**	**366,528**	**100%**	**100%**	**100%**	**100%**	**1%**	**-11%**	**0%**



Language Trend

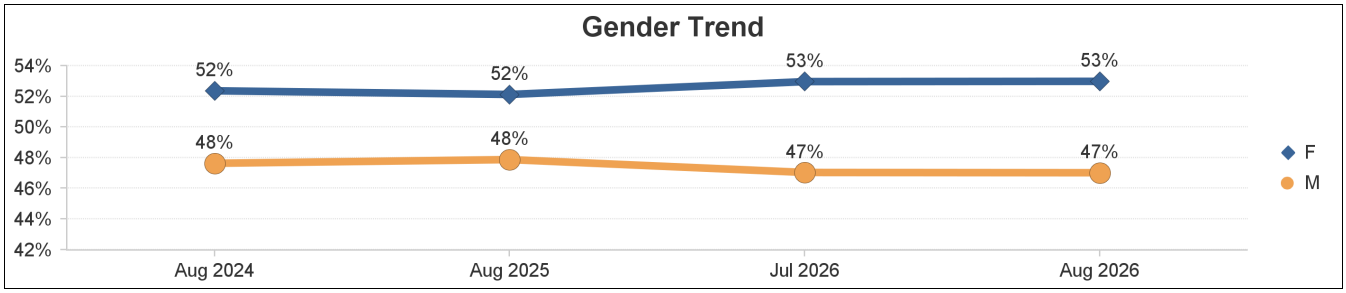
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Aug 2024	Aug 2025	Jul 2026	Aug 2026	ug 2024	ug 2025	Jul 2026	ug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
English	245,150	244,403	212,220	**212,457**	60%	60%	58%	58%	0%	-15%	0%
Spanish	102,034	104,959	96,620	**96,179**	25%	26%	26%	26%	3%	-9%	0%
Chinese	30,695	30,355	30,064	**29,957**	8%	7%	8%	8%	-1%	-1%	0%
Vietnamese	8,310	8,083	8,582	**8,550**	2%	2%	2%	2%	-3%	5%	0%
Other Non-English	19,133	19,870	19,449	**19,385**	5%	5%	5%	5%	4%	-3%	0%
Total	**405,322**	**407,670**	**366,935**	**366,528**	**100%**	**100%**	**100%**	**100%**	**1%**	**-11%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

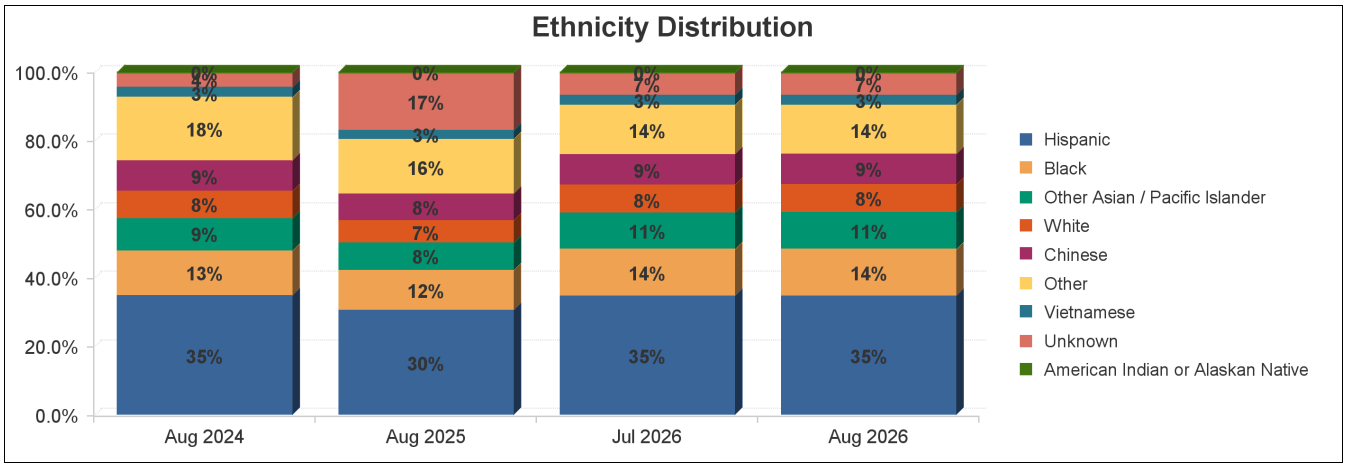
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
F	212,258	212,501	194,501	**194,361**	52%	52%	53%	53%	0%	-9%	0%
M	193,064	195,169	172,706	**172,464**	48%	48%	47%	47%	1%	-13%	0%
Total	**405,322**	**407,670**	**367,207**	**366,825**	**100%**	**100%**	**100%**	**100%**	**1%**	**-11%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
Hispanic	141,075	124,198	127,298	**127,159**	35%	30%	35%	35%	-14%	2%	0%
Black	52,860	47,397	49,949	**50,050**	13%	12%	14%	14%	-12%	5%	0%
Other Asian / Pacific Islander	38,062	32,594	38,924	**38,975**	9%	8%	11%	11%	-17%	16%	0%
White	32,586	26,772	30,068	**30,093**	8%	7%	8%	8%	-22%	11%	0%
Chinese	35,869	31,878	32,573	**32,577**	9%	8%	9%	9%	-13%	2%	0%
Other	74,954	64,699	52,928	**52,592**	18%	16%	14%	14%	-16%	-23%	-1%
Vietnamese	11,804	10,438	10,634	**10,614**	3%	3%	3%	3%	-13%	2%	0%
Unknown	17,310	69,002	24,116	**24,041**	4%	17%	7%	7%	75%	-187%	0%
American Indian or Alaskan Native	802	692	717	**724**	0%	0%	0%	0%	-16%	4%	1%
Total	**405,322**	**407,670**	**367,207**	**366,825**	**100%**	**100%**	**100%**	**100%**	**1%**	**-11%**	**0%**



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

Medi-Cal By City

City	Aug 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	143,056	40%	21,473	36,214	15,632	69,737
HAYWARD	45,910	13%	10,772	12,166	5,181	17,791
FREMONT	34,508	10%	14,637	5,430	1,872	12,569
SAN LEANDRO	22,720	6%	6,056	3,595	2,852	10,217
UNION CITY	13,052	4%	5,285	2,225	734	4,808
ALAMEDA	12,559	3%	3,097	2,297	1,951	5,214
BERKELEY	14,610	4%	3,197	2,355	1,622	7,436
LIVERMORE	11,879	3%	1,973	317	1,912	7,677
NEWARK	8,117	2%	2,597	3,120	404	1,996
CASTRO VALLEY	10,080	3%	2,951	1,528	1,582	4,019
SAN LORENZO	5,512	2%	1,133	1,212	635	2,532
PLEASANTON	7,383	2%	2,287	254	770	4,072
DUBLIN	7,243	2%	2,519	269	829	3,626
EMERYVILLE	2,838	1%	509	632	506	1,191
ALBANY	2,239	1%	413	255	517	1,054
PIEDMONT	397	0%	92	147	53	105
SUNOL	85	0%	30	9	6	40
ANTIOCH	32	0%	8	6	6	12
Other	17,833	5%	3,504	3,473	2,457	8,399
Total	360,053	100%	**82,533**	**75,504**	**39,521**	**162,495**

Group Care By City

City	Aug 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,927	30%	352	441	0	1,134
HAYWARD	745	12%	346	198	0	201
FREMONT	733	11%	454	94	0	185
SAN LEANDRO	707	11%	278	111	0	318
UNION CITY	299	5%	173	56	0	70
ALAMEDA	338	5%	97	39	0	202
BERKELEY	164	3%	39	21	0	104
LIVERMORE	105	2%	30	1	0	74
NEWARK	164	3%	95	40	0	29
CASTRO VALLEY	238	4%	106	38	0	94
SAN LORENZO	180	3%	53	46	0	81
PLEASANTON	77	1%	30	3	0	44
DUBLIN	140	2%	56	5	0	79
EMERYVILLE	46	1%	9	10	0	27
ALBANY	26	0%	8	4	0	14
PIEDMONT	5	0%	0	2	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	8	4	0	12
Other	556	9%	185	100	0	271
Total	**6,475**	**100%**	**2,320**	**1,213**	**0**	**2,942**

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

D-SNP By City

City	Aug 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	111	37%	24	9	0	78
HAYWARD	31	10%	12	3	0	16
FREMONT	22	7%	16	0	0	6
SAN LEANDRO	21	7%	10	4	0	7
UNION CITY	6	2%	4	1	0	1
ALAMEDA	21	7%	6	5	0	10
BERKELEY	21	7%	2	0	0	19
LIVERMORE	12	4%	1	1	0	10
NEWARK	8	3%	7	1	0	0
CASTRO VALLEY	4	1%	1	2	0	1
SAN LORENZO	6	2%	3	0	0	3
PLEASANTON	6	2%	3	0	0	3
DUBLIN	8	3%	1	0	0	7
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	18	6%	10	1	0	7
Sum:			**2,320**	**1,213**	**0**	**2,942**

Total By City

City	Aug 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	144,983	40%	21,825	36,655	15,632	70,871
HAYWARD	46,655	13%	11,118	12,364	5,181	17,992
FREMONT	35,241	10%	15,091	5,524	1,872	12,754
SAN LEANDRO	23,427	6%	6,334	3,706	2,852	10,535
UNION CITY	13,351	4%	5,458	2,281	734	4,878
ALAMEDA	12,897	4%	3,194	2,336	1,951	5,416
BERKELEY	14,774	4%	3,236	2,376	1,622	7,540
LIVERMORE	11,984	3%	2,003	318	1,912	7,751
NEWARK	8,281	2%	2,692	3,160	404	2,025
CASTRO VALLEY	10,318	3%	3,057	1,566	1,582	4,113
SAN LORENZO	5,692	2%	1,186	1,258	635	2,613
PLEASANTON	7,460	2%	2,317	257	770	4,116
DUBLIN	7,383	2%	2,575	274	829	3,705
EMERYVILLE	2,884	1%	518	642	506	1,218
ALBANY	2,265	1%	421	259	517	1,068
PIEDMONT	402	0%	92	149	53	108
SUNOL	86	0%	31	9	6	40

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

ANTIOCH	56	0%	16	10	6	24
Other	18,389	5%	3,689	3,573	2,457	8,670
Total	366,528	100%	**84,853**	**76,717**	**39,521**	**165,437**

Operations

Beau Hennemann

To: Alameda Alliance for Health Board of Governors

From: Operations Division

Date: October 9, 2026

Subject: Operations Report Executive Summary

Operations Division Executive Summary

- **Core Operations:** Member Services received 17,830 calls in September, a 9% decrease year over year. Performance improved, with a 3% abandonment rate, 95% service level, and nine-second average speed to answer. Claims processing met the 30-day target for 99.7% of claims, and the auto-adjudication rate increased to 87.5%. Credentialing approved 165 initial network providers, including 115 behavioral health providers, and recredentialed 80 providers. The provider call center handled 7,006 calls, compared with 8,883 in September 2025.

- **Member Experience:** A total of 4,440 grievance and appeal cases were processed, with 98.5% meeting turnaround time targets. Access to care and quality of service were the largest grievance categories; leading drivers included timely access, telephone access, customer service, and provider/staff interactions. All 165 D-SNP grievances processed met turnaround time targets. Quality of service was the largest standard-grievance category. No D-SNP appeals or CMS complaints were filed in September.

- **D-SNP Implementation:** Efforts focus on the October 1 marketing and benefit launch, the October 15–December 7 Annual Enrollment Period (AEP), and readiness for the January 1, 2027, Open Enrollment Period (OEP). Sales capacity is expanding, with two new field agents onboarded and 11 additional positions in recruitment: three full-time agents and eight temporary support positions.

- **Community Outreach:** Q1 engagement reached 6,032 people, up 28% year over year; 32% of those engaged were identified as current Alliance members. The team completed 1,026 orientation outreach calls, 140 telephone orientations, 21 community events, 14 member education events, and one community presentation.

- **Integrated Planning Division:** The IPD portfolio includes 64 initiatives: 27 active, 11 on hold, and 26 requested. 29 initiatives have been completed fiscal year to date. Priority initiatives include D-SNP AEP/OEP Readiness, CMS Interoperability and Prior Authorization Readiness, CHCN D-SNP Delegation, ERP Implementation, Symplr/sPayer Implementation, MedImpact PBM Transition, and ECM Program Enhancement Implementation.

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

From: **Operations Division**

Date: **October 9th, 2026**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:
  - The Member Services Department received 17,830 calls in September 2026 compared to 19,384 in September 2025 which represents a 9% decrease in calls.
  - The abandonment rate for September 2026 was 3% compared to 5% in September 2025.
  - The Department's service level was 95% in September 2026, compared to 94% in September 2025. The average speed to answer (ASA) was nine seconds (00:09) in September 2026, compared to twelve seconds (00:12) in September 2025. The Department continues to recruit to fill open positions, when approved. Customer Service support service vendor continues to provide overflow call center support.
  - The average talk time (ATT) was seven minutes and eighteen seconds (7:18) for September 2026 compared to seven minutes and twenty-six seconds (7:26) for September 2025.
  - 100% of calls were answered within 10 minutes for September 2026 and 100% of calls were answered within 10 minutes for September 2025.
  - Outbound calls totaled 10,375 in September 2026 compared to 10,222 in September 2025.
  - The top five (5) call reasons for September 2026 were 1) Grievances/Appeals, 2) Change of PCP, 3) Eligibility/Enrollment, 4) Benefits, and 5) Provider Network Information. The top five (5) call reasons for September 2025 were: 1) Change of PCP, 2) Grievances/Appeals, 3) Eligibility/Enrollment, 4) Benefits, and 5) ID Card/Member Materials Request.
  - September 2026 utilization of the member automated eligibility IVR system totaled 1,346 compared to 1,454 in September 2025.
  - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests, and in-person). The Department responded to 944 web-based requests in September 2026 compared to 1,310 in September 2025. The top three (3) web request reasons for September 2026 were: 1) Change of PCP, 2) ID Card Requests, and 3) Update Contact Information. 46 members were assisted in-person in September 2026 compared to 68 in September 2025.

MS Behavioral Health:

- The Member Services Behavioral Health (MS BH) Unit received a total of 1,137 calls in September 2026 compared to 1,250 in September 2025.
- The abandonment rate was 2% in September 2026 compared to 6% in September 2025.
- The service level was 88% in September 2026 and 80% in September 2025.
- The average speed to answer (ASA) in September 2026 was twenty-six seconds (00:26) compared to forty-eight seconds (00:48) in September 2025.
- 100% of calls were answered within 10 minutes in September 2026 compared to 100% of calls answered within 10 minutes in September 2025.
- The Average Talk Time (ATT) in September 2026 was nine minutes and forty seconds (09:40) compared to nine minutes and forty-three seconds (09:43) in September 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.
- 2,196 outbound calls were completed in September compared to 1,624 in September 2025.
- 119 screenings were completed in September 2026 compared to 80 in September 2025.
- 34 referrals were made to the County (ACCESS) in September 2026 compared to 27 in September 2025.
- 23 members were referred to Center Point for SUD services in September 2026 compared to 10 in September 2025.

- D-SNP Member Services blended:
  - The Member Services D-SNP Unit received a total of 590 calls in September 2026.
  - The abandonment rate was 4%.
  - Calls answered in 2 minutes was 98%.
  - The Average Speed to Answer (ASA) was ten seconds (00:10).
  - The service level was 98%.
  - The Average Talk Time (ATT) was seven minutes and forty-nine seconds (7:49).
  - The top five (5) call reasons were: 1) Appeals/Grievances, 2) Benefits/Organizational Determinations, 3) Eligibility/Enrollment, 4) Change of PCP, and 5) ID Card Request.

- Training:
  - The MS Leadership Team primarily conducts routine and new-hire training via remote methods to promote consistency and scalability across the organization. In-person training sessions are facilitated by MS Supervisors and Trainers, as necessary, to address diverse learning preferences, deliver targeted refresher courses, and support personnel on-site. Ongoing

updates and education ensure preparedness for D-SNP AEP/OEP readiness, aligning with CMS standards and enhancing the overall member experience.

Claims – Claims Processing

- 12-Month Trend Summary:
  - The Claims Department received 356,875 claims for all lines of business in September 2026 compared to 373,025 in September 2025.
  - The Auto Adjudication rate was 87.5% in September 2026 compared to 84% in September 2025.
  - Claims compliance for the 30-day turn-around time was 99.7% in September 2026 compared to 88.9% in September 2025.

- Medi-Cal/Group Care Monthly Analysis:
  - In September, we received a total of 355,573 claims in the HEALTHsuite system, which represents a decrease of 3.2% from August 2026. It is also 4.7% lower than the number of claims received in September 2025 (373,025).
  - 90% of claims were received via EDI, and 10% of claims via paper during September.
  - The Auto Adjudication rate was 87.8% for September.

- D-SNP Monthly Analysis:
  - In September, we received a total of 1,302 claims in the HEALTHsuite system, which represents a 5.4% decrease from August 2026, when 1,376 claims were received.
  - 1,064 claims (82%) were received via EDI, and 238 claims (18%) were received via paper in September.
  - Out of 1,302 claims, 708 claims have been finalized.
  - The Auto Adjudication rate was 46% for September.

- D-SNP YTD Analysis
  - A total of 8,634 D-SNP claims have been received since the January 1st, 2026, go-live, and 7,948 claims have been finalized.

Claims – Provider Dispute Resolution

- 12-Month Trend Summary:
  - In September 2026, the Provider Dispute Resolution (PDR) team received 2,263 PDRs versus 3,266 in September 2025.
  - The PDR team resolved 2,113 cases in September 2026 compared to 2,823 cases in September 2025.

- In September 2026, the PDR team upheld 75% of cases versus 87% in September 2025.
- The PDR team resolved 96.8% of cases within the compliance standard of 95% within 45 working days in September 2026, compared to 99.6% in September 2025.

- Monthly Analysis:
  - In September 2026, the Provider Dispute Resolution (PDR) team received 2,263 PDRs versus 3,632 in August 2026. This represents a 37.7% decrease from August 2026.
  - In September 2026, 2,113 PDRs were resolved, with 1,587 upheld and 526 overturned.
  - 2,047 of 2,113 cases were resolved within 45 working days, resulting in a 96.8% compliance rate.
  - The average turnaround time for resolving PDRs in September was 37 days.
  - There were 4,666 PDRs pending resolution as of 9/30/2026, with no cases older than 45 working days.
  - The overturn rate for PDRs was 25%, which met our goal of 25% or less.

Grievances & Appeals

- Grievances & Appeals (MCAL & IHSS)
  - Standard Grievance, Expedited Grievance, and Exempt Grievance cases were resolved within the goal of 95% of regulatory timeframes.
  - Standard Appeal and Expedited Appeal cases were resolved within the goal of 95% of regulatory timeframes.
  - Total Unique grievances resolved in September were 9.61 complaints per 1,000 members.

September 2026 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,437	30 Calendar Days	95% compliance within standard	2,369	97.2%	5.11
Expedited Grievance	6	72 Hours	95% compliance within compliance standard	6	100.0%	0.01

Exempt Grievance	1,921	Next Business Day	95% within standard	1,921	100.0%	4.48
Standard Appeal	75	30 Calendar Days	95% compliance within standard	75	100.0%	0.20
Expedited Appeal	1	72 Hours	95% compliance within standard	1	100.0%	0.00
Total Cases:	4,440		95% compliance within standard	4,372	98.5%	9.61

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

- <u>Standard/Expedited Grievances:</u>
  - There were 1,866 unique grievance cases resolved during the reporting period, with a total of 2,443 grievances including 577 shadow cases.
    - **899** of 2,443 (37%) cases were related to Access to Care; the following are the top four (4) categories:
      - Timely Access – 271
      - Technology/Telephone – 234
      - Authorization – 155
      - Provider Availability – 87
    - **863** of 2,443 (35%) cases were related to Quality of Service; the following are the top four (4) categories:
      - Plan Customer Service – 261
      - Provider/Staff Attitude – 248
      - Referral – 139
      - Transportation – 103
    - **441** of 2,443 (18%) cases were related to Coverage Dispute; the following are the top two (2) categories:
      - Provider Direct Member Billing – 241
      - Provider Balance Biling – 109
    - **157** of 2,443 (7%) cases were related to Other; the top category was:
      - Enrollment – 106
    - **83** of 2,443 (3%) cases were related to Quality of Care; the top category was:
      - Quality of Care – 69
  - Resolution Determination:

        - **1,899** of 2,443 (78%) cases were resolved In Favor of Enrollee
        - **495** of 2,443 (20%) cases were resolved In Favor of the Plan
        - **49** of 2,443 (2%) cases were Withdrawn by Member

- Exempt Grievances:
    - There were 1,635 unique exempt grievance cases resolved during the reporting period, with a total of 1,921 exempt grievances including 286 shadow cases.
        - **751** of 1,921 (39%) cases were related to Quality of Service; the following are the top two categories:
            - Plan Customer Service – 447
            - Provider / Staff Attitude – 229
        - **725** of 1,921 (23%) cases were related to Other; the top two categories were:
            - Enrollment – 672
        - **442** of 1,921 (38%) cases were related to Access to Care; the following are the top two (2) categories:
            - Technology / Telephone – 130
            - Provider Availability – 122
        - **3** of 1,921 (0%) cases were related to Coverage Dispute; the top category was:
            - Benefit – 3
    - Resolution Determination:
        - **1,609** of 1,921 (84%) cases were resolved In Favor of Enrollee
        - **311** of 1,921 (16%) cases were resolved In Favor of the Plan
        - **1** of 1,921 (0%) cases were Withdrawn by Member

- Appeals:
    - The Alliance's goal is to have an overturn rate of less than 25%; for the reporting period of September 2026, we met our goal with an 18% overturn/approved rate.
        - **59** out of 76 (78%) cases had an upheld/denied decision for the month of September 2026:
            - Disputes Involving Medical Necessity – 34
            - Out of Network – 25
        - **14** out of 76 (17%) cases had an overturn/approved decision for the month of September 2026:
            - Disputes Involving Medical Necessity – 10
            - Out of Network – 4
        - **3** out of 76 (4%) cases had a partial uphold/denial decision for the month of September 2026:
            - Out of Network – 2
            - Coverage Dispute – 1

D-SNP Grievances & Appeals (Resolved)

- Standard Grievance cases were resolved within the goal of 95% of regulatory timeframes.
- First Call Resolution cases were not resolved within the goal of 95% of regulatory timeframes.
- Standard Appeal cases were resolved within the goal of 95% of regulatory timeframes.
- There were no Expedited Grievance cases filed in August 2026.

September 2026 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate
Standard Grievance	122	30 Calendar Days	95% compliance within standard	122	100.0%
Expedited Grievance	0	72 Hours	95% compliance within standard	N/A	N/A
First Call Resolution	43	Next Business Day	95% compliance within standard	43	100.0%
Standard Appeal	0	30 Calendar Days	95% compliance within standard	N/A	N/A
Expedited Appeal	0	72 Hours	95% compliance within standard	N/A	N/A
Total Cases:	165		95% compliance within standard	165	100.0%

*Per 1,000 not calculated for DSNP because enrollment is below 10,00.

- Standard Grievances:
  - There were 79 unique grievance cases resolved during the reporting period, with a total of 96 grievances including 43 shadow cases.
    - **62** of 122 (51%) cases were related to Quality of Service; the categories are:
      - Plan Customer Service – 28
        - Member Services – 11
        - Grievance & Appeals – 8
        - CM Department – 3
        - BH Mental Health Team – 1
        - CHME – 1
        - Nations – 1
        - Propio – 1
        - Sales – 1
        - UM Department – 1
      - Referral – 18
      - Provider / Staff Attitude – 9
      - Transportation – 4
      - Member Informing Materials – 2
      - Authorization – 1

- **34** of 122 (28%) cases were related to Access to Care; the categories are:
  - Technology / Telephone – 15
  - Authorization – 7
  - Timely Access – 6
  - Out-of-Network – 5
  - Physical Access – 1
- **20** of 122 (17%) cases were related to Coverage Dispute; the categories are:
  - Provider Direct Member Billing – 8
  - Provider Balance Billing – 6
  - Benefit – 3
  - Reimbursement – 3
- **5** of 122 (1%) cases were related to Other; the category:
  - Eligibility – 4
  - Enrollment – 1
- **1** of 122 (1%) cases was related to Quality of Care: the category is:
  - Assault / Harassment / Retaliation

- <u>First Call Resolution (FCR) Grievances:</u>
  - There were 32 total unique exempt grievance cases resolved during the reporting period including 11 shadow cases.
    - **19** of 43 (44%) cases were related to Quality of Service; the categories were:
      - Plan Customer Service – 13
        - Member Services – 9
        - CM Department – 2
        - Nations – 1
        - Other – 1
      - Member Informing Materials – 3
      - Provider / Staff Attitude – 2
      - Transportation – 1
    - **12** of 43 (28%) cases were related to Access to Care; the categories are:
      - Technology / Telephone – 6
      - Timely Access – 4
      - Authorization – 1
      - Geographic Access – 1

      10 of 43 (23%) cases were related to Other; the category was:
      - Enrollment – 10
    - **2** of 43 (5%) of cases were related to Coverage Dispute; the categories were:
      - Benefit – 1
      - Provider Balance Billing – 1

- Appeals:
    - There were no appeals filed in September.

- CTM Information:
    - There were no CTMs filed in September.

Provider Services

- 12-Month Trend Summary:
    - The Provider Services department's call volume in September 2026 was 7,006 calls (5,835 Medi-Cal/Group Care and 1,171 D-SNP) compared to 8,883 calls (Medi-Cal/Group Care only) in September 2025.

- Monthly Analysis:
    - The Provider Services department completed 556 calls/visits during September 2026.
    - The Provider Services department answered 6,032 calls (5,007 Medi-Cal/Group Care and 1,025
    - D-SNP) for September 2026 and made 252 outbound calls (229 Medi-Cal/IHSS and 23 D-SNP).

Credentialing

- Monthly Analysis:
    - At the Peer Review and Credentialing (PRCC) meeting held on September 15th, 2026, there were one hundred and sixty-five (165) initial network providers approved.
        - Ten (10) primary care providers
        - Twenty-one (21) specialists
        - Seven (7) ancillary providers
        - Twelve (12) mid-level providers
        - One hundred and fifteen (115) behavioral health providers
    - 80 providers were re-credentialed at this meeting
        - Three (3) primary care providers
        - Seven (7) specialists
        - Three (3) ancillary providers
        - Two (2) mid-level providers
        - Sixty-five (65) behavioral health providers
    - 446 facilities are currently credentialed.

Community Relations and Outreach

- 12-Month Summary:
  - In Q1 2026, the Alliance completed 1,026 member orientation outreach calls, 124 net new and 16 non-utilizer member orientations by phone compared to 2,796 member orientation outreach calls, 170 net new and 19 non-utilizer member orientations by phone in Q1 2025.
  - The C&O Department reached 6,032 people, 32% identified as Alliance members, compared to 4,723 people, 2,392 individuals who identified as Alliance members in Q1 2025.
  - The C&O Department spent a total of $3,590.00 on donations, fees, and/or sponsorships, compared to $520.00 in Q1 2025.
  - The C&O Department reached members in 18 cities/unincorporated areas throughout Alameda County, and Bay Area, compared to 21 locations in Q1 2025.

- Quarterly Analysis:
  - In Q1 2026, the C&O Department completed 1,026 member orientation outreach calls, 140 member orientations by phone, 21 community events, 14 member education events, and one (1) community meeting/ presentation.
  - Among the 6,032 people reached, 32% identified as Alliance members.
  - In Q1 2026, the C&O Department reached members in 18 locations throughout Alameda County and the Bay Area.

- Monthly Analysis:
  - In September 2026, the C&O Department completed 248 member orientation outreach calls and 30 new and 0 non-utilizer member orientations by phone, four (4) services requests, and 19 Alliance website inquiries.
  - Among the 2,158 people reached, 23.4% identified as Alliance members.
  - In September 2026, the C&O Department reached members in eight (8) locations throughout Alameda County and the Bay Area.

Medicare Operations

- D-SNP Upcoming Key Initiatives and Dates:
    - Drug Pricing and Plan Benefit Data previews – August and September 2026.
    - Annual Enrollment Period (AEP) – October 15th through December 7th, 2026.
    - Open Enrollment Period (OEP) Begins – January 1st, 2027.

- Medicare Product Updates:
    - Dental – Liberty Dental - In September, efforts with Liberty Dental remained focused on the October 1st provider directory and Medicare Plan Finder (MPF) readiness activities. Key work included continued review of provider directory data, and discussions on the testing and refinement of provider file submissions. Additional activities included finalizing and publishing 2027 member-facing dental materials and FAQs.
    - Vision – Vision Service Plan (VSP) - In September, the primary focus of the VSP partnership was readiness for the October 1st vision benefit launch and ongoing MPF provider directory requirements. The team completed testing and implementation of the MPF provider directory file process, established monthly provider file submissions, and continued provider network review and recruitment activities. Additional efforts included finalizing and publishing 2027 VSP member FAQs in multiple languages, reviewing website and member-facing materials, and supporting operational readiness for AEP. VSP also continued outreach initiatives for diabetic eye exams, claims and encounter reconciliation efforts, and interoperability compliance activities to enhance member experience and operational performance.
    - Over the Counter (OTC) and Hearing – Nations Benefits - In September, efforts focused on 2027 readiness activities for both the OTC and hearing benefit programs in preparation for the October 1st marketing launch and AEP. The team completed reviews and approvals of member-facing materials, FAQs, supplemental benefit communications, and educational resources. Ongoing coordination with Nations Benefits addressed OTC operations, hearing benefits, Flex Card administration, reporting, regulatory readiness, and overall implementation activities. Additional work included developing internal guidance, resolving member issues, supporting frontline staff education, and preparing member support resources to promote a seamless experience during AEP and OEP.
    - Medicare Online Enrollment Center (OEC) - In September, efforts shifted from OEC process design into operational readiness and implementation activities for the upcoming AEP and Medicare.gov enrollment launch. The team continued reviewing and validating OEC enrollment data, completed manual enrollment field reviews, consolidated and tracked early OEC applications, and refined monitoring processes for enrollment file exceptions and downstream processing. Additional work focused on

approving cross-functional business requirements, advancing enrollment integration and workflow readiness, reviewing CMS CY2027 OEC requirements, and preparing operational support processes for OEC intake, reconciliation, and enrollment processing activities.

- Medicare Projects:
    - Work to implement new Pharmacy Benefit Manager (PBM), MedImpact, is in progress.
    - The CHCN delegation project charter has been approved by AAH leadership and is currently under CHCN review. A delegation agreement and Delegation of Financial Responsibility DOFR) are in development.
    - TeamDynamix (TDX) project 14695: PY2027-D-SNP CMS Marketing and Sales Readiness – AEP / OEP is in progress.
    - TeamDynamix (TDX) project 14696: PY2027-D-SNP Operational Readiness AEP / OEP is in progress.
    - Alameda Alliance for Health held our 2nd annual D-SNP Town Hall on September 24th.
        - Ahead of this year's Medicare AEP and OEP, the Alliance held a successful event that focused on provider and community partnership to improve community health outcomes.
        - Attendees heard updates from leadership team members on the D-SNP program including care management initiatives, quality improvement efforts, member support programs legislation updates, and exciting future enhancements.

- Medicare Sales & Retention Updates:
    - Two (2) Medicare Field Sales and Community Agents started in September.
    - Three (3) additional Medicare Field Sales and Community Agent positions have been approved and posted.
    - Eight (8) temp positions have been approved to provide support during AEP/OEP.
    - Sales/IT Enhancements and Projects:
        - Ongoing discussion with IT/Enrollment for CISCO and Cirrus API.
        - Integration of pre-enrollment sales script initiated with Nations and on track for implementation in October.
        - Outbound dialer function requested with Nations.
        - Continued development of Cirrus CRM Sales Tool reporting dashboards for enrollment and retention data.
    - Enhanced onboarding program and developed concierge-focused training for field staff.
    - Established Sales & Retention Code of Conduct, Sales Playbook, and Sales Scheduling process.
    - Contracted with Hanna Interpreting Services to provide onsite interpreter support at AHS and La Clínica.
    - Developing staff coverage and backup plans to ensure continuity across health center locations.

    - Conducted onsite facility tours and stakeholder introductions during August and September.
    - Collaborating with health center leadership on enrollment workflows and frontline staff processes.
    - Developing talking points to support Medicare Stars, Annual Wellness Visits (AWVs), and member education.
    - Translating sales scripts into threshold languages to improve efficiency and member experience.
    - Equipping staff with laptops, tablets, personal hot spots, and access to required policies and procedures while onsite.
    - Enhancing business cards with program branding, contact information, and licensing details to improve member access and recognition.
    - Ordered Alameda Alliance Wellness (HMO D-SNP) branded apparel to increase visibility and professionalism onsite.
    - Preparing educational, enrollment, and outreach materials to support member engagement.
    - Developing co-branded outreach opportunities and awareness-building activities to support future growth.

- Medicare Marketing, Communications, & Branding Updates:
    - Anderson partnership continues to drive a phased Medicare acquisition campaign, with October and November outreach planned to support year-end growth.
    - Materials on track for AEP launch (10/1/2026), supporting CY2027 readiness, compliance, and member experience improvements.
    - Completed enhancements to enrollment kits and welcome materials.
    - Website pages and AEP content are scheduled to launch on 10/1/2026.
    - Following deployment, Medicare Operations and business content owners will conduct post-launch quality control validation to confirm content accuracy and functionality.
    - 1/1/2027: Removal of CY2026 plan year content.
    - Co-branding work underway with Alameda Health Consortium (AHC) and clinic leadership to establish visual co-branding identity, messaging, and patient facing experience.
    - Co-branded marketing campaign targeted for Q1 2027 launch; Anderson developing creative concepts for presentation to clinic leadership in October.
    - Assessing enterprise-wide training needs to inform the 2027 learning strategy.
    - Learning & Development Program Manager onboarding is expected in mid-October 2026 to support enterprise training, workforce readiness, and Medicare implementation efforts.

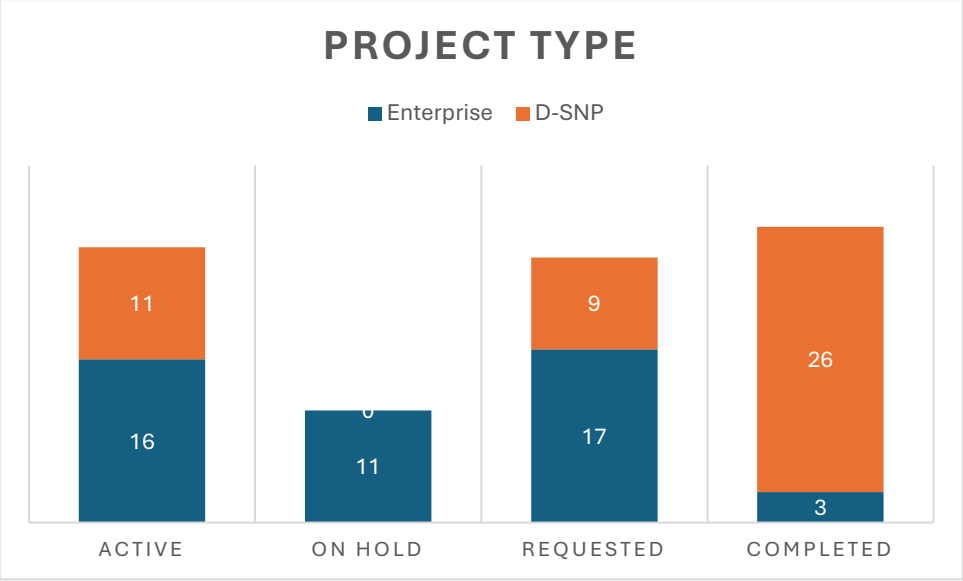


Integrated Planning

Beau Hennemann

Integrated Planning Division

- IPD Portfolio
  - 64 initiatives currently on the Alameda Alliance for Health (AAH) portfolio
    - 27 Active (discovery, initiation, planning, execution, warranty)
    - 11 On Hold
    - 26 Requested
    - 29 Completed (Fiscal YTD)



Enterprise Portfolio (Active Projects) for all Lines of Business (includes projects in Initiation, Planning, and Execution)

Project Name	Status	Health	Initial Start Date	Projected Close Date	Notes
Member Correspondence	Execution	●	2/9/2026	1/23/2027	
D-SNP: 1A Contracting & Credentialing	Execution	●	10/1/2023	10/15/2026	
AOR Workflow Optimization and Systems Integration	Execution	●	2/17/2025	11/5/2026	
CS Policy Guide 04.30.25 changes	Execution	●	6/20/2025	11/27/2026	

Project Name	Status	Health	Initial Start Date	Projected Close Date	Notes
CYBHI Statewide Multi-Payer School-Linked Fee Schedule	Execution	🟡	1/1/2024	11/30/2026	Risk/Issues being managed include: • Timely submission of paid and denied claims/ encounters to AAH by Carelon • DHCS File with Erroneous Member Zip Codes • Discrepancies in Carelon Go Live date.
DMHC APL 25-021 Infertility and Fertility Services [SB 729] (applicable to Group Care only)	Execution	🔴	2/2/2026	12/31/2026	Risk/Issues being managed include: • Lack of DMHC billing guidance requires AAH to independently develop rates and billing codes for SB 729 services • Provider contracting dates behind due to unresolved SB 729 reimbursement rates
Receiving, Storing, and Retrieving SOGI Data	Execution	🟢	3/14/2024	1/29/2027	
IPD Strategy FY 2026/27	Initiation	🟢	9/4/2026	1/29/2027	
PY2027-D-SNP: Centralized Medicare Website Enhancement	Execution	🟡	3/2/2026	2/2/2027	Risk/Issues being managed include: • Appointment form link reconfiguration with AAH Branding has been moved to the 1/1/27 deployment. • Web content tight deadlines for AEP/OEP deployments and required CMS Content changes.
PY2027-D-SNP CMS Marketing and Sales Readiness - AEP/OEP	Planning	🟡	6/1/2026	2/26/2027	See update below
DHCS APL 26-004 Medi-Cal MCP Responsibilities for BH	Planning	🟡	3/26/2026	3/4/2027	Risk/Issues being managed include: • Lack of engagement in formalizing a plan for

Project Name	Status	Health	Initial Start Date	Projected Close Date	Notes
					meeting data sharing requirements with ACBH.
D-SNP: Provider Exclusions Project	Planning	🟢	5/20/2026	3/11/2027	
(CMS-0057-F) Interoperability and Prior Authorization Final Rule	Execution	🟡	10/1/2025	3/12/2027	See update below
D-SNP: 2D - Chronic Care Improvement Program	Execution	🟢	3/3/2025	3/31/2027	Risk/Issues being managed include: • Timelines for implementation of 3 new assessments do not align with 1/1/27 requirement. • Timelines for implementation of CCIP Member Welcome Letter does not meet 1/1/27 requirement.
PY2027-D-SNP Operational Readiness - AEP/OEP	Planning	🟡	7/1/2026	3/31/2027	See update below
2026 PBM Transition - PerformRx to MedImpact	Execution	🟢	2/18/2026	3/31/2027	See update below
DHCS Medi-Cal Connect Risk Stratification, Segmentation, and Tiering (RSST) Implementation	Initiation	🟢	8/21/2026	3/31/2027	
ECM Enhancement Program	Execution	🟡	5/11/2026	5/31/2027	See update below
sPayer Contracting Repository	Planning	🟡	1/2/2023	1/28/2028	See update below
PY2028-C-SNP Product Assessment, Launch, and Implementation	Initiation	🟢	10/1/2026	3/31/2028	
D-SNP: CHCN Delegation	Initiation	🟢	2/2/2026	1/31/2029	See update below

Strategic Project Initiatives:

Plan Year 2027 D-SNP Program (Bid & Benefit Design and Submission, Marketing & Sales Readiness, Operational Readiness & Medicare Website Enhancements)

- **Project Overview:** Integrates the design, regulatory approval, member communication, and operational implementation of the PY2027 D-SNP benefit offering. Current execution is focused on 10/1/26 marketing launch, 10/15/26 AEP enrollment readiness, and 1/1/27 plan cutover and OEP readiness.
- **Project Health: Yellow**
- **Completed Milestones:** PY2027 ANOC mailing across required language and alternate formats were completed by 9/25 to support 9/30 in-home. Remaining CMS-required D-SNP integrated member materials, including EOC, List of Covered Drugs, Directory, and Summary of Benefits, were also approved and moved into production readiness. Project governance granted formal Go approval for the 10/1 marketing launch.
- **Risks/Issues:** The primary near-term risk is 10/15 enrollment readiness, driven by Medicare.gov file processing and end-to-end enrollment validation. Final Medicare Plan Finder and provider/pharmacy directory validations also remain open, with initial MedImpact pharmacy data integration and downstream print-vendor handoff still in progress. Mitigation includes finalizing and testing an interim Medicare.gov processing approach, validating MPF through the CMS portal ahead of the 10/8 required-by date, holding focused IT and business working sessions, and escalating decisions as needed to protect the remaining October milestones.

DSNP CHCN Delegation: (Target Go Live 1/1/28, Project Close out 3/31/28)

- **Project Overview:** Establishes delegated claims administration, provider network, provider relations, and utilization management for D-SNP to Community Health Center Network (CHCN), including pre-delegation, regulatory approval, and system and operational changes.
- **Project Health: Green**
- **Completed Milestones:** D-SNP Delegation Amendment and DOFR updates completed by AAH and shared with CHCN for review and comment.
- **Risks/Issues:** CHCN's Core Administrative System implementation for the D-SNP line of business is dependent on completion of the Medi-Cal upgrade, which is currently scheduled for February 2027. Any delays to the Medi-Cal upgrade may impact the D-SNP implementation timeline.

ERP Implementation: (Target kick off date: 10/15/2026, Target Go Live: 10/15/2027, Project Close Out: 12/31/27)

- **Project Overview:** Replaces the Alliance's legacy Microsoft Dynamics SL platform with Oracle NetSuite to modernize financial operations, reporting, and integrations across Finance and enterprise systems.
- **Project Health: Green**

- **Completed Milestones:** The ERP RFP and selection process was completed, with Oracle NetSuite selected as the ERP platform. The Oracle NetSuite subscription and Caravel implementation SOW have both been fully executed.
- **Risks/Issues:** No material risks at this stage. Vendor onboarding, project activation, implementation timeline, resource plan, and budget are being finalized ahead of the kickoff to support the planned schedule.

SympIr Implementation: (Target Phase 1 Go Live: 3/28/2027, Pending Go Lives for Phases 2&3, Project Close Out: 3 mo Warranty)

- **Project Overview: The** sPayer project aims to centralize provider data, automate key provider workflows, and migrate legacy data into a single platform. The implementation scope includes configured test and production environments, provider workflow automation, contract management, data migration and import utilities, eSearch functionality, reporting, training, and role-based permissions.
- **Project Health: Yellow**
- **Completed Milestones:** Internal Sign Off of Discovery Business Process Phase, Sign off of Scope, Sign Off of 2nd Iteration of Provider Data Conversion, End to End Business Process Validation Completed, Receipt of Proposed Draft Implementation Plan from vendor.
- **Risks/Issues:**
    - Incomplete implementation baseline (scope, schedule, budget) pending final plan approval.
    - Provider Repository replication and downstream integration dependencies.
    - Risk to go-live readiness due to expanded testing and validation requirements.
    - Internal capacity constraints for contract templates, rosters, forms, and related configuration activities.

PBM Replacement (PerformRX to MedImpact) - Target Go Live: 1/1/2027, Project Close Out: 3/31/27

- **Project Overview:** The project is transitioning Alameda Alliance's D-SNP and GroupCare pharmacy benefits from PerformRx to MedImpact effective 1/1/2027. Implementation activities remain on track, with 2027 formulary readiness, eligibility testing, member communications planning, operational workflow development, and vendor transition activities progressing toward go-live.
- **Project Health: Green**
- **Completed Milestones:**
    - Type 23 and Type 24 eligibility test files delivered to MedImpact.
    - 2027 formulary (printed and digital) and pharmacy locator materials delivered for AEP readiness.
    - GroupCare member communication and ID card reissuance planning completed; KP PO submitted.
    - Updated pharmacy directory file received from MedImpact for provider directory configuration.
- **Risks/Issues:**

- Issue - Accumulator File Development Delays**:** RAM HealthSuite enhancements required for Type 112 and Type 42 accumulator file processing continue to impact development and testing timelines and may affect downstream implementation milestones pending final LOE and deployment dates.
- Issue- Provider Directory File Readiness: MedImpact's pharmacy directory file required modifications to meet AAH formatting requirements. Updated files have been received, with final validation pending.
- Risk - PerformRx Exit Activities: Exit contract negotiations and transition planning remain in progress, presenting risk to project scope and schedule.

ECM Enhancement Program - Iterative implementation addressing priority scope.

- **Project Overview:** This initiative is intended to provide a comprehensive approach to managing various ECM processes and system enhancements to reduce manual processes, improve the end-to-end ECM billing and reimbursement process, improve turnaround times, and reduce ECM provider's attrition and dissatisfaction.
- **Project Health:** Yellow - due to schedule delays
- **Completed Milestones:** Completion of the future state ECM Claims design, Finalized business requirements for Outreach and Enrollment authorizations.
- **Risks/Issues:** With no schedule slack available, the project team must closely monitor scope, dependencies, and milestone completion to prevent delays and maintain the planned timeline.

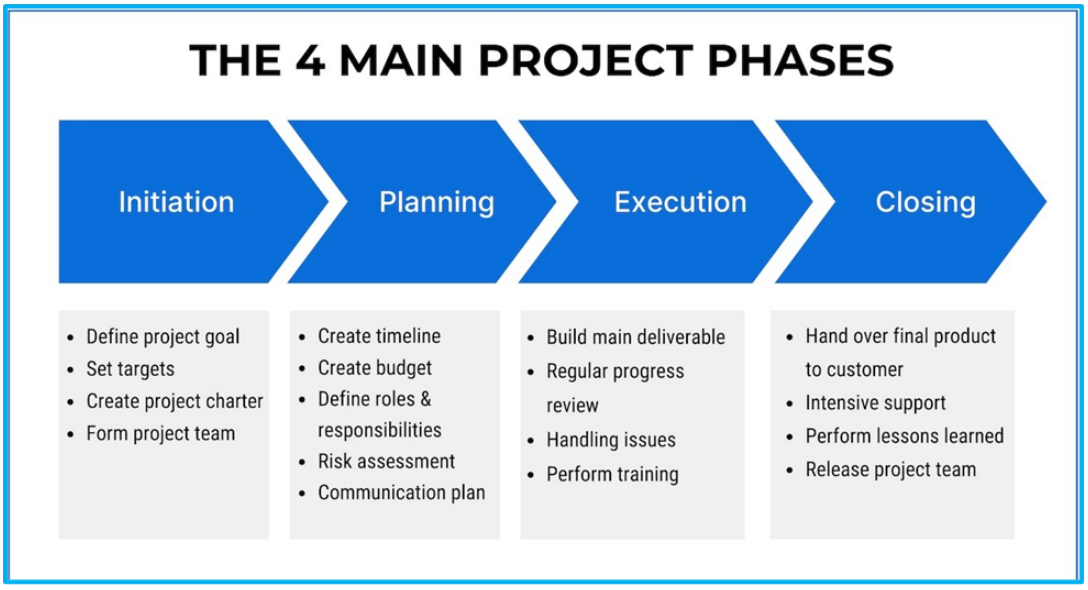
(CMS-0057-F) Interoperability and Prior Authorization Final Rule

- **Project Overview:** This project is implementing the regulatory requirements of CMS-0057-F, which includes deploying four APIs (Prior Auth, Patient Access, Payer-to-Payer, Provider Access) with the help of our partner Cotiviti/Edifecs.
- **Project Health:** The project is now RED due to not having a clear path forward through C&O for the needed Member & Provider educational materials on multiple communication channels.
- **Completed Milestones:**
  - No milestones were reached in September.
- **Risks/Issues:**
  - ISSUE: Very low confidence that we will have Member & Provider materials in place in time for the four APIs
  - DECISION: P2P API Member Consent Opt-In Capture Approach

IPD Strategy – Process Improvement

- **Project Overview:** Evaluate, enhance and introduce AAH Portfolio and Project Governance Structure, IPD processes & best practice methodology, reporting transparency and accuracy.
- **Project Health: Green**
- **Completed Milestones:** Established a roadmap and drafting timeline.
- **Risks/Issues: None**

- ***Project Phases**



- ****Project Health**

ALAMEDA Alliance FOR HEALTH

Project Health Legend

Health	Schedule	Budget	Resources	Scope	Overall
	Ahead or on target for all Milestones and less than 5% delay to estimated time of completion (ETC).	Actual total expense is on or below budget.	Required resources & skills are available as planned.	The project scope has not changed this period.	If one of the key indicators is temporarily yellow, the project may retain the green indicator score.
	A milestone is missed or between 5 – 15% increase in ETC.	Actual total expense is within 10% of budget.	Planned resources and skills are not available but a mitigation strategy is in place.	Minor scope change(s).	The project is experiencing problems with one or more key indicators. Or the project requires management attention to prevent major issues from negatively impacting the project.
	A **KEY** milestone is missed that will impact the project or greater than 15% increase in ETC.	Actual total expense is greater than 10%.	Project resource levels and skills are not adequate to complete the project.	Major scope change(s).	The project is experiencing problems with more than 2 key indicators. Or the project is at risk and requires immediate management attention to help resolve.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	September 2026
Incoming Calls (R/V)	17,830
Abandoned Rate (R/V)	3%
Answered Calls (R/V)	17,264
Average Speed to Answer (ASA)	00:09
Calls Answered in 30 Seconds (R/V)	95%
Average Talk Time (ATT)	07:18
Calls Answered in 10 minutes	100%
Outbound Calls	10,375

Top 5 Call Reasons (Medi-Cal and Group Care) September 2026
Grievances and Appeals
Change of PCP
Eligibility/Enrollment
Benefits
Provider Network Information

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) September 2026
Change of PCP
ID Card Requests
Update Contact Information

Member Services Behavioral Health	September 2026
Incoming Calls (R/V)	1,137
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	1,110
Average Speed to Answer (ASA)	00:26
Calls Answered in 30 Seconds (R/V)	88%
Average Talk Time (ATT)	09:40
Calls Answered in 10 Minutes	100%
Outbound Calls	2,196

Screenings Completed	1,137
ACBH Referrals	2%
SUD Referrals to Center Point	1,110

Blended Call Results

D-SNP Blended Results	September 2026
Incoming Calls (R/V)	590
Abandoned Rate (R/V)	4%
Answered Calls (R/V)	566
Average Speed to Answer (ASA)	00:10
Calls Answered in 30 Seconds (R/V)	98%
Average Talk Time (ATT)	07:49
Calls Answered in 2 minutes	99%

Top 5 Call Reasons (D-SNP) September 2026
Appeals/Grievances
Benefits/Organizational Determinations
Eligibility/Enrollment
Change of PCP
ID Card Request

Claims Department – Claims Processing
August 2026 and September 2026

METRICS

Claims Compliance	**Aug-26**	**Sep-26**
90% of clean claims processed within 30 calendar days	99.6%	99.7%
	(includes D-SNP)	(includes D-SNP)
Claims Volume (Received)	**Aug-26**	**Sep-26**
Paper claims	36,114	34,241
EDI claims	333,953	322,634
Claim Volume Total	**370,067**	**356,875**
	(includes D-SNP)	(includes D-SNP)
Percentage of Claims Volume by Submission Method	**Aug-26**	**Sep-26**
% Paper	9.8%	9.6%
% EDI	90.2%	90.4%

Claims Processed	**Aug-26**	**Sep-26**
HEALTHsuite Paid (original claims)	254,493	304,540
HEALTHsuite Denied (original claims)	94,971	112,542
HEALTHsuite Original Claims Sub-Total	**349,464**	**417,082**
HEALTHsuite Adjustments	5,731	6,254
HEALTHsuite Total	**355,195**	**423,336**

Claims Expense	**Aug-26**	**Sep-26**
Medical Claims Paid	$143,864,821	$178,341,433
Interest Paid	$171,068	$680,451

Auto Adjudication	**Aug-26**	**Sep-26**
Claims Auto Adjudicated	228,886	228,886
% Auto Adjudicated	85.3%	87.5%

Average Days from Receipt to Payment	**Aug-26**	**Sep-26**
HEALTHsuite	12	11

Pended Claim Age	Aug-26	Sep-26
0-30 calendar days	15,419	11,914
HEALTHsuite		
31-62 calendar days	33	338
HEALTHsuite		
Over 63 calendar days	20	16
HEALTHsuite		

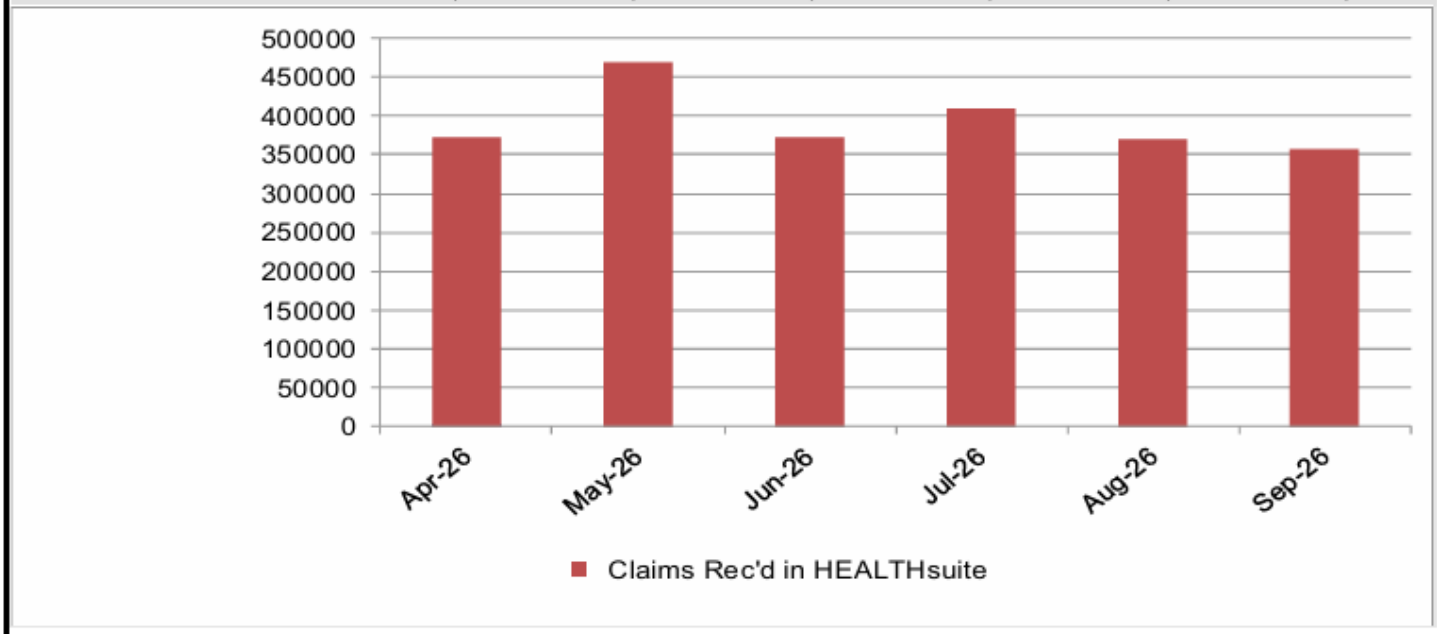
Overall Denial Rate	Aug-26	Sep-26
Claims denied in HEALTHsuite	94,971	112,542
% Denied	26.7%	26.6%

Claim Department- Claim Processing
August 2026 Final and September 2026
Sep-26

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	20%
No Benefits Found For Dates Of Service	15%
Non-Covered Benefit For This Plan	15%
Must Submit Paper Claim With Copy of Primary Payor EOB	10%
Duplicate Claim	7%
% Total of all denials	**67%**

Claims Received By Month

	5/1/2026	6/1/2026	7/1/2026	8/1/2026	9/1/2026	10/1/2026
Claims Received Through	**Apr-26**	**May-26**	**Jun-26**	**Jul-26**	**Aug-26**	**Sep-26**
Claims Rec'd in HEALTHsuite	373,472	468,360	372,767	408,603	370,067	356,875



Claims Year Over Year Summary		
Monthly Results	**Regulatory Requirement**	**AAH Goal**
Claims Compliance - comparing September 2026 to September 2025 as follows: 30 Days - 99.7% (2026) vs 88.4% (2025)	* 95% of clean claims in 30 calendar days (effective 1/1/2026) * 99% of all claims in 90 calendar days *(interest is required on any claim paid after 30 calendar days)*	* 95% of clean claims in 30 calendar days (effective 1/1/2026) * 99% of all claims in 90 calendar days *(interest is required on any claim paid after 30 calendar days)*
Claims Received - AAH received 356,875 claims for all lines of business in September 2026 vs 373,025 in September 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 417,082 in September 2026 (22 working days) vs 352,758 in September 2025 (21 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in September 2026 was $178,341,433 (5 check runs) vs $135,164,354 in September 2025 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in September 2026 was $680,451 vs $122,638 in September 2025	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in September 2026 was 87.5% vs 88.9% in September 2025	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in September 2026 was 11 days vs 16 days in September 2025	N/A	<= 25 days
Pended Claim Age - comparing September 2026 to September 2025 as follows: 0-30 calendar days - 11,914 (2026) vs 44,263 (2025) 31-62 calendar days - 338 (2026) vs 17,934 (2025) Over 63 calendar days - 16 (2026) vs 47,834 (2025)	N/A	N/A
Top 5 Denial Reasons - the claim denial reasons remain consistent from month to month so there are no significant changes to report from September 2026 to September 2025	N/A	N/A

Claims Department - Provider Dispute Resolution

August 2026 and September 2026

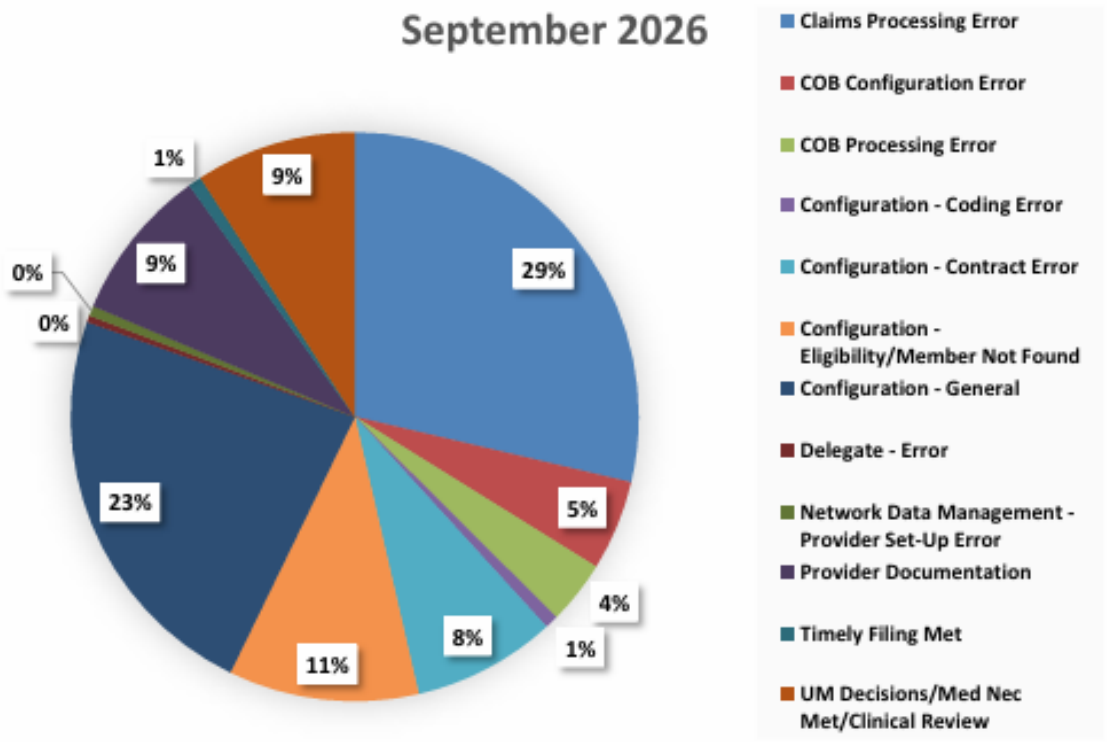
METRICS

PDR Compliance	**Aug-26**	**Sep-26**
# of PDRs Resolved	2,388	2,113
# Resolved Within 45 Working Days	2,340	2,047
% of PDRs Resolved Within 45 Working Days	98.9%	96.8%
PDRs Received	**Aug-26**	**Sep-26**
# of PDRs Received	3,632	2,263
PDR Volume Total	**3,632**	**2,263**
PDRs Resolved	**Aug-26**	**Sep-26**
# of PDRs Upheld	1,660	1,587
% of PDRs Upheld	70%	75%
# of PDRs Overturned	728	526
% of PDRs Overturned	30%	25%
Total # of PDRs Resolved	**2,388**	**2,113**
Average Turnaround Time	**Aug-26**	**Sep-26**
Average # of Days to Resolve PDRs	38	37
Oldest Resolved PDR in Days	194	156
Unresolved PDR Age	**Aug-26**	**Sep-26**
0-45 Working Days	4,388	4,666
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**4,388**	**4,666**

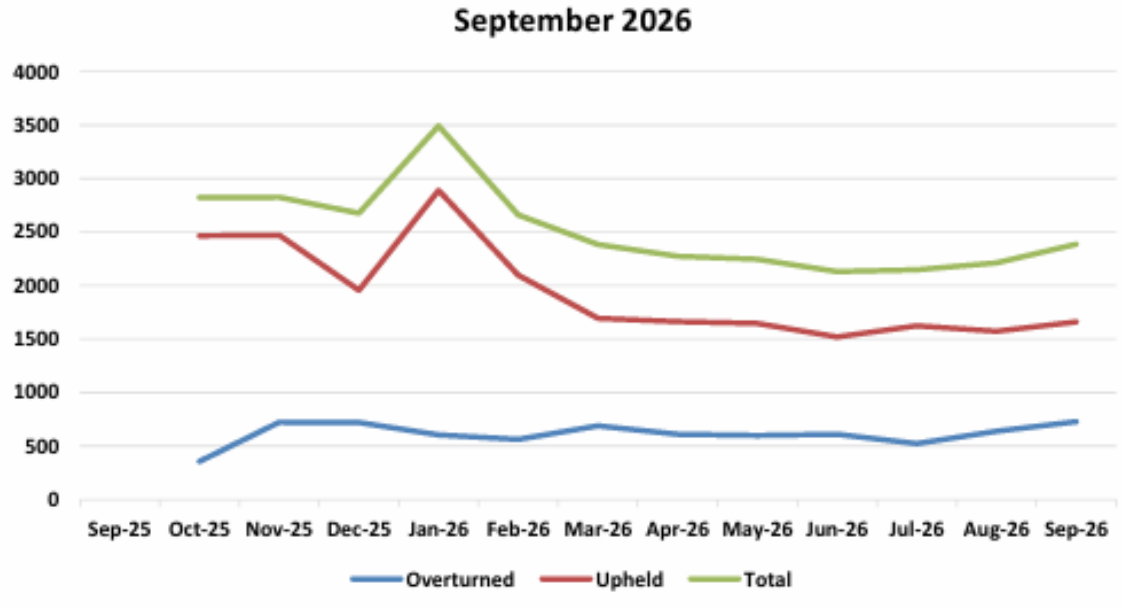
Provider Dispute Resolution
September-26

Sep-26

PDR Resolved Case Overturn Reasons



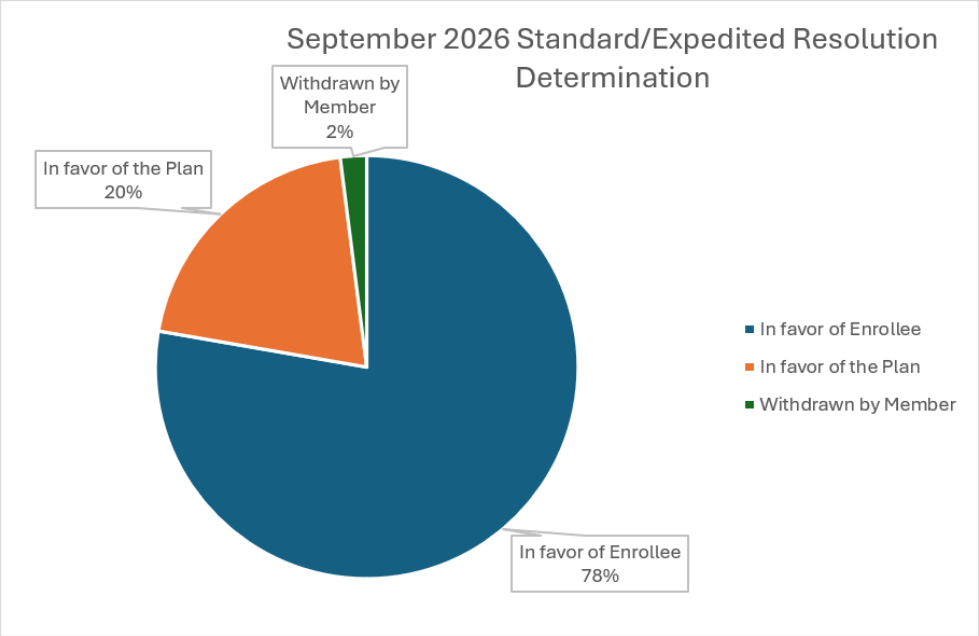
Rolling 12-Month PDR Trend Line

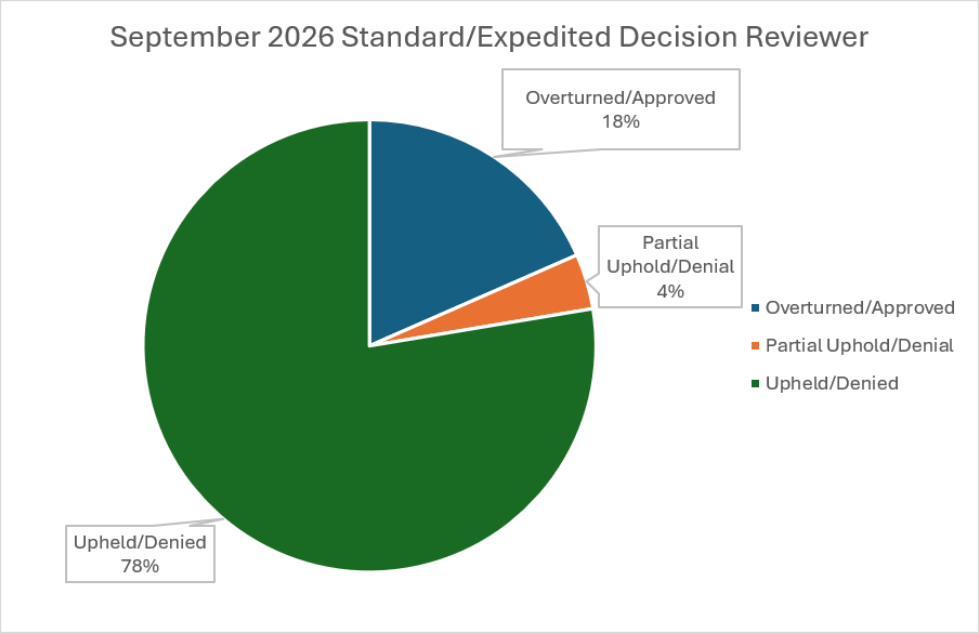


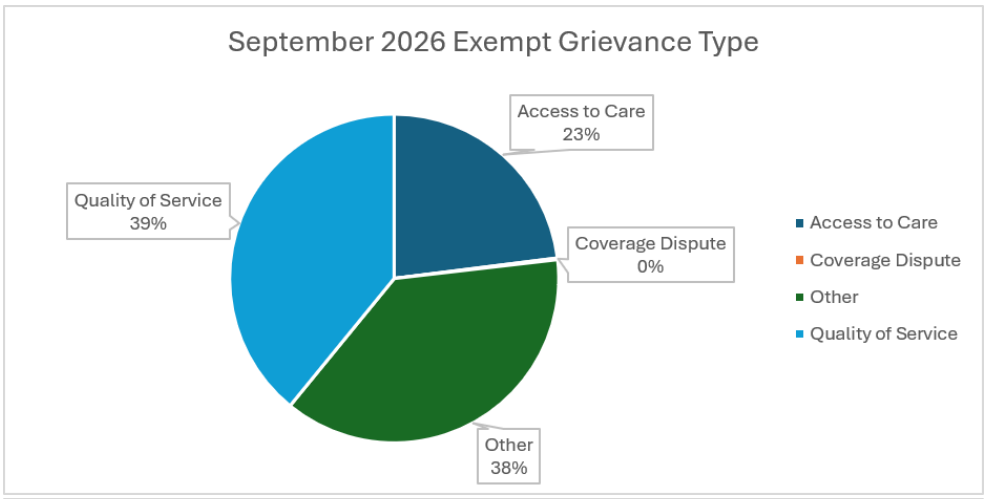
Provider Dispute Resolution Year Over Year Summary		
Monthly Results	**Regulatory Requirements**	**AAH Goal**
# of PDRs Resolved - 2,113 in September 2026 vs 2,823 in September 2025	N/A	N/A
# of PDRs Received - 2,263 in September 2026 vs 3,266 in September 2025	N/A	N/A
# of PDRs Resolved within 45 working days - 2,047 in September 2026 vs 1,889 in September 2025	N/A	N/A
% of PDRs Resolved within 45 working days – 96.8% in September 2026 vs 99.6% in September 2025	95%	95%
Avg. # of Days to Resolve PDRs - 37 days in Sept. 2026 vs 40 days in Sept. 2025	N/A	30
Oldest Resolved PDR in Days - 156 days in Sept. 2026 vs 268 days in Sept. 2025	N/A	N/A
# of PDRs Upheld - 1,587 in September 2026 vs 2,467 in September 2025	N/A	N/A
% of PDRs Upheld - 75% in September 2026 vs 87% in September 2025	N/A	> 75%
# of PDRs Overturned - 526 in September 2026 vs 356 in September 2025	N/A	N/A
% of PDRs Overturned - 25% in September 2026 vs 13% in September 2025	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 29% (2026) vs 37% (2025) Configuration errors - 43% (2026) vs 40% (2025) COB - 9% (2026) vs 13% (2025) Clinical Review/UM Decisions/Medical Necessity Met - 19% (2026) vs 10% (2025)	N/A	N/A

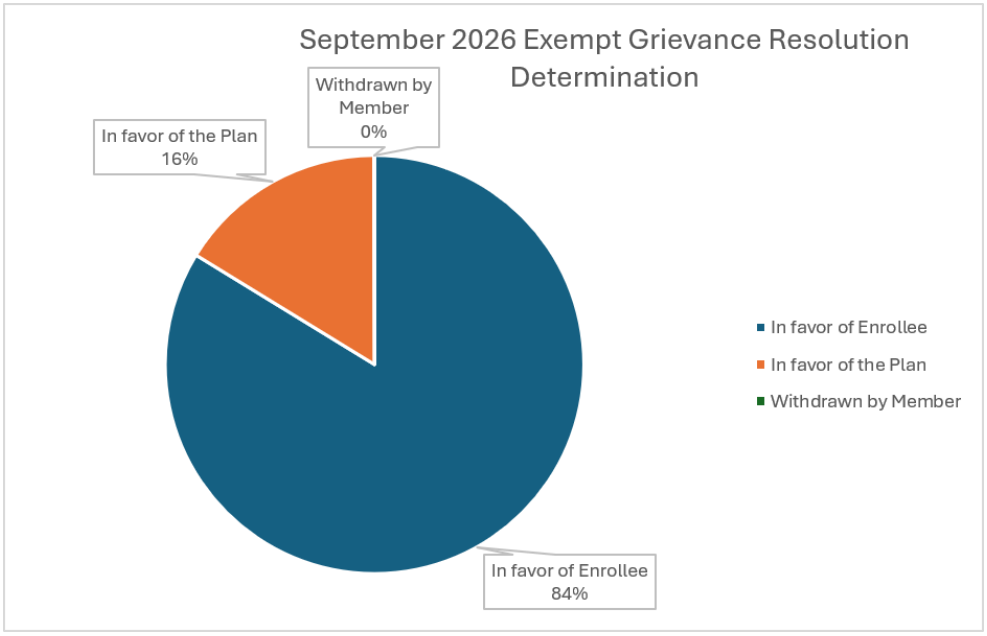
Grievance & Appeals

MCAL & IHSS

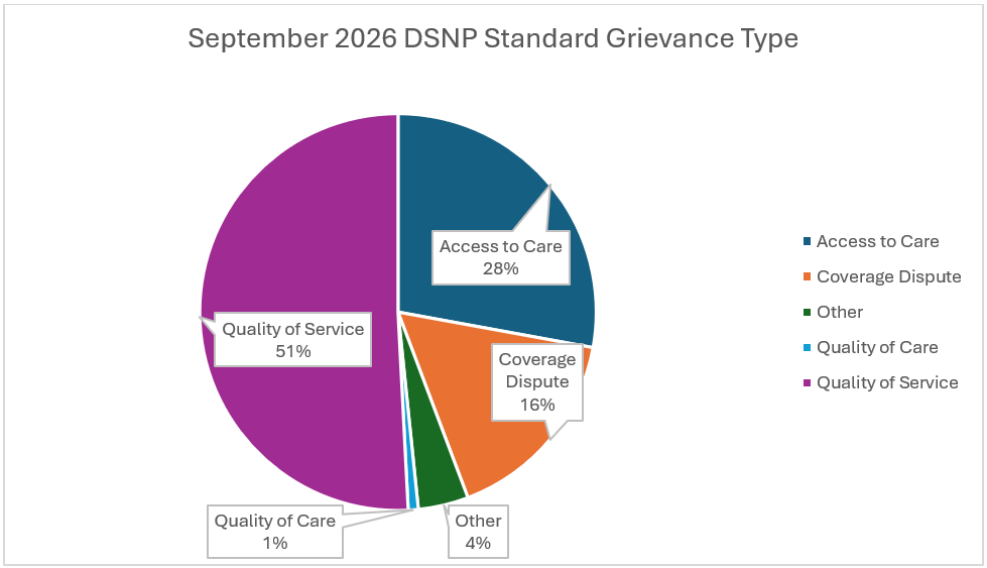


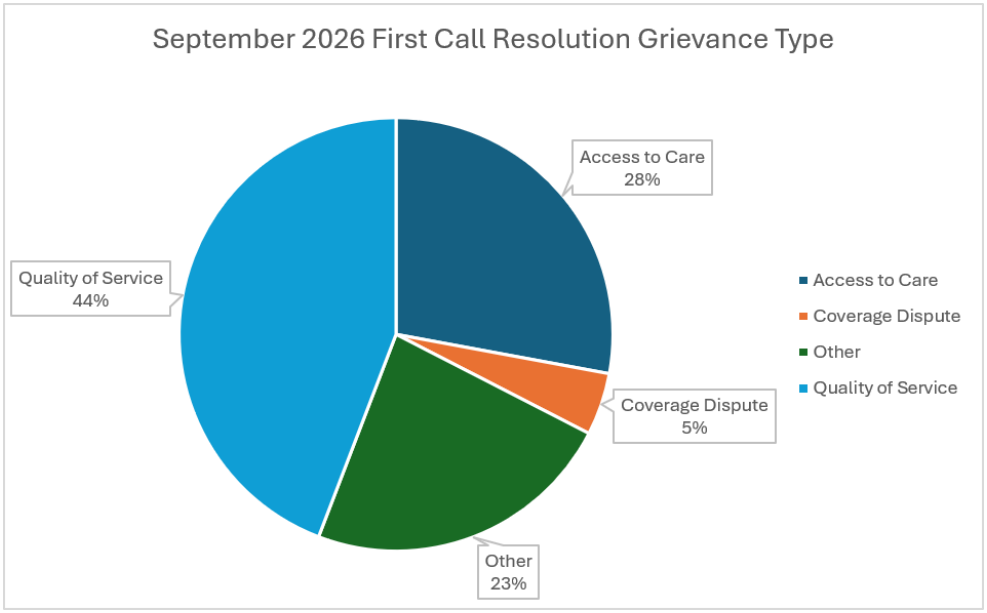



September 2026 Exempt Grievance Type
Access to Care 23%
Coverage Dispute 0%
Other 38%
Quality of Service 39%
Access to Care
Coverage Dispute
Other
Quality of Service


September 2026 Exempt Grievance Resolution Determination
Withdrawn by Member 0%
In favor of the Plan 16%
In favor of Enrollee 84%
In favor of Enrollee
In favor of the Plan
Withdrawn by Member

D-SNP


September 2026 DSNP Standard Grievance Type
Access to Care 28%
Coverage Dispute 16%
Other 4%
Quality of Care 1%
Quality of Service 51%
Access to Care
Coverage Dispute
Other
Quality of Care
Quality of Service


September 2026 First Call Resolution Grievance Type
Access to Care 28%
Coverage Dispute 5%
Other 23%
Quality of Service 44%
Access to Care
Coverage Dispute
Other
Quality of Service

Provider Relations Call Center Dashboard

Medi-Cal and Group Care						
Alliance Provider Relations Staff	Apr	May	Jun	Jul	Aug	Sep
Incoming Calls	7,416	5,195	5,918	7,383	7,736	5,835
Answered Calls	5,410	4,375	4,843	4,848	5,484	5,007
Abandoned Calls	2,006	820	1,075	2,535	2,252	828
Outbound Calls	507	395	285	259	180	229
Voicemails Received	21	3	22	17	16	19
Agent Answered Rate ≥ 85% or above	96%	96%	97%	98%	98%	98%
Average Speed of Answer ≤ 30 seconds	207 seconds	133 seconds	162 seconds	264 seconds	410 seconds	170 seconds
Call Abandonment Rate ≤ 15% or less	27%	13%	18%	34%	29%	14%
Totals	Apr	May	Jun	Jul	Aug	Sep
Total Incoming, R/V, Outbound Calls	7,944	6,313	6,225	7,659	7,932	6,083
Total Abandoned Calls	2,006	820	1,075	2,535	2,252	828
Total Answered Incoming, R/V, Outbound Calls	5,938	4,773	5,150	5,124	5,680	5,255
Alliance Wellness D-SNP						
Alliance Provider Relations Staff	Apr	May	Jun	Jul	Aug	Sep
Incoming Calls	1,295	1,152	1,238	1,411	1,534	1,171
Answered Calls	950	962	1,024	983	1,096	1,025
Abandoned Calls	345	190	214	428	438	146
Outbound Calls	56	43	49	29	21	23
Voicemails Received	0	0	0	2	0	0
Agent Answered Rate ≥ 85% or above	96%	96%	97%	98%	98%	98%

Average Speed of Answer ≤ 30 seconds	215 seconds	119 seconds	144 seconds	136 seconds	311 seconds	177 seconds
Call Abandonment Rate ≤ 15% or less	26%	16%	17%	30%	29%	12%
Totals	Apr	May	Jun	Jul	Aug	Sep
Total Incoming, R/V, Outbound Calls	1,351	1,195	1,287	1,442	1,555	1,194
Total Abandoned Calls	345	190	214	428	438	146
Total Answered Incoming, R/V, Outbound Calls	1,006	1,005	1,073	1,014	1,117	1,048

Total All Lines of Business	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Total Incoming Calls	8,711	6,347	7,156	8,794	9,270	7,006
Total Answered Calls	6,360	5,337	5,867	5,831	6,580	6,032
Total Abandoned Calls	2,351	1,010	1,289	2,963	2,690	974
Total Outbound Calls	563	438	334	288	201	252
Total Voicemails Received	21	3	22	19	16	19
Total Incoming, R/V, Outbound Calls	9,295	6788	7,512	9,101	9,487	7,277
Total Answered Incoming, R/V, Outbound Calls	6,944	5778	6,223	6,138	6,797	6,303

Provider Relations Call Reasons & Field Visits Dashboard

Medi-Cal and Group Care Call Reasons

Category	Apr	May	Jun	Jul	Aug	Sept
Authorizations	6%	6.1%	5.2%	5.1%	6%	14%
Benefits	5%	4.1%	3.7%	3.5%	4%	5%
Claims Inquiry	39%	41.9%	42.3%	40.5%	29%	31%
Change of PCP	3%	2.2%	2.4%	1.6%	0%	2%
Check Tracer	1%	0.9%	0.7%	0.7%	1%	1%
Complaint/Grievance (includes PDRs)	10%	12.2%	12.0%	12.9%	9%	13%
Contracts/Credentialing	0.7%	0.6%	1.1%	0.6%	1%	1%
Demographic Change	0.1%	0.0%	0.0%	0.0%	0%	0%
Disconnected Calls	4.7%	4.9%	4.6%	5.8%	3%	3%
Eligibility	19.6%	17.7%	18.3%	20.3%	23%	19%
Exempt Grievance/ G&A	2.3%	0.0%	0.0%	0.0%	0%	0%
Interpreter Services Request	0.5%	0.4%	0.4%	0.6%	0%	0%
Provider Portal Assistance	1.0%	3.1%	2.4%	1.8%	2%	3%
Pharmacy	0.3%	0.1%	0.1%	0.0%	0%	0%
Prop 56	0.0%	0.1%	0.1%	0.0%	0%	0%
Provider Information Updates/ W9	1.0%	0.5%	0.5%	0.2%	1%	1%
Transportation Services	0.1%	0.1%	0.3%	0.2%	0%	0%
All Other Calls	5.1%	5.0%	6.1%	6.1%	16%	6%
TOTAL	100%	100%	100%	100%	100%	100%

D-SNP Call Reasons

Category	Apr	May	Jun	Jul	Aug	Sept
D-SNP Authorizations	3%	1%	2%	6%	3%	3%
D-SNP Benefits	4%	3%	5%	8%	18%	5%
D-SNP Claims	59%	53%	55%	38%	70%	49%
D-SNP Eligibility	18%	27%	20%	46%	8%	32%
D-SNP Enrollment	1%	0%	0%	0%	0%	0%
D-SNP PCP Assignment	4%	8%	9%	0%	0%	5%
D-SNP PDR/Reconsideration	8%	3%	2%	2%	2%	0%
D-SNP Check Tracer	1%	0%	0%	0%	0%	0%
D-SNP Provider Portal	1%	2%	2%	0%	0%	0%
D-SNP Contracts / Credentialing	1%	1%	4%	0%	0%	3%
D-SNP Interpreter Request	0%	0%	0%	0%	0%	3%
D-SNP Member Call	1%	0%	0%	0%	0%	0%
D-SNP Transportation Services	1%	0%	0%	0%	0%	0%
D-SNP Provider Information Updates / W9	0%	0%	2%	0%	0%	0%
D-SNP Pharmacy	0%	0%	0%	0%	0%	0%
TOTAL	100%	100%	100%	100%	100%	100%

Field Activity Visits

Alliance Provider Relations Staff	Apr	May	Jun	Jul	Aug	Sept
Claims Issues	47	33	43	33	35	17
Contracting/Credentialing	87	70	99	76	61	46
Drop-ins	72	142	43	73	174	313
JOMs	1	2	1	3	3	2
New Provider Orientation	172	246	168	177	155	141
Quarterly Visits	0	40	40	40	40	36
UM Issues	0	1	3	2	0	1
Total Field Visits	379	534	397	404	468	556

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS - September 2026						
Practitioners		PCP 420	SPEC 822	AHP 945	BH/ABA 4,033	PCP/SPEC 12
Direct Network vs Delegated Network Breakdown			AAH 4,888	AHS 293	CHCN 681	COMBINATION OF GROUPS 370
Facilities	446					

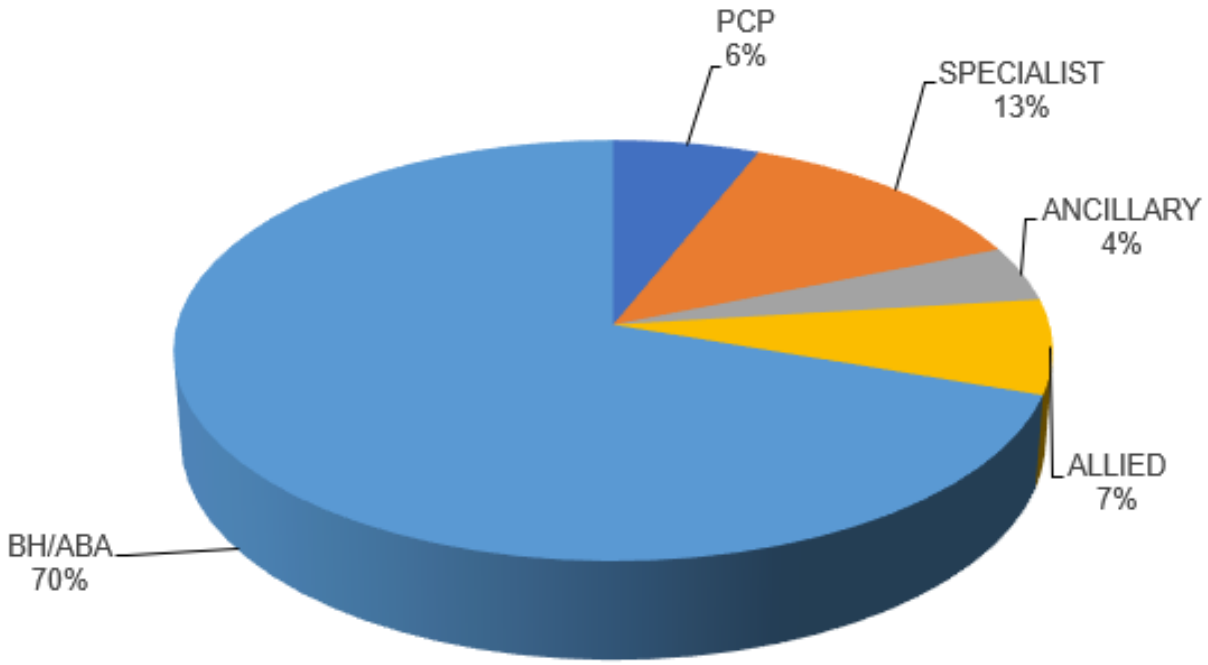
VENDOR SUMMARY **Credentialing Verification Organization, Symplyr CVO**					
	Number	**Average Calendar Days in Process**	**Goal - 25 Business Days***	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	294	4	Y	Y	Y
Recred Files in Process	100	44	N	Y	N
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**394**				
					*** 25 business days = 35 calendar days**

September 2026 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	10
SPEC	21
ANCILLARY	7
MIDLEVEL/AHP	12
BH/ABA	115
Sub-total	**165**
Recredentialing	
PCP	3
SPEC	7
ANCILLARY	3
MIDLEVEL/AHP	2
BH/ABA	65
Sub-total	**80**
TOTAL	**245**

September 2026 Facility Approvals	
Initial Credentialing	7
Recredentialing	1
Sub-total	**8**
Facility Files in Process	**38**

September 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

SEPTEMBER PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2026-2027 | **1st Quarter (Q1) 2026 OUTREACH REPORT**

Alliance in the Community Events and Activities:

Between July 2026 and September 2026, the Alliance completed **1,026** member orientation outreach calls among net new members and non-utilizers and conducted **124** net new member orientations and **16** non-utilizer member orientations (**14%** member participation rate). In addition, the Outreach team completed **36** Alliance website inquiries, **13** service requests, **21** community events, **13** member education events, **1** Community Meeting/Presentation, and **1** Coffee & Conversations event in Q1. We successfully hosted our second Coffee & Conversation event in collaboration with the Alliance Community Advisory Committee. The event gave us an opportunity to engage with members face-to-face, hear their feedback, and answer questions about important health care topics and coverage renewals. Approximately 70 people attended, and 78.5% identified as Alliance members. Building on this success, we look forward to hosting a third event in April 2027 and continuing to serve our members in the community.

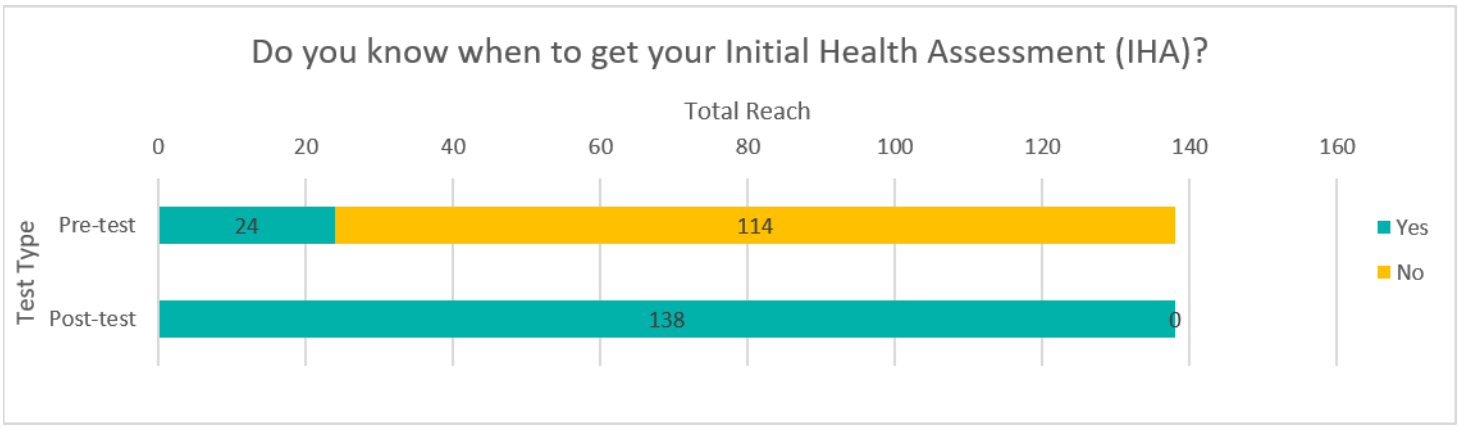
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, approximately **49,298** self-identified Alliance members have been reached during outreach activities.

Alliance Member Orientation Program:

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of **Wednesday, September 30, 2026**, the Outreach Team has completed **59,220** member orientation outreach calls and conducted **10,709** orientations, achieving an **18.1%** participation rate.

Between July 1, through September 30, 2026, **138** members completed an MO by phone. After completing the MO, **100%** of members who completed the post-test survey in Q1 FY 26-27 reported knowing when to get their IHA, compared to only **17.4%** 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 26-27\Q1\September 2026**

ALLIANCE IN THE COMMUNITY

FY 2026-2027 | **First Quarter (Q1) 2026 OUTREACH REPORT**

Q1 FY 2026-2027 TOTALS





21	COMMUNITY EVENTS	**4,193**	TOTAL REACHED AT COMMUNITY EVENTS
14	MEMBER EDUCATION EVENTS	**1,786**	TOTAL REACHED AT MEMBER EDUCATION EVENTS
140	MEMBER ORIENTATIONS	**140**	TOTAL REACHED AT MEMBER ORIENTATIONS
1	MEETINGS/ PRESENTATIONS	**53**	TOTAL REACHED AT MEETINGS/PRESENTATIONS
44	TOTAL INITIATED/INVITED EVENTS	**2,070**	TOTAL MEMBERS REACHED AT EVENTS
176	TOTAL EVENTS	**6,172**	TOTAL REACHED AT ALL EVENTS



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

TOTAL REACH 18 CITIES

Cities represent the mailing addresses for members who completed a Member Orientation by phone. The following cities had <1% reach during Q1 2026: Cherryland, Daily City, San Jose, and San Francisco. The C&O Department started including these cities in the Q3 FY21 Outreach Report.



$3,590.00

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

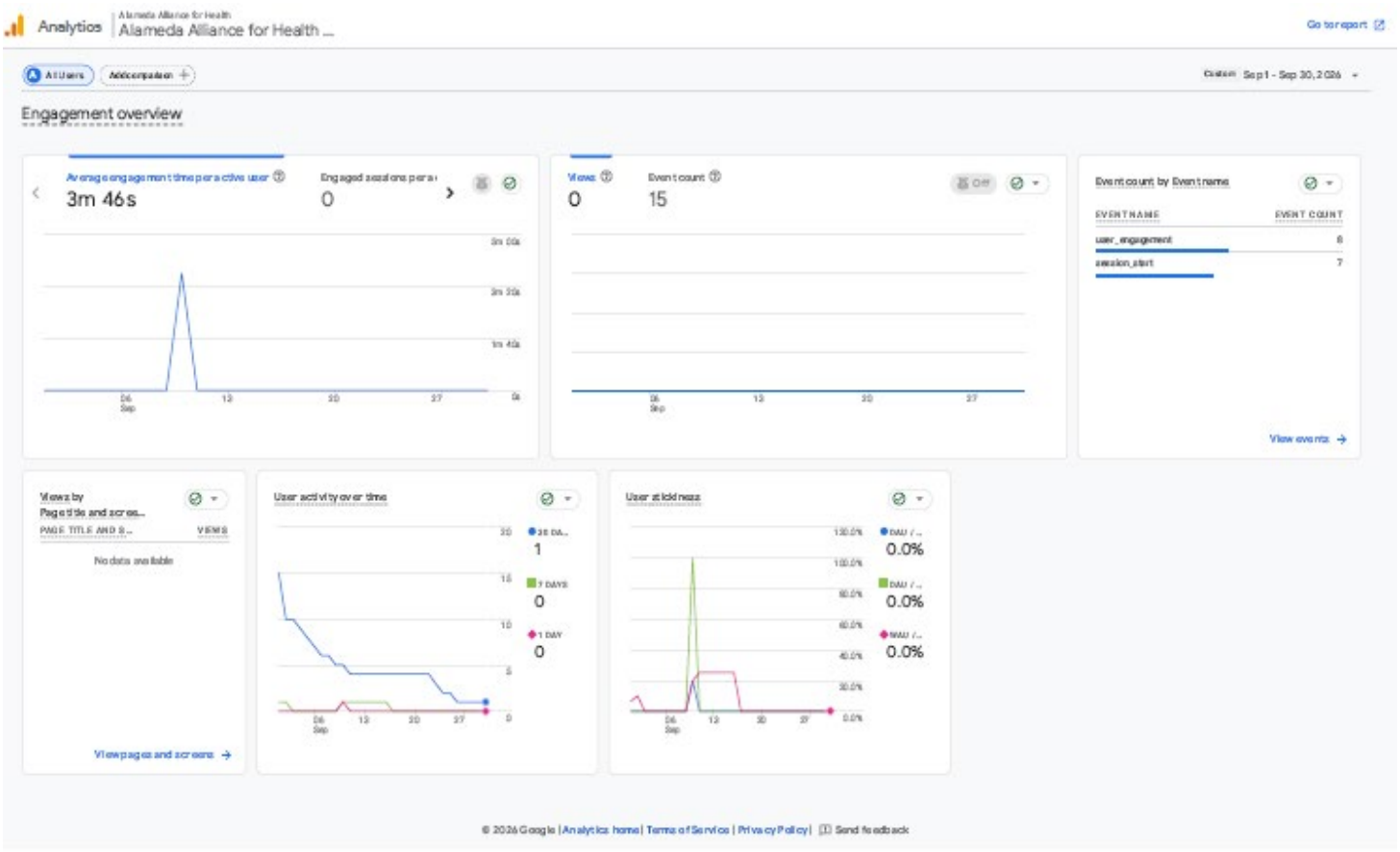
The Alliance Communications and Outreach (C&O) Department created the social media and website activity (SM&WA) Report to provide a high-level overview of stakeholder engagement through various digital media platforms. Between **September 1, 2026**, and **September 30, 2026**:

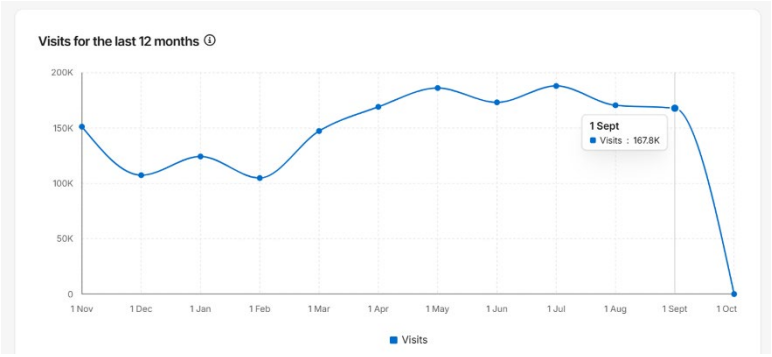
1. Alliance Website:
    - Received **167,800**unique visits
    - Served more than 729,000 page visits
    - The top 7 website page visits were:

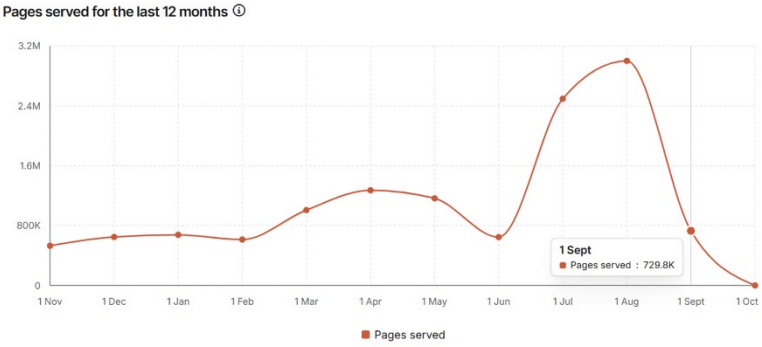
        i. Homepage
        ii. Careers
        iii. Find a Doctor
        iv. Group Care
        v. Benefits and Covered Services
        vi. Medi-Cal Benefits and Covered Services Providers
        vii. Provider Manual

2. Facebook Page:
    - Increased followers from 708 to **709**
    - Did not receive any reviews in **September 2026**
3. Glassdoor Page:
    - Maintained **3.1** out of a **5-star** overall rating
    - Did not receive any reviews in **September 2026**
4. Google Page:
    - **1,435** website clicks were made from the business profile
    - **1,471** calls were made from the business profile
    - Did not receive any reviews in **September 2026**
5. Instagram Page:
    - Increased in followers from **777**to **814**
6. LinkedIn Page:
    - Increased followers from **7.8k to 7.9k**
    - Received **31** page clicks
7. X (previously Twitter) Page:
    - Maintained followers at **349**
8. Yelp Page:
    - Page visits **49**
    - Appeared in Yelp searches **102** times
    - Did not receive any reviews in **September 2026**

ALLIANCE WEBSITE OVERVIEW:

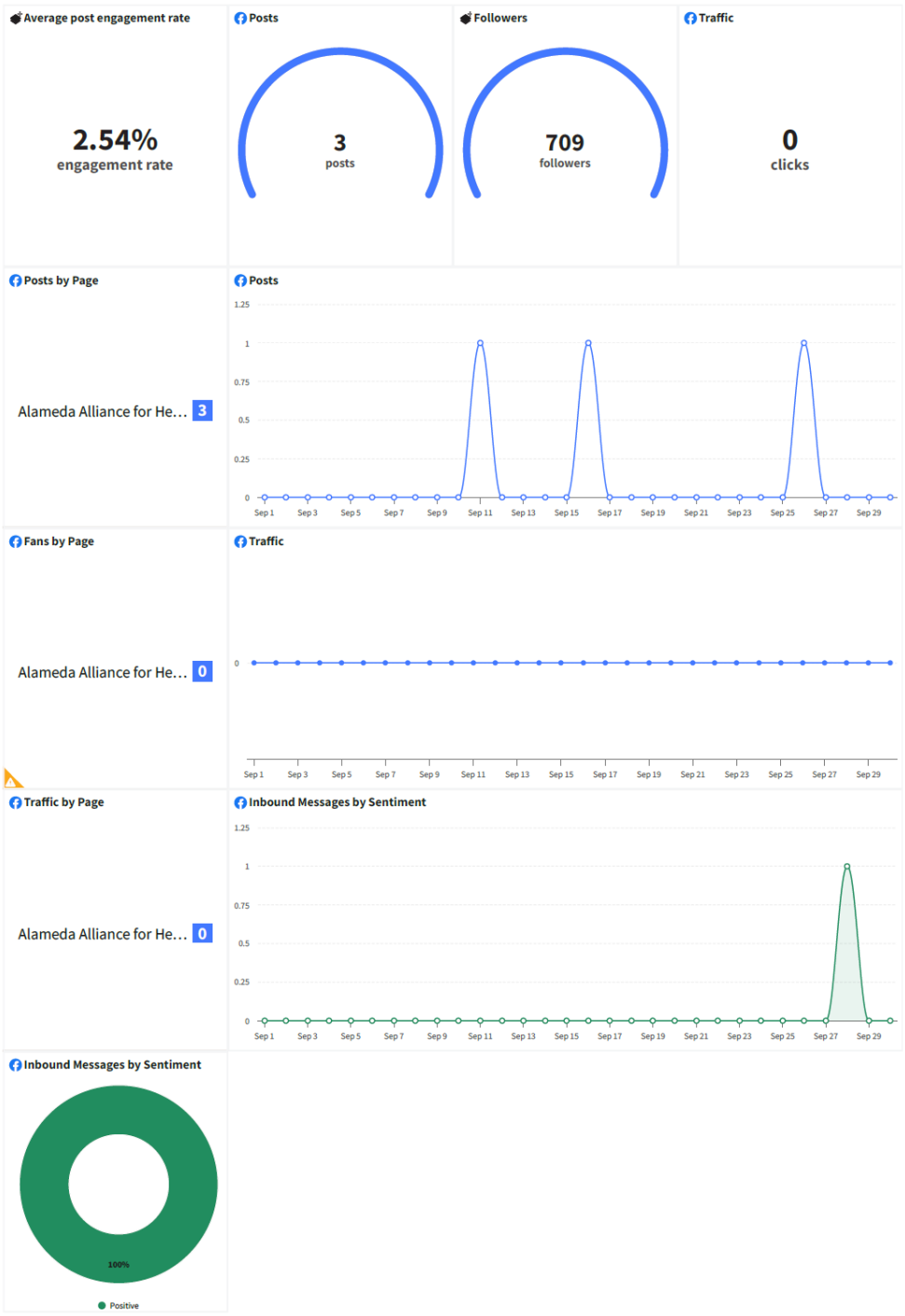






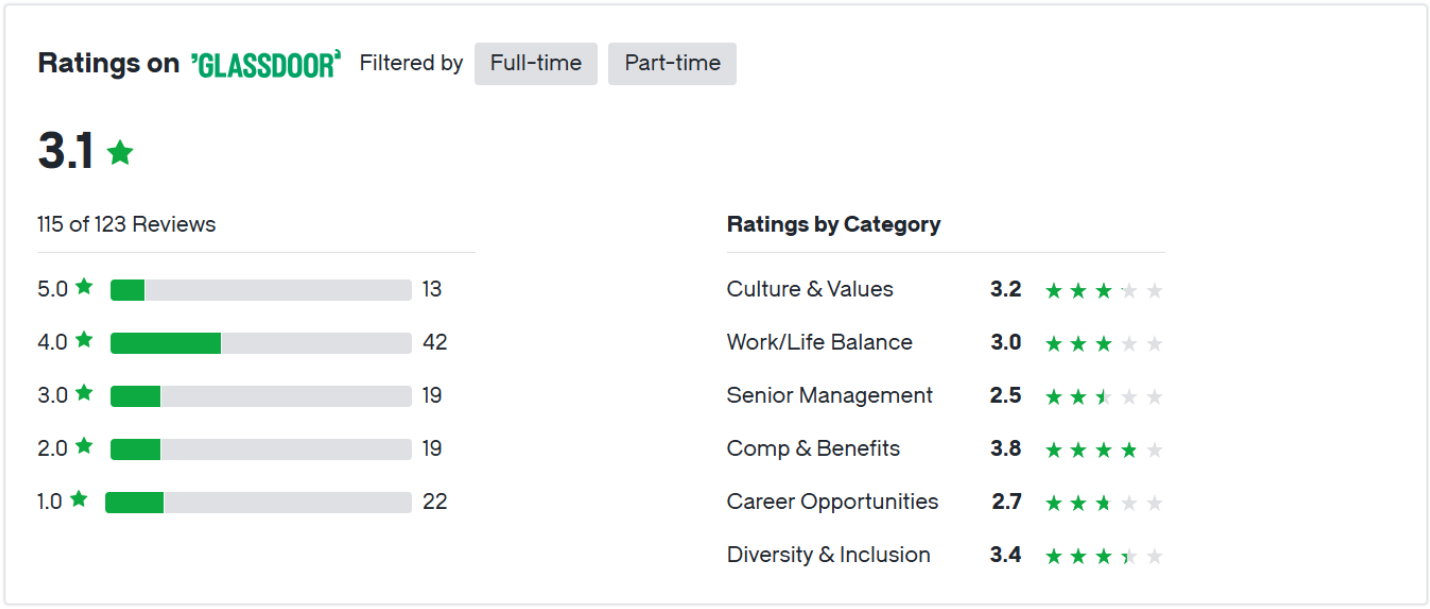
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2026-2027\Q1\3. September 2026

FACEBOOK OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2026-2027\Q1\3.September 2026

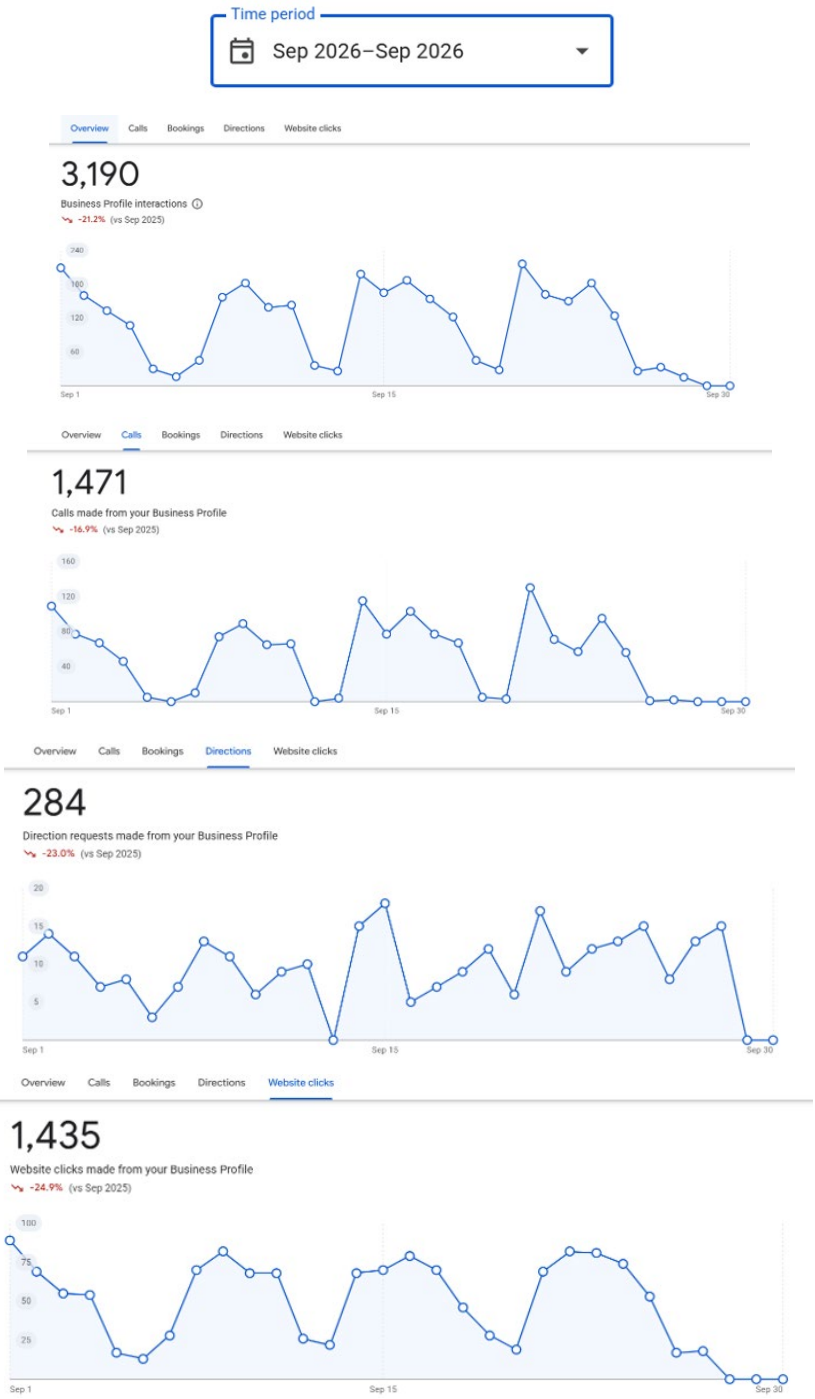
GLASSDOOR OVERVIEW:





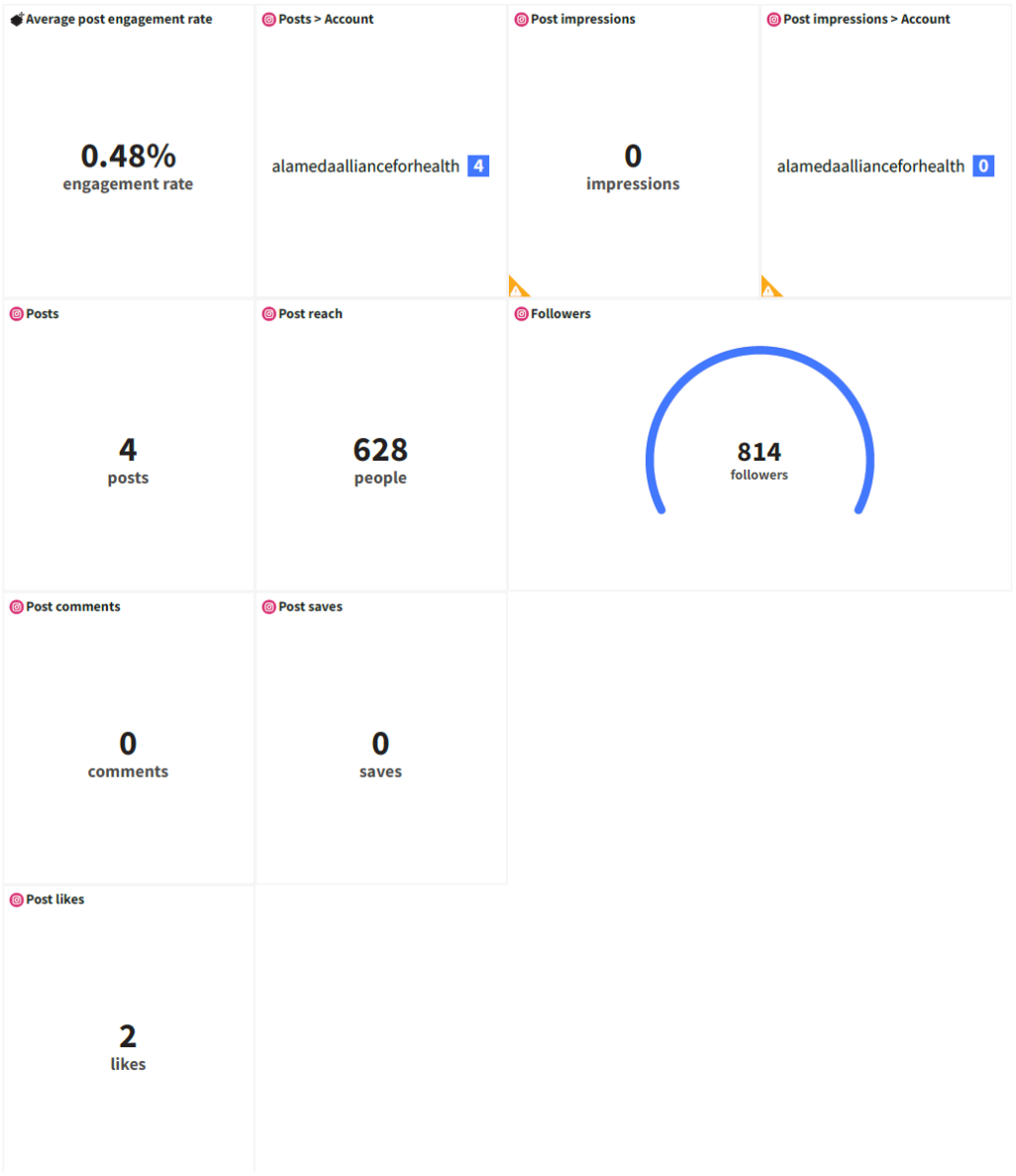
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2026-2027\Q1\3. September 2026

GOOGLE OVERVIEW:



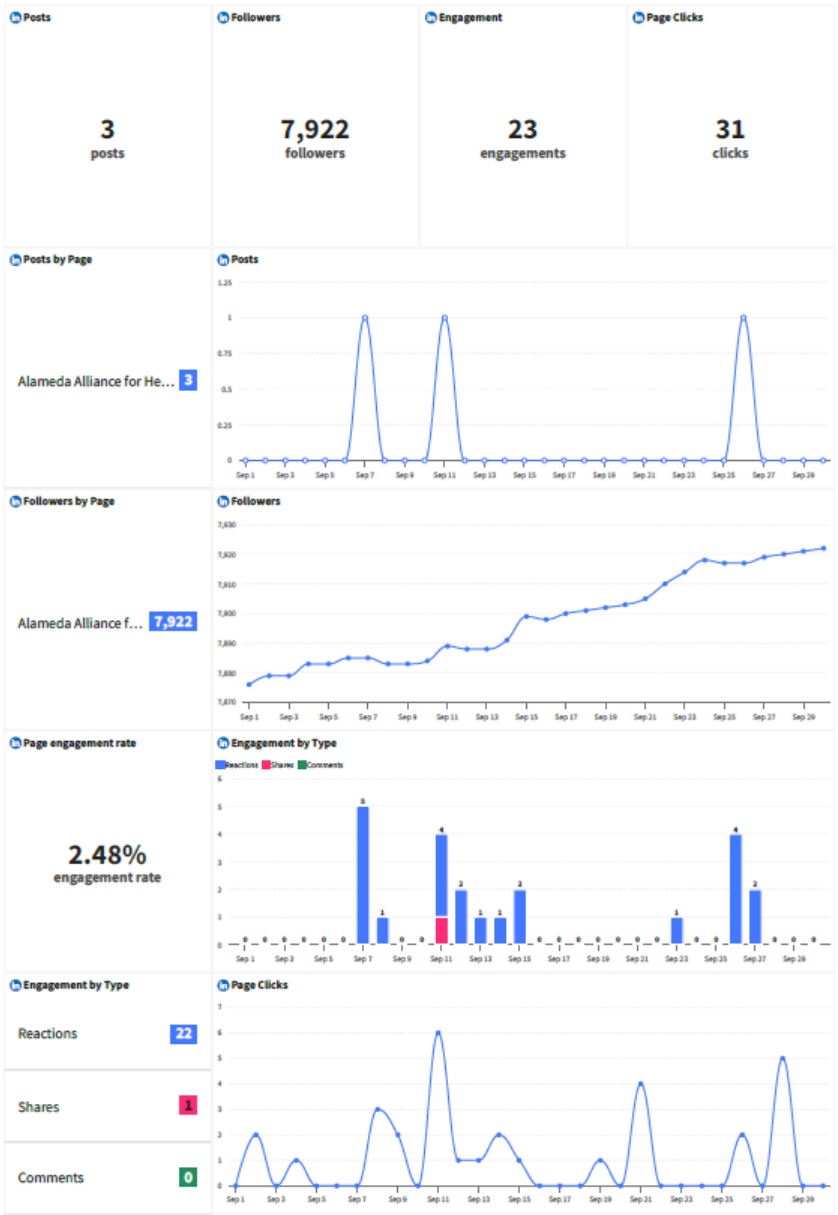
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2026-2027\Q1\3. September 2026

INSTAGRAM OVERVIEW:



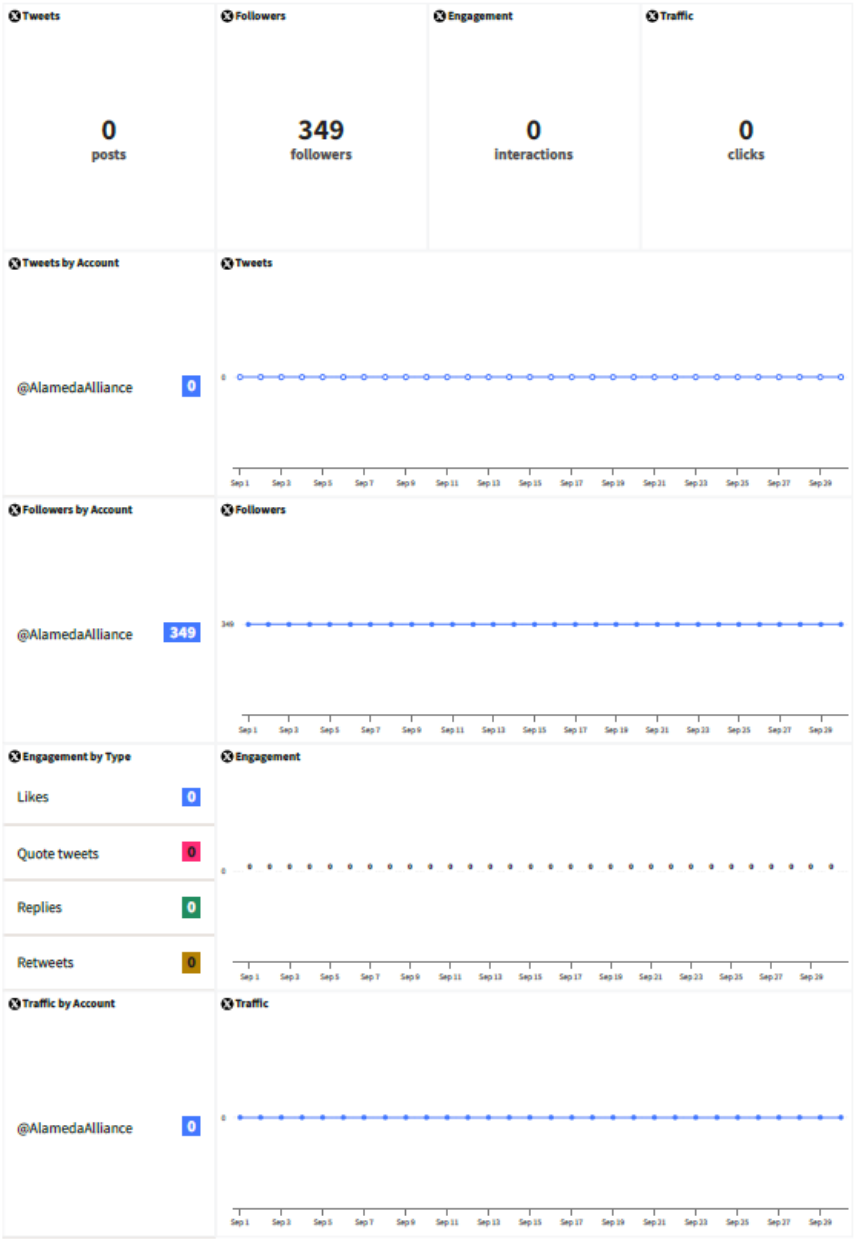
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2026-2027\Q1\3. September 2026

LINKEDIN OVERVIEW:



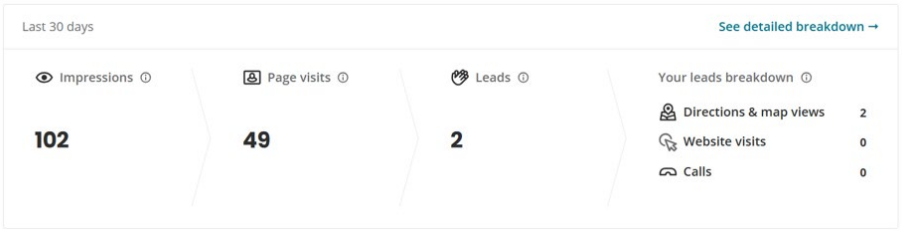
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2026-2027\Q1\3. September 2026

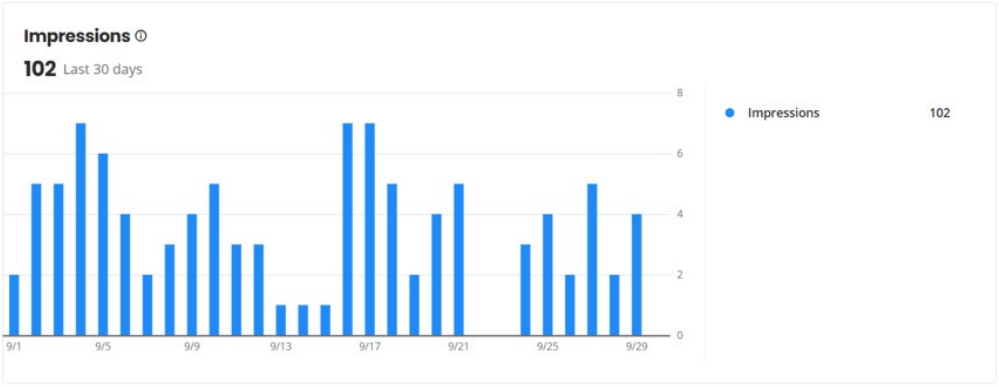
X (previously TWITTER) OVERVIEW:

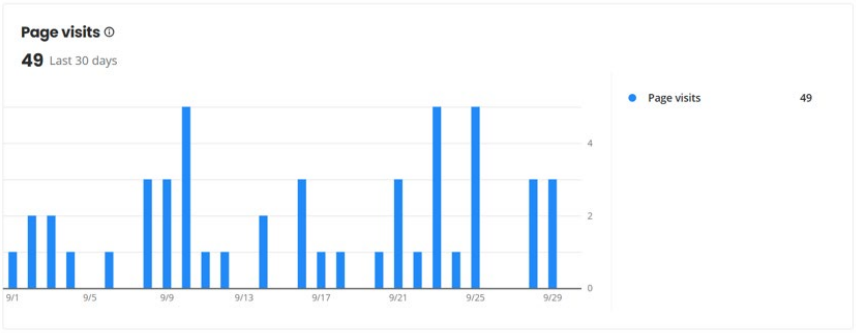


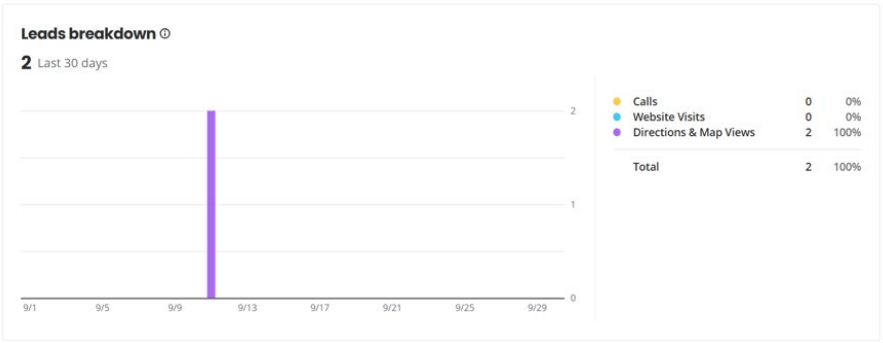
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YELP OVERVIEW









All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2026-2027\Q1\3. September 2026



Compliance

Stephen A. Smythe

COMPLIANCE DIVISION REPORT

BOARD MEETING DATE

October 9th, 2026

KEY MATTERS FOR BOARD ATTENTION

1

2025 Department of Managed Health Care (DMHC) Routine Full Medical Survey (Page 1)

- Deficiency #9: Ninety percent of impacted authorizations have been entered into HEALTHsuite to prompt Claims review.

BOARD IMPACT / ACTION: Information only

2

Medi-Cal Fee for Service Unsatisfactory Immigration Status Member Transition (Page 3)

- Compliance is leading cross-functional readiness project; transition activities include operational workstreams, data-sharing deliverables, and coordination with provider, county, and community partners.
- Member and provider communications and outreach are underway.

BOARD IMPACT / ACTION: Information only

REPORT DETAILS

PREPARED BY	Stephen A. Smythe, Interim Chief Compliance & Privacy Officer
SUBJECT	Compliance Division Report
STATUS	For Board Review

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

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

Date: **October 9th, 2026**

Subject: **Compliance Division Report**

Oversight Agency Audit Updates

- 2025 Department of Managed Health Care (DMHC) Routine Full Medical Survey
    - Efforts remain underway with stakeholders to address the twelve (12) open deficiencies identified in the Final Report. The deficiency related to the concurrent review process requires ongoing prior authorization reviews and claims re-adjudication. Ninety (90) percent of Utilization Management (UM) cases have been reviewed and entered into HEALTHsuite to prompt Claims review. Claims remediation activities are in progress, which includes the review and adjustment of affected claims. UM review and updates also continue in HEALTHsuite, The Plan is also working with a delegate that is responsible for reviewing a small number of impacted cases as they are delegated for UM and Claims. Courtesy notifications continue to be issued to affected providers.
- 2026 Department of Health Care Services (DHCS) Routine Audit
    - The Department conducted its exit conference on August 25th, 2026, and issued the Preliminary Report on August 19th, 2026, which identified ten (10) preliminary findings: two (2) related to Utilization Management, two (2) related to Enhanced Care Management, and six (6) related to Grievances and Appeals. The Alliance is contesting one (1) Utilization Management (UM) finding and one (1) Grievances and Appeals (G&A) finding identified in the Preliminary Report. The Alliance submitted its response to the Preliminary Report on September 10th, 2026, within the required timeframe.
- 2026 Health Services Advisory Group (HSAG) Network Adequacy Validation (NAV) Audit
    - Review is ongoing. To date, no concerns have been identified by HSAG.
- 2026 Health Services Advisory Group (HSAG) Encounter Data Validation (EDV) Audit

- No additional follow-up requests have been received. HSAG's review is ongoing.

- 2026 Health Equity Quality Performance CAP MY 2024
    - On July 1st, 2026, the Plan received DMHC's notification of deficiencies identified in the Measurement Year (MY) 2024 Health Equity and Quality Performance Review. Of the twenty (20) benchmarks evaluated, twelve (12) were found deficient, including repeat deficiencies in Breast Cancer Screening, Glycemic Status Assessment for Patients with Diabetes (two (2) measures), Controlling High Blood Pressure, Asthma Medication Ratio, Well-Child Visits (First 15 Months and 15-30 Months), Child and Adolescent Well-Care Visits, Plan All-Cause Readmissions, and the CAHPS Child Survey.
    - The Alliance submitted its Root Cause Analysis (RCA) and Corrective Action Plan (CAP) response timely on September 28th, 2026.

Compliance Program Activity

- D-SNP Compliance Activities
    - Compliance continues to support organizational readiness for CY2027 D-SNP, with focus on required member materials, enrollment processing, provider, and pharmacy directory accuracy, PBM transition activities, and delegation oversight. Key member-facing materials and the CY2027 website have progressed to implementation, while remaining enrollment, pharmacy directory, and accessibility dependencies continue to be tracked ahead of Annual Enrollment Period (AEP) which runs October 15th through December 7th each year.

- Compliance Support of Pharmacy Benefit Manager Transition
    - Compliance continues to support implementation readiness, stakeholder coordination, and ongoing communications with DMHC, DHCS, and CMS. The regulatory activities associated with the transition from PerformRx to MedImpact as its PBM effective January 1st, 2027, continues to advance. On June 25th , 2026, As part of its Material Modification filing, the Alliance submitted its Letter of Agreement to the Department of Managed Health Care (Department). As of October 1st, 2026, the Alliance was awaiting the fully executed MedImpact Administrative Services Agreement (ASA), as

contract negotiations between MedImpact and the Alliance remain ongoing. The Department's most recent comment table was received on September 14 and the Alliance's formal response to the Department which is expected to include the final executed ASA is due on October 13th, 2026. Overall, the transition appears to be on track for DMHC approval by December 31st, 2026.

- Unsatisfactory Immigration Status (UIS) Population Transition to Fee-for-Service (FFS)
    - Compliance is leading the Alliance's cross-functional implementation of the DHCS Policy Guide for the January 1st, 2027, UIS transition to Fee-for-Service Medi-Cal. Activities include translating DHCS requirements into operational workstreams, coordinating member and provider communications, supporting provider outreach, tracking required data-sharing deliverables, and aligning readiness activities across impacted departments, provider partners, county organizations, and community stakeholders. Compliance is also monitoring the timing and content of DHCS outreach because affected members may begin receiving text messages from DHCS as early as October 1st, 2026.
- 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 eleven (11) newly enacted legislation applicable to the Alliance. The bills span several areas, including but not limited to health benefits and coverage requirements, pharmacy and prescription drug, prior authorization, and provider credentialing and contracting timelines. A DMHC review remains ongoing. The Alliance received a comment letter on August 20th; the Plan submitted its responses to the DMHC by September 19th due date. Compliance is also monitoring pending guidance from the Department with remaining activities focused on resolving outstanding items and closing the regulatory filing. Compliance is working toward closure of the filing by the mid to late November.
    - DMHC published APL 25-021 on December 30th, 2025. The APL provides guidance and outlines the Senate Bill (SB) 729 - Treatment for Infertility and

Fertility Services compliance requirements. Although SB 729 is only applicable to Group Care, implementation of these previously non covered benefits is operationally complex, requiring the Alliance to develop rates and to contract new provider types such as cryo-preservation vendors. The Alliance continues enterprise-wide implementation activities in preparation for the January 1st, 2027- effective date. Plans are still awaiting a revised APL and FAQ document from DMHC.

Privacy Office (The Privacy Office): Operational Updates

- Privacy & IT Security Collaboration Forum
    - On September 18th, 2026, the Privacy Office hosted the inaugural Privacy & IT Security Collaboration Forum, a full-day, in-person convening at Alameda Alliance for Health designed to strengthen statewide alignment on privacy, compliance, and information security practices across California's Medi-Cal managed care community. The Forum brought together privacy, compliance, legal, and IT security leaders from eleven California health plans, with forty attendees signing in across the day, including representation from Central California Alliance for Health, L.A. Care Health Plan, Inland Empire Health Plan, Health Plan of San Joaquin, Santa Clara Family Health Plan, Health Plan of San Mateo, Health Net Community Solutions, Contra Costa Health Plan, and San Francisco Health Plan.
    - The seven-session agenda addressed the most pressing regulatory and operational issues facing California health plans today, including:
        - Artificial intelligence and emerging privacy risk
        - Business Associate Agreement (BAA) challenges, Letter of Agreement (LOA) assessments, offshoring oversight, NIST/FIPS security requirements, and privacy incident management
        - Live privacy incident case study walkthroughs led by outside legal and compliance experts.
        - Data sharing and interoperability under AB 133 and the California Data Exchange Framework, including D-SNP-specific considerations.
        - ASCMI consent management and behavioral health privacy under 42 CFR Part 2

- Following the event, the Privacy Office distributed the full session deck and a de-identified survey summary to all participating organizations and established a shared virtual resource binder, hosted in partnership with Local Health Plans of California (LHPC), where participating plans can contribute and access shared privacy tools, policies, and risk assessments. Based on the strength of participation and feedback, the Privacy Office is evaluating options for an annual or recurring version of the Forum, including hybrid in-person/virtual formats, to sustain the collaboration momentum generated by this inaugural event.

- Q3 2026 Annual Alameda Alliance for Health Compliance Training.
    - On August 3rd, 2026, the Alliance launched its annual compliance and security awareness training program for workforce members. The program supports the Alliance's commitment to protecting member information, promoting a culture of integrity and accountability, and ensuring workforce members are equipped to identify, prevent, and respond to compliance, privacy, and security risks. The 2026 training curriculum includes Cultural Sensitivity Training; Health Insurance Portability and Accountability Act (HIPAA) Training, including review and attestation of the Code of Conduct; Medicare Fraud, Waste & Abuse (FWA) Training; and Security Awareness courses covering cybersecurity awareness, common threats, phishing, artificial intelligence, data privacy, core security principles, and security incident reporting.
        - The Cultural Sensitivity Training transitioned from Power Point and SurveyMonkey in 2025 to Percipio in 2026 through the efforts of the Cultural & Linguistics Services and Human Resources teams.
        - Compliance training is delivered through the EverFi platform.
        - Security Awareness training is delivered through the KnowBe4 platform.
    - Workforce members were provided with a 90-day period to complete assigned training. The 2026 training period began on August 3rd, 2026, and runs through November 6th, 2026.
    - Workforce members who completed all required courses after July 1st, 2026, are not required to retake those courses during the annual training period.

Staff who completed all required courses after July 1st, 2026, are not required to retake those courses during the annual training period.

- As of this report, 406 of the 644 workforce members assigned the compliance training have completed their assignments for a 63% completion rate, and 399 workforce members have completed the IT Security Awareness training for a 62% completion rate.
- This annual training program remains a key component of the Alliance's compliance program and supports ongoing workforce education, regulatory compliance, and the protection of member information.

- Q3 2026 Board of Governors Annual Training Program.
  - On August 3rd, 2026, the Alliance launched the 2026 Board of Governors (BOG) Annual Training Program. The annual training program supports effective governance, regulatory compliance, protection of member information, and Board oversight of the health plan's operations.
  - The 2026 BOG training curriculum includes:
    - HIPAA Privacy and Security Training, addressing the appropriate use, disclosure, and protection of Protected Health Information (PHI) and other confidential information;
    - Compliance Program and Code of Conduct Training, including standards of conduct, reporting obligations, regulatory requirements, and Board oversight responsibilities;
    - Fraud, Waste, and Abuse (FWA) Training, addressing federal and state requirements related to the prevention, detection, and reporting of fraud, waste, and abuse in government-sponsored health care programs; and
    - Model of Care (MOC) Training and Attestation, addressing the Alliance's coordinated, member-centered care model, care coordination activities, interdisciplinary collaboration, individualized care planning, and Board oversight responsibilities for member outcomes and services.
  - To provide flexibility and promote timely completion, Board members were offered the option of completing training through self-paced online modules or participating in live instructor-led training sessions. Three live training

opportunities were initially offered on August 24th, August 28th, and August 31st, 2026. To support continued completion of outstanding training requirements, the Alliance offered an additional live session on September 21st, 2026, which has since taken place, with two further sessions scheduled for October 2nd and October 26th, 2026.

- As of the most recent reporting period, thirteen (13) of eighteen (18) Board of Governors members have completed the required annual training requirements, representing a 72% completion rate. The Alliance continues to provide multiple training options and conduct outreach to support completion of outstanding training requirements. Completion status and supporting documentation continue to be monitored to ensure compliance with applicable regulatory and contractual training obligations.

- Q3 2026 Privacy Policy and Procedure Updates
  - CMP-222 – Legal Representative Documentation: Intake, Verification, and Determination
    - CMP-222 is a new policy that establishes requirements for verifying an individual's legal authority to act on behalf of a member. It covers in-state Powers of Attorney, guardianships, conservatorships, and estate representative documents, as well as out-of-state, tribal court, and foreign legal instruments. The policy supports compliance with HIPAA, CMIA, Medicare, and Medi-Cal, while protecting member rights and confidentiality.
  - CMP-215 – Offshore Arrangements
    - CMP-215 was substantively revised to establish requirements for evaluating, approving, and overseeing offshore arrangements involving access to Protected Health Information (PHI) by Vendors, Delegates, and Subcontractors. The policy covers risk assessment, contractual controls, audit and corrective action requirements, minimum necessary access, secure system access, multifactor authentication, role-based access controls, workforce screening, and incident reporting. It prohibits the storage, downloading, or retention of PHI outside the United States and supports compliance with HIPAA, HITECH, and applicable federal and state requirements.

- CMP-200 – Privacy Officer
    - CMP-200 establishes the authority, responsibilities, and oversight functions of the Chief Privacy Officer (CPO), including development, implementation, and monitoring of privacy policies and practices to protect PHI and PII. The policy covers privacy governance, workforce training, privacy risk management, member privacy rights, incident response, and regulatory reporting, supporting compliance with HIPAA, CMIA, DHCS, DMHC, and applicable accreditation standards.

Alameda Alliance Special Investigations Unit: Operational Updates

- Fraud, Waste, and Abuse Program Overview and Performance
    - In September 2026, the Special Investigations Unit (SIU) continued its oversight of program integrity activities through evaluation of referrals, management of active investigations, and coordination with operational business areas to identify, assess, and mitigate fraud, waste, and abuse (FWA) risks impacting the Alliance. The SIU maintained its focus on timely case progression, risk-based prioritization, and support of organizational compliance objectives.
    - During the reporting period, the SIU received twenty-seven (27) referrals for review. Following initial assessment, none of the referrals received during the reporting period met criteria for escalation to a formal FWA investigation. The twenty-seven (27) referrals were reviewed, documents, and incorporated into ongoing monitoring and trending activities. Review results did not identify indicators warranting further investigative action at this point.
    - The SIU completed reviews and closed one (1) investigation during September. The case was determined to have no substantiated FWA concerns and so was formally closed following review, allowing investigative resources to remain focused on matters presenting the highest potential financial, operational, or regulatory impact.
    - Ongoing efforts during September also included continued refinement of investigative case management practices and tracking methodologies. Enhancements to case categorization and documentation were implemented to improve visibility into investigative activity, support workload management, strengthen tracking of claims-review efforts, and provide

clearer monitoring of recovery and recoupment activities associated with completed investigations.

- The SIU advanced development of a “Verification of Services” (VOS) initiative intended to strengthen investigative validation activities and support oversight of billing concerns when warranted. During the reporting period, draft member communication templates and supporting processes were developed and reviewed in collaboration with SIU leadership as part of broader implementation planning efforts.
- The SIU also collaborated with internal partners to evaluate opportunities for process standardization related to provider billing concerns, payment integrity activities, recovery efforts, and potential payment-hold considerations in circumstances involving suspected FWA. These discussions support the organization’s ongoing commitment to consistent, risk-based responses and alignment with legal, operational, and financial requirements.
- Consistent with the Alliance’s program integrity strategy, the SIU continued working closely with business partners to identify opportunities for corrective action, overpayment recovery, and prevention of future losses. Efforts remain focused on ensuring investigative resources are directed toward matters presenting the greatest potential organizational risk while supporting responsible stewardship of healthcare resources.

Enterprise Risk Management (ERM) and Operational Oversight Updates

- The Enterprise Risk Management (ERM) team continues to partner with leaders across the organization to assess and calibrate risks using the Alliance's risk taxonomy, risk assessment methodology, and COSO-based framework.
- Internal Audit continues to execute the approved risk-based audit plan and advance the transition to risk-focused approach.
  - Three audits are in progress: Policies and Procedures, DSNP Claims, and the Medi-Cal Quality Program Validation.
- Q3 2026 ERM-IA Office Hours: ERM-IA concluded its Q3 2026 Office Hours series, reaching approximately 270 participants. Sessions focused on common themes identified through audit and oversight activities, including strengthening policies and procedures through clear evidence requirements, clarifying ownership and

accountability using RACI principles, improving the identification and evaluation of internal controls, and building a shared understanding of the Alliance's risk methodology and risk-ranking process. RACI is a responsibility-assignment framework that defines who is Responsible for completing the work, Accountable for the outcome, Consulted for input, and Informed of decisions or progress. When incorporated into policies and procedures, RACI helps clarify roles, reduce ambiguity, strengthen accountability, and ensure stakeholders understand their responsibilities throughout a process. The sessions provided practical tools and best practices to help leaders and staff improve compliance, accountability, consistency, and risk management in day-to-day operations.

Compliance

Supporting Documents

COMPLIANCE DASHBOARD SUMMARY

	Resource	Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	TOTAL	% Completed
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	24	20	0	10	175	
		Total Self-Identified Issues	12	0	0	2	0	2	6	3	5	30	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**26**	**3**	**15**	**205**	
		Total In Progress	0	0	0	0	0	0	0	0	15	15	
		Total Completed	50	28	7	35	15	26	26	3	0	190	**93%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**26**	**3**	**15**	**205**	
	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		12		12	
		Total Completed			8	6	8	3		10		35	**74%**
		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			0		0	
		Total Completed		5			4			2		11	**100%**
		Total Findings	**NA**	**5**	**NA**	**NA**	**4**	**NA**	**NA**	**2**	**NA**	**11**	
STATE AUDIT FINDINGS		In Progress	0	0	0	0	0	0	0	12	10	22	
		Completed	38	33	12	39	27	27	20	6	0	202	**90%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**27**	**20**	**18**	**10**	**224**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	0	0	5	5	
		Completed	12	0	3	2	0	2	6	9	0	34	**87%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**6**	**9**	**5**	**39**	
DMHC HEQ M24 CAP		In Progress								0	12	12	
		Completed								11	0	11	**48%**
		Total Findings								**11**	**12**	**23**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**29**	**26**	**38**	**27**	**286**	**86%**



Health Care Services

Donna Carey, MD

ALAMEDA ALLIANCE FOR HEALTH	BOARD OF GOVERNORS

HEALTH CARE SERVICES DIVISION REPORT

BOARD MEETING DATE
October 9th, 2026

KEY MATTERS FOR BOARD ATTENTION

1 High Medical Loss Ratio	**BOARD IMPACT / ACTION: Interventions in Pharmacy, UM, CM, ECM**
2 IT Automations in UM and CM	**BOARD IMPACT / ACTION: Improved efficiencies**

REPORT DETAILS

PREPARED BY	**Donna White Carey, MD,MS**
SUBJECT	**Chief Medical Officer**
STATUS	**For Board Review**

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

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

Date: **October 9th, 2026**

Subject: **Health Care Services (HCS) Report**

Credentialing Committee

- At the Peer Review and Credentialing (PRCC) meeting held on September 15th, 2026, there were one hundred and sixty-five (165) initial network providers approved.
  - Ten (10) primary care provider
  - Twenty-one (21) specialists
  - Seven (7) ancillary providers
  - Twelve (12) mid-level providers
  - One hundred and fifteen (115) behavioral health providers

- 80 providers were re-credentialed at this meeting
  - Three (3) primary care providers
  - Seven (7) specialists
  - Three (3) ancillary providers
  - Two (2) mid-level providers
  - Sixty-five (65) behavioral health providers

- 446 facilities are currently credentialed.

Utilization Management: Outpatient

- OP processed a total of 3,857 authorizations for the month of September. We also processed 479 CCS referrals, of which 88 cases were submitted to our regional CCS office for review (40 approved, 10 denied, 38 pending). CBAS 8 New CEDT, 10 Discharge, 3 ERS, 44 renewals.
- Overall OP Turnaround times exceeded the threshold of 95% for Medi Cal and IHSS however missed the benchmark for September 2026. This miss is attributed to 2 missed MD Decision TATs and 1 missed Notification TAT. The OP UM team, in collaboration with the MDs, continue to explore process improvements to streamline efficiency and reduce missed TATs.
- The top 5 categories remain unchanged TQ, Home Health, Radiology, Outpatient Rehab and DME. These 5 categories represent ~75% of this volume. The highest overall category for Denials is Out of Network Genetic testing.

- 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 stabilized as April was the first month that the 90-day Continuity of Care provisions were lifted for the original D-SNP members. There were 29 Outpatient D-SNP Authorizations created in September 2026 which is a decrease as compared to August 2026.

Total Outpatient Authorization Volumes						
	July 2026 Approvals	July 2026 Denials	August 2026 Approvals	August 2026 Denials	September 2026 Approvals	September 2026 Denials
Medi-Cal	3,401	526	3,501	452	3,223	463
IHSS	132	22	140	20	104	22
D-SNP	36	4	37	5	38	7
Overall	**3,569**	**550**	**3,673**	**447**	**3,365**	**492**

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

Outpatient Authorization Denial Rates			
Denial Rate Type	**July 2026**	**August 2026**	**September 2026**
Denial Rate Excluding Partial Denials	5.7%	5.1%	4.3%
Partial Denial Rate	0.4%	0.4%	0.4%
Overall Denial Rate	6.0%	5.5%	6.0%

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

Outpatient Turn Around Time Compliance *(benchmark: 95%)*			
Line of Business	**July 2026**	**August 2026**	**September 2026**
Overall	99.8%	99.2%	97.2%
Medi-Cal	99.5%	99.0%	99.0%
IHSS	100%	98.8%	99.2%
D-SNP	100%	100%	93.3%

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- Total inpatient auth volume (including all IP authorization types processed by department: Acute, LTACH, Skilled SNF, and OP auths related to discharge) increased from 3,466 in August, to 3,586 September.
- 50 D-SNP Authorizations were processed by the Inpatient Department in September, a slight decrease from 64 in August.
- Inpatient overall average LOS increased from 5.8 in June to 5.9 in July, decreasing to 5.0 in September . Admits per thousand increased from 49.9 in June, to 50.4 in July,

decreasing to 49.9 in August. Days per thousand followed a similar pattern, increasing from 289.7in in June, to 294.9 in July, followed by decrease to 251.2 in August.

- IP overall denial rate increased from1.8% in August to 2.3 % in September.
- IP Auth TAT 100% overall continues to surpass 95% benchmark across all lines of business in September 2026.
- 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, refer to Case Management including ECM and Upward Health to coordinate for best possible outcomes post discharge.
- Alameda Alliance IP UM RN onsite nurse pilot program completed its 8th month at Washington Hospital. Data comparing Jan-July 2025 –21.4%-to Jan-July of 2026 – 20.1% showing decrease in readmission rates for Washington Hospital by 1.3%. Average Length of stay, claims based data points to significant decrease in length of stay: 0.5 days; 5.6 in the first 2 quarters of 2025 vs 5.1 in the first two quarters of 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						
	July 2026 Approvals	July 2026 Denials	August 2026 Approvals	August 2026 Denials	September 2026 Approvals	September 2026 Denials
Medi-Cal	3,424	62	3,310	63	3453	49
IHSS	30	0	55	0	24	0
D-SNP	48	1	65	1	59	1
Overall	**3,502**	**63**	**3,430**	**64**	**3586**	**50**

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

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**June 2026**	**July 2026**	**August 2026**
Authorized LOS	5.8	5.9	5.0
Admits/1,000	49.9	50.4	49.9
Days/1,000	289.7	294.9	251.2

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

Inpatient Authorization Denial Rates			
Denial Rate Type	**July 2026**	**August 2026**	**September 2026**
Full Denials Rate	1.2%	0.5%	0.9%
Partial Denials	2.5%	1.3%	1.4%
All Types of Denials	3.7%	1.8%	2.3%

Source: #01292_AllAuthDenialsRate

Inpatient Turn Around Time Compliance *(benchmark: 95%)*			
Line of Business	**July 2026**	**August 2026**	**September 2026**
Overall	100%	99.9%	100%
Medi-Cal	100%	99.7%	100%
IHSS	100%	100%	100%
D-SNP	100%	100%	100%

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during September 2026 is pending.

Totals	July 2026	August 2026	September 2026
Medi-Cal	2,384	2,228	pending
D-SNP	2	2	pending

- Continued monitoring of average length of stay (ALOS) for inpatient stays for members in LTC settings; August data is pending.

  NOTE: there were no admissions for D-SNP members in LTC settings

Medi-Cal Totals	June 2026	July 2026	August 2026
Admissions	138	46	pending
Days	1549	191	pending
Readmissions	40	13	pending
Average Length of Stay	11.2	4.2	pending

Source: #14236_LTC_Dashboard

- Planning for the next LTC Provider Office Hours for SNF, Subacute, and ICF/DD facilities in November 2026 – this is a quarterly forum for providers to ask questions related to operational processes (including claims, authorizations, and appeals). We are refining facility contact lists to ensure the appropriate representatives at the facilities are attending and receiving the necessary information.
- LTC Team continues to meet 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. Re-evaluating workflows with inpatient SNF team to more proactively manage transitions from acute to skilled levels of care, and skilled to custodial levels of care.
- Social Workers continue visiting LTC facilities in person, as needed, 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. Team is revisiting referral criteria for Social Worker onsite visits to maximize impact on member outcomes – reviewing data related to readmissions and frequent IP/ER utilization to tailor interventions.
- 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	**July 2026**	**August 2026**	**September 2026**
Approvals	731	804	809
Partial Approvals	0	0	0
Denials	40	35	72
Total	**774**	**839**	**881**

Source: #02569_AuthTAT_Summary
****Numbers change month-over-month based on the void and copy process to adjust authorizations for bed holds***

Total D-SNP LTC Authorization Volume			
Authorization Status	**July 2026**	**August 2026**	**September 2026**
Approvals	2	0	1
Partial Approvals	0	0	0
Denials	1	0	0
Total	**3**	**0**	**1**

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	**July 2026**	**August 2026**	**September 2026**
Medi-Cal	99%	99%	99%
D-SNP	100%	N/A	100%

Source: #02569_AuthTAT_Summary

Behavioral Health

Behavioral Health Authorizations by Determination Status					
	26-May	26-June	26-July	26-Aug	26-Sept
Approvals	712	626	619	771	599
Partial Approval	0	0	0	0	0
Denials	7	7	7	9	8
Total	719	633	626	780	607

MH TAT						
Goal ≥95%	26-Apr	26-May	26-Jun	26-Jul	26-Aug	26-Sep
Determination TAT%	100%	98%	98%	98%	96%	99%
Notification TAT%	98%	98%	97%	99%	96%	99%

BHT/ABA TAT						
Goal ≥95%	26-Apr	26-May	26-Jun	26-Jul	26-Aug	26-Sept
Determination TAT%	100%	98%	98%	94%	99%	99%
Notification TAT%	100%	95%	98%	99%	99%	99%

TOTAL % TAT MET BY LOB						
Goal ≥95%	26-Apr	26-May	26-Jun	26-Jul	26-Aug	26-Sept
Medi-Cal	100%	97%	97%	97%	98%	98%
DSNP	NA	100%	NA	100%	50%	100%
Group Care	86%	88%	100%	100%	100%	N/A

BH Denial Rates						
	Goal ≤ 5%					
Year/Month	**26-Apr**	**26-May**	**26-Jun**	**26-Jul**	**26-Aug**	**26-Sept**
	1.50%*	<1%	<1%	1.10%	1.80%	1.30%

Corrected data from <1% to 1.5%

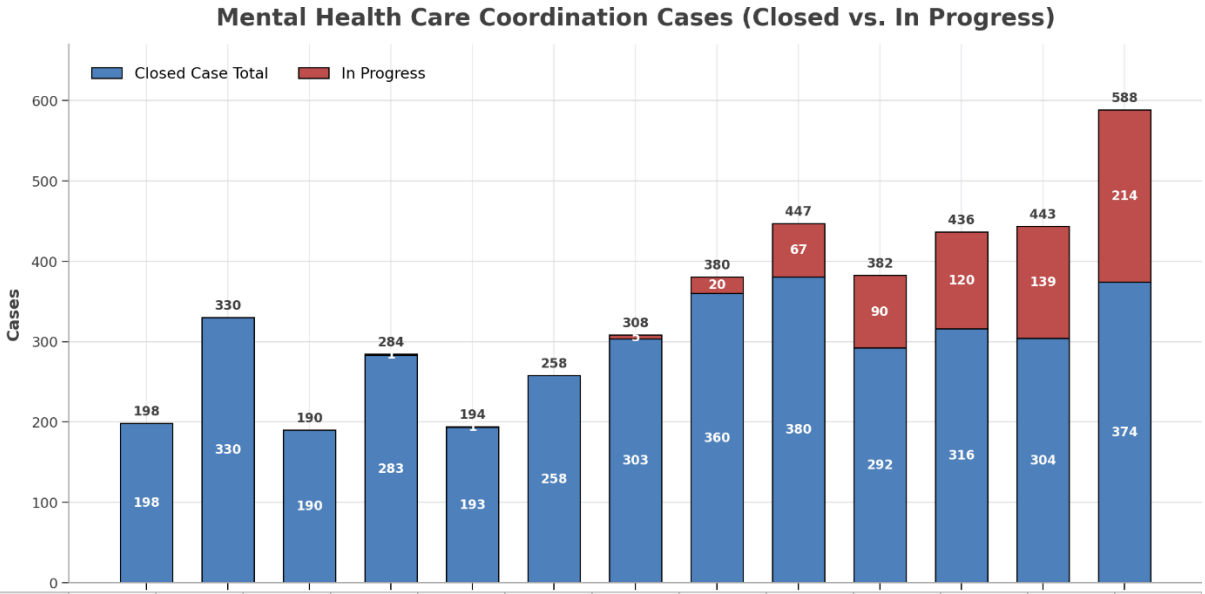
Mental Health Care Coordination

- 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-May	26-June	26-July	26-Aug	26- Sept
Youth Screenings	75	70	48	13	35
Adult Screenings	149	118	117	132	85
Incoming ACBH Referrals	91	164	154	216	187
Outgoing Referrals to ACBH	43	6	43	58	58
Transition of Care Tools to ACBH	1	2	1	1	4

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. The MH Care Coordination team continues to close a high number of cases per month.



Month	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Closed Case Total	198	330	190	283	193	258	303	360	380	292	316	304	374
In Progress	0	0	0	1	1	0	5	20	67	90	120	139	214
Total (provided)	241	295	187	262	223	269	305	383	346	382	436	443	588

Source: 14665_BH_Cases

Case numbers continue to climb this past quarter. Staff have increased productivity and closed more cases despite the elevated demand.

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.

Month	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Closed Case	238	301	205	210	265	211	199	264	290	287	258	232	256
In Progress	11	10	6	8	21	31	42	71	111	99	164	272	224
*** Monthly Case Total	249	311	211	218	286	242	241	335	401	386	422	504	480

Source: 14665_BH_Cases

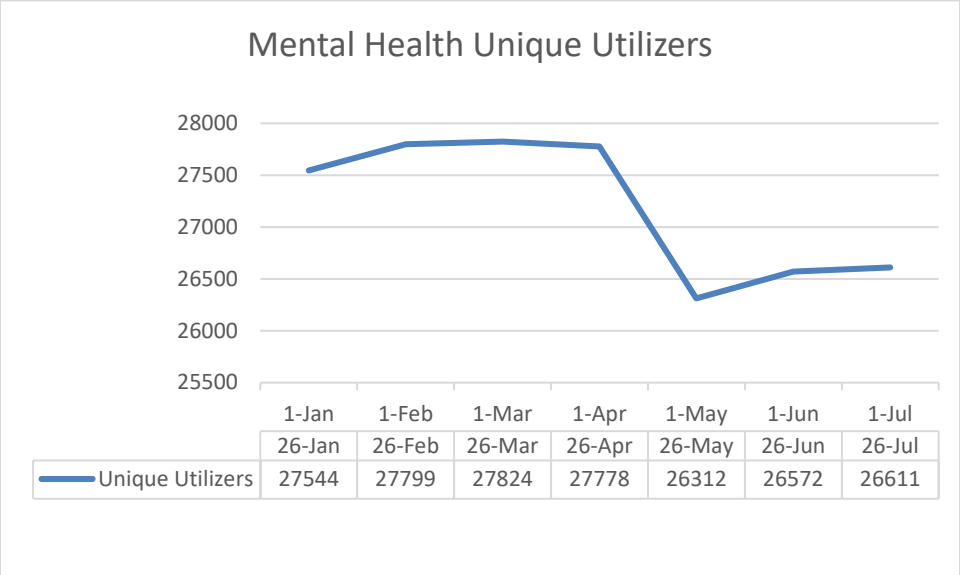
- Demand for BHT/ABA services continues to rise and subsequent care coordination cases. Closing cases is dependent upon an ABA provider accepting the child into

care. The challenges in placement are reflecting in the overall rise in care coordination cases.

Behavioral Health Unique Utilizers

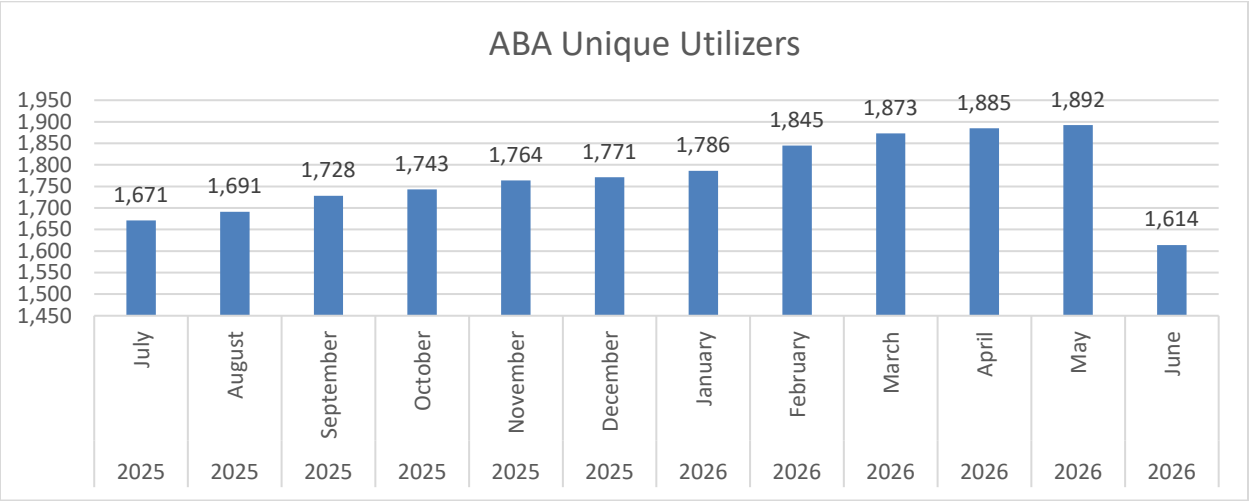
- Removing barriers to accessing BHT/ABA and MH services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.

Mental Health Unique Utilizers:



- Data is based on claims and reflects rolling 12 months with a 2-month claim lag.
- June shows a drop with a slight increase in July. This may be a claims lag beyond two months or be tied to changes in membership volume. Plan: Continue to monitor.
-

***BHT/ABA Unique* Utilizers:**



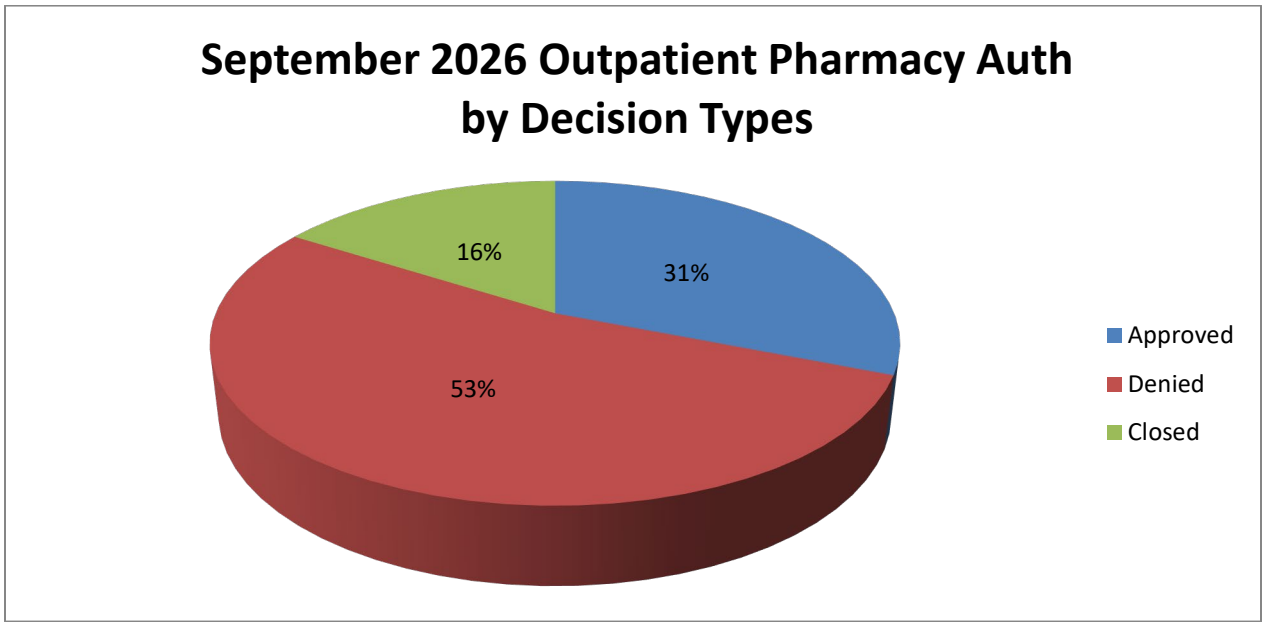
Source: PBI 14621 BHT Utilization Report

- June shows a drop from prior months. This may be a claims lag beyond two months or be tied to changes in membership volume. Plan: Continue to monitor.

Pharmacy

Group Care September 2026 Prior Authorization Request Summary

Decisions	Number of PAs Processed
Approved	57
Denied	96
Closed	30
Total	**183**



24 Hour TAT Compliance

	Number of PA Request	Percentage of PA Requests
Compliant	183	100%
Non-Compliant	0	0%
Total	**183**	**100%**

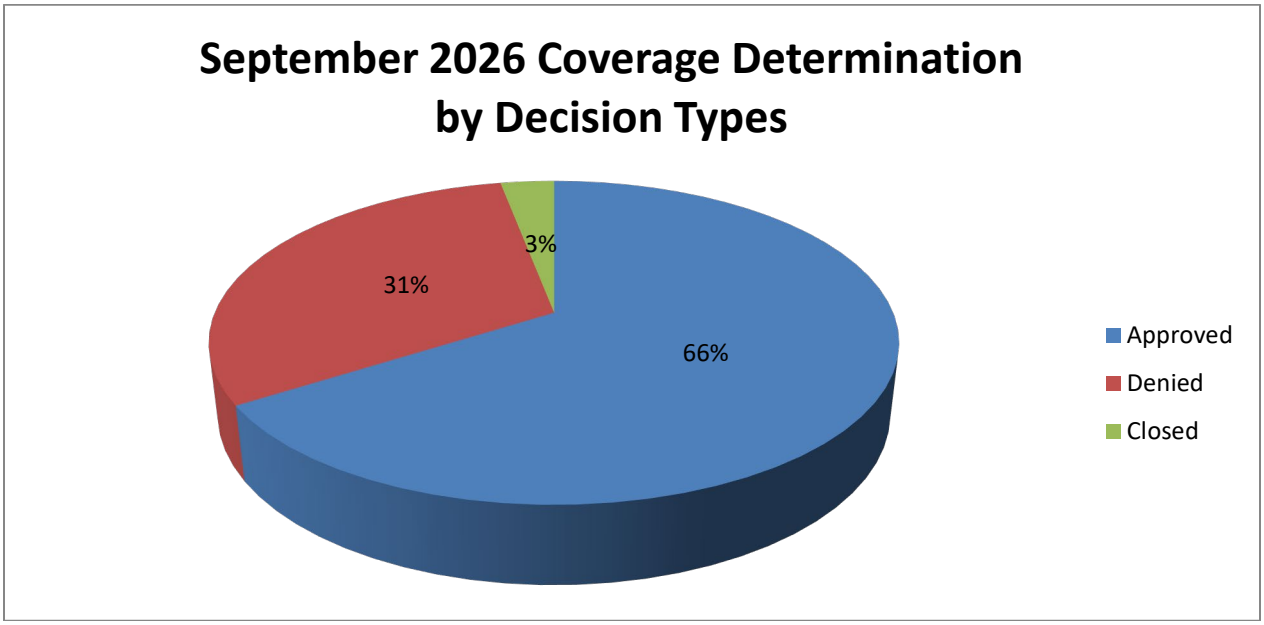
Top 10 Drugs by Number of Denials

Rank	**Drug Name**
1	WEGOVY Soln Auto-inj 0.25MG/0.5ML
2	ZEPBOUND Soln Auto-inj 2.5MG/0.5ML
3	LIDOCAINE Patch 5%
4	JARDIANCE Tablet 10MG
5	WEGOVY Soln Auto-inj 0.5MG/0.5ML
6	ZORYVE Cream 0.15%
7	ICOSAPENT ETHYL Capsule 1GM

8	WEGOVY Tablet 4MG
9	DOXYCYCLINE HYCLATE Capsule 100MG
10	TRANEXAMIC ACID Tablet 650MG

DSNP September 2026 Coverage Determination Summary

Decisions	Number of PAs Processed
Approved	19
Denied	9
Closed	1
Total	**29**



24/72 Hour TAT Compliance

	Number of Coverage Determinations	Percentage of Coverage Determinations
Compliant	29	100%
Non-Compliant	0	0%
Total	**29**	**100%**

Top Drugs by Number of Denials

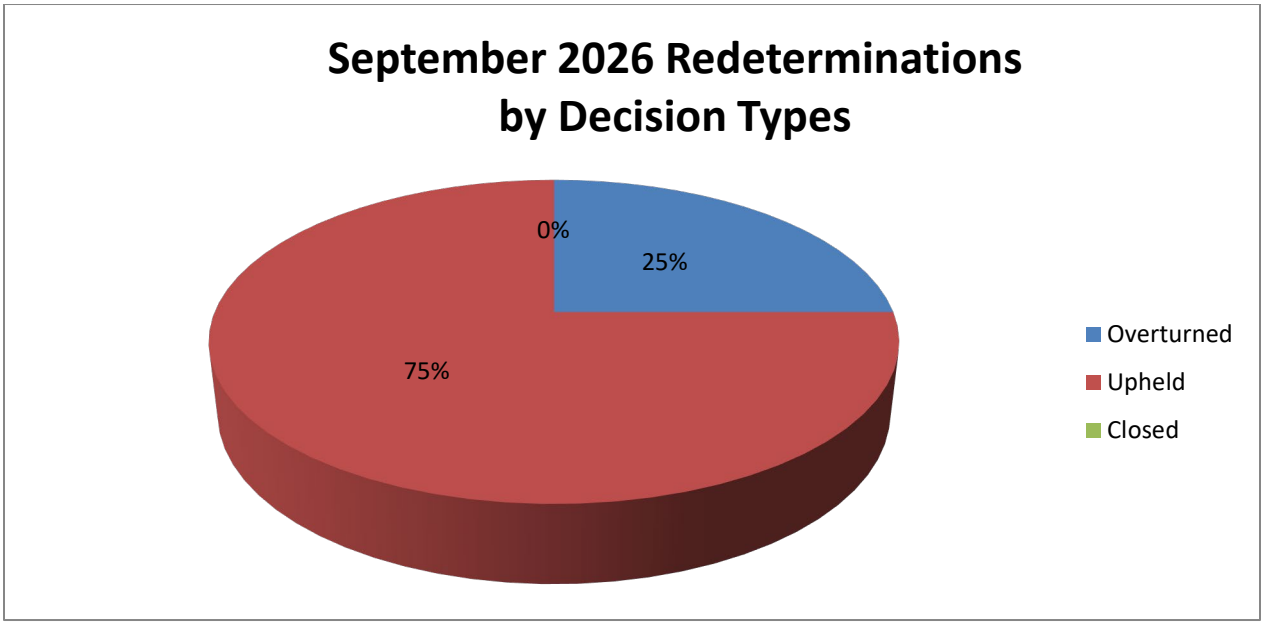
Rank	**Drug Name**
1	LIDOCAINE Patch 5%
2	WEGOVY Soln Auto-inj 0.25MG/0.5ML
3	ESTRADIOL Gel 0.25MG/0.25GM
4	ZTLIDO Patch 1.8%

5	BUPRENORPHINE Patch Weekly 5MCG/HR
6	OZEMPIC (2 MG/DOSE) Soln Pen-inj 8MG/3ML

DSNP September 2026 Redetermination (Appeal) Summary

Summary Table

Decisions	Number of Appeals Processed
Overturned	1
Upheld	3
Closed	0
Total	**4**



72/168 Hour TAT Compliance

	Number of Redeterminations	Percentage of Redeterminations
Compliant	4	100%
Non-Compliant	0	0%

Total	**4**	**100%**

Top 10 Drug Categories by Number of Upheld

Rank	Drug Name	Common Use	Common Denial Reason
1	LIDOCAINE Patch 5%		

The Pharmacy Transitional Care Services (TCS) program has screened 13 **Heart Failure** cases, 16 **Sepsis** cases, and received 1 **direct referral** for the month of August 2026.

Alameda Alliance for Health Pharmacy & Therapeutics (P&T) Committee Decisions

The P&T Committee reviewed the efficacy, safety, cost, and utilization profiles of the following therapeutic categories and drug monographs at the September 15,2026 meeting:

Therapeutic/Monograph Class Reviews	
• Chelating agents Class Review • Hepatitis B agents Class Review • Intranasal steroids Class Review	• Pancreatic Enzymes Class Review • Pneumococcal Vaccines Class Review • Respiratory Aids and Devices Class Review

The P&T Committee approved the following modifications to the formulary for the Alliance's Group Care programs.

Pharmacy Benefit Group Care & DSNP Policy & Procedure Updates	
• RX-017 Investigational Drug Review and Coverage Determination Policy	• RX-D-001 Part D Transition Process • RX-D-010 Medicare Part D Daily Claims Review • RX-D-021 Medicare Part D Best Available Evidence (BAE)

New Business (New Group Care and PAD Guidelines)	
Group Care • Hepcludex monograph and MRG criteria	**PAD** • Mucopolysaccharidosis II (Hunter Syndrome) Agents • Cartilaginous Repair Agents

Generic//Biosimilar Name & Strength/Dosage Form	Brand Name	Committee Actions
filgrastim-laha Injection Solution Prefilled Syringe 480 MCG/0.8ML	Filkri Injection Solution Prefilled Syringe 480 MCG/0.8ML	Add to Formulary with Prior Authorization (F-PA)
filgrastim-laha Injection Solution Prefilled Syringe 300 MCG/0.5ML	Filkri Injection Solution Prefilled Syringe 300 MCG/0.5ML	Add to F-PA
orforglipron-Weight Management Oral Tablet 0.8 MG	Foundayo Oral Tablet 0.8 MG	Add to Formulary with Prior Authorization (F-PA) Quantity Limit (QL) (30 tablets/30 days)
orforglipron-Weight Management Oral Tablet 2.5 MG	Foundayo Oral Tablet 2.5 MG	Add to F-PA-QL (30 tablets/30 days)
orforglipron-Weight Management Oral Tablet 5.5 MG	Foundayo Oral Tablet 5.5 MG	Add to F-PA-QL (30 tablets/30 days)
orforglipron-Weight Management Oral Tablet 9 MG	Foundayo Oral Tablet 9 MG	Add to F-PA-QL (30 tablets/30 days)
orforglipron-Weight Management Oral Tablet 14.5 MG	Foundayo Oral Tablet 14.5 MG	Add to F-PA-QL (30 tablets/30 days)
orforglipron-Weight Management Oral Tablet 17.2 MG	Foundayo Oral Tablet 17.2 MG	Add to F-PA-QL (30 tablets/30 days)
resmetirom Oral Tablet 60 MG	Rezdiffra Oral Tablet 60 MG	Add to F-PA-QL (30 tablets/30 days)
resmetirom Oral Tablet 80 MG	Rezdiffra Oral Tablet 80 MG	Add to F-PA-QL (30 tablets/30 days)
resmetirom Oral Tablet 100 MG	Rezdiffra Oral Tablet 100 MG	Add to F-PA-QL (30 tablets/30 days)
doravirine-Islatravir Oral Tablet 100-0.25 MG	Idvynso Oral Tablet 100-0.25 MG	Add to F-PA-QL (30 tablets/30 days)
trientine HCl Oral Capsule 250 MG	Syprine Oral Capsule 250 MG	Update to Formulary (F)

PRIOR AUTHORIZATION GUIDELINE UPDATES	
Iron-chelating Agents	Hepatitis C Medications
Dronabinol	Duvyzat
White Blood Cell Stimulators	Anti-Obesity Medications
Constipation agents	Injectable/Infusible Bone-Modifying Agents for Oncology Indications
Immunizations	Injectable/Infusible Agents for Osteoporosis and Paget's Disease
Medications for the treatment of Multi-Drug Resistant Tuberculosis	Pulmonary Biologics for Respiratory and Eosinophilic Conditions
Palforzia	Agents for Primary Biliary Cholangitis
Hepcludex	

PRIOR AUTHORIZATION GUIDELINES REVIEWED (NO UPDATES)	
Physician Administered Medication (PAD)/ Medical Benefit Guidelines	Multaq (dronedarone)
Off-label uses	Erythropoiesis-Stimulating Agents
Safety Edit Exception	Drugs for Gender Dysphoria For Less Than 21 Years Old
Quantity Limit Exception	Drugs for Gender Dysphoria For At Least 21 Years Old
Antibiotic Eye Medications	Lidocaine Patch
Antiemetics	Mesalamine
Nuedexta (dextromethorphan/quinidine)	Corticosteroids for Ulcerative Colitis and Crohn's disease
Cartilaginous Repair Agents	Atovaquone-proguanil (Malarone)
Memantine ER (Namenda XR)	Intranasal Steroids
Ophthalmic Anti-inflammatory Immunomodulators	Scabicides and Pediculicides
Penicillamine (Depen, Cuprimine), Trientine HCl (Syprine) for Wilson's disease	Rifamycin Antibiotics
Vancomycin	Topical Acne Agents
Viberzi (eluxadoline)	Alosetron (Lotronex)
Rifabutin (Mycobutin)	Vowst
Tranexamic acid (Lysteda)	Rho Kinase Inhibitors
Moxifloxacin Oral Tablet	Xolremdi
Santyl Ointment	Anti-Parkinson's Agents for OFF Episodes
Topical Antibiotics	Ctexli
Vykat XR	

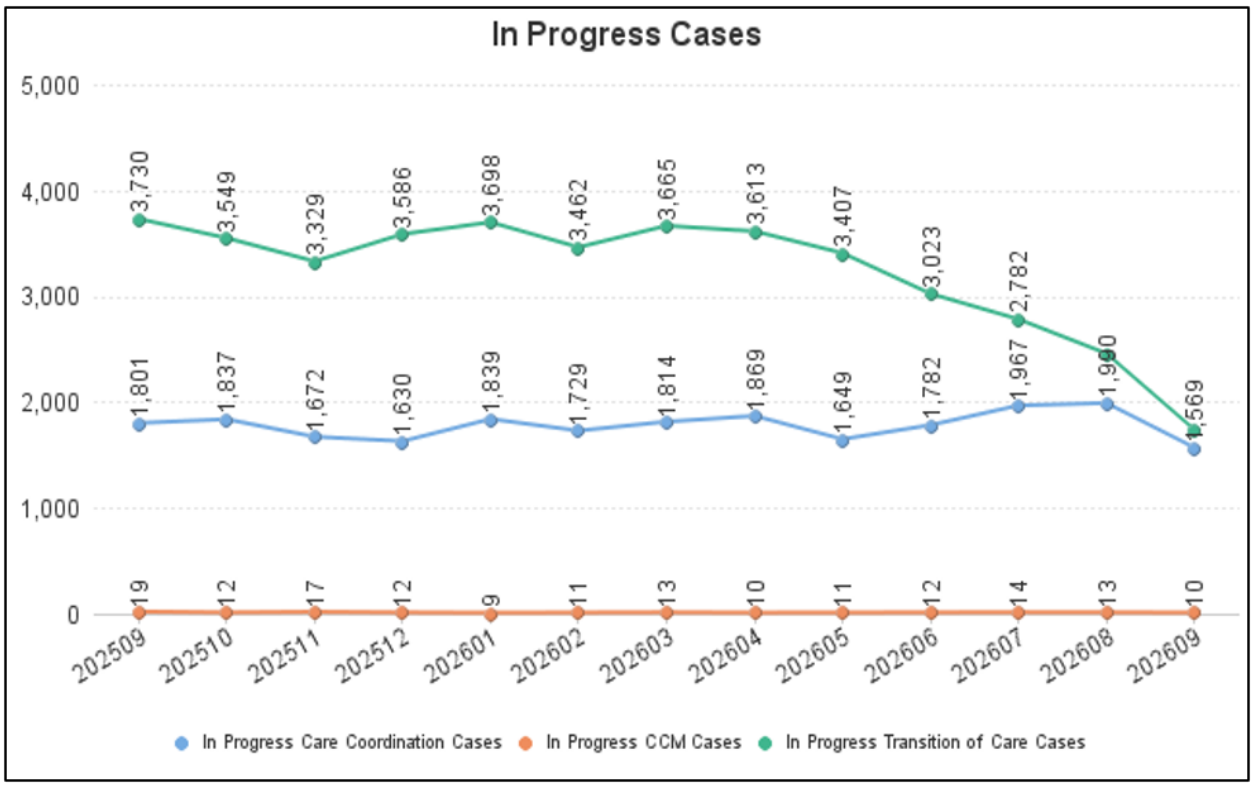
The P&T Committee approved the following guidelines for Physician Administered Drugs (PAD).

PAD GUIDELINE UPDATES	
Ophthalmic indications for bevacizumab	Omisirge
White Blood Cell Stimulators	Elevidys
Iron-containing Products	Injectable/Infusible Bone-Modifying Agents for Oncology Indications
Tepezza	Injectable/Infusible Agents for Osteoporosis and Paget's Disease
Gene Therapy for Hemophilia B	

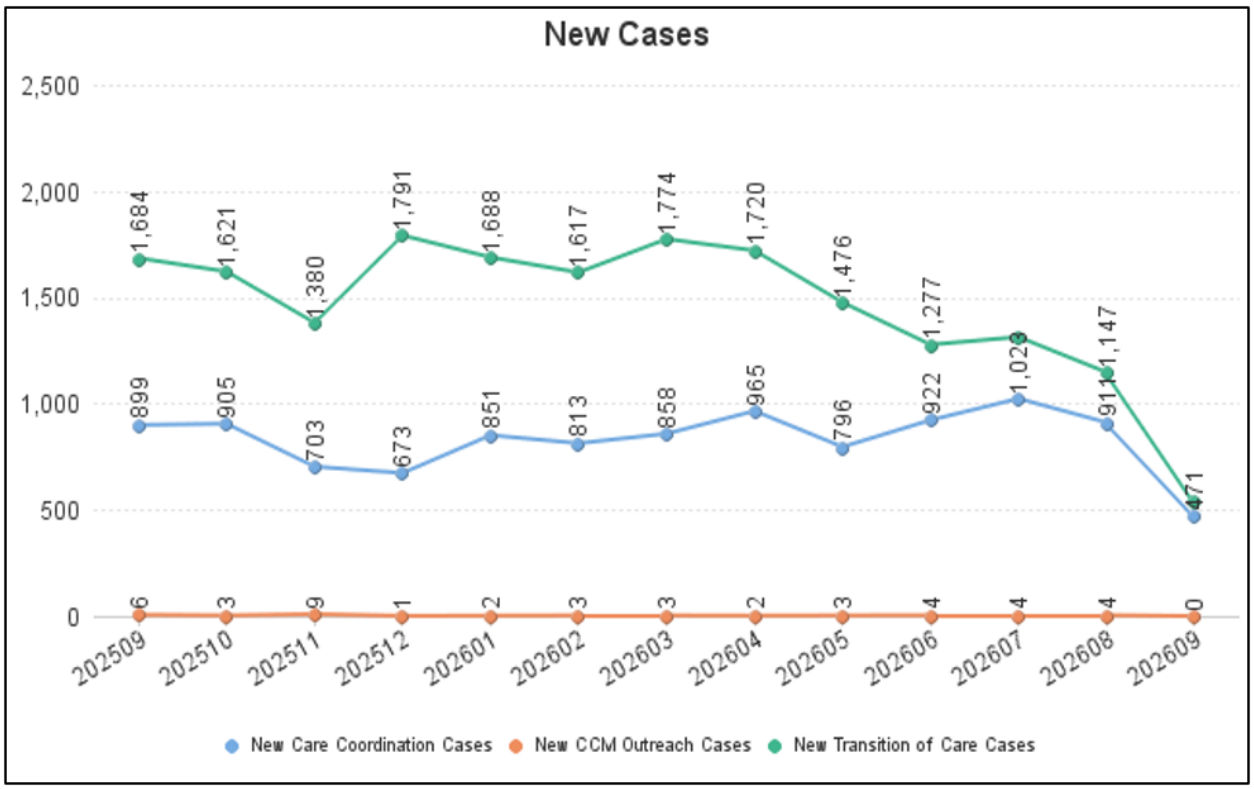
PAD GUIDELINES REVIEWED (NO UPDATES)	
Exondys 51	Enzyme replacement therapy for acid sphingomyelinase deficiency (ASMD)
Erythropoiesis-Stimulating Agents	Rytelo (imetelstat)
B-Cell Maturation Antigen (BCMA) Directed Chimeric Antigen Receptor (CAR) T-Cell Therapy	Anti-Parkinson's Agents for OFF Episodes
Fecal microbiota	Encelto
Qalsody (tofersen)	Nulibry
Lamzede	Zevaskyn
Enzyme Replacement Therapies for Fabry Disease	

Case and Disease Management

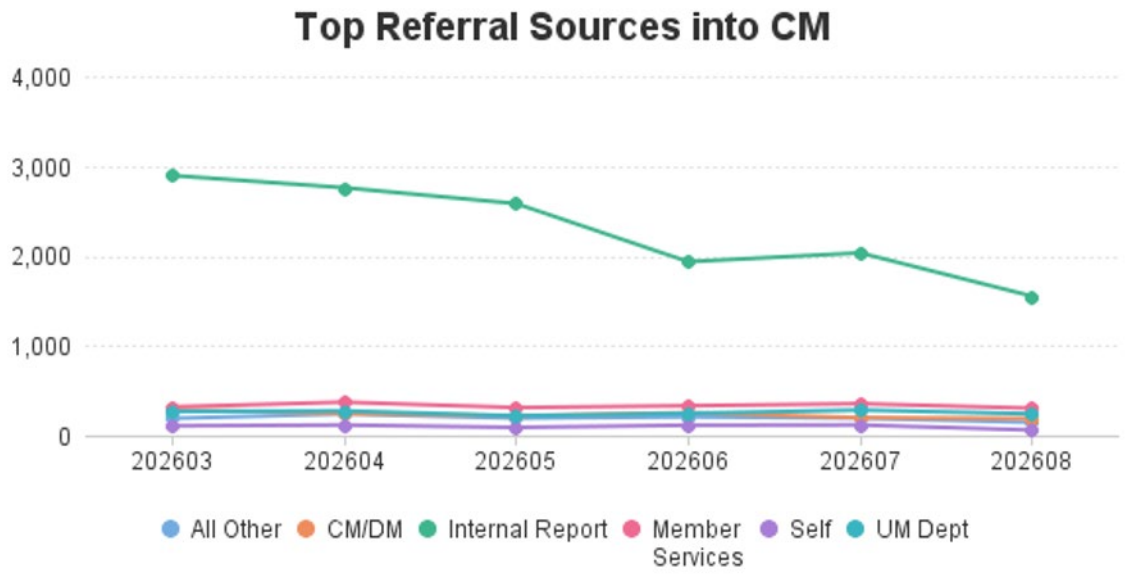
- D-SNP case management is live. The Case Management (CM) team is engaging D-SNP members in completing HRA assessments, building care plans, and supporting members to help meet their needs.
- The CM team continues to assist the high volume of members needing Transitional Care Services (TCS) as they transition 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. This will result in a decrease of "in progress cases" as those cases are now with Upward Health.
- The CM team is in the process of rolling out OB Case Management for pregnant and postpartum members, beginning outreach at the beginning of pregnancy to ensure access to care including doula's, behavioral health, and transportation.
- 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

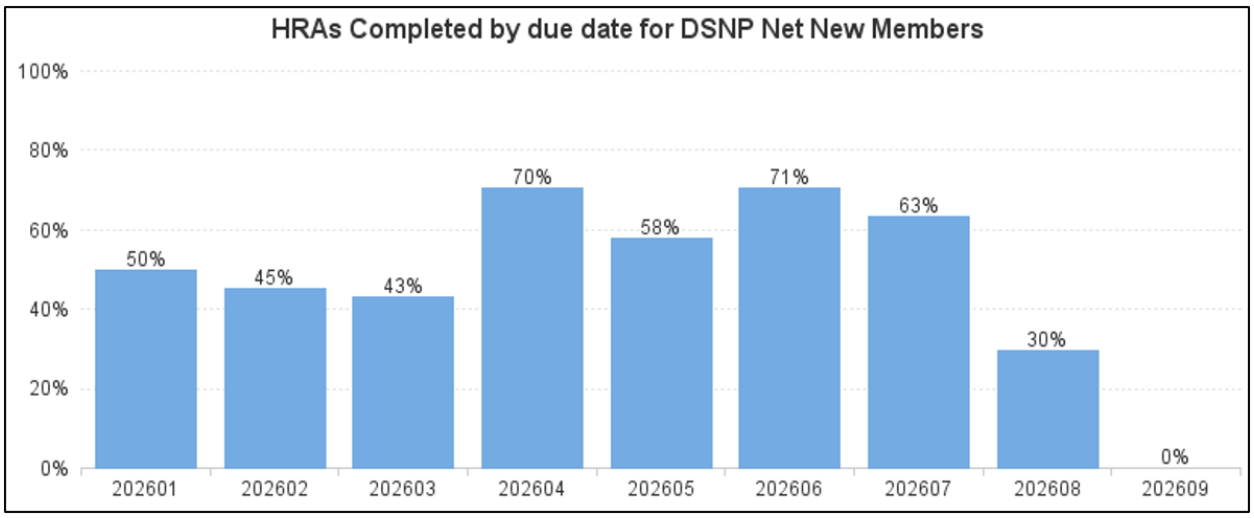


Source: #03342 TruCare Caseload



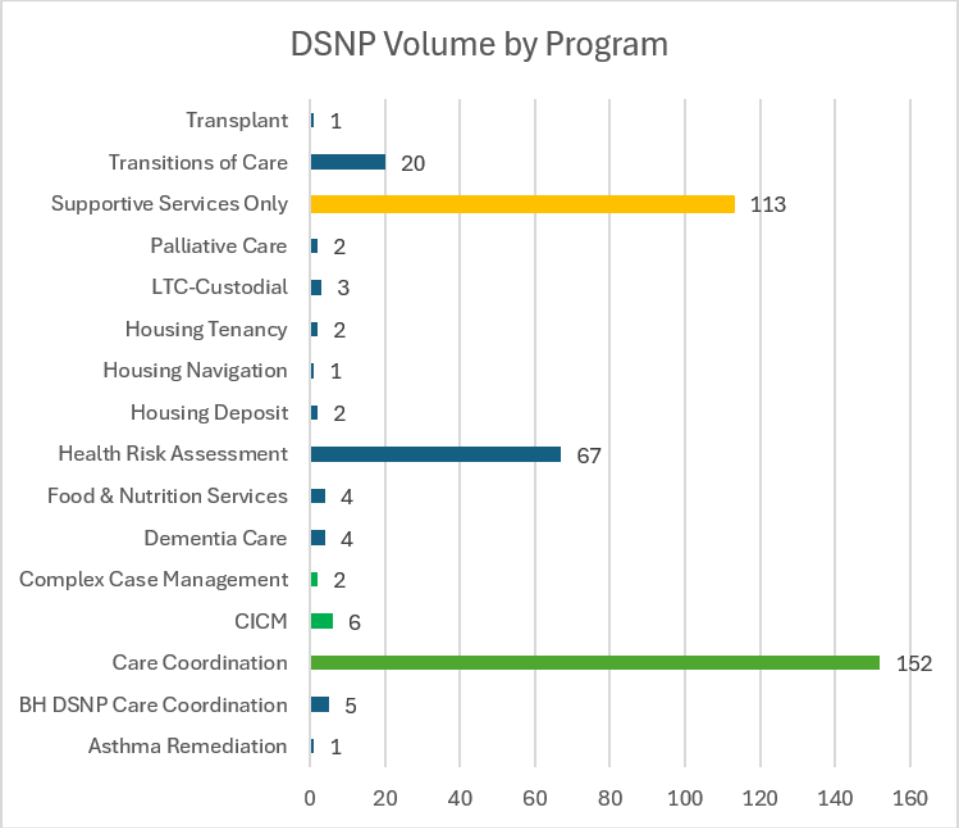
*Internal Report represents Transitional Care Services (TCS) data for recently admitted patients via Admissions Discharges Transfers (ADT) feed from hospital / skilled nursing facility partners

***Source*: #03881 Case and Disease Management Dashboard -**



Note: HRA's due 90 days from enrollment, so members who enrolled 7/1/26 or later are still outreached
***Source*: #00835 HRA Dashboard**

DSNP CM Volume by Program Type



Source: #17175 CM DSNP Aging

Definitions:

- 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 will be revisited in 2027. Work on system and billing enhancements are in progress. DHCS ECM policy guide was released on 9/21 and teams are in process of reviewing and implementing changes associated with policy guide revisions.
- 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 Transitional Rent, ensuring smooth transitions into ECM, as necessary.
- 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.

	June 2026		July 2026		August 2026	
ECM Providers	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**
ACBH	-	13	-	13	-	13
Alameda Health System (AHS)	-15	266	11	224	-	211
Bay Area Community Services (BACS)	30	274	23	270	-	267
California Cardiovascular Consultants	1	132	-	129	-	129
California Children's Services (CCS)	7	59	10	59	-	58
CHCN	80	1420	81	1469	-	1387
East Bay Innovations (EBI)	6	182	3	180	-	178
Full Circle	-	239	-	228	-	222
Institute on Aging (IOA)	182	289	14	294	-	284
La Familia	40	44	35	44	-	36
MedZed	139	1951	395	1983	-	1668
Pair Team	24	1,879	31	1870	-	1704
Roots Community Health Center (includes Street Medicine)	1	588	-	573	-	577
Seneca Family Services	9	54	72	58	-	54
Star Nursing	1	27	-	30	-	30
Titanium Health Care	625	2117	428	2187	-	2142
Tiburcio Vasquez Health Center (Street Medicine)	-	126	-	125	-	134
BACH (Street Medicine)	-	69	-	63	-	65
Lifelong (Street Medicine)	-	381	-	326	-	296
UCSF	-	-	-	-	-	-

Source: #13360 ECM Dashboard – enrolled data available through August 2026, pending outreach data

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.
- Draft DHCS Community Support Policy Guides Volume 1 and 2 released for public comment on July 20th, 2026. Expected finalized DHCS Community Support Policy Guides in Fall of 2026.

Community Supports	Services Authorized in July 2026	Services Authorized in August 2026	Services Authorized in September 2026
Housing Navigation	1047	1031	1006
Housing Deposits	398	368	311
Housing Tenancy	2032	1405	1230
Asthma Remediation	159	156	138
Medically Tailored/Supportive Foods	1257	1005	752
Medical Respite	54	59	49
Transition to Home	1	1	1

Nursing Facility Diversion	3	3	3
Home Modifications	10	9	9
Personal Care and Homemaker Services	19	20	13
Caregiver Respite	1	1	1
Transitional Rent	49	55	47
Total	**5030**	**4113**	**3560**

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

- There was a decrease in the amount of authorization requests by 18% from July 2026 to August 2026. There was a 13% decrease from August 2026 to September 2026. Total decrease in the number of authorizations from July 2026 to September 2026 is 29%.

Total Medi-Cal CS Authorization Volume			
Authorization Status	**July 2026**	**August 2026**	**September 2026**
Approvals	758	892	663
rtial Approvals	0	0	0
Denials	82	84	81
Total	**840**	**985**	**744**

Total D-SNP CS Authorization Volume			
Authorization Status	**July 2026**	**August 2026**	**September 2026**
Approvals	1	1	2
Partial Approvals	0	0	0
Denials	0	0	0
Total	**1**	**1**	**2**

Source: #02569_AuthTAT_Summary

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

CS Turn Around Time Compliance *(benchmark: 95%)*			
Line of Business	**July 2026**	**August 2026**	**September 2026**
Medi-Cal	99%	99%	98%
D-SNP	100%	100%	100%

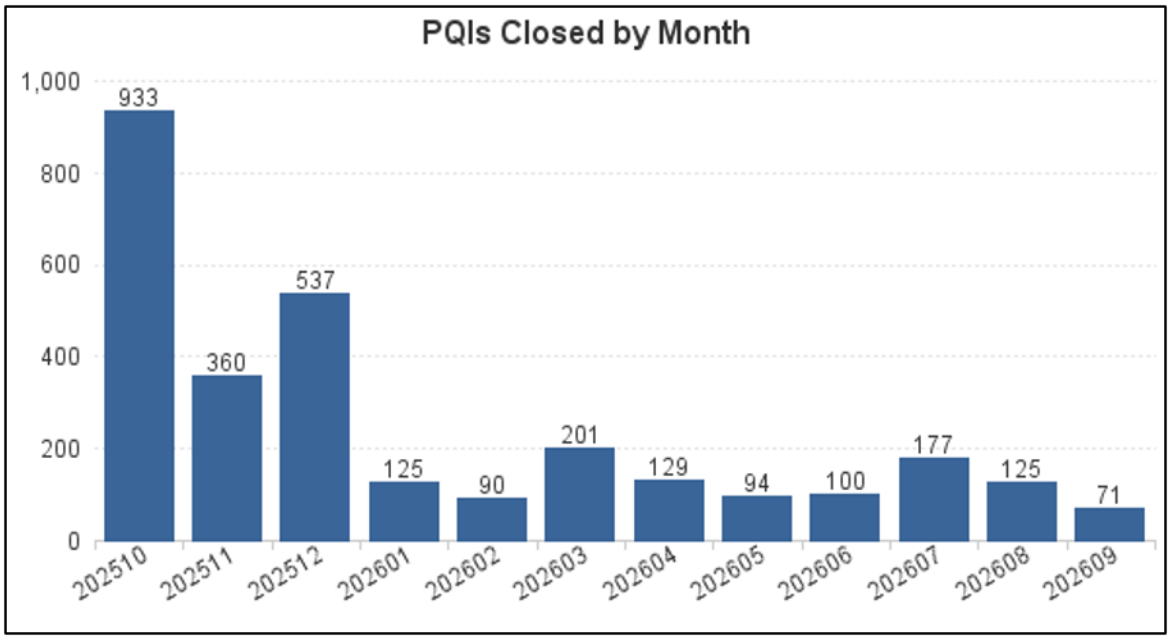
Source: #02569_AuthTAT_Summary

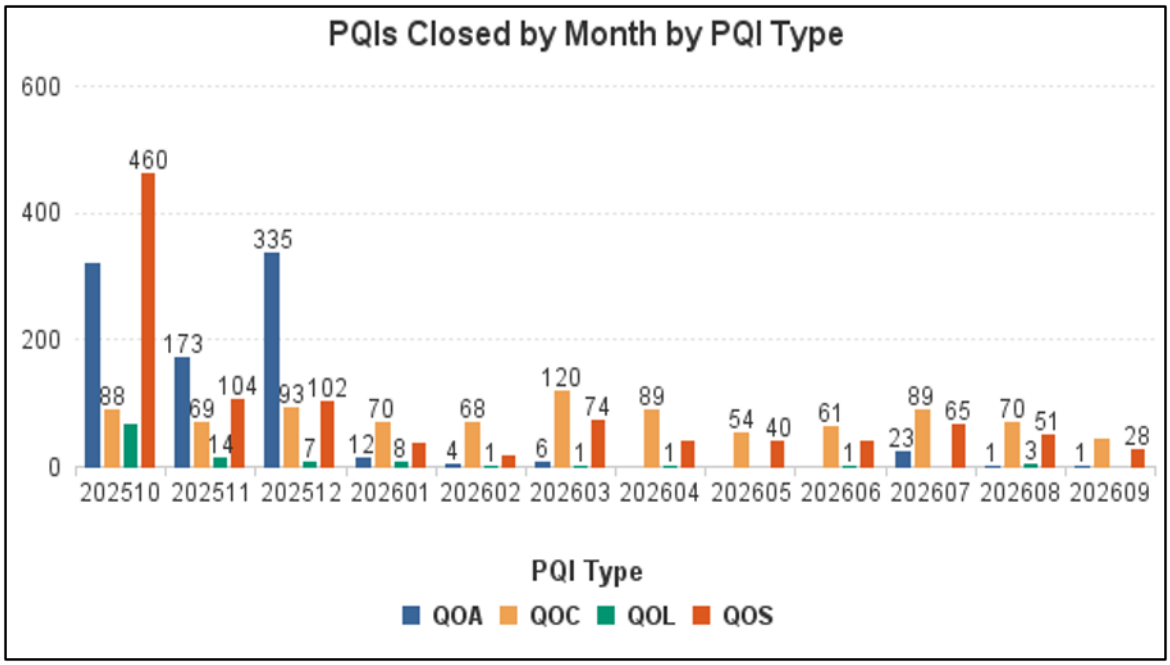
Quality

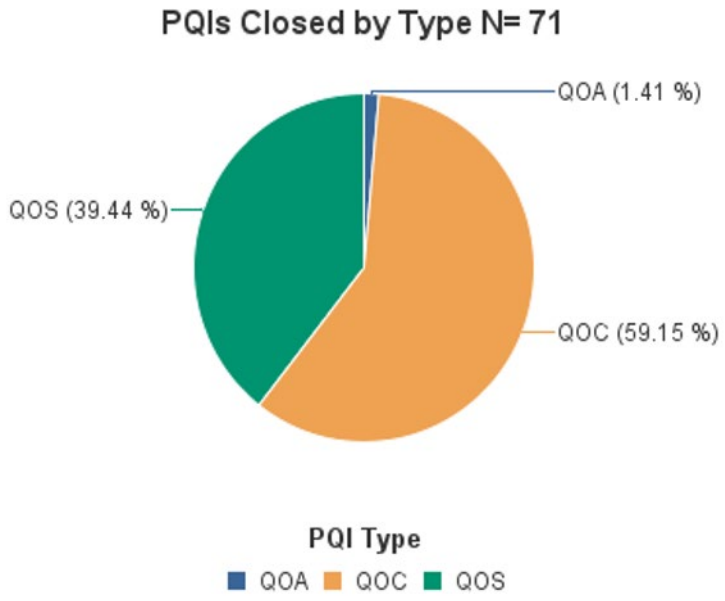
- There was a decrease in the number of PQIs closed compared to last month by 43% (from 125 to 71 cases). As of September 30, 2026, the turnaround time (TAT)

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 (98%). The majority of cases closed were quality of care (QOC) types signifying appropriate referrals of PQIs for clinical quality issues. The TAT at which PQI cases are being leveled and closed with final MD recommendations was met for the last 3 consecutive months.

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







Department of Managed Health Care (DMHC) Health Equity

The Department of Managed Health Care (DMHC) issued a corrective action plan for the Health Equity Quality Measure Set (HEQMS) which identified disparities for HEDIS quality measures in measurement year 2024 across commercial and Medi-Cal lines of business. The results included aggregate and race/ethnicity-stratified results. It found no administrative reporting deficiencies but identified benchmark shortfalls—especially in controlling high blood pressure, asthma medication ratio, readmissions, child/adolescent well-care, and certain cancer-screening and diabetes outcomes among specific Medi-Cal populations. Root cause analyses identified barriers such as provider capacity and workflow limitations, fragmented data and care coordination, incomplete member contact information, language and health-literacy challenges, transportation and financial hardship. There was notation of mistrust of the healthcare system, limited culturally responsive care, and disproportionate effects across several racial and ethnic populations based on evidence-based supporting information (i.e. stakeholder input, community health assessments, etc.) when available. Corrective actions and monitoring activities included tailored activities to address disparities by race and ethnicity such as provider engagement, targeted and multilingual member outreach, care management, incentives, community partnerships, improved data exchange, and performance tracking. The Alliance continues to proactively develop, implement, and evaluate health equity initiatives to ensure its effectiveness in closing health disparity gaps.

Managed Care Accountability Set (MCAS)

The Quality Performance team, operating within the Quality Improvement Department, oversees performance improvement and strategic management for the Managed Care Accountability Set (MCAS), which includes HEDIS quality measures based on NCQA

specifications. The team executes a coordinated, three-part strategy focused on provider partnerships and education, member outreach and incentives, and data-driven performance management. This aligned approach is designed to improve preventive care, strengthen provider performance, close care gaps, and support members in completing needed health services.

The HEDIS results for measurement year 2025 were finalized in June 2026. A comprehensive strategy drove significant year-over-year gains, culminating in the Alliance achieving national benchmarks for 17 out of 18 MCAS measures held to benchmark goals.

Core Strategic Pillars & Operational Impact

Provider Partnership & Education
The team deeply values its provider relationships and actively supports them in meeting quality goals through direct engagement and formal training:

- Direct Provider Engagement: Conducts customized, one-on-one meetings with providers to review localized MCAS rates, clarify complex measure requirements, resolve questions, and map out specific operational opportunities and challenges.
- Front-Line & Access Support: Engages front-line clinic staff by offering financial/performance incentives for year-over-year improvement and supports expanded patient access by helping clinics extend their office hours.
- The Improvement Academy: Serves as the primary educational vehicle, hosting deep-dive webinar series covering MCAS measures, quality improvement basics, and peer-to-peer best practices from high-performing network providers. In 2025, the academy trained 365 participants across 20 distinct training sessions, offering continuing education credits. The program is currently on track to become a CME-certified organization in the later part of 2026, which will allow the Alliance to directly award Continuing Medical Education (CME) credits to participating providers.

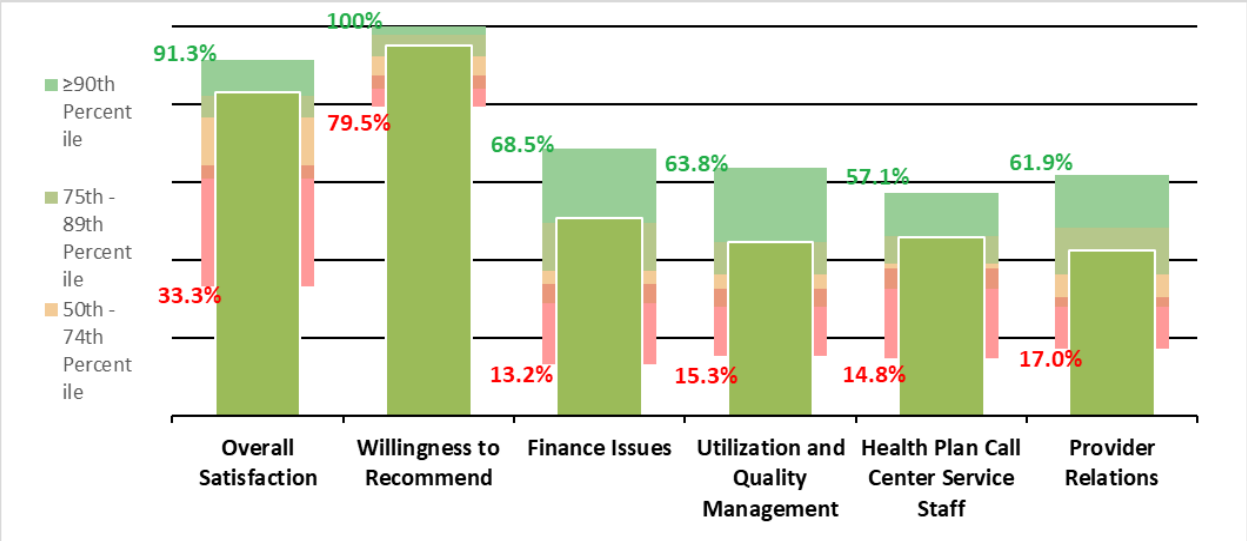
Member Outreach & Incentives
Placing members at the forefront of operations, the team utilizes targeted communication and motivational incentives to prioritize preventive health:

- Direct Outreach: In 2025, dedicated Engagement Coordinators completed more than 8,000 direct outreach calls to educate and remind members about critical preventive screenings.
- Targeted Mailings: Mailed tailored health materials, including community engagement touchpoints like birthday cards with health screening reminders to more than 5,000 members in 2025.
- Health Incentives: Successfully motivated more than 2,000 members in 2025 to complete vital preventive and clinical services, specifically targeting well-child visits, cancer screenings, and chronic disease management activities.

Data-Driven Performance Management
Data is utilized as an operational compass to accurately identify care gaps, uncover systemic barriers, and rigorously assess program outcomes:

- Provider Data Sharing: Delivers actionable, appropriate data sources directly to providers to help them rapidly identify and contact members who are overdue for care.
- Cross-Departmental Collaboration: Partners closely with the Analytics team to secure comprehensive data streams that fully account for all completed clinical services.
- Data Integration Mechanisms: Maximizes data capture by streamlining the intake of supplemental data from provider offices, ensuring the utilization of appropriate clinical codes, and expanding active participation in the Health Information Exchange (HIE).

The Alliance continues to utilize these strategies to improve the rates and ultimately, to ensure improved health outcomes for members.



Community Health Strategy (CHS) – September 2026

Community Health Strategy advances health equity by strengthening the connection between healthcare and community. Through trusted partnerships, Community Health Workers and community-based organizations improve access, address social drivers of health, and create coordinated, person-centered care that improves health outcomes for Alameda Alliance members**.**

Staffing Updates:

- No updates at this time.

September Program Summary:

September marked an important inflection point for Community Health Strategy (CHS), as the work continued to mature from administration of a covered benefit into an enterprise strategy for deploying trusted community-based interventions where they can have the greatest impact. Across policy, technology, provider development, evaluation, and community engagement, CHS advanced a common objective: building the infrastructure that allows the Alliance to translate health equity from commitment into consistent member experience.

Current DHCS direction further elevates the strategic importance of CHWs. As California prepares for the January 1, 2027, transition of Medi-Cal members with Unsatisfactory Immigration Status (UIS) from managed care to Fee-for-Service (FFS), CHW services will remain available through enrolled FFS providers even as other named services shift. DHCS has also identified CHW services, chronic care management, doula services, and new navigation supports among the resources available to help members maintain connection to care, emphasizing the importance of braided service opportunities. For the Alliance, the signal is clear: as delivery systems change, trusted navigation and community-based support become more—not less—important.

The Alliance is helping shape that transition, not simply preparing to receive it. During September, CHS continued providing implementation feedback to DHCS on intended and unintended consequences of policy change, elevating health equity, provider capacity, continuity of care, and the practical role CHWs can play in preventing members from becoming disconnected as services and payment pathways shift. This positions the Alliance to bring frontline implementation experience and community realities into state policy discussions while simultaneously strengthening local readiness.

DHCS policy momentum also creates an important organizational consideration: implementation capacity must keep pace with strategy. The CHW portfolio now spans policy interpretation, provider development, targeted interventions, technology workflows, clinical escalation, community partnerships, evaluation, and transition readiness. The next phase is therefore not simply to grow the benefit, but to ensure the Alliance has the workforce, provider-support infrastructure, analytics, clinical partnership, technology, and quality measurement needed to deploy CHWs intentionally

as an equity intervention and demonstrate whether members are successfully connected to care.

Operational Foundation: From Policy to Practice
CHS completed the annual review of CHS-001: Community Health Worker Benefit and CHS-002: Prescreening Procedure, maintaining alignment with current Medi-Cal CHW requirements while strengthening consistency in program administration, oversight and new DHCS policy guidance.

CHS also advanced integration of the CHW assessment into TruCare following its September 14 production launch. The next phase includes CHS-specific task activities, a department work queue, and a clinical medical-review pathway for assessments requiring additional medical review. Together, these enhancements will improve documentation, workforce efficiency, escalation, and accountability across the member journey.

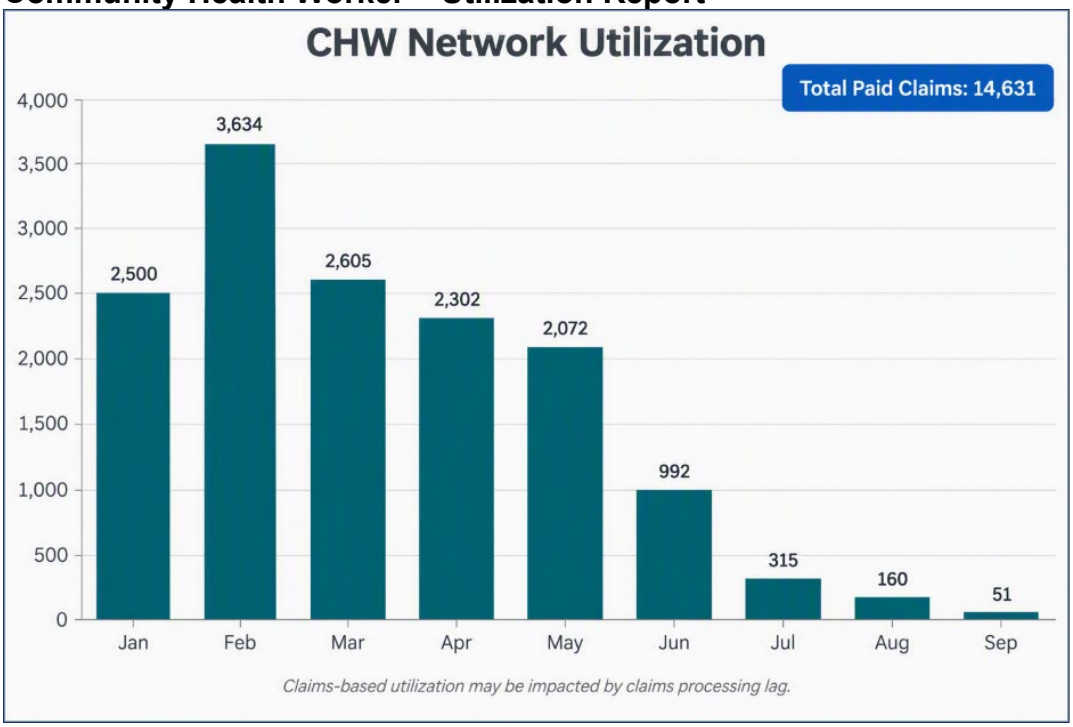
Equity in Action: How the Alliance Is Showing Up in Community

The Alliance does not ask the community to come to us before we show up for them. We build care around trusted relationships, local knowledge, and the places where members already live, learn, heal, and seek support.

September's community engagement demonstrated that the Alliance's equity strategy is visible beyond benefit design and internal operations. CHS advanced its partnership with the Vietnamese American Community Center of the East Bay (VACCEB), including Alliance support for its October Autumn Health Fair and continued CHW provider-development work. VACCEB already supports community members with Medi-Cal enrollment and renewal, food access, citizenship resources, health education, and wellness, illustrating how trusted community relationships can become durable pathways to health and social support.

The CHS staff also lead community outreach representing Alliance at the Love Thy Neighbor community Health event hosted by CHW network provider Glad Tidings. In parallel, CHS continued implementation planning for the Alliance's Well Child Visit programming, using the CHW benefit to strengthen pediatric navigation, developmental and behavioral-health connections, health education, family support, and closed-loop linkage to community resources. These efforts reflect a deliberate model: community engagement, network development, and member access are not separate strategies; together they create the trusted infrastructure through which equitable care becomes reachable and durable.

Community Health Worker – Utilization Report



Through September 2026, the Alliance has recorded 14,631 paid Community Health Worker (CHW) claims. While recent claims-based utilization reflects a downward trend, CHS is monitoring several concurrent factors that affect how these data should be interpreted. Importantly, paid claims represent only one dimension of CHW activity and should not be viewed as a direct proxy for member need, engagement, or program impact. Recent dates of service remain subject to both provider billing lag and claims-processing run-out. Providers may submit claims after the month in which services were delivered, and additional time is required for adjudication and payment. Accordingly, the most recent months should be considered preliminary and may increase as claims mature.

CHS is also seeing the operational impact of DHCS billing requirements for the CHW 98960–98962 series. Individual interactions must meet the required time threshold to generate a billable unit, and shorter contacts cannot be accumulated across encounters to meet that requirement. This has particular implications for relationship-based CHW models, where navigation, follow-up, trust-building, and connection to resources often occur through multiple shorter touchpoints. One of the Alliance's historically highest-volume CHW initiatives relies heavily on this type of engagement; consequently, meaningful member contact may continue even when fewer interactions are reflected as paid claims.

Additionally, two time-limited CHW scope-of-work initiatives are approaching completion. Some reduction in claims volume is therefore an anticipated result of portfolio transition rather than an indication of a corresponding decline in the relevance or need for CHW services.

CHS is also monitoring the broader environment surrounding member trust and willingness to engage with public systems. Changes in the public climate may influence how some members approach government-sponsored programs and services;

however, CHS does not currently have sufficient data to attribute the observed claims trend directly to this factor. It remains an important access consideration, particularly as a significant Medi-Cal transitions approach.

These trends reinforce an important measurement consideration for the Alliance: claims data alone cannot tell the full story of CHW performance. Going forward, CHS is strengthening its approach to distinguish among member outreach, actual engagement, voluntary acceptance of services, billable encounters, paid claims, successful referrals, closed-loop linkage, member experience, and health outcomes. This distinction is increasingly important as billing rules and delivery models evolve. The strategic risk is not declining claims alone; it is mistaking a billing signal for a member-need signal. As CHW delivery models, billing requirements, and payer pathways change, the Alliance must distinguish between member engagement, billable utilization, successful linkage, and health impact.

As the CHW benefit continues to be socialized and utilization is evaluated, CHS is emphasizing an important distinction: CHW services are voluntary. Participation counts should therefore be interpreted alongside who was eligible, who could be reached, who chose to engage, the intensity of outreach required, and what happened after a member said yes. A targeted intervention serving 10 or 20 members is not inherently low value; it may represent a narrow population exercising member autonomy to accept a service that is relevant to them. The more meaningful question is whether voluntary engagement results in trusted connection, completed linkage, and improved ability to navigate care.

Equity respects member choice. In a voluntary benefit, success is not defined by forcing volume; it is defined by whether members who choose support can turn that choice into connection, care, and better health.

CHS is also preparing for an additional utilization-reporting shift beginning January 1, 2027, when members affected by the UIS transition move from managed care to Medi-Cal Fee-for-Service. Because CHW services will remain available through FFS, some CHW activity that is currently visible through Alliance-paid claims may subsequently occur outside the Alliance managed-care claims environment. This makes it increasingly important to ensure that future changes in Alliance-paid claims are not automatically interpreted as changes in member need, access, or CHW activity. Taken together, the current utilization trend is helping CHS refine not only how CHW services are delivered, but also how their value is measured. The emerging strategy is to move beyond a claims-only view of utilization toward a more complete picture of reach, choice, connection, continuity, quality, and impact.

Provider partnerships remain central to Alameda Alliance’s ability to translate strategy into measurable member impact. CHS continues to prioritize strategic network expansion by cultivating partnerships with organizations that can deliver culturally responsive, community-based interventions for members with complex health and social needs, including older adults and other populations experiencing barriers to care.

During September, CHS conducted targeted outreach and exploratory discussions with five prospective CHW provider organizations: Amani Project, Kindful Restoration, Mercy

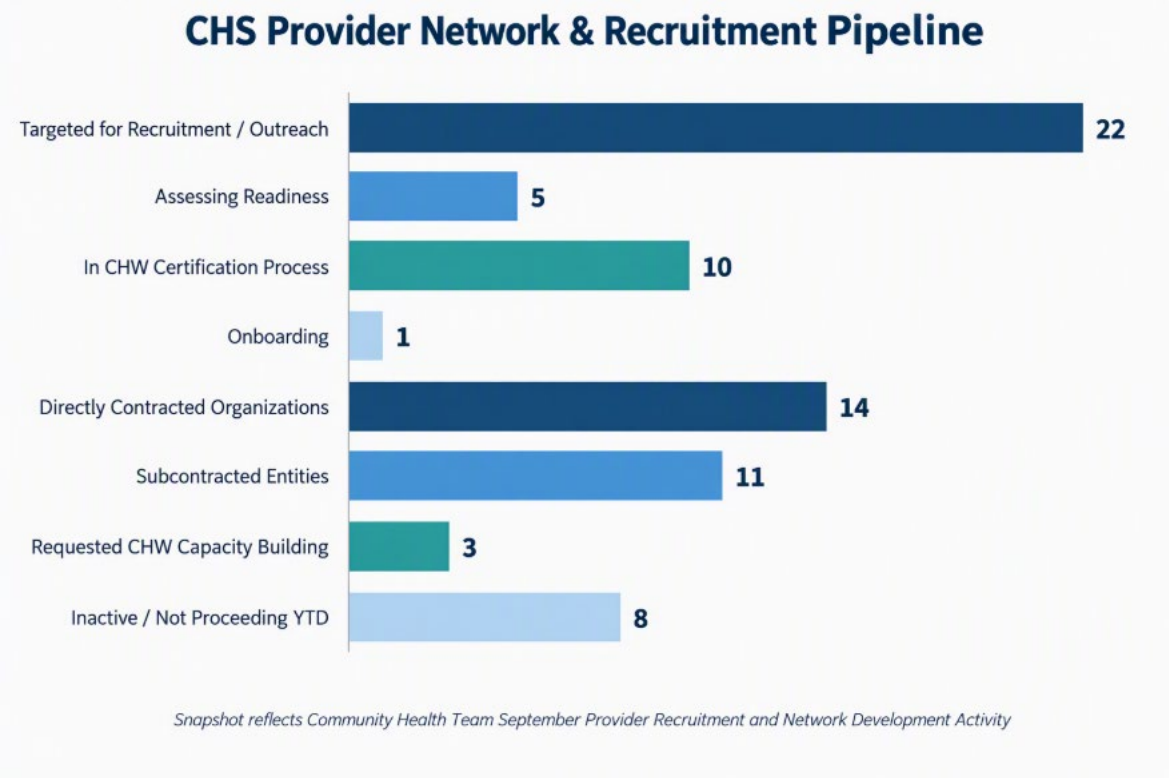
Housing, Joy4U2, and Love's Pathway. Notably, Amani Project and Love's Pathway serve maternal health populations through services such as doula support, lactation consultation, care coordination, and other family-centered interventions. These partnerships represent an opportunity to strengthen the Alliance's maternal health strategy while advancing equitable access to culturally responsive support services for pregnant and postpartum members.

CHS also continued provider readiness activities by conducting CHW Certification Overview sessions with ThriveLink and Kindful Restoration, helping both organizations better understand the CHW certification pathway, Medi-Cal requirements, and operational expectations associated with participation in the CHW benefit.

Network growth is being balanced with quality guardrails. CHS advanced One Love Center for Health as a contracted CHW provider effective September 1 and continued readiness support for emerging organizations, while also electing not to advance other prospective organizations that did not yet demonstrate sufficient organizational, workflows, capacity, and program infrastructure. This approach reflects a core principle: expanding access does not mean lowering the standard. Members need community partners that are trusted, prepared, and capable of sustaining the operational requirements of the benefit.

Together, these efforts advance Alameda Alliance's strategic priorities to expand provider capacity, strengthen community partnerships, improve access to preventive and supportive services, and increase the availability of community-based interventions for populations experiencing inequities in health and healthcare access.

CHS Provider Recruitment Snapshot:



As of September 2026, the CHS provider network includes twenty-four (24) contracted providers, consisting of:

- Fourteen (14) directly contracted organizations.
- Eleven (11) subcontracted entities.
- Five (5) organizations actively assessing readiness to pursue certification and contracting.
- Ten (10) organizations are currently engaged in the CHW certification process.
- One (1) organization is currently onboarding.
- Eight (8) organizations deemed inactive or electing not to proceed year-to-date.
- Three new (3) organizations requested CHW Capacity Building
- Twenty-two (22) organizations targeted for recruitment/outreach

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

Quality Improvement: Population Health Management (PHM)

- In July 2026, the Department of Health Care Services (DHCS) released policy updates regarding the Population Health Management (PHM) Program's Risk Stratification, Segmentation, and Tiering (RSST) approach. Beginning January 1, 2027, Managed Care Plans will be required to use DHCS' standardized RSST risk tiers to guide outreach and engagement, identify member needs, and connect members to appropriate services.
    - The Alliance receives monthly files from DHCS with RSST data.
    - Initiated a project with IPD (Integrated Planning Department) involving Case Management, Information Technology, Analytics, Compliance, Behavioral Health, and Quality Improvement to plan outreach and engagement for high-risk members.
    - Submitted the DHCS RSST Managed Care Plan Implementation Template on 9/23/26 outlining implementation goals and outreach for adult, pediatric, and birthing populations.



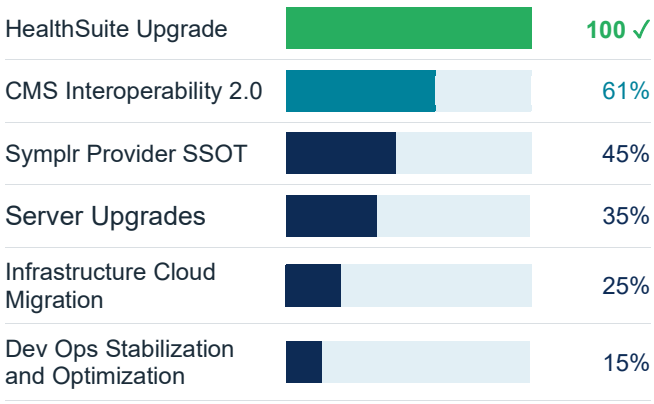
Information Technology

Sasikumar Karaiyan

EXECUTIVE SUMMARY

99.5% System Availability	**99%** Regulatory Compliance	**A–** IT Security Grade	**95** System Change Request	**1,119** IT Service Desk Tickets Resolved
88% Claims Auto-Adjudication	**97%** IT Service Desktop Tickets Closed On Time	**96%** On-Time Enrollment Processing		

STRATEGIC INITIATIVES



IT supports the delivery of 30+ IPD projects that includes regulatory mandates.

SECURITY & GOVERNANCE - LOW RISK

Zero critical security incidents reported.
3 zero-day vulnerability patches deployed proactively.
IT Security Program 2026: 67% complete.
Micro-Segmentation Phase 1: 82% complete.
Implemented AI Governance

MEMBER & PROVIDER CHANNELS

2 Production incidents – minimum impact and low severity.
Consumer call center supported 60,000+.
Provider Portal utilization up by 2%
Member Portal utilization down by 1.7%
Online form submission increased by 7% YTD.

IT WORKFLOW AUTOMATION

~55K Staff Hours Saved (YTD)	**$150K** Annual Vendor Savings	**90%** Compliance Workflows Live	**+10** Automations Inflight	**85%→92%** Claims Auto-Adjudication	**200** Staff using Co-Pilot

Next 90 days Roadmap on Workflow Automation

Automation Request	Target Date	Workstream
Hospice Rate SOP go-live in production	End of October 2026	Claims / AI Stack
Call Center end-to-end testing automation	End of October 2026	Call Center
AI Chatbot rollout — IT Service Desk	End of October 2026	IT Ops/ CoPilot
Provider Resolution Dispute QA validation	End of November 2026	Provider Operations
Claims Auto-Adjudication Improvement (50%)	End of December 2026	Claims / AI Stack
OCR – AI Fax to Electronic Conversation	Ongoing / Q4 2026	Enterprise/ OpenAI
G&A Automation - QA process and letter Automation	End of December 2026	G&A and Quality Suite

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

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

Date: **October 9th, 2026**

Subject: **Information Technology Report**

Enrollment

- September membership fell by 2,636 members (0.72%) month over month. PCP assignments were nearly balanced: 54.4% were auto-assigned and 45.6% were member-selected. All 48 DHCS, CMS, and Public Authority files were processed successfully with no issues or downtime.

Provider & Member Portals

- In August 2026, the five most-used Provider Portal pages generated 3.24 million views, while the five most-used Member Portal pages generated 14,084 views. Providers submitted 6,495 authorizations, and members submitted 12 grievances through the portals. Active accounts totaled 7,009 providers and 3,555 members.

Call Center Metrics

- Call center systems remained stable in September, with no outages affecting operations. The Alliance received 13,863 member calls and 8,894 provider calls, while Alliance Wellness handled 59 calls during evenings, weekends, and holidays.

Encounter Data

- In the month of September 2026, the Alliance submitted 172 encounter files to the Department of Health Care Services (DHCS) with a total of 510,536 encounters.
- In the month of September 2026, the Alliance submitted 1,029 encounters to the Centers for Medicare Services (CMS) for D-SNP members.

Change Management

- Change Management activity remained strong in September 2026, with 95 Change Requests (CRs) submitted and 89 CRs closed. While submissions exceeded closures, the gap narrowed compared to previous months, reflecting continued efforts to manage incoming demand and maintain delivery performance.
- Normal CRs represented the largest share of activity, with 46 submitted and 51 closed, followed by FastTrack CRs, which increased to 48 submissions and 37 closures, indicating growing demand for expedited changes. Emergency CRs remained low, with 1 submitted and 1 closed,

demonstrating effective management of high-priority requests.

Workflow Automation

Initiative	Status	Key Highlights
AI-Powered Compliance Platform	• **On Track**	90% of workflows are configured and live in production. Regulatory documents linked to internal requirements via AI automation.
AI-Driven Software Development	• **On Track**	20% of IT professionals actively use AI for development and testing. 12-month transformation roadmap underway across the full SDLC.
OCR / Intelligent Document Processing	• **Completed**	High-accuracy OCR (OpenAI) deployed for fax and prompt-based text extraction. Post Acute Auth (June) and Inpatient Auth (July) workflows live. Docustream vendor retired — saving $150K/year.
Speech-to-Text Enterprise Rollout	• **Completed**	Platform deployed enterprise-wide. 10 staff members onboarded; expansion to all requested staff members in progress.
Claims Adjudication Automation (Optum AI)	• **Pilot Complete**	Optum AI pilot successfully tested for Hospice Rate SOP. Target: raise auto-adjudication rate from 85% to 92%. COB claim workflow solutioning underway.
AI Chatbot — Service Desk & HR	• **On Track**	IT Service Desk ticketing and HR/Facilities processes scoped. Solution design in progress for Q4 2026 and Q1 2027 rollout.
Additional Automation Initiatives	• **On Track**	Provider Resolution Dispute QA validation, 834 Enrollment and end-to-end Call Center testing automation both targeted for Q4 2026 go-live.
Co-Pilot Deployment	• **On Track**	Co-polit deployed to approximately 200 staff members and the efficiency rate is around 63%. Total administrative hours saved is assumed around 5khrs/month.

Claims – HEALTHsuite Application

- The Alliance received 354,233 claims in the month of September 2026.
- For the MediCal and Group Care lines of business, a total of 334,662 claims were finalized, out of which 294,346 claims auto adjudicated, setting the auto-adjudication rate at 88.0%.
- The D-SNP line handled 1553 finalized claims during the period, out of which 742 were auto adjudicated, resulting in a 47.8% auto-adjudicationrate.
- HEALTHsuite Upgrade went live during the weekend of September 18th, 2026. No issues reported.
- Alliance has kicked off AI-led claims transformation solution to boost claims auto-adjudication percentages and improve processing accuracy. The first use-case to process Hospice claims is estimated to go-live in October 2026.

Quality Suite Application

- High level dashboard of cases for the month of September 2026:
  - G&A cases received in the month – 2437
  - Exempt Grievances received in the month - 1732
  - PQI cases received in the month - 81
  - PDR cases received in the month – 2640

- 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. This process will support the coordinator score card for performance as well.
  - Estimating to move this automation solution to Production by End of October 2026.

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 23,446 intake authorizations in September 2026, supporting timely care coordination and authorization management.

Data Integration

- TruCare Integration — Completed AOR data enhancement within the Member XML file, enabling TruCare ingestion and improving care management data accessibility.
- CYBHI Eligibility File Go-Live — Achieved production go-live on September 24 for the CYBHI Eligibility File, establishing ongoing member eligibility transmission to Carelon in support of program objectives and regulatory requirements.
- ECM Enhancement (Provider Segment Parsing) — Designed and delivered an ETL solution to parse provider-specific segments into the Health ECM Enhancement table, improving data quality and downstream enterprise consumption.
- DHCS 834 Process Improvement — Automated DOB and Gender updates from the DHCS 834 file, eliminating manual Service Requests and accelerating member data processing timelines.
- Infrastructure & Stability — Supported HealthSuite upgrade and replication resynchronization; completed TruCare test environment upgrades and SQL Server modernization to strengthen platform stability.
- Data Flow Optimization — Re-engineered the Hospice CIS data flow to source directly from DB2, reducing architectural dependencies and

improving efficiency.

- Connectivity & Modernization — Established PolyBase connectivity for Big ID and Azure Parquet data access; applied SQL Server 2022 patches and conducted production-to-QA environment refreshes.
- Performance & Resilience — Proactively resolved performance bottlenecks, storage, and latency issues to enhance enterprise data availability and operational resilience.

IT Service Desk

- 1,103 Service Desk tickets were opened in September 2026, a 9.37% decrease from August (1,217) and 27.73% lower than the previous 4-month average of 1,526.25 (May–August).
- 1,119 Service Desk tickets were closed in September 2026, a 10.41% decrease from August (1,249) and 26.63% lower than the previous 4-month average of 1,525.25 (May–August).

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) coordination with Server Core team on Azure security (2) staging annual 2026 Security Risk Assessment and Penetration testing (3) implemented Security Architectural Reviews as a gate for new projects.
- Network Micro-segmentation project is now on phase 2 0 file server, sql server, and privileged accounts.

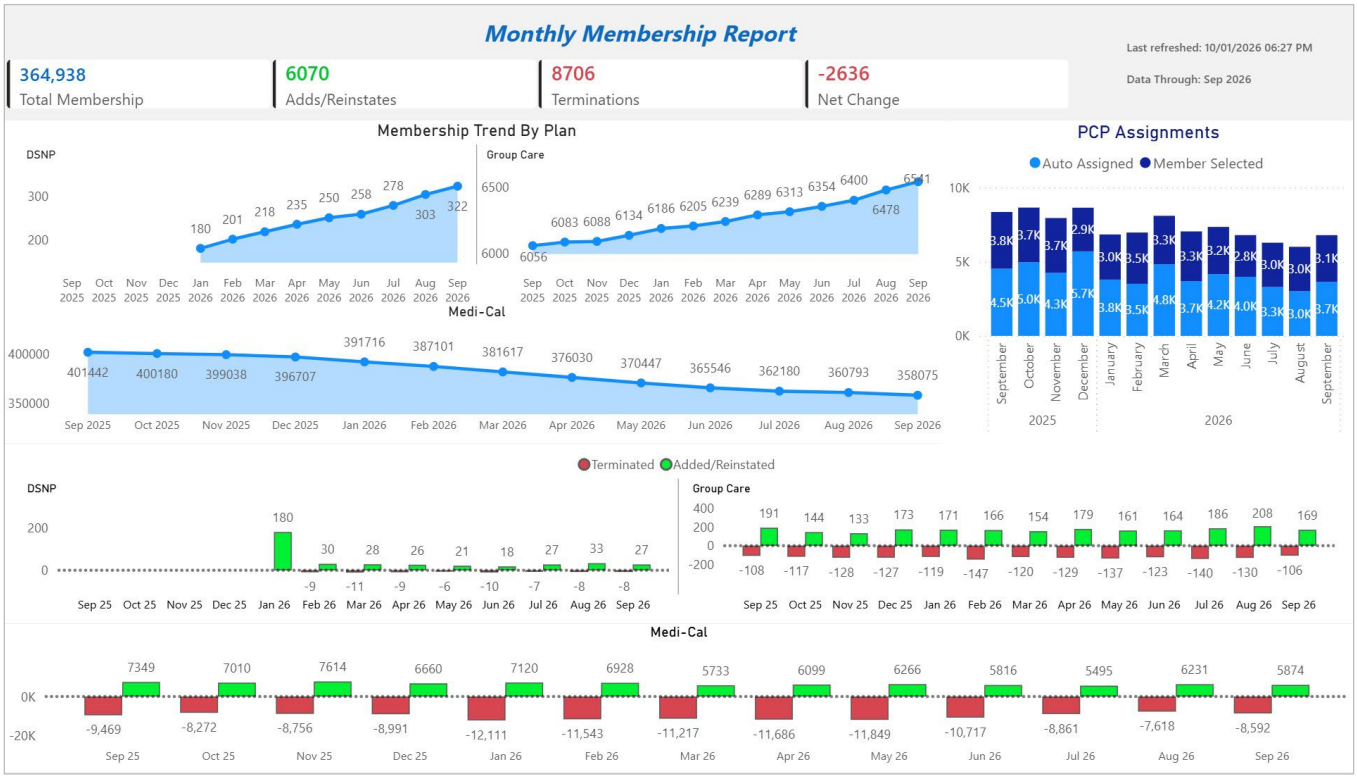
Information Technology

Supporting Documents

Enrollment

Membership Trend & PCP Assignments

September 2026 membership totaled 364,938, a decrease of 2,636 members (0.72%) from August. During the month, 6,070 members were added or reinstated and 8,706 members were disenrolled. Of PCP assignments completed in September, approximately 54.4% were auto-assigned and 45.6% were member-selected.



Alliance Wellness Enrollment Activity

September 2026 Alliance Wellness membership totaled 322 active members. During the month, 26 new enrollments, 1 disenrollment, and 4 deeming members were recorded.

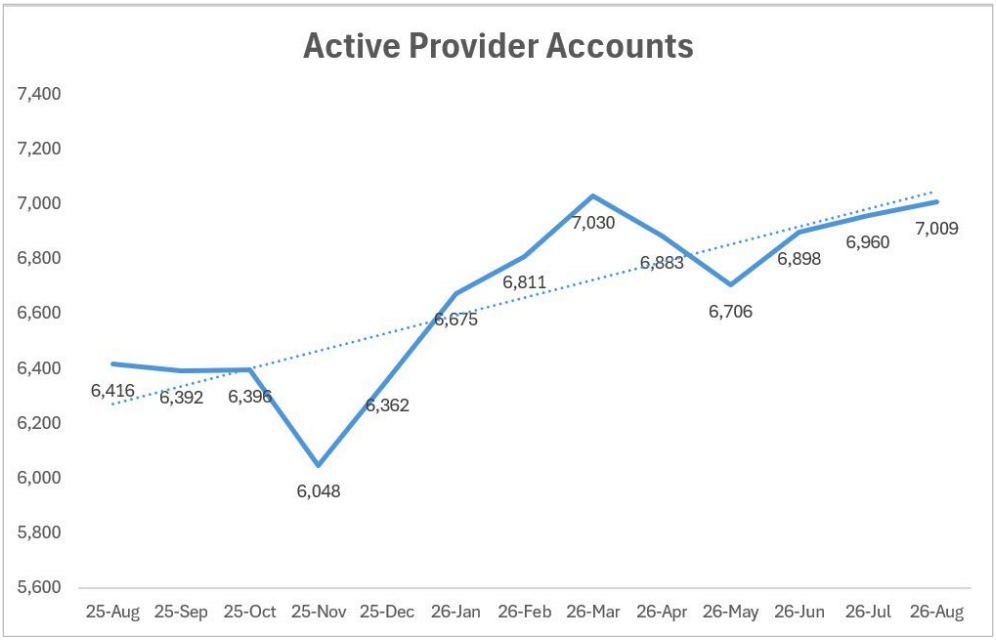


Provider & Member Portals

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

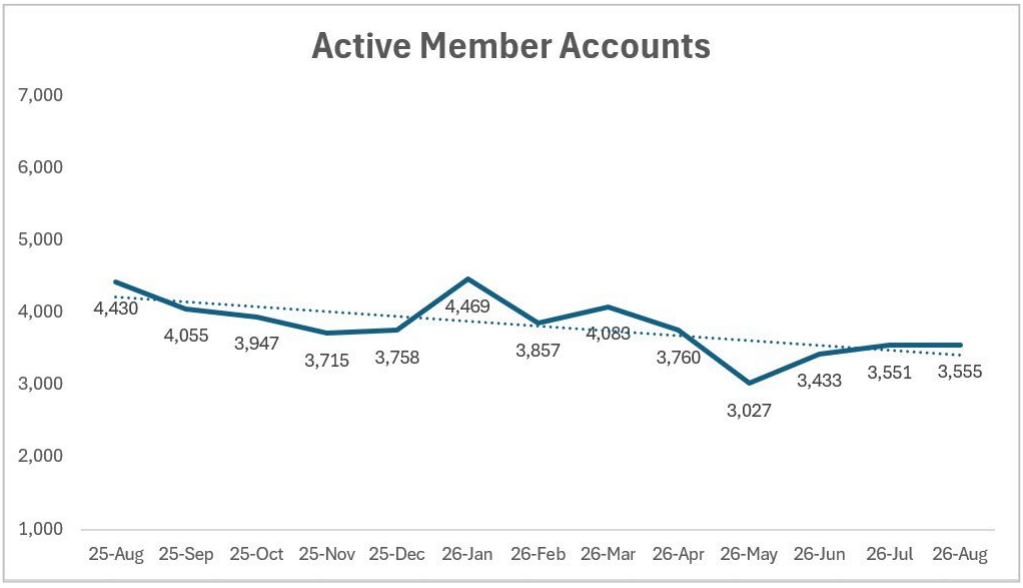
Provider Portal Users

Active provider accounts increased by 49 accounts (0.7%), from 6,960 to 7,009 over the reporting period.



Member Portal Users

Active member accounts increased by 4 accounts (0.1%) from 3,551 to 3,555 over the reporting period.



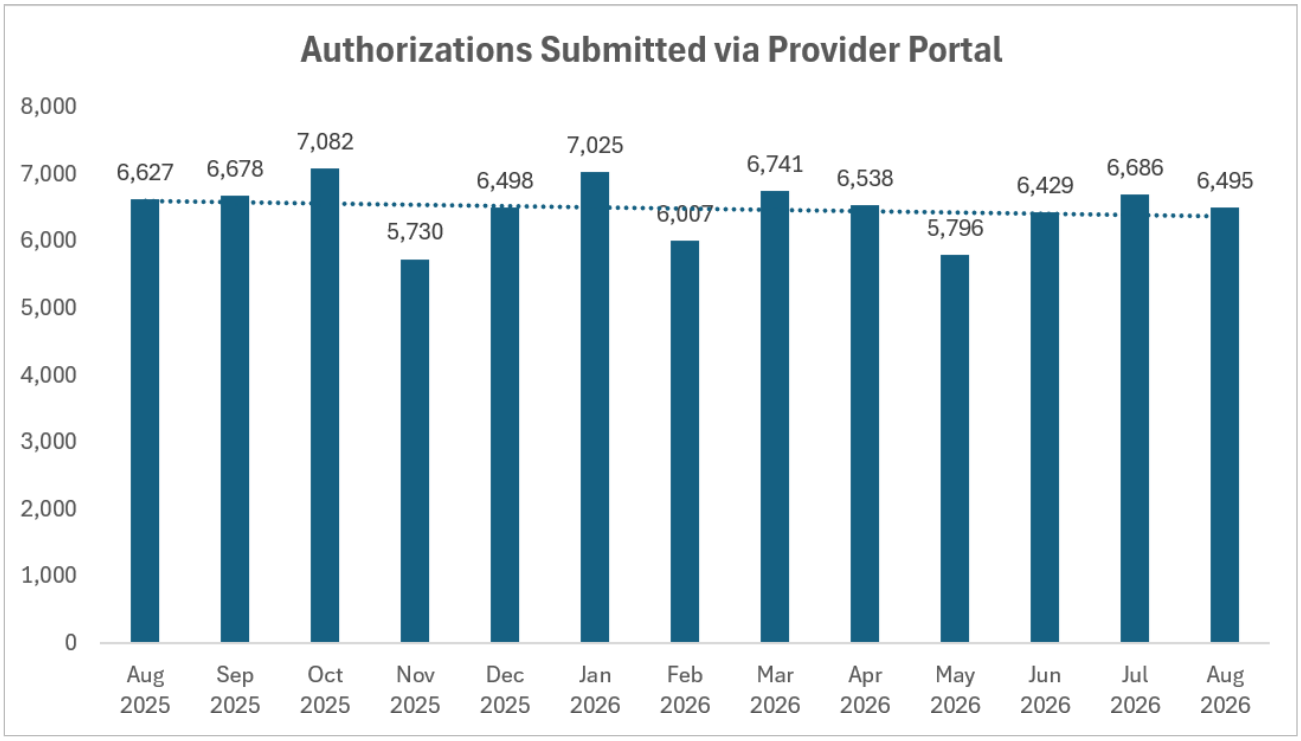
Provider & Member Portal top 5 pages viewed

The most-viewed Provider Portal page, member eligibility, recorded 2,500,091 page views in August, an increase of 53,986 views (2.2%) from July. The most-viewed Member Portal page, ID card, recorded 4,531 page views, a decrease of 380 views (7.7%) from July.

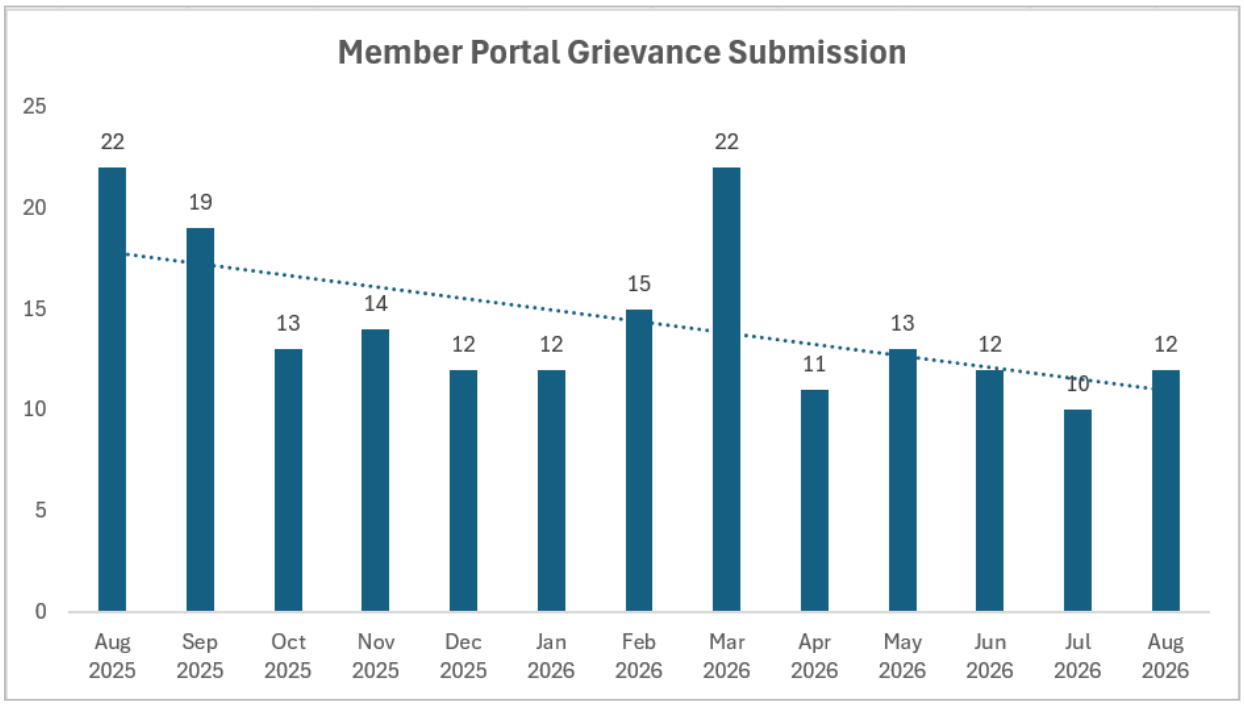
Portal	Page	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026	May-2026	Jun-2026	Jul-2026	Aug-2026
Provider	Member eligibility	1,690,469	1,755,600	1,856,262	1,842,582	2,080,703	2,170,351	1,664,301	1,886,751	2,006,389	2,080,398	2,145,772	2,446,105	2,500,091
	Claim status	262,796	270,824	279,976	234,095	267,856	254,651	248,100	255,715	241,944	314,619	327,081	297,785	713,213
	Authorization status	10,237	10,574	11,381	9,103	10,845	11,322	10,422	11,741	11,140	10,051	11,365	11,880	11,216
	Submit authorizations	7,676	7,965	9,874	6,653	8,109	8,561	7,433	8,257	7,981	7,308	8,810	8,741	9,064
	Submit professional claims	7,035	6,304	6,444	5,246	6,025	6,198	6,357	7,379	6,621	6,557	6,622	7,016	6,863
	Total	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	2,499,650	2,771,261	3,240,447
Member	ID Card	6,175	5,082	4,824	4,436	4,082	4,771	3,953	4,046	3,960	3,385	4,318	4,911	4,531
	Member eligibility	5,781	5,555	4,903	4,775	4,312	4,421	3,377	3,643	3,173	2,810	3,011	3,355	3,848
	Provider Directory	3,905	3,650	3,229	3,152	2,862	4,051	2,691	3,092	2,667	2,153	2,544	2,764	2,099
	Select/Change PCP	2,390	2,363	1,990	1,830	1,887	2,337	1,568	1,882	1,569	1,370	1,374	1,576	2,150
	My Claims Services	1,571	1,623	1,606	1,355	1,451	1,589	1,418	1,524	1,371	1,329	1,274	1,344	1,456
	Total	19,822	18,273	16,552	15,548	14,594	17,169	13,007	14,187	12,740	11,047	12,521	13,950	14,084

Provider Authorizations (Portal Submissions)

Provider Portal authorization submissions increased from 6,627 in August 2025 to 6,495 in August 2026, an actual decrease of 132 submissions (2.0%) over the reporting period.

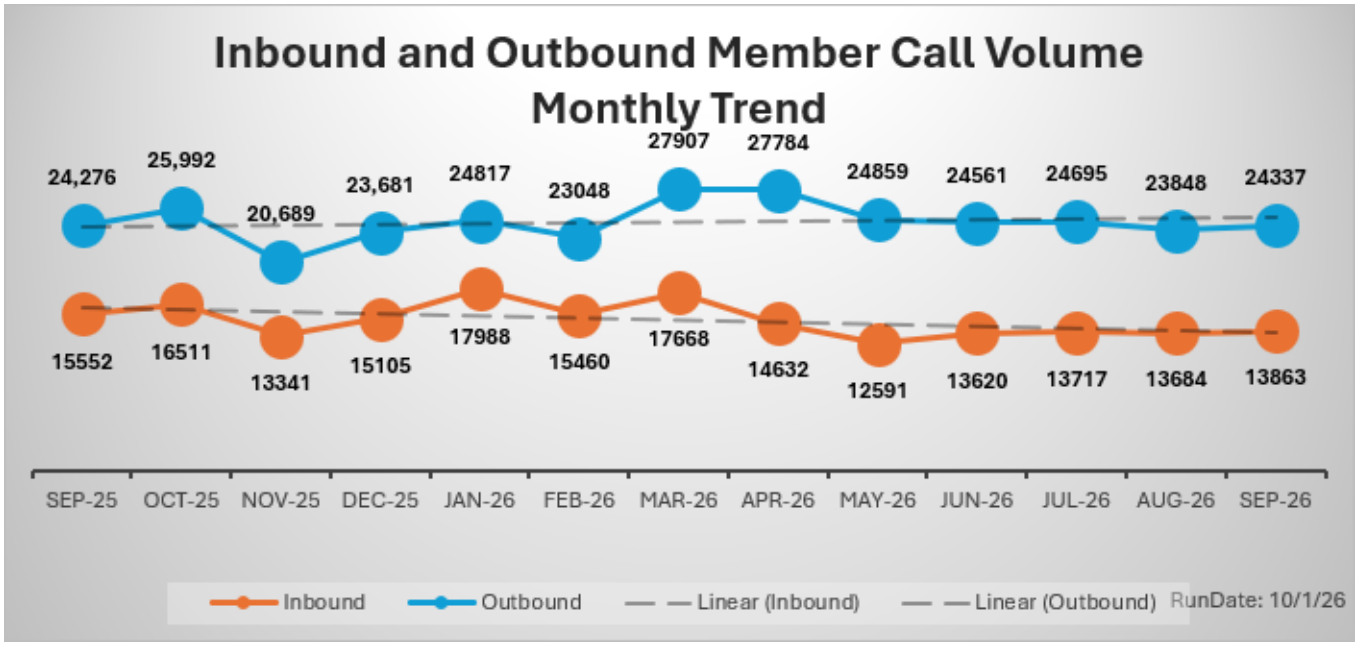


Member Grievances (Portal Submissions)
Member Portal grievance submission decreased from 22 in August 2025 to 12 in August 2026, a decrease of 10 submissions (45.5%) over the reporting period.



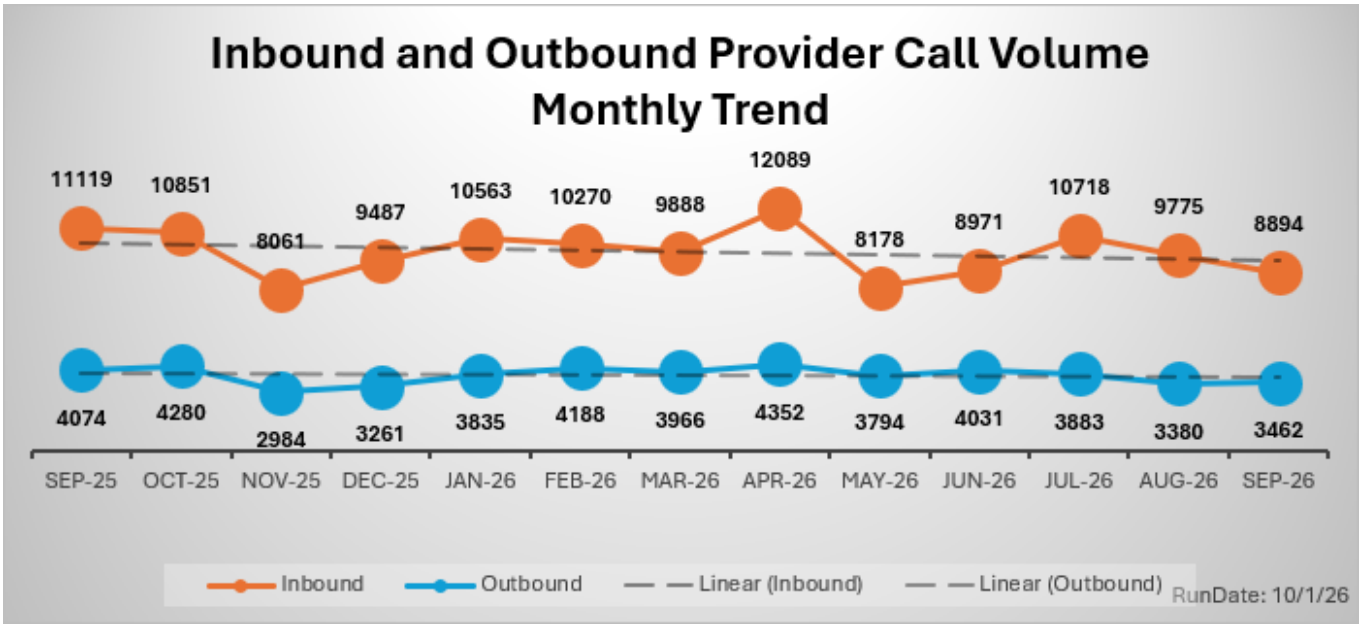
Call Center Metrics

Member Call Utilization
Member call utilization remained stable during September 2026, with no application outages or downtime reported. During September 2026, member-facing call center applications supported 13,863 inbound and 24,337 outbound calls. Compared with August 2026, inbound calls increased by 1.3% and outbound calls increased by 2.1%.



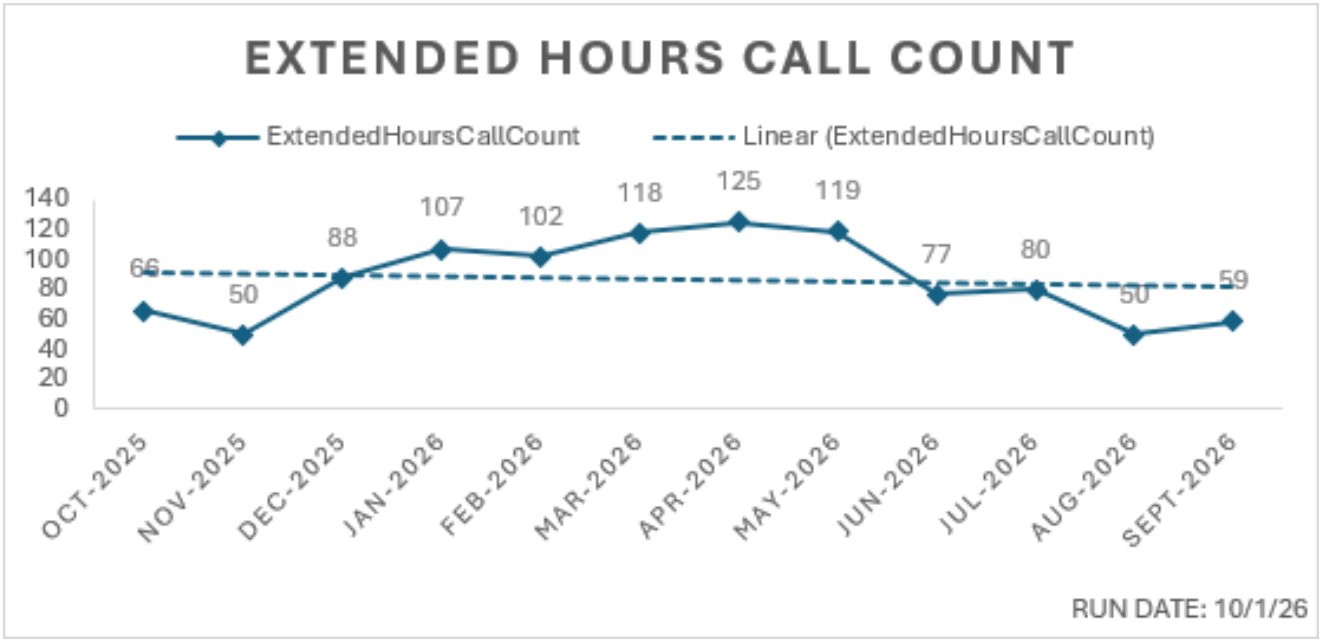
Provider Call Utilization

Provider call utilization remained stable during September 2026, with no application outages or downtime reported. During September 2026, provider-facing call center applications supported 8,894 inbound and 3,462 outbound calls. Compared with August 2026, inbound calls decreased by 9.0% and outbound calls increased by 2.4%.



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 59 extended-hours calls were received in September 2026, compared with 50 in August 2026.

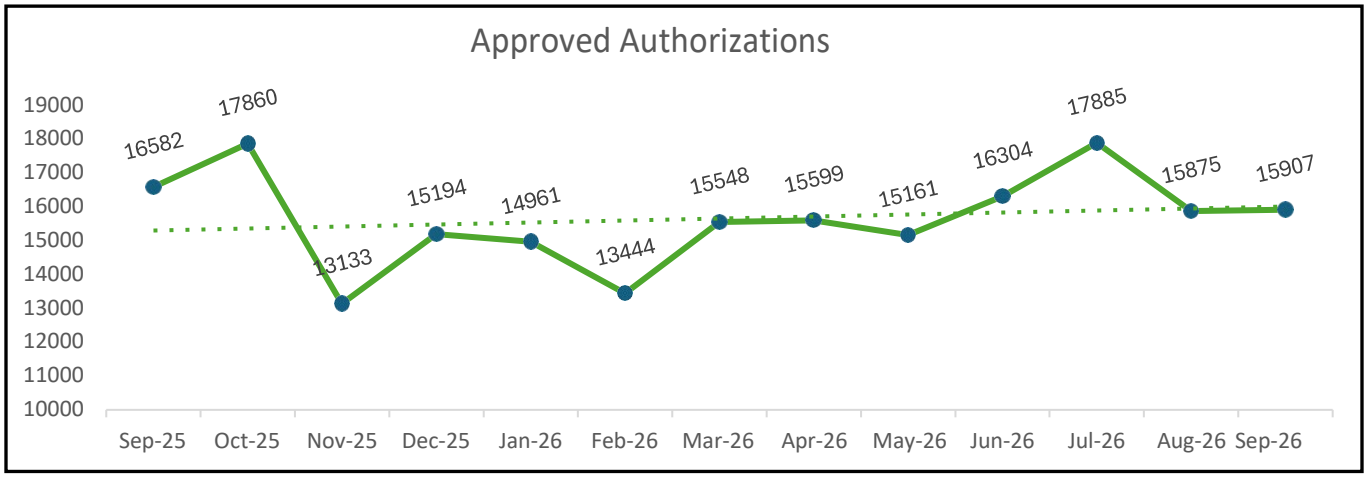


Authorizations

Over a 13-month period, approved authorizations averaged 15,650 monthly cases, peaking at 17,885 in July 2026 before stabilizing between 13,133 and 17,885. Auto-approved authorizations averaged 8,193 cases monthly, representing a 52.4% average automation rate that peaked at 57.3% in August 2026. Denied authorizations averaged 836 cases monthly, peaking at 1,296 in June 2026 following an upward climb that began in early spring.

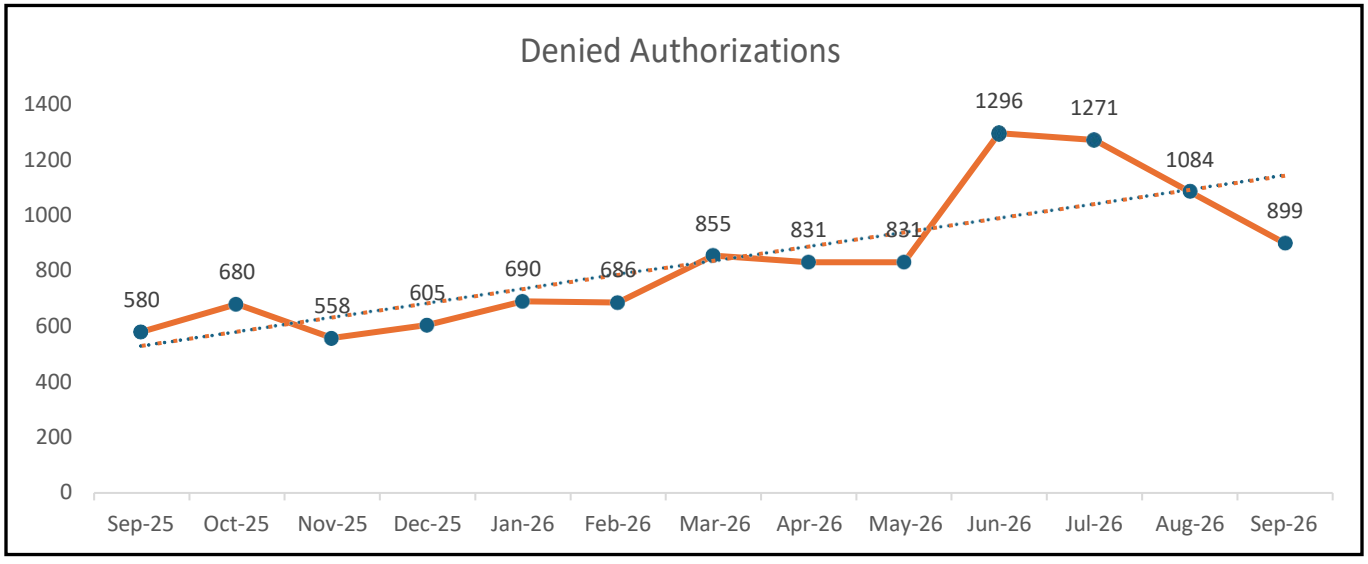
Approved Authorizations:

Authorizations averaged 15,650 monthly over the 13-month period. Volumes peaked significantly in July 2026 at 17,885 approvals before dropping the following month. Since then, demand has normalized into a predictable operational baseline ranging between 13,133 and 17,885 monthly cases.



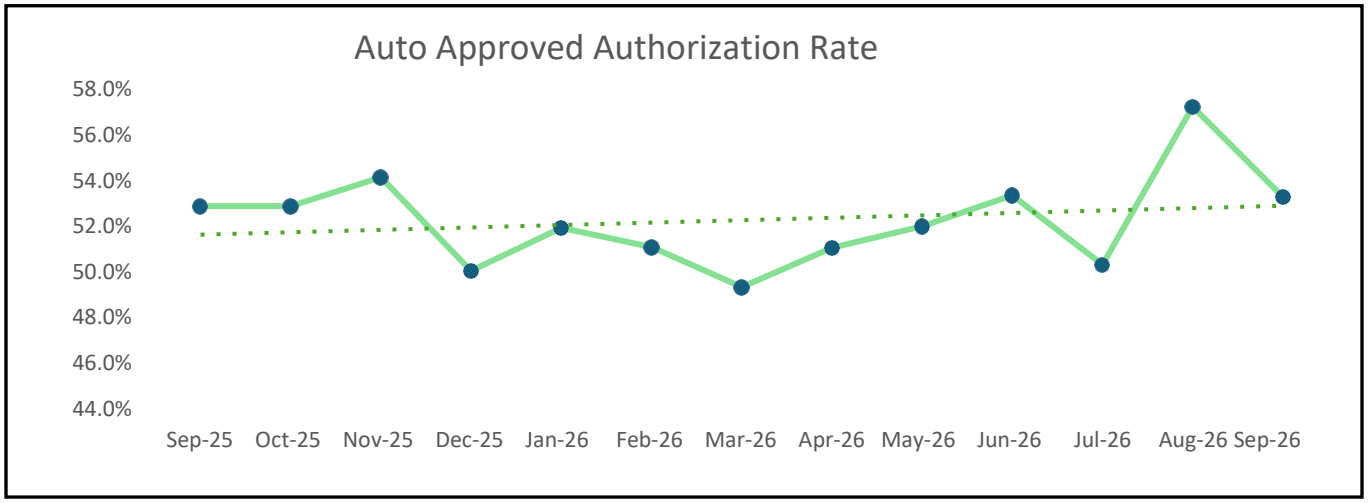
Denied Authorizations:

Denied authorizations averaged 836 cases monthly over the 13-month period. Volumes hit a peak in June 2026, reaching 1,296 denials, following an upward trend that began in early spring. Prior to this upward climb, denial metrics fluctuated within a lower baseline range between 558 and 690 monthly cases.



Auto Approved Authorization Rate:

The auto-approval rate remained highly stable over the 13-month period, processing an average of **52.4%** of all approved authorizations. System automation peaked at **57.3%** in August 2026, while consistently streamlining at least half of the total case volume month-over-month, with a single minor dip to 49.4% in March 2026.



OCR-Based Form Processing and Automation

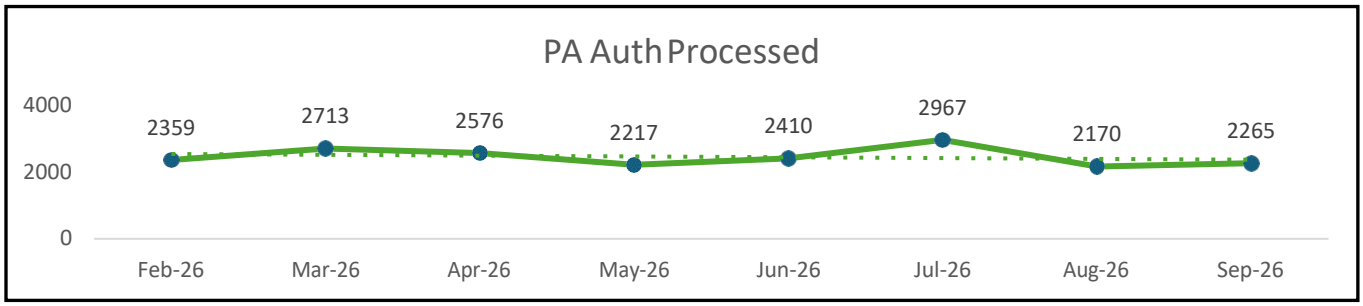
To improve operational efficiency, reduce manual effort, and minimize data-entry errors, the Alliance has implemented Optical Character Recognition (OCR) technology for the automated processing of key authorization and enrollment forms. OCR enables faster document intake, data extraction, and workflow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

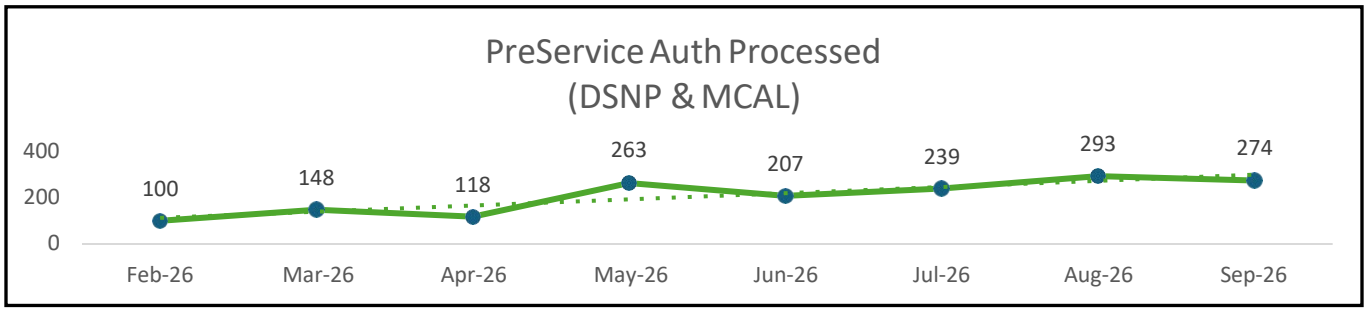
PA Authorization (alternative to DocuStream):

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 September, the new OCR workflow processed a total of 19,677 cases, averaging 2,460 monthly authorizations while maintaining a volume range between 2,170 and 2,967.



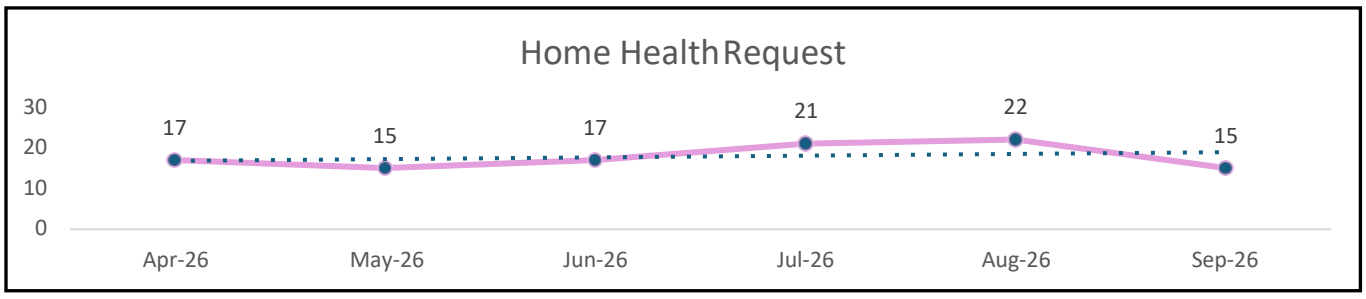
Pre-Service Auth:

Pre-Service Auth processing for DSNP and MCAL maintained consistent activity from February through September. During this eight-month period, monthly volumes reached a low of 100 in February and peaked at 293 in August.



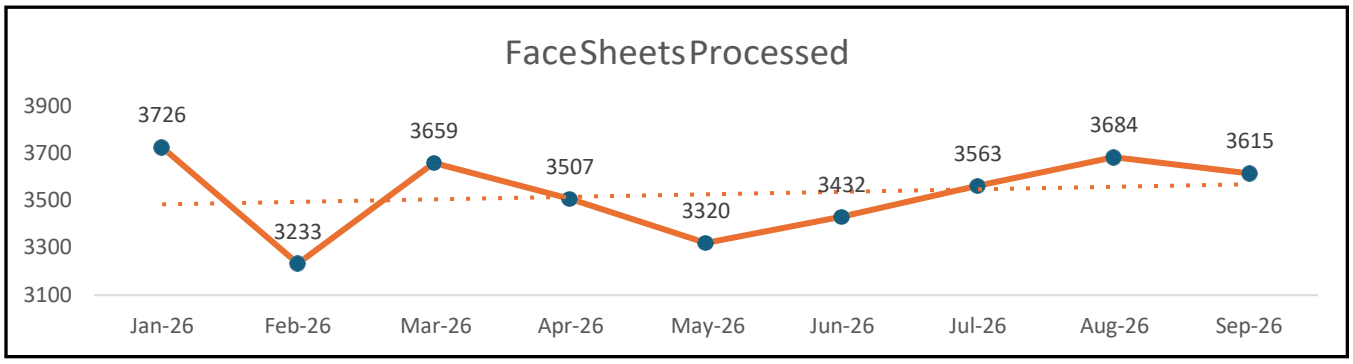
Home Health Request:

Home health request processing transitioned to OCR in April 2026, maintaining stable volume levels through September with monthly requests ranging between 15 and 22.



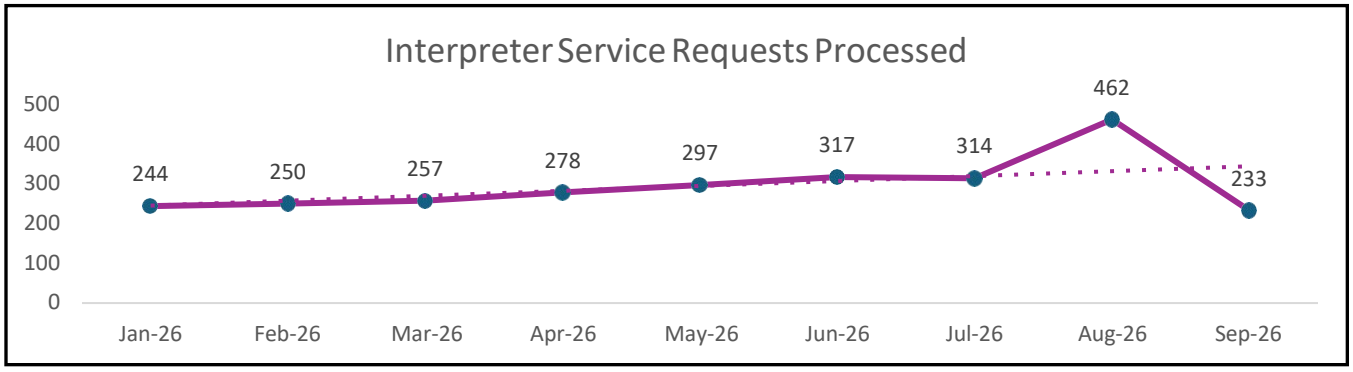
Face Sheet:

Monthly face sheet processing volumes remained stable from January through September, ranging between 3,233 and 3,726 with an average of 3,527 per month.



Interpreter Service Requests:

Monthly interpreter service requests ranged from 233 to 462 from January through September. Across this full 9-month timeline, volumes averaged 295 requests per month, totaling 2,652 overall.

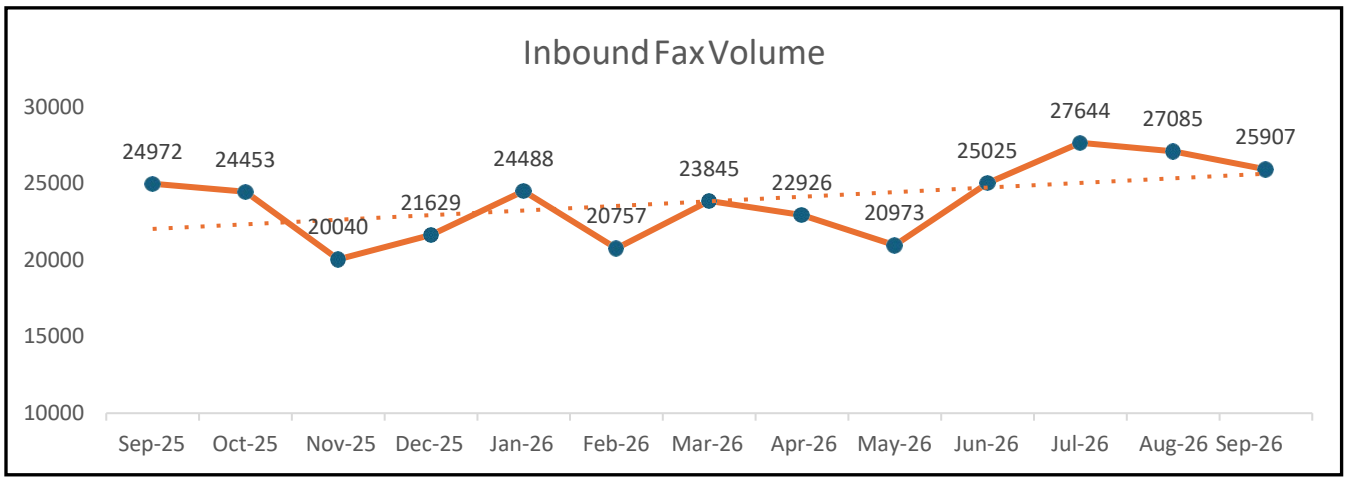


Fax-Based Authorization and Provider Communication

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

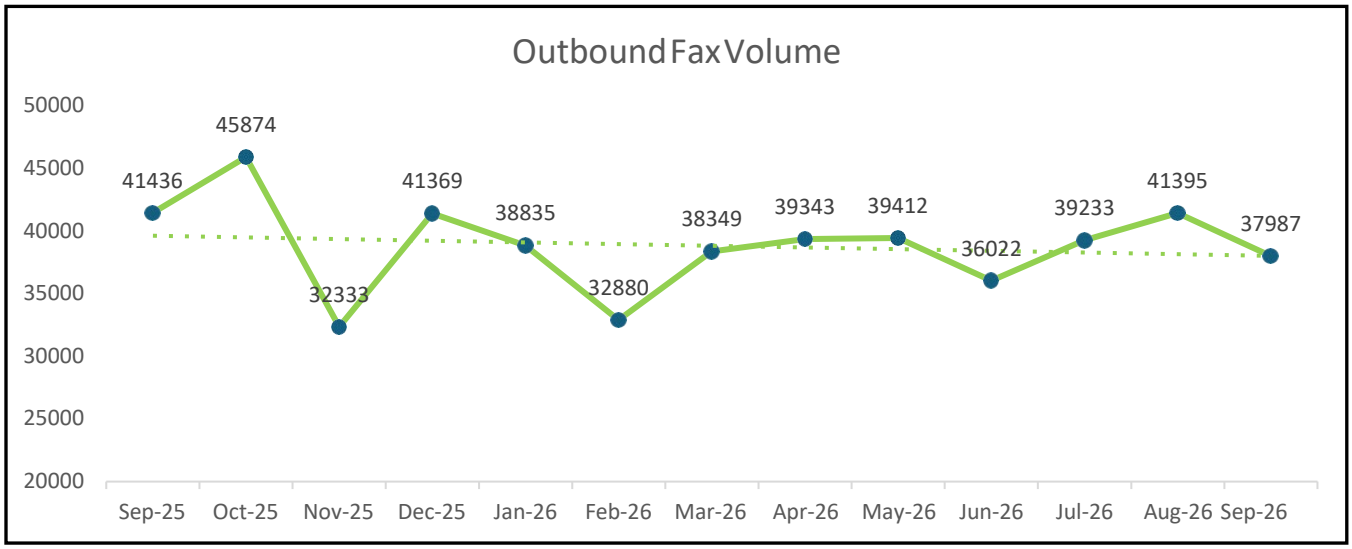
Inbound Fax Processing for Prior Authorization Support:

Inbound faxes averaged 23,826 monthly over the 13-month period. Volume peaked significantly in July 2026 at 27,644 transmissions before settling into a consistent operational pattern. Since then, the communication channel has maintained a highly stable baseline, with volume tracking between 20,040 and 27,644 faxes each month.



Outbound Fax Delivery for Authorization Decisions:

Outbound faxes averaged 38,805 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 45,874 faxes per month.

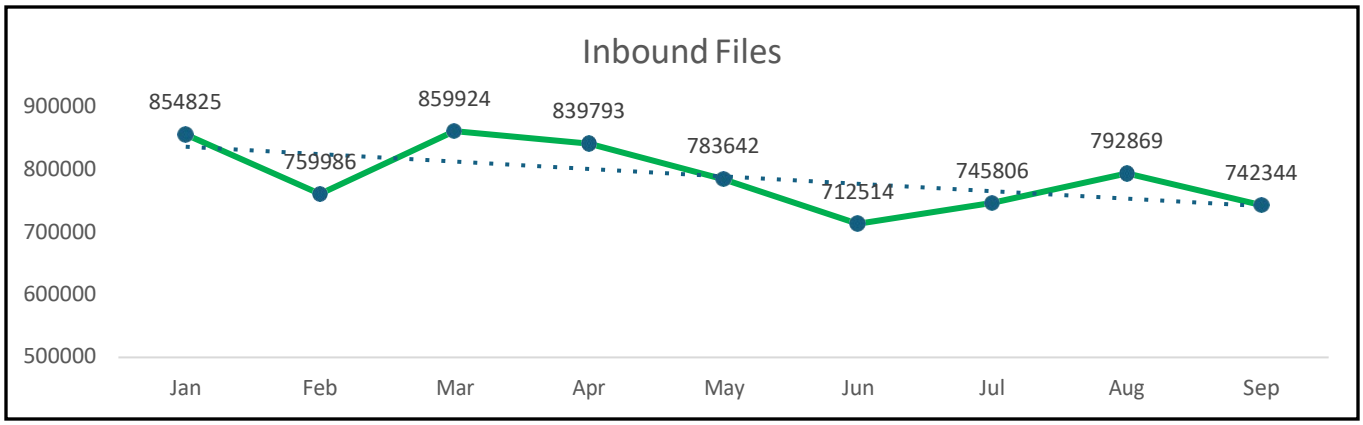


Monthly Inbound and Outbound file processing

From January through September, file processing averaged approximately 797,840 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.

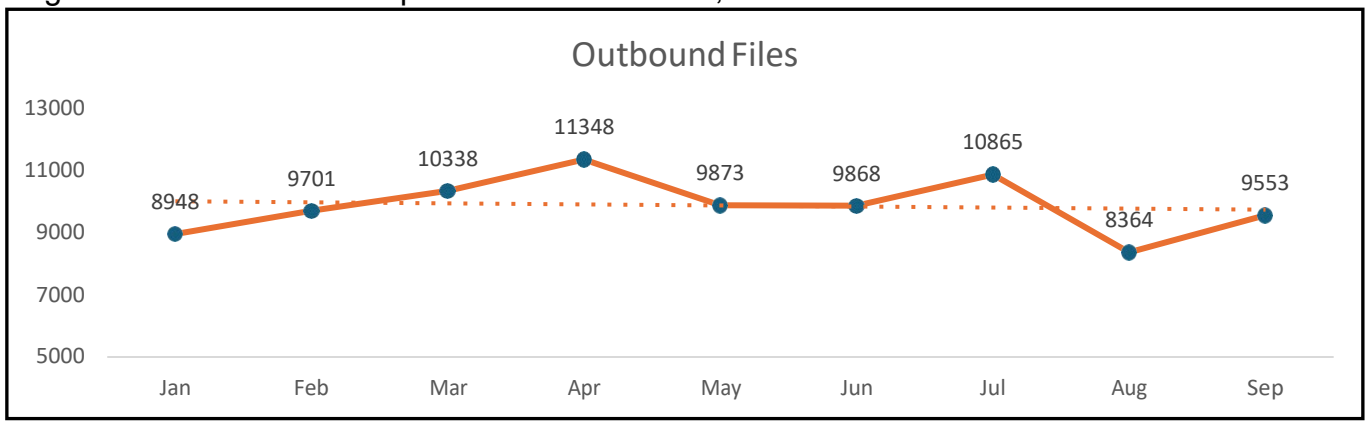
Inbound files processing:

Inbound file processing averaged approximately 787,967 files per month from January through September, with steady activity across the period and the highest volume recorded in March at 859,924 files, while June marked the lowest operational volume at 712,514



Outbound file processing:

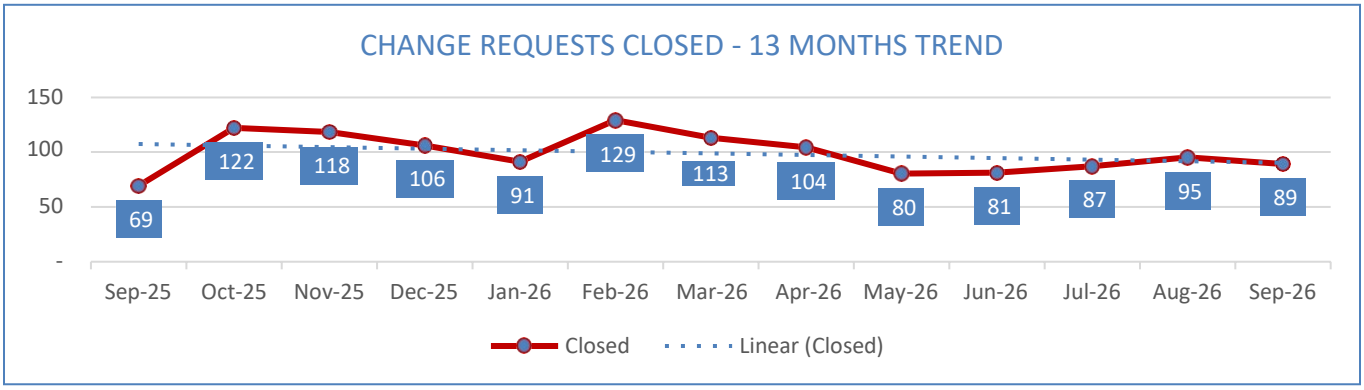
Outbound file processing averaged approximately 9,873 files per month from January through September, consistently representing the smaller share of total file activity. Volume grew progressively early in the year, reaching its highest throughput in April at 11,348 files, while August marked the lowest operational volume at 8,364.



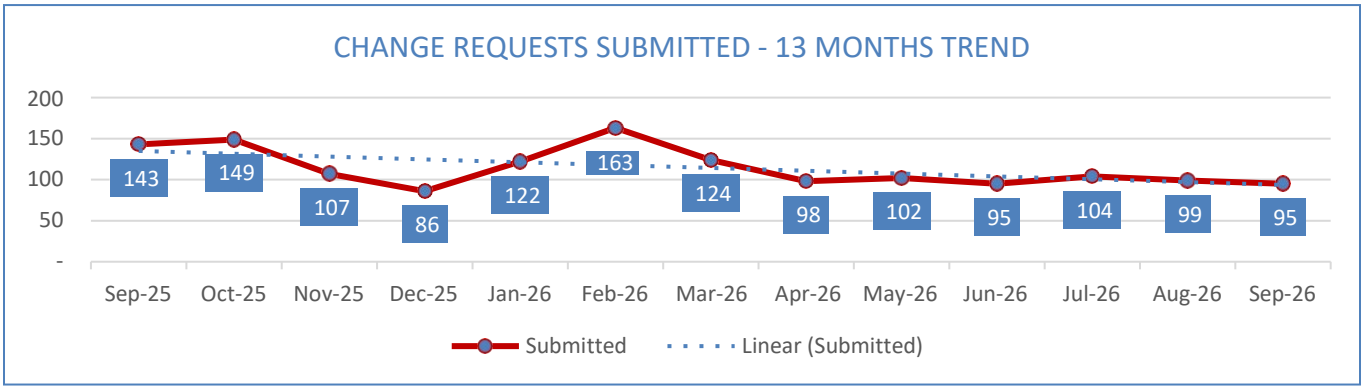
Change Management Key Performance Indicator (KPI)

- Change Management activity remained strong in September 2026, with 95 Change Requests submitted and 89 CRs closed, reflecting continued business demand and steady operational performance. As a result, 144 CRs remained active at month-end, with aging requests continuing to be an area of focus, including 87 open for more than 30 days, 68 over 60 days, 52 over 90 days, and 6 open for more than one year.

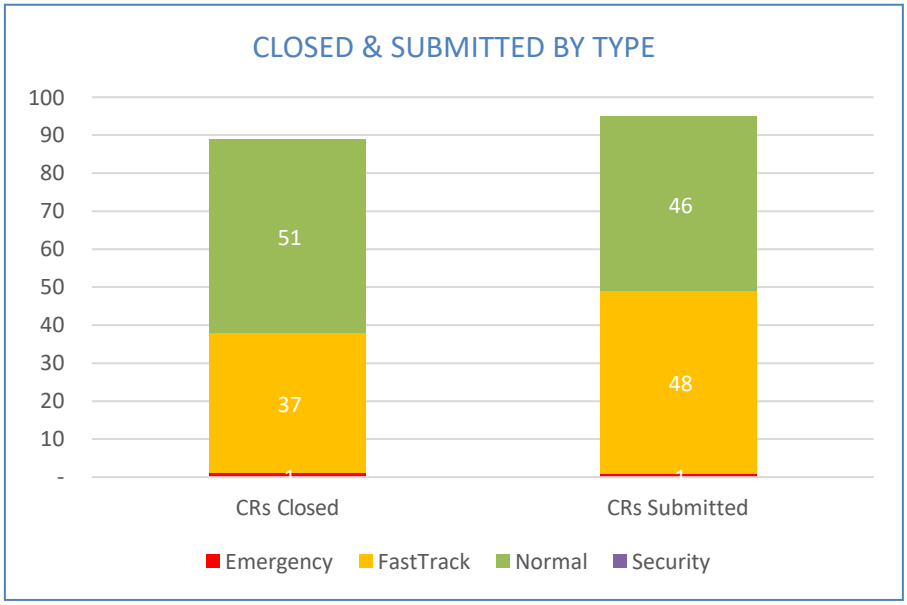
- During the 13-month period from September 2025 through September 2026, a total of 1,284 Change Requests were successfully closed, averaging approximately 99 CRs per month. The volume of completed change activity remained consistently strong throughout the reporting period, demonstrating the organization's ability to manage and execute production changes effectively while maintaining operational stability



- Over the past 13 months, 1,487 Change Requests have been submitted, averaging approximately 114 requests per month, reflecting sustained demand for change management services across the organization. Submission volumes fluctuated throughout the period, reaching a peak of 163 submissions in February 2026 and a low of 86 submissions in December 2025.



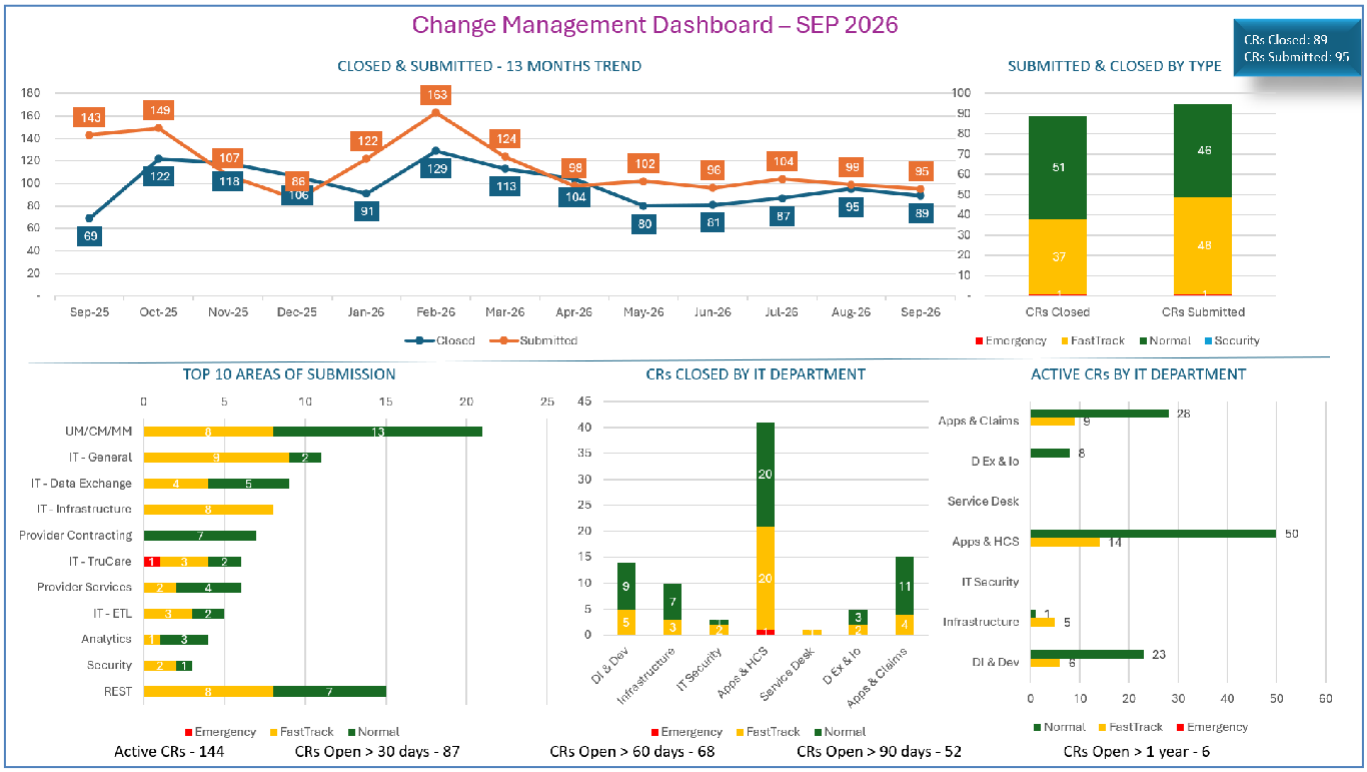
- In September 2026, 95 Change Requests (CRs) were submitted, and 89 CRs were closed, reflecting steady change activity and strong execution performance. FastTrack and Normal CRs accounted for most requests, with 48 FastTrack and 46 Normal CRs submitted. Closure activity remained strong, with 51 Normal and 37 FastTrack CRs successfully completed.



- A total of 89 Change Requests (CRs) were successfully closed across all departments in September 2026. Most completed CRs were processed through the Normal and Fast Track change pathways, accounting for 51 (57%) and 37 (42%) CRs respectively. Only one Emergency Change Request was closed during the month, representing 1% of total change activity, indicating strong planning, scheduling, and adherence to the standard change management process
- Apps & HCS recorded the highest volume of closed CRs with 41 requests, representing approximately 46% of all changes closed during the month. The department also processed the organization's only Emergency CR, while maintaining an equal distribution of Fast Track and Normal changes. Apps & Claims followed with 15 closed CRs, and Data Integration completed 14 CRs, demonstrating continued project and operational delivery across application and data-related services.

Change Requests Closed in September 2026 (Percentage of Emergency CRs closed by IT Department)					
	CRs Closed			TOTAL	% of Emergency CRs
	Emergency	**Fast Track**	**Normal**		%
Data Integration	-	5	9	14	
Infrastructure	-	3	7	10	
IT Security	-	2	1	3	
Apps & HCS	1	20	20	41	2%
Service Desk	-	1	-	1	
Data Exchange	-	2	3	5	-
Apps & Claims	-	4	11	15	-
	1	37	51	89	1%

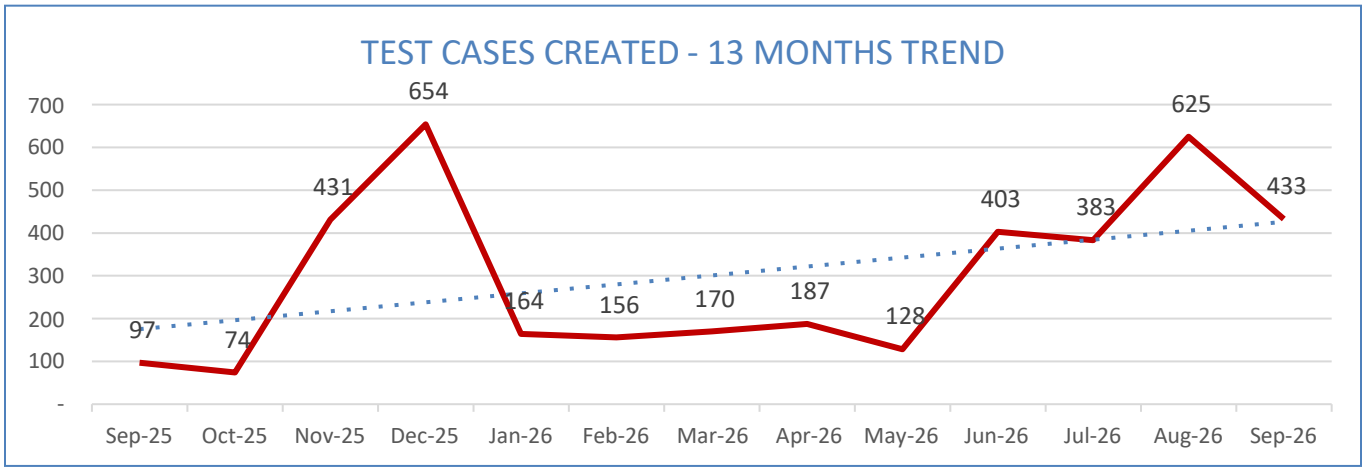
- **September 2026 Change Management Dashboard**



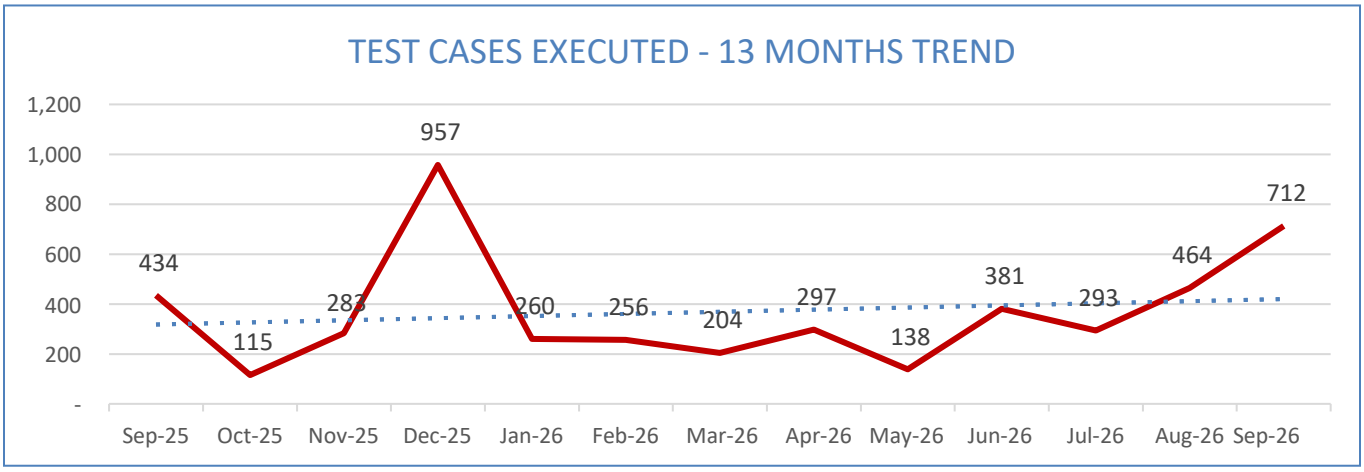
IT Quality Assurance

- A total of 3,905 test cases were created over the last 13 months. Test case creation peaked in December 2025 (654) and August 2026 (625). The significant increase in November and December 2025 was primarily driven by the D-SNP project, which required extensive test case development and expanded testing coverage.

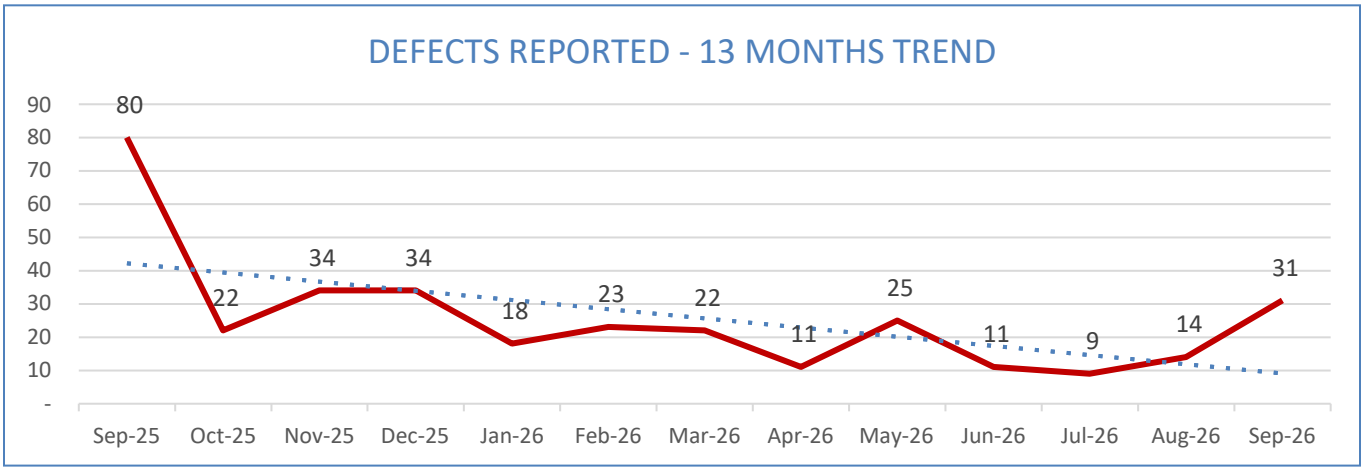
- After stabilizing in early 2026, test case creation increased significantly from June through September 2026, with consistently high volumes, including 433 test cases in September 2026.



- Test case Execution: A total of 4,794 test cases were executed over the last 13 months. Execution activity peaked in December 2025 (957), largely driven by the D-SNP project, which required extensive testing to support implementation and release readiness. After stabilizing in early 2026, execution volumes increased during the second half of the year, reaching 712 test cases executed in September 2026, the second-highest month in the reporting period.



- Defects Reported: A total of 334 defects were identified during testing over the last 13 months. Defect counts were highest in September 2025 (80) and remained moderate during the D-SNP project period in November and December 2025 (34 each month) despite increased testing activity. The increase to 31 defects in September 2026 corresponds with higher test execution volumes and continued efforts to identify issues before production deployment.



- 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
Modernize Change Management (Process Improvement)	On Track	12/31/2026	Redesign the Change Management framework to streamline processes, improve stakeholder adoption, and establish a sustainable, self-governing operating model with shared accountability between Delivery and Change Management teams. Reviewed and shared the updated Change Management Framework with all IT Directors. New Change Management framework will be active starting 10/5/2026
AppEnhancer (ApplicationXTender) Upgrade	Completed	7/31/2026	Upgrades are completed and validated by Business.
TruCare Correspondence in AppXTender	Delayed	2/28/2027	Initial development and discovery phase. KP dependency. Due to the priority on Member Correspondence project
TruCare Environment Sync up	Completed	9/30/2026	All TruCare environment on 25.2.1.2 with MCG Version 17.3 Content Version: 29.1
Letters Enclosure Automation	Completed	8/30/2026	100% Completed, already utilized the standardization in few letters.
Call Center Test Automation	On Track	12/31/2026	Complete Production smoke test suite and regression test suite for Call Center
Katalon - Procurement and standardize	Completed	9/30/2026	Completed: Procured the tool and all team members are setup with Katalon tool. Started using Katalon for Quality Suite, TruCare, and EREx applications.
QA/Testing Dashboard	Delayed	11/30/2026	Automated QA / Testing Dashboard to be published. The Completion date moved from 9/30 to 11/30 as we need to put in additional effort to gather all the details for test cases and test execution.
Delphix – Upgrade to version 27.0.0.0	Not Started	12/31/2026	Upgrade Delphix from version 2026.2 to version 27.0.0.0
SFTP Archiving Strategy	Completed	9/30/2026	Completed on 09/04/2026; all documents have been archived
Letters – Correspondence Metatag	Delayed	11/30/2026	Delayed due to resource (Prasanna) unavailability
Enrollment - End to End test automation	On Track	3/31/2027	Activity to start in August 2026. End to End regression test scripts to be delivered as part of this initiative. Team has started with designing the automated regression suite for End of End Enrollment functionality using Katalon.
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
Ownership of QA/Testing for Change Requests related to Infrastructure/Security/Service Desk.	On Track	11/30/2026	Engaging with Infrastructure, Security, and Service Desk stakeholders to define and standardize the testing process for change requests.
Member Correspondence	On Track	12/31/2026	Initial development and discovery phase. KP, AppEnhancer, ODS Viewer integration, POC is in progress, working on SOW with Vendor support
Liaison ECS/Delta Upgrade	Not Started	2/28/2027	This initiative will be started in Q2 2026-27
ABA Form (Referrals)	On Track	10/29/2026	Offshore and JSON development completed, EREx development in progress.
BH Form (Referrals)	On Track	11/19/2026	Offshore and JSON development completed, EREx development in progress.
Community Support Referral (CalAIM)	On Hold		Offshore and JSON development completed, EREx development is on hold.
Health Ed & Wellness Form	On Hold		Offshore and JSON development completed, EREx development is on hold.
CFMG	On Hold		Status: On hold until end of October. Awaiting updated Excel data, delivery solution may shift from PDF to Excel.

Initiative	Status	Estimated Completion	Notes
ICF/DD	On Hold		Offshore development in progress, EREx development will be on hold
HIF/MET	On Hold		Offshore development in progress, EREx development will be on hold
Enrollment and Call Center - Metrics and Dashboards	On Track	12/31/2026	Refining and enhancing reporting sections
Inbound 834 Eligibility Process Improvement Phase 1	Completed	9/3/2026	Phase 1 - Member matching DOB/Gender 250 fewer records and 1.5 hours saved in the DHCS monthly review process.
Inbound 834 Eligibility Process Improvement - Phase 2	On Track	10/29/2026	Phase 2 - Multi-CIN/duplicate resolution and audit trace Expected to reduce approximately 500 monthly review and manual-processing records and save approximately 6 hours per month.
Inbound 834 Eligibility Process Improvement - Phase 3	On Track	12/3/2026	Phase 3 - Coverage / Eligibility Decisioning Expected to automatically process or prevent approximately 400 monthly eligibility and baby exceptions and save approximately 5 hours per month.
Inbound 834 Eligibility Process Improvement - Phase 4	On Track	1/14/2027	Phase 4 - PCP / Enrollment Logic Expected to prevent approximately 225 monthly manual corrections and save approximately 3 hours per month.
Inbound 834 Eligibility Process Improvement - Phase 5	On Track	1/28/2027	Phase 5 - Term-by-Absence / Review Routing Expected to prevent approximately 300 repeated or unnecessary monthly review cases and save approximately 4.5 hours per month.
Inbound 834 Eligibility Process Improvement - Phase 6	On Track	1/31/2027	Phase 6 - ID Card Output Expected to save approximately 1.5 hours of monthly reconciliation and validation effort.
Call Center Modernization	On Track	4/30/2027	This date is at risk due to vendor selection process not being complete. I will update once a vendor is selected. The Call Center vendor selection process is progressing as planned, with the top three vendors identified and moving forward in the final evaluation phase.
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

IT Workflow Automation

AI-Powered Compliance Platform: Alliance has completed the development of its AI-powered compliance platform, designed to automate regulatory adherence by intelligently linking internal policies with external regulatory requirements. Currently, 90% of compliance workflows are fully configured and operating in production, ensuring continuous alignment with evolving regulatory standards.

AI-Driven Software Development Transformation: Alliance is pursuing a 12-month enterprise transformation to integrate AI across the full Software Development Life Cycle (SDLC). The initiative targets enhanced developer productivity, improved code quality, and accelerated delivery through:

- Automated code generation and intelligent code review
- DevOps and CI/CD pipeline automation
- AI-assisted quality assurance and testing

Approximately 20% of IT professionals are currently leveraging AI tools for development and testing activities.

OCR & Intelligent Document Processing: In the past three months, IT deployed a high-accuracy Optical Character Recognition (OCR) solution built on OpenAI, automating image interpretation and text extraction from faxes and user prompts. This capability is now integrated into critical clinical authorization workflows:

- Post Acute Authorization request workflow — completed June 2026
- Inpatient Authorization request workflow — completed July 2026
- Decommissioned the legacy Docustream vendor process
- Projected annual savings: $150,000

These deployments have contributed directly to the ~45,000 staff hours saved year to date.

Next Steps:

- Roll out Hospice Rate SOP to production — target: end of September 2026
- Identify and automate 10+ additional manual SOPs — target: end of December 2026
- ABA Form (Referrals) by October 2026
- Behavioral Health Form (Referrals) by December 2026
- Community Support Referral (CalAIM) in CYQ1 2027
- Health Ed & Wellness Form in CYQ1 2027
- CFMG Forms (5 types) in CYQ12027

Claims Adjudication

IT's Configuration team has identified three key process improvement areas with the potential to increase Alliance's claims auto-adjudication rate from 85% to 92%. To achieve this, Alliance engaged Optum AI for a pilot program targeting manual claims processing workflows. Key achievements to date:

- Optum AI pilot program completed and successfully tested for Hospice Rate Standard Operating Procedure (SOP)
- Solution design underway for Coordination of Benefits (COB) claim workflow automation

Next Steps:

- Roll out Hospice Rate SOP to production — target: end of October 2026
- Identify and automate 10+ additional manual SOPs — target: end of December 2026

AI Self-Service Chatbot — IT Service Desk & HR

Alliance is designing an AI-influenced self-service chatbot to support three internal service functions: IT Service Desk, Human Resources, and IT Facilities. The solution will enable automated ticketing, knowledge inquiry, and process self-service to reduce staff dependency on manual triage.

Deployment Roadmap:

- IT Service Desk — ticketing process and knowledge inquiry: October 2026
- IT Facilities and Human Resources process onboarding: January 2027

Additional Automation Initiatives

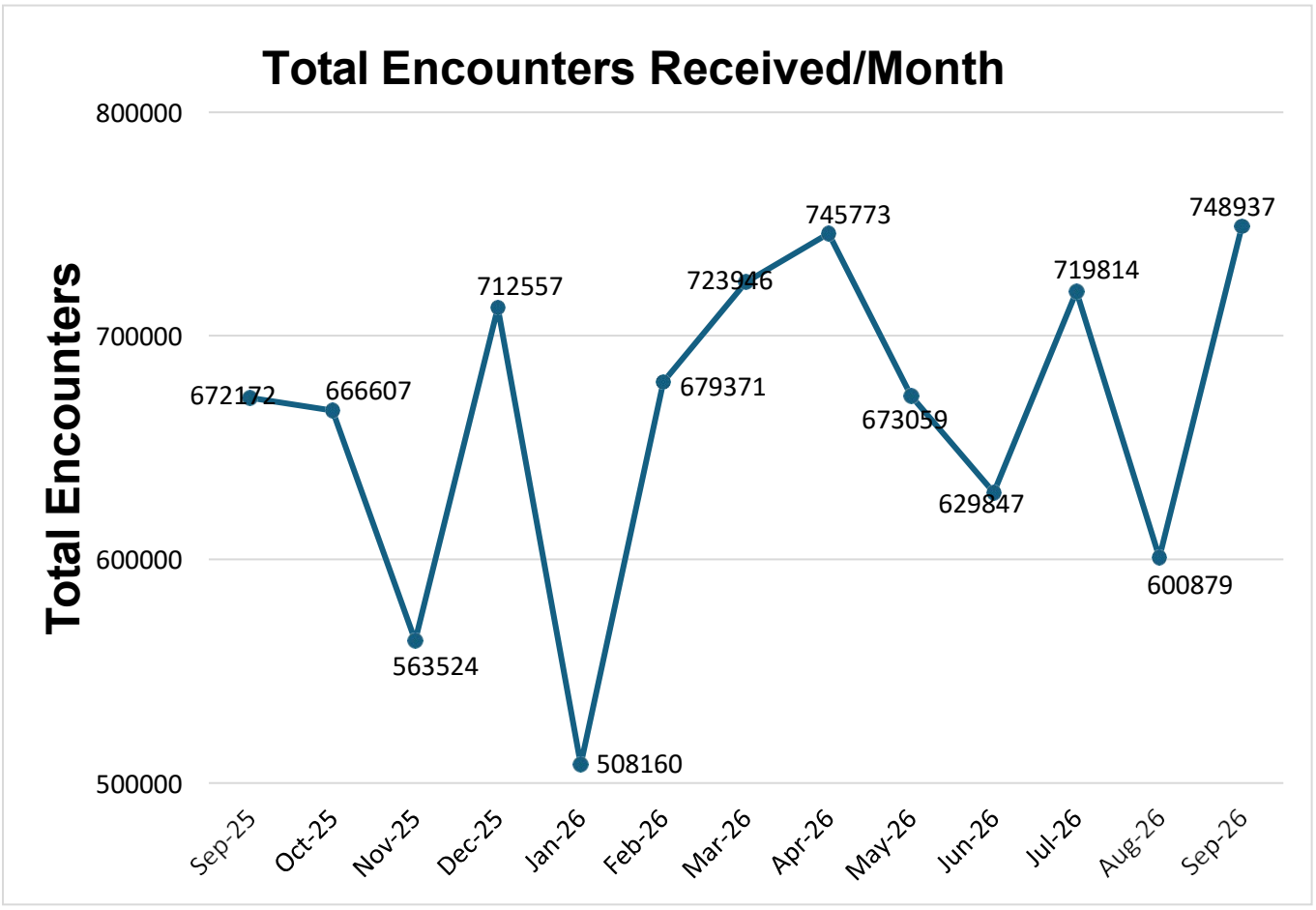
- Provider Resolution Dispute quality assurance and validation workflow: planned go-live November 2026
- End-to-end Call Center ecosystem testing automation: planned go-live October 2026

Encounter Data from Trading Partners 2026

- **AHS:** September weekly files (9,935 records) were received on time.
- **BACH:** September monthly files (211 records) were received on time.
- **BACS:** September monthly files (193 records) were received on time.
- **CFMG:** September weekly files (21,135 records) were received on time.
- **CHCN:** September weekly files (189,985 records) were received on time.
- **CHME:** September monthly files (8,673 records) were received on time.
- **Docustream:** September monthly files (210 records) were received on time.
- **EBI:** September monthly files (1,319 records) were received on time.
- **FULLCIR:** September monthly files (7,243 records) were received on time.
- **HCSA:** September monthly files (4,811 records) were received on time.
- **IOA:** September monthly files (1,478 records) were received on time.
- **LAFAM:** September monthly files (75 records) were received on time.
- **LIFE:** September monthly files (241 records) were received on time.
- **Logisticare:** September weekly files (45,739 records) were received on time.
- **Magellan:** September monthly files (572,217 records) were received on time.
- **March Vision:** September monthly files (457 records) were received on time.
- **MED:** September monthly files (2,340 records) were received on time.
- **PAIRTEAM:** September monthly files (7,738 records) were received on time.
- **Quest:** September weekly files (22,501 records) were received on time.
- **SENECA:** September monthly files (468 records) were received on time.
- **STAR:** September monthly files (184 records) were received on time.
- **TITANIUM:** September monthly files (6,978 records) were received on time.
- **TVHC:** September monthly files (58 records) were received on time.
- **UCSF:** September monthly files (734 records) were received on time.
- **VSP:** September monthly files (6,421 records) were received on time.

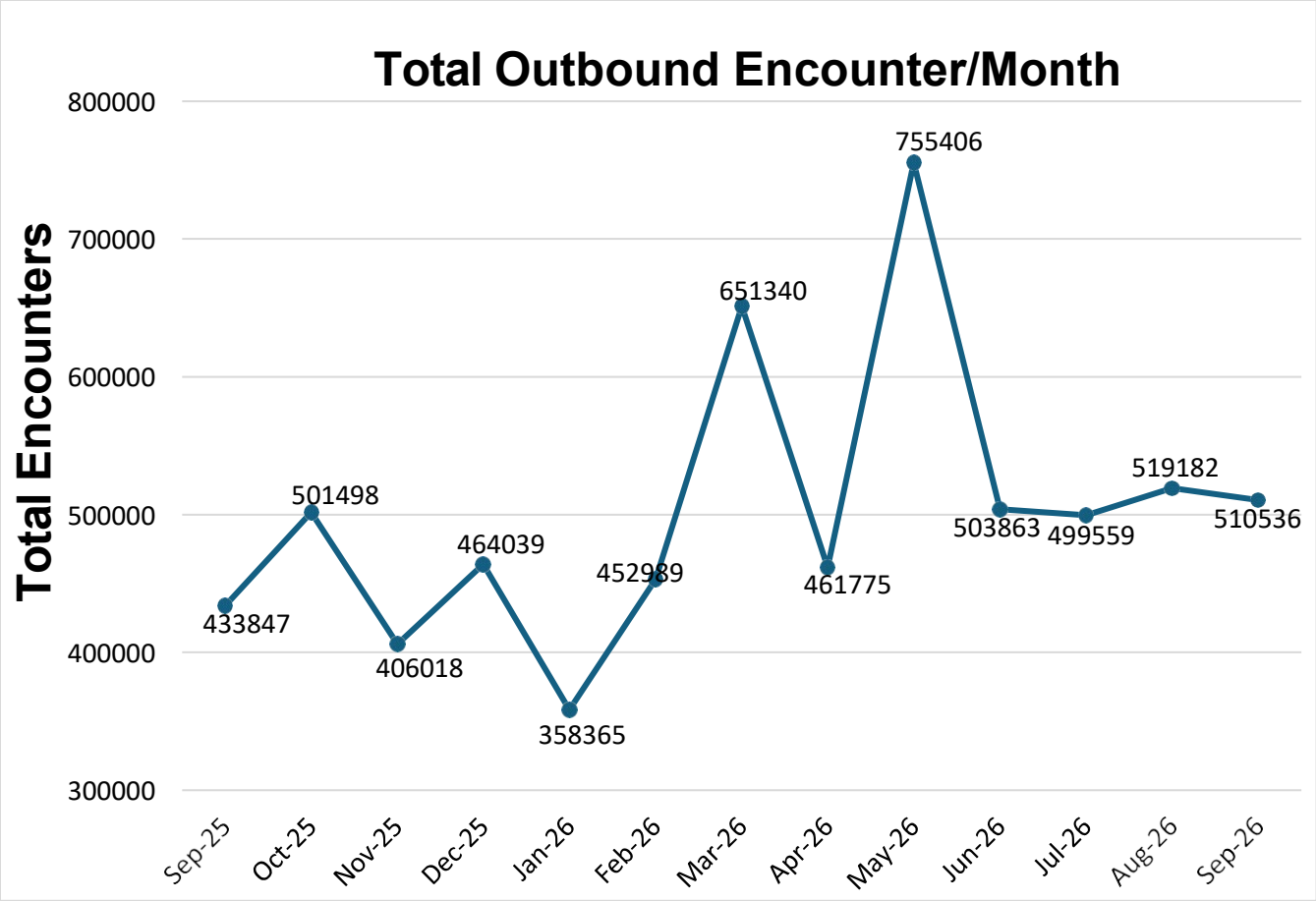
Trading Partner Encounter Inbound Submission History

TradingPartnerName	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
AHS	8455	9267	11333	8671	8345	10599	9835	8399	9261	11371	9529	6560	9935
BACH	180	181	0	0	0	0	0	0	0	0	0	851	211
BACS	100	102	114	109	196	140	359	409	248	278	255	226	193
CFMG	20280	15705	20083	16647	10692	22313	17563	13461	18591	11152	17465	8818	21135
CHCN	170744	152102	138524	153899	104101	193474	177607	178392	147494	187040	133429	137197	189985
CHME	8228	7938	9119	7579	8492	8597	7129	6348	7571	8785	8795	9223	8673
Docustream	423	829	322	0	1568	852	1292	420	164	276	467	337	210
EBI	1800	1823	1922	1683	1856	1690	1910	1825	1881	1627	1619	4874	1319
FULLCIR	5006	2176	168	1358	462	3150	2698	1077	1641	1718	1096	3101	7243
HCSA	2930	172	2481	2876	2532	3008	3496	4888	5710	6705	5876	4806	4811
Health Suite	348287	415005	296717	413349	291556	381026	396918	452453	381442	338080	435512	343119	409810
IOA	1377	1683	0	3095	1697	1672	1660	1485	1570	1717	1433	1336	1478
LAFAM	74	87	247	84	87	85	72	78	86	77	82	98	75
LIFE	245	290	330	361	250	229	255	281	293	258	278	357	241
Logisticare	62760	15649	36206	59563	34215	16237	62637	38508	40646	16373	63205	40773	45739
March Vision	8374	9295	9338	7336	10116	2845	2702	2040	1197	983	392	347	457
MED	1172	1468	1299	2894	1443	1434	912	5462	5381	7430	2018	2527	2340
PAIRTEAM	9446	9972	7871	10633	7419	5779	14368	8550	6195	5637	8028	6330	7738
Quest	18001	18001	22500	18004	18001	22499	18000	18002	22501	17998	17997	18000	22501
SENECA	188	66	0	123	360	206	932	395	407	632	747	424	468
STAR	0	0	0	0	0	0	0	0	0	127	297	536	184
TITANIUM	4102	4796	4950	4244	4746	3536	3558	3300	4824	6119	5035	6098	6978
TVHC	0	0	0	49	26	0	43	0	0	52	87	0	58
UCSF	0	0	0	0	0	0	0	0	0	0	0	11	734
VSP	0	0	0	0	0	0	0	0	15956	5412	6172	4930	6421
TOTAL	**672172**	**666607**	**563524**	**712557**	**508160**	**679371**	**723946**	**745773**	**673059**	**629847**	**719814**	**600879**	**748937**


Total Encounters Received/Month
Total Encounters
800000
700000
600000
500000
672172
666607
563524
712557
508160
679371
723946
745773
673059
629847
719814
600879
748937
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Apr-26
May-26
Jun-26
Jul-26
Aug-26
Sep-26

Trading Partner Encounter Outbound Submission History

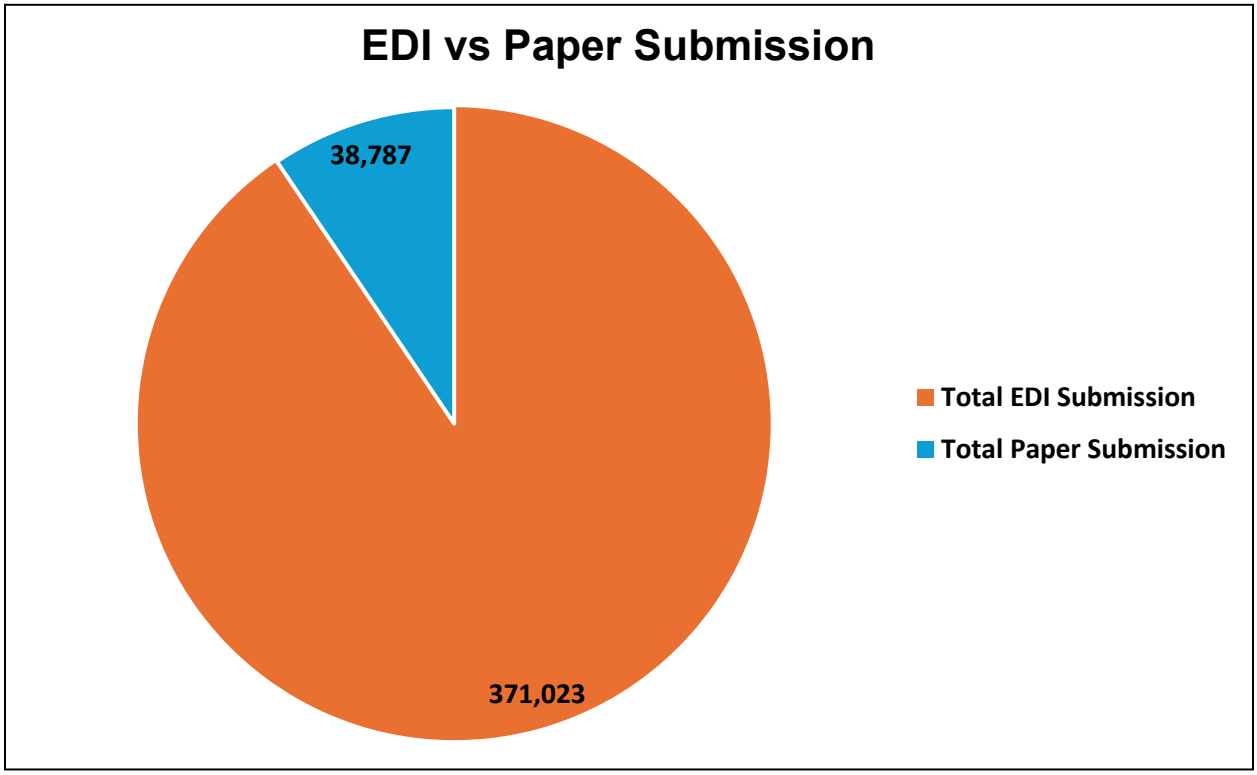
TradingPartnerName	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
AHS	8358	9125	11095	8218	8090	10555	9316	8363	9211	10082	7347	6303	11151
BACH	147	139	0	0	0	0	0	0	0	0	0	651	183
BACS	82	77	86	79	96	112	178	332	186	247	241	209	183
CFMG	10764	11978	11518	13611	7425	13874	17300	10228	12177	9867	9782	7976	16476
CHCN	89837	133350	93935	101887	69962	121092	119747	127177	98429	102319	117420	96052	131352
CHME	8090	7822	8407	7470	7697	8191	6682	6170	7386	8386	8596	9015	8307
Docustream	131	247	99	0	338	307	496	148	69	92	89	71	34
EBI	1634	1718	1834	1600	1770	1610	1869	1777	1827	1553	1552	761	1271
FULLCIR	2713	1748	89	1081	165	2479	2226	634	1121	923	837	2591	5986
HCSA	2871	149	2462	2840	2505	2979	3451	4832	5661	6637	5819	4750	4784
Health Suite	236163	253075	207026	228028	188845	245896	390092	230072	534368	306039	250117	315706	241138
IOA	1176	1304	0	2911	1617	1474	1108	1338	1178	1360	1134	88	1304
LAFAM	69	84	93	83	87	82	64	73	75	64	59	84	67
LIFE	152	111	222	175	140	119	144	157	188	144	142	212	99
Logisticare	36968	41267	36150	59480	34166	16213	62539	38458	40564	16326	63128	40756	45692
March Vision	4724	5103	4847	3696	6051	1272	518	312	119	292	73	35	143
MED	974	1103	1160	1547	1360	1344	65	5010	1482	4756	1804	2348	2144
PAIRTEAM	8229	7901	5824	6500	6777	5157	11205	6835	4360	3413	3802	4125	5506
Quest	16855	20951	16810	20937	16905	16777	20859	16724	16798	20753	16565	16554	20648
SENECA	164	19	0	109	319	190	174	168	92	106	564	403	450
STAR	0	0	0	0	0	0	0	0	0	94	44	230	144
TITANIUM	3746	4227	4361	3772	4039	3266	3293	2967	4242	5014	4497	5428	6463
TVHC	0	0	0	15	11	0	14	0	0	36	45	0	44
UCSF	0	0	0	0	0	0	0	0	0	0	0	10	633
VSP	0	0	0	0	0	0	0	0	15873	5360	5902	4824	6334
TOTAL	**433847**	**501498**	**406018**	**464039**	**358365**	**452989**	**651340**	**461775**	**755406**	**503863**	**499559**	**519182**	**510536**


Total Outbound Encounter/Month
Total Encounters
800000
700000
600000
500000
400000
300000
433847
501498
406018
464039
358365
452989
651340
461775
755406
503863
499559
519182
510536
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Apr-26
May-26
Jun-26
Jul-26
Aug-26
Sep-26

HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
26-SEP	371,023	38,787	409,810

Key: EDI – Electronic Data Interchange



Onboarding EDI Providers – Updates

September 2026 EDI Claims:

A total of 3800 new EDI submitters has been added since October 2015, with 63 added in September 2026.

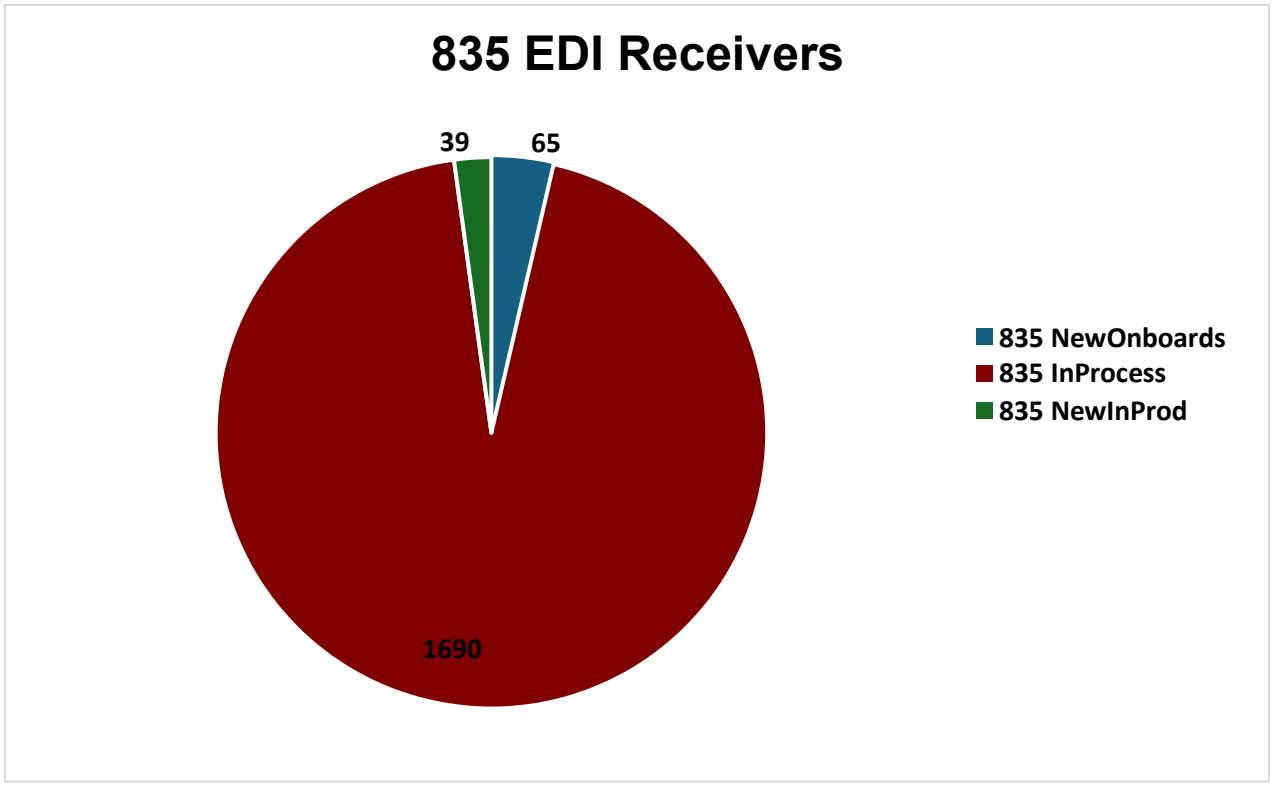
The total number of EDI submitters is 4540 providers.

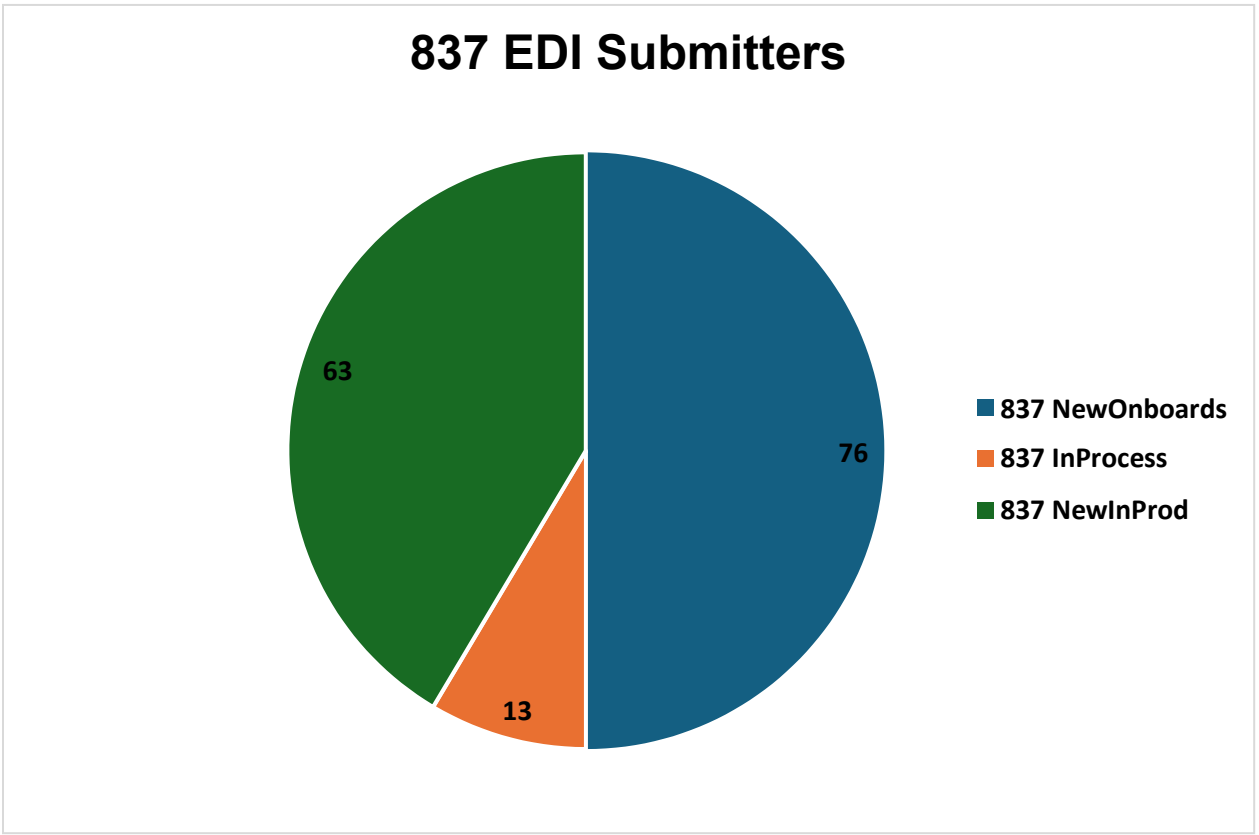
September 2026 EDI Remittances (ERA):

A total of 1783 new ERA receivers have been added since October 2015, with 39 added in September 2026.

The total number of ERA receivers is 1799 providers.

YearMonth	837 NewOnboards	837 InProcess	837 NewInProd	837 TotalInProd	835 NewOnboards	835 InProcess	835 NewInProd	835 TotalInProd
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
Jul-26	53	7	46	4405	35	1644	29	1742
Aug-26	72	0	72	4477	38	1664	18	1760
Sep-26	76	13	63	4540	65	1690	39	1799


835 EDI Receivers
39
65
1690
835 NewOnboards
835 InProcess
835 NewInProd


837 EDI Submitters
63
76
13
837 NewOnboards
837 InProcess
837 NewInProd

Encounter Medi-Cal DHCS Rejection and Acceptance

Summary	Total Encounter Submissions	Percentages
Submitted Encounters	510536	100.00%
Denied Encounters	183	0.04%
Accepted Encounters	409937	80.30%
Pending DHCS Update	100416	19.67%

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 September 2026.

FILE TYPE	TOTAL COUNT	YEAR MONTH
837 I Files	30	Sep-26
837 P Files	142	Sep-26
Total Files	**172**	

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	LagPercent	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	95%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	91%	65%
Timeliness-% Within Lag Time - Professional 0-180 days	99%	80%

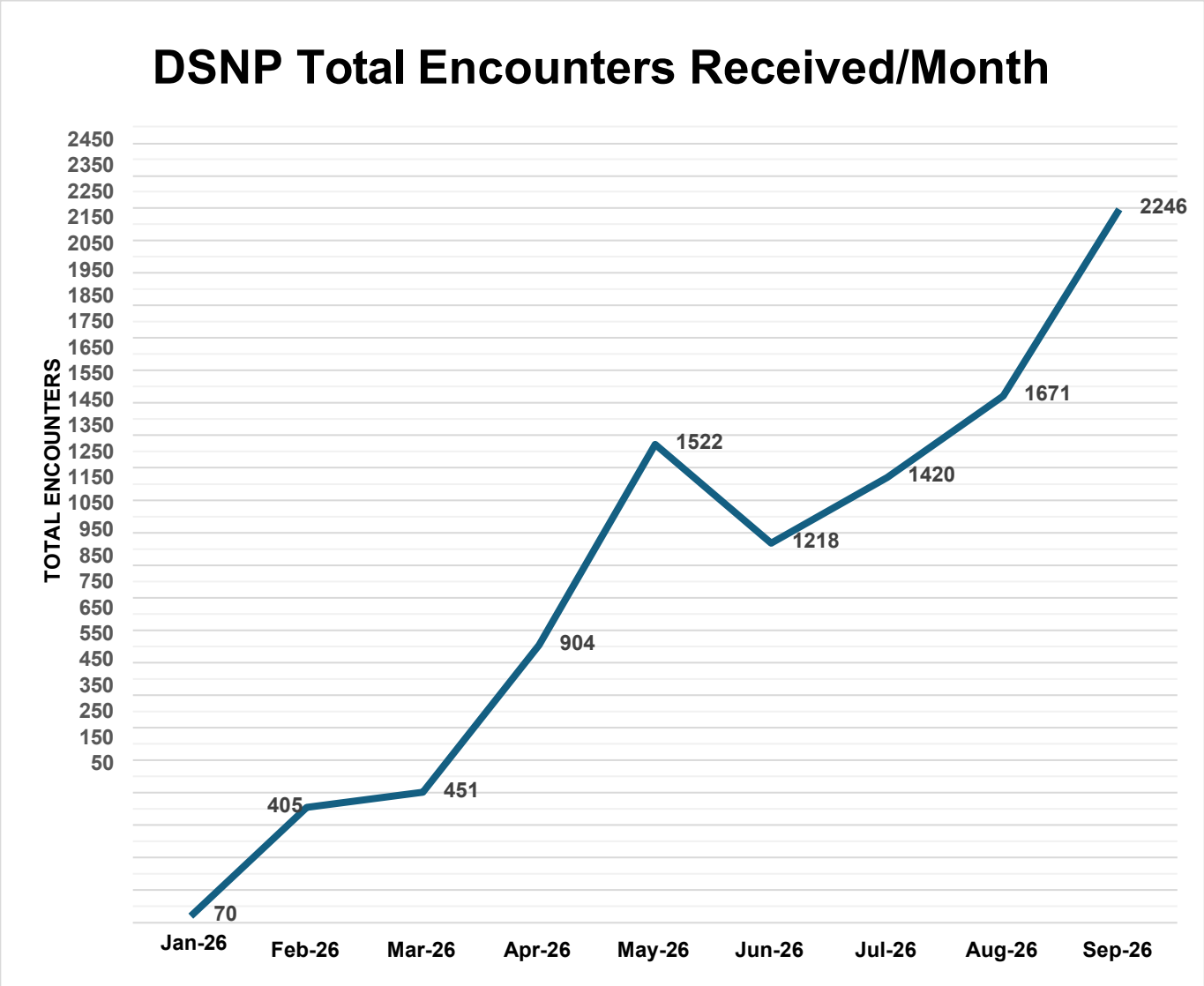
*Note, the Number of Encounters comes from: Total at bottom of this chart:

Encounter CMS Optum Rejection and Acceptance

Summary	Total Encounter Submissions	Percentages
Submitted Encounters	1029	100.00%
Rejected Encounters	12	1.17%
Accepted Encounters	720	69.97%
Pending CMS Update	297	28.86%

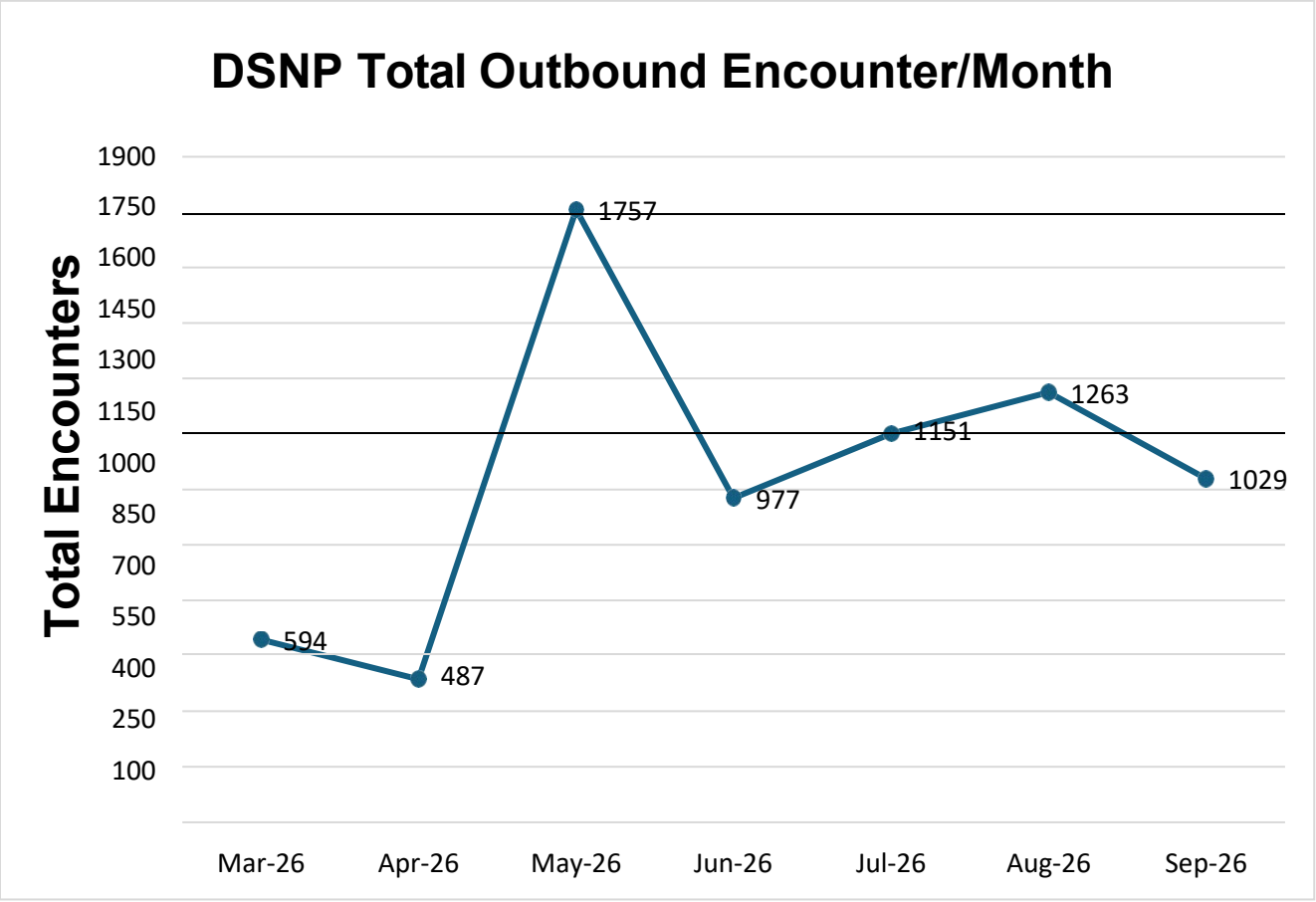
DSNP Trading Partner Encounter Inbound Submission History

TradingPartnerName	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
CHME		10	11	29	31	46	44	58	52
HealthSuite	70	395	440	875	918	959	1186	1417	1986
Nations Benefits					545	209	182	186	200
Vision Service Plan					28	4	8	10	8
TOTAL	70	405	451	904	1522	1218	1420	1671	2246



DSNP Trading Partner Encounter Outbound Submission History

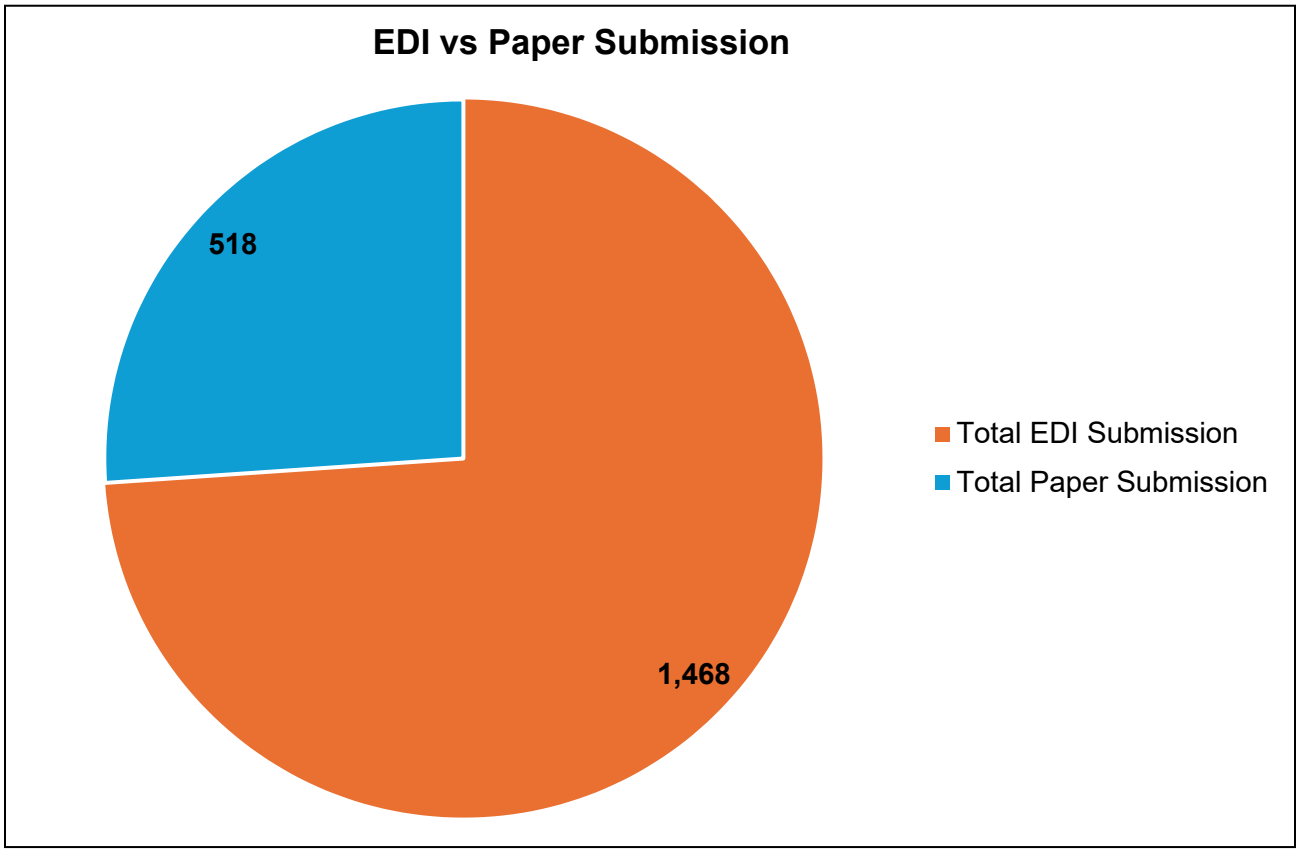
TradingPartnerName	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
CHME	20	29	29	40	41	55	52
HealthSuite	574	458	1155	725	920	1016	769
Nations Flex Card			542	208	180	179	200
Nations Hearing			3		2	3	
Vision Service Plan			28	4	8	10	8
TOTAL	594	487	1757	977	1151	1263	1029



DSNP HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
26-SEP	1,468	518	1,986

Key: EDI – Electronic Data Interchange

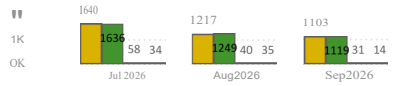


Alliance FOR H EA LTH

SERVICE DESK DASHBOARD

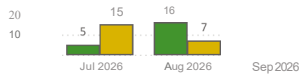
Sep t embe r 2026

Track-It Tickets



O Tickets Received e ri cketsClosed e r ickets Open e rickets Overdue

Onboard and Offboard



e onboard Q Offboar d

Top Track-It Ticket Trends During Month

Category	Tickets Received
IT Service Desk -Troubleshoot ->Access->Maintenance Checklist	23
IT Service Desk- Request->Access ->Termination	
IT Service Desk-Troubleshoot ->Access->Website	"
IT Service Desk - Request->Access ->Weekly Sta t us Updates	
IT Service Desk-Troubleshoot ->Access->Hea lthsuite	
IT Service Desk - Request->Access ->Windows Password	
IT Service Desk - Troubleshoot->S.Oftw are->Finesse	
IT Service Desk - Request->Access->Title and Access Change	34
IT Service Desk - Troubleshoot ->Conference Rooms	55
IT Service Desk - Troubleshoot->Hardware ->Laptop	58
IT Service Desk - Request	59
IT Service Desk - Troubleshoot	87

Laptops Issued



e w arranty Not Expired Q Warranty Expired

Laptops Deployed, In Stock, Decommissioned



e Deptoyed e 1n Stock e oecomm issioned

Top Updates During Month

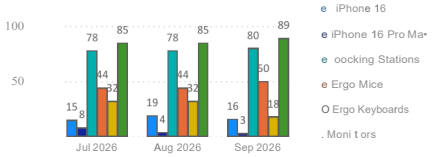
ategory	Item
Driver	Intel Corporation ComputeAcce lerator Driver Update (32.0.100.5540)
Driver	Intel Corporation E•tension Driver Update (32.0.100.5540)
Driver	Intel Net Driver Update (12.19.2.68)
Driver	Intel Net Driver Update (20.0.3.28)
Driver	Leno vo ltd.Firmware Driver Update (1.43.0.0)
Driver	Realtek Net Driver Update (11S3. 23.20.818)
05 / Feature Windows 11, version 26H2	
OS/ Update 2026-09 Windows ML OpenVINO Update (KBS12877S)	
Software	Chrome Enterprise(X64)
Software	Edge (X64)
Software	Firefo•(X64)
Software	Microsoft36S (X64)

Mob ile Devices



e company Issued Phones O Bring Your Own Devices

Equ i pment in Stock



Cybersecurity Posture Update

Alameda Alliance for Health • Board of Governors Briefing • October 2026

LOW RISK
Trend: Improving

0
Open Critical / High Incidents
Based on Arctic Wolf metrics (user impacting)

A
Reputation Score
Based on BlackKite security controls. Trended up.

90%
Critical Asset Control Coverage
Based on Arctic Wolf Config, Monitoring, Incidents, and Ticketing #s

100%
Multi-Factor Auth. Coverage
DUO User Adoption

Control Health by Domain

Identity & Privileged Access	GREEN	*Privileged accounts are highly restricted*
Endpoint & Vulnerability	AMBER	*Vulnerability remediation backlog. Improvement plan being staged.*
Data Protection (PHI / PII)	GREEN	*Zero reportable PHI/PII incidents*
Cloud & Third-Party	AMBER	*Azure security efforts being staged*

Regulatory & Compliance Assurance

HIPAA Security Rule	95%
NIST CSF 2.0	50%
CIS Controls	50%

No material HIPAA gaps identified – annual penetration test and risk assessment on track. CIS and NIST are non-regulatory.

Top Enterprise Risks (Likelihood x Impact)

1	Shadow IT in cloud	High × Med	*Security effort between IT Security and Server Core being staged (linked to Modernization project)*
2	Network visibility and cohesion	Low × High	*Network transparency and silo concerns requires addressing*
3	DB access control + Stored Procedure weakness	Med × High	*Foundational security weakness in access control and stored procedure operations*

LEADERSHIP ACTION REQUESTED

- **APPROVE** *Security's continued efforts to improve the org's risk posture*
- **SPONSOR** *Security's charter as the security authority across all IT functions*
- **FUND** *Continued training and resource needs*



Analytics

Tiffany Cheang

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

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

Date: **October 9th, 2026**

Subject: **Performance & Analytics Report**

Performance and Analytics Executive Summary

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

Current reporting period: Jul 2025 – June 2026 dates of service
Prior reporting period: Jul 2024 – June 2025 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 13.2% of members account for 89.8% of total costs.
- In comparison, the Prior reporting period was lower at 12.0% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
- The SPD/LTC (non duals) and ACA OE categories of aid decreased to account for 53.3% of the members, with SPD/LTCs accounting for 17.7% and ACA OE's at 35.6%.
- The percent of members with costs >= $30K slightly increased from 3.1% to 3.4%.
- Of those members with costs >= $100K, the percentage of total members has slightly increased to 1.1%.
    - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 28.4%.
- 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 13.2% is more concentrated in the 45-66 year old category (33.2%) compared to the overall population (20.6%).

Analytics

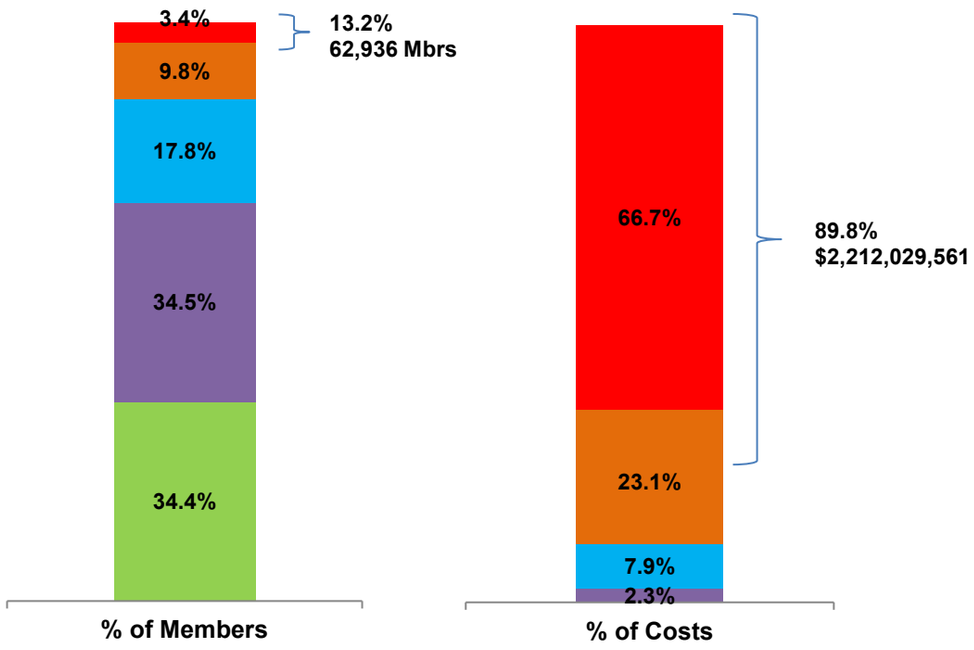
Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jul 2025 - Jun 2026

Note: Data incomplete due to claims lag

Run Date: 09/29/2026

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	16,061	3.4%	$ 1,642,169,480	66.7%
$5K - $30K	46,875	9.8%	$ 569,860,082	23.1%
$1K - $5K	84,901	17.8%	$ 194,499,078	7.9%
< $1K	164,243	34.5%	$ 56,554,460	2.3%
$0	163,833	34.4%	$ -	0.0%
Totals	**475,913**	**100.0%**	**$ 2,463,083,099**	**100.0%**

Top 13.2% of Members = 89.8% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	5,075	1.1%	$ 1,056,212,835	42.9%
$75K to $100K	1,880	0.4%	$ 163,543,991	6.6%
$50K to $75K	3,211	0.7%	$ 195,264,098	7.9%
$40K to $50K	2,273	0.5%	$ 101,714,416	4.1%
$30K to $40K	3,622	0.8%	$ 125,434,140	5.1%
SubTotal	***16,061***	***3.4%***	***$ 1,642,169,480***	***66.7%***
$20K to $30K	6,575	1.4%	$ 160,066,909	6.5%
$10K to $20K	17,543	3.7%	$ 247,721,266	10.1%
$5K to $10K	22,757	4.8%	$ 162,071,907	6.6%
SubTotal	***46,875***	***9.8%***	***$ 569,860,082***	***23.1%***
Total	**62,936**	***13.2%***	**$ 2,212,029,561**	***89.8%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Jun 2026	371,134	$ 2,219,950,139
Dis-Enrolled During Year	104,779	$ 243,132,960
Totals	**475,913**	**$ 2,463,083,099**

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
13.2% of Members = 89.8% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jul 2025 - Jun 2026
Note: Data incomplete due to claims lag
Run Date: 09/29/2026

13.2% of Members = 89.8% of Costs
17.7% of members are SPD/LTCs and account for 24.5% of costs.
35.6% of members are ACA OE and account for 33.4% of costs.
9.0% of members disenrolled as of Jun 2026 and account for 9.9% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	242	1,032	1,274	2.0%
MCAL	MCAL - ADULT	1,451	8,218	9,669	15.4%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	889	4,295	5,184	8.2%
	MCAL - ACA OE	5,213	17,197	22,410	35.6%
	MCAL - DUALS	-	-	-	0.0%
	MCAL - SPD-LTC	3,940	7,198	11,138	17.7%
	MCAL - SPD-LTC/Full Dual	2,596	4,890	7,486	11.9%
D-SNP	DSNP	21	83	104	0.2%
Not Eligible	Not Eligible	1,709	3,962	5,671	9.0%
Total		**16,061**	**46,875**	**62,936**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 20,718,442	$ 12,382,648	$ 33,101,090	1.5%
MCAL	MCAL - ADULT	$ 130,383,010	$ 100,022,633	$ 230,405,643	10.4%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 66,075,306	$ 48,623,628	$ 114,698,934	5.2%
	MCAL - ACA OE	$ 528,296,558	$ 209,971,674	$ 738,268,232	33.4%
	MCAL - DUALS	$ -	$ -	$ -	0.0%
	MCAL - SPD-LTC	$ 448,926,207	$ 92,741,320	$ 541,667,527	24.5%
	MCAL - SPD-LTC/Full Dual	$ 275,249,970	$ 57,686,325	$ 332,936,295	15.1%
D-SNP	DSNP	$ 1,743,597	$ 967,216	$ 2,710,813	0.1%
Not Eligible	Not Eligible	$ 170,776,387	$ 47,464,639	$ 218,241,026	9.9%
Total		**$ 1,642,169,480**	**$ 569,860,082**	**$ 2,212,029,561**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
26.3% of members are SPD/LTCs and account for 29.4% of costs.
27.6% of members are ACA OE and account for 31.3% of costs.
8.9% of members disenrolled as of Jun 2026 and account for 9.5% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	47	0.9%
MCAL	MCAL - ADULT	313	6.2%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	105	2.1%
	MCAL - ACA OE	1,400	27.6%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,334	26.3%
	MCAL - SPD-LTC/Full Dual	1,420	28.0%
D-SNP	DSNP	4	0.1%
Not Eligible	Not Eligible	452	8.9%
Total		**5,075**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 10,788,583	1.0%
MCAL	MCAL - ADULT	$ 72,908,703	6.9%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 28,092,151	2.7%
	MCAL - ACA OE	$ 331,077,010	31.3%
	MCAL - DUALS	$ -	0.0%
	MCAL - SPD-LTC	$ 310,637,587	29.4%
	MCAL - SPD-LTC/Full Dual	$ 201,181,193	19.0%
D-SNP	DSNP	$ 926,578	0.1%
Not Eligible	Not Eligible	$ 100,601,030	9.5%
Total		**$ 1,056,212,835**	**100.0%**

% of Total Costs By Service Type

Breakout by Service Type/Location

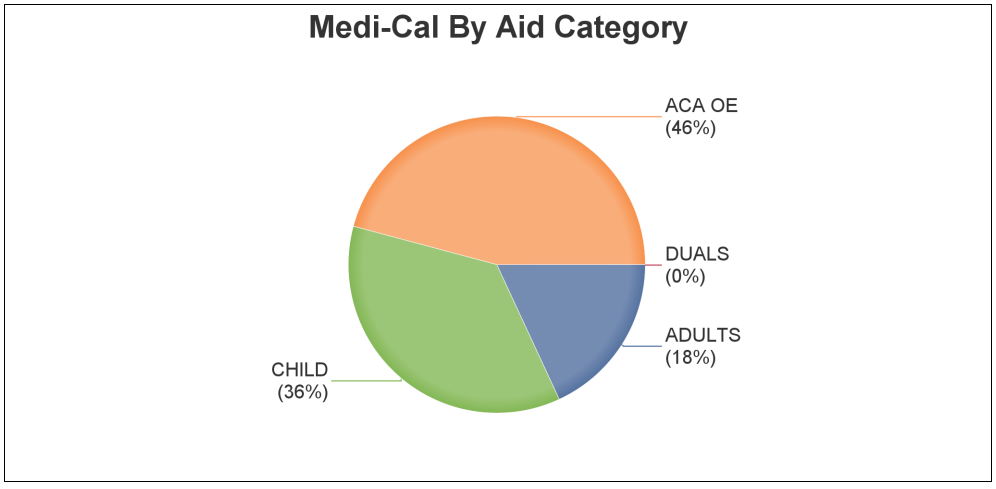
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	4%	0%	1%	16%	33%	2%	10%	3%	1%	34%
$75K to $100K	4%	0%	1%	22%	24%	3%	6%	5%	4%	36%
$50K to $75K	5%	0%	2%	27%	24%	5%	8%	8%	3%	25%
$40K to $50K	7%	0%	2%	33%	22%	8%	6%	9%	1%	22%
$30K to $40K	8%	0%	3%	33%	21%	11%	6%	8%	1%	20%
$20K to $30K	2%	0%	6%	34%	21%	6%	9%	9%	1%	19%
$10K to $20K	0%	0%	10%	36%	21%	7%	9%	11%	1%	17%
$5K to $10K	1%	0%	4%	32%	9%	11%	13%	15%	1%	19%
Total	**4%**	**0%**	**3%**	**24%**	**26%**	**4%**	**9%**	**7%**	**2%**	**28%**

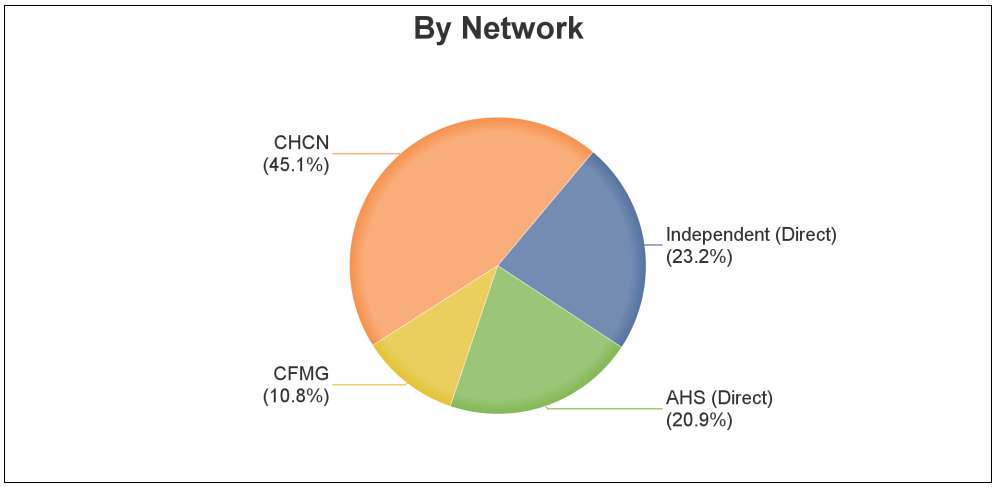
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

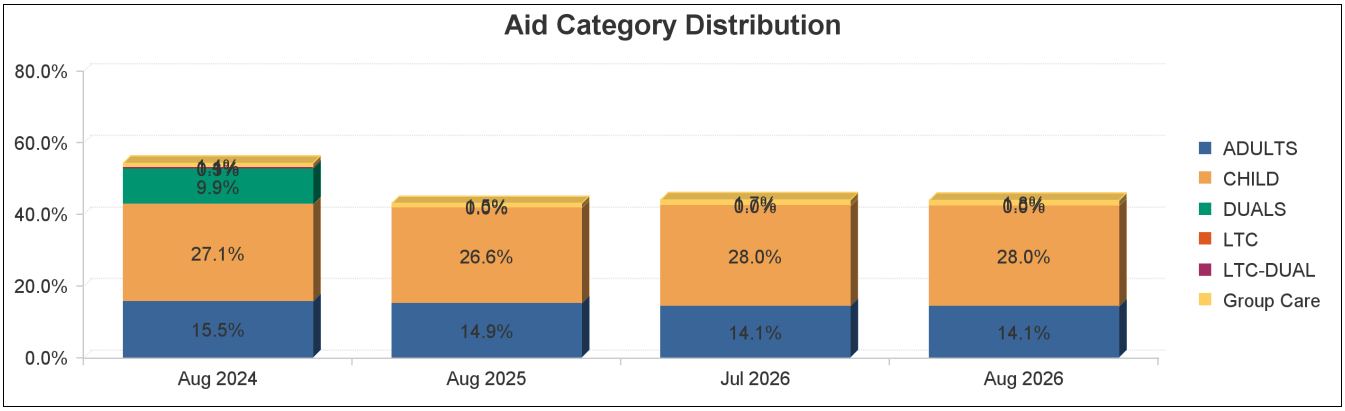
Category of Aid	Aug 2026	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	51,574	14%	10,464	12,400	1	28,709
CHILD	102,828	29%	9,214	13,631	36,604	43,379
SPD	0	0%	0	0	0	0
ACA OE	130,639	36%	24,326	41,114	1,403	63,796
DUALS	18	0%	18	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	27,273	8%	7,818	4,975	1,513	12,967
SPD-LTC/Full Dual	47,721	13%	30,693	3,384	0	13,644
Other	0		0	0	0	0
Medi-Cal	360,053		82,533	75,504	39,521	162,495
Group Care	6,475		2,320	1,213	0	2,942
D-SNP	297		101	27	0	169
Total	**366,825**	**100%**	**84,954**	**76,744**	**39,521**	**165,606**
Other %	0.0%		0.0%	0.0%	0.0%	0.0%
Medi-Cal %	98.2%		97.2%	98.4%	100.0%	98.1%
Group Care %	1.8%		2.7%	1.6%	0.0%	1.8%
D-SNP %	0.1%		0.1%	0.0%	0.0%	0.1%
	Network Distribution		**23.2%**	**20.9%**	**10.8%**	**45.1%**
			% Direct:	**44%**	**% Delegated:**	**56%**




By Network
CHCN
(45.1%)
Independent (Direct)
(23.2%)
CFMG
(10.8%)
AHS (Direct)
(20.9%)

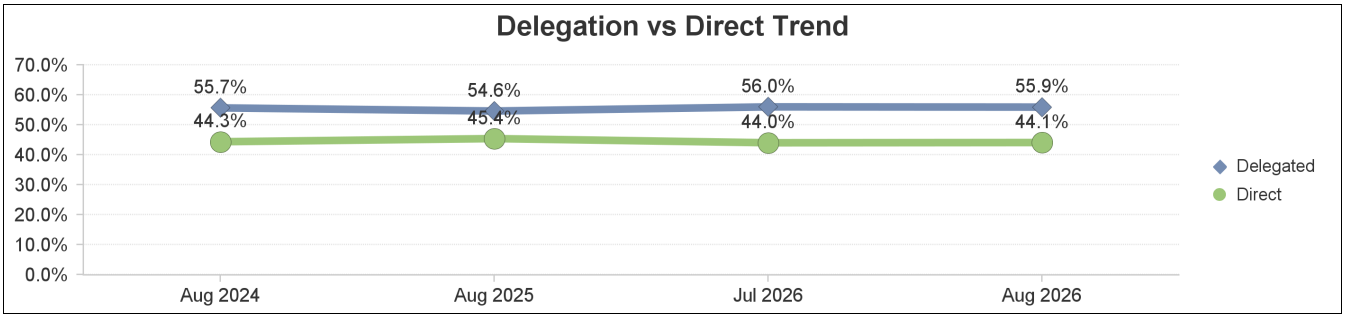
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
ADULTS	62,671	60,720	51,920	**51,574**	15.5%	14.9%	14.1%	14.1%	-3.2%	-17.7%	-0.7%
CHILD	109,803	108,568	102,952	**102,828**	27.1%	26.6%	28.0%	28.0%	-1.1%	-5.6%	-0.1%
SPD	35,177	0	0	**0**	8.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ACA OE	150,482	153,348	130,849	**130,639**	37.1%	37.6%	35.6%	35.6%	1.9%	-17.4%	-0.2%
DUALS	40,030	2	14	**18**	9.9%	0.0%	0.0%	0.0%	##########	88.9%	22.2%
LTC	226	0	0	**0**	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LTC-DUAL	1,247	0	0	**0**	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SPD-LTC	0	29,686	27,080	**27,273**	0.0%	7.3%	7.4%	7.4%	100.0%	-8.8%	0.7%
SPD-LTC/ Full Dual	0	49,372	47,722	**47,721**	0.0%	12.1%	13.0%	13.0%	100.0%	-3.5%	0.0%
Other	0	0	0	**0**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medi-Cal	399,636	401,696	360,537	**360,053**	98.6%	98.5%	98.2%	98.2%	0.5%	-11.6%	-0.1%
Group Care	5,686	5,974	6,398	**6,475**	1.4%	1.5%	1.7%	1.8%	4.8%	7.7%	1.2%
D-SNP	0	0	272	**297**	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
Total	**405,322**	**407,670**	**367,207**	366,825	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.6%**	**-11.2%**	**-0.1%**



Delegation vs Direct Trend

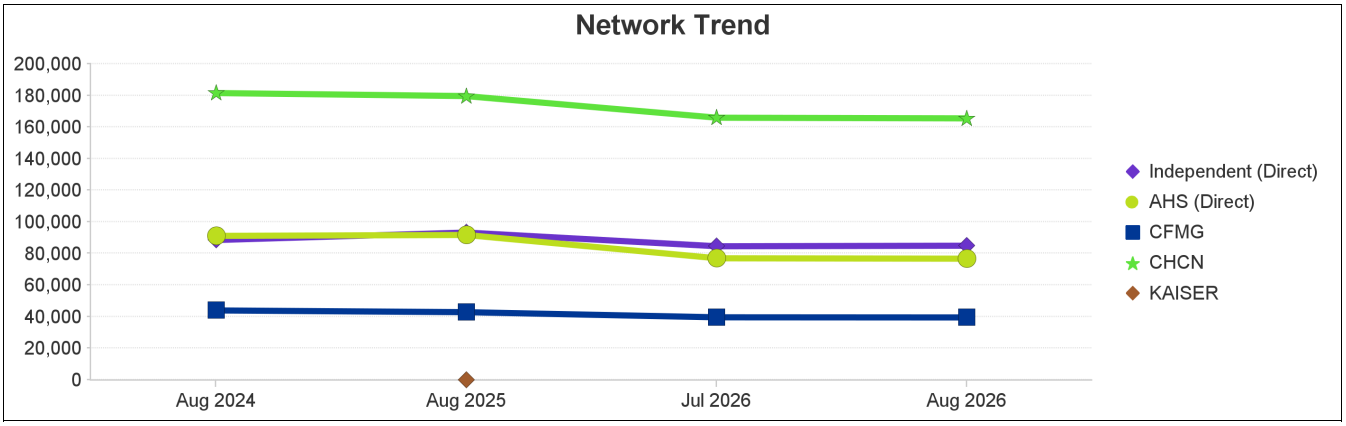
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
Delegated	225,590	222,601	205,621	**205,127**	55.7%	54.6%	56.0%	55.9%	-1.3%	-8.6%	-0.2%
Direct	179,732	185,069	161,586	**161,698**	44.3%	45.4%	44.0%	44.1%	2.9%	-14.5%	0.1%
Total	**405,322**	**407,670**	**367,207**	366,825	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.6%**	**-11.2%**	**-0.1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

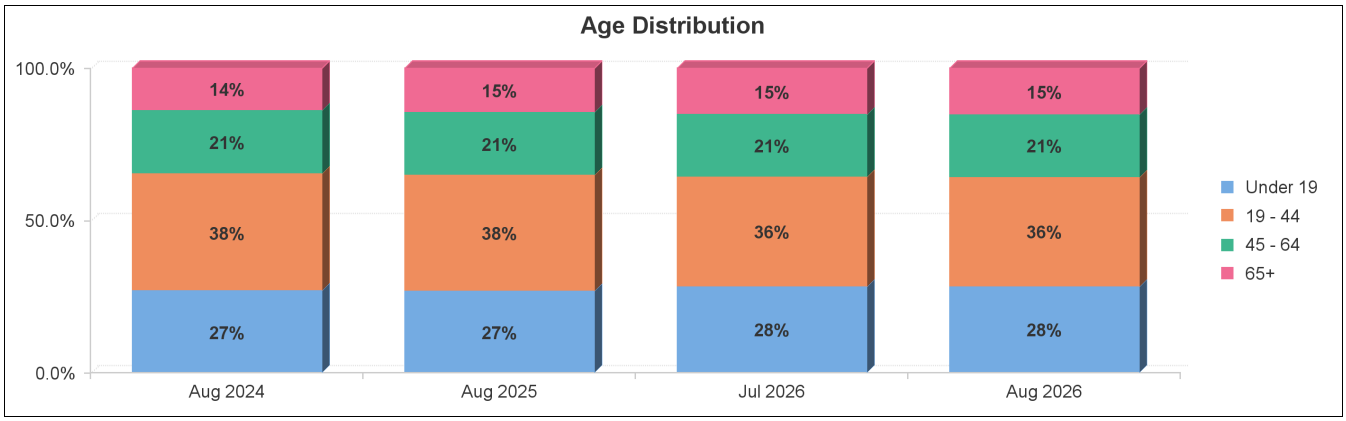
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
Independent (Direct)	88,550	93,300	84,598	**84,954**	21.8%	22.9%	23.0%	23.2%	5.1%	-10.0%	0.4%
AHS (Direct)	91,182	91,769	76,988	**76,744**	22.5%	22.5%	21.0%	20.9%	0.6%	-19.6%	-0.3%
CFMG	43,959	42,868	39,606	**39,521**	10.8%	10.5%	10.8%	10.8%	-2.5%	-8.5%	-0.2%
CHCN	181,631	179,713	166,015	**165,606**	44.8%	44.1%	45.2%	45.1%	-1.1%	-8.6%	-0.3%
KAISER	0	20	0	**0**	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Total	**405,322**	**407,670**	**367,207**	**366,825**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.6%**	**-11.2%**	**-0.1%**



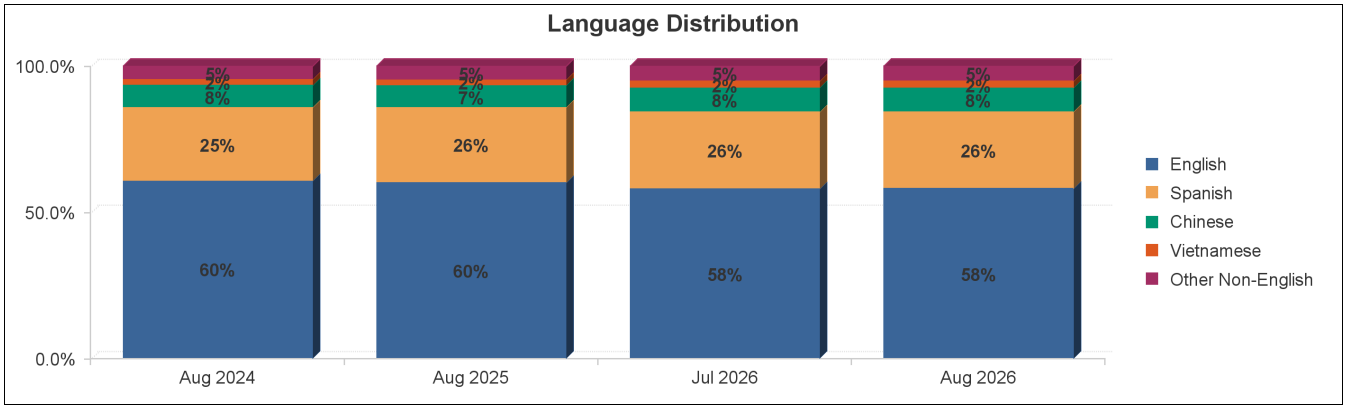
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
Under 19	108,349	108,381	102,657	**102,540**	27%	27%	28%	28%	0%	-6%	0%
19 - 44	155,686	155,276	132,299	**131,867**	38%	38%	36%	36%	0%	-18%	0%
45 - 64	84,199	84,220	75,549	**75,514**	21%	21%	21%	21%	0%	-12%	0%
65+	57,088	59,793	56,430	**56,607**	14%	15%	15%	15%	5%	-6%	0%
Total	**405,322**	**407,670**	**366,935**	**366,528**	**100%**	**100%**	**100%**	**100%**	**1%**	**-11%**	**0%**



Language Trend

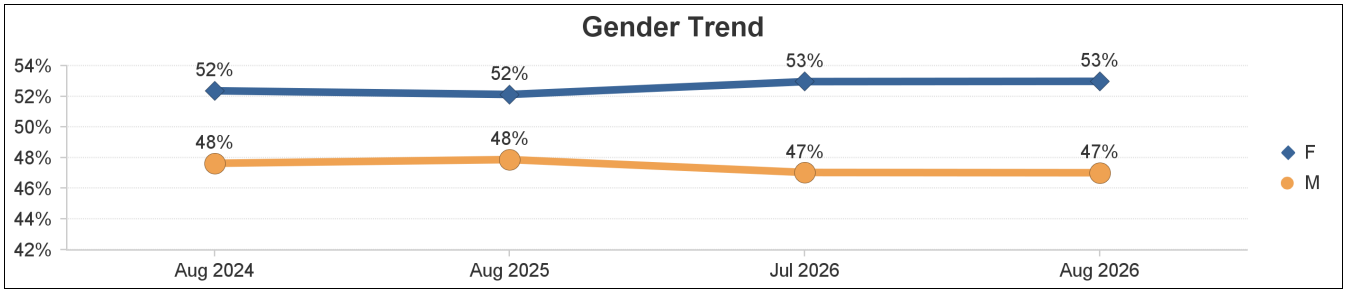
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Aug 2024	Aug 2025	Jul 2026	Aug 2026	ug 2024	ug 2025	Jul 2026	ug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
English	245,150	244,403	212,220	**212,457**	60%	60%	58%	58%	0%	-15%	0%
Spanish	102,034	104,959	96,620	**96,179**	25%	26%	26%	26%	3%	-9%	0%
Chinese	30,695	30,355	30,064	**29,957**	8%	7%	8%	8%	-1%	-1%	0%
Vietnamese	8,310	8,083	8,582	**8,550**	2%	2%	2%	2%	-3%	5%	0%
Other Non-English	19,133	19,870	19,449	**19,385**	5%	5%	5%	5%	4%	-3%	0%
Total	**405,322**	**407,670**	**366,935**	**366,528**	**100%**	**100%**	**100%**	**100%**	**1%**	**-11%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

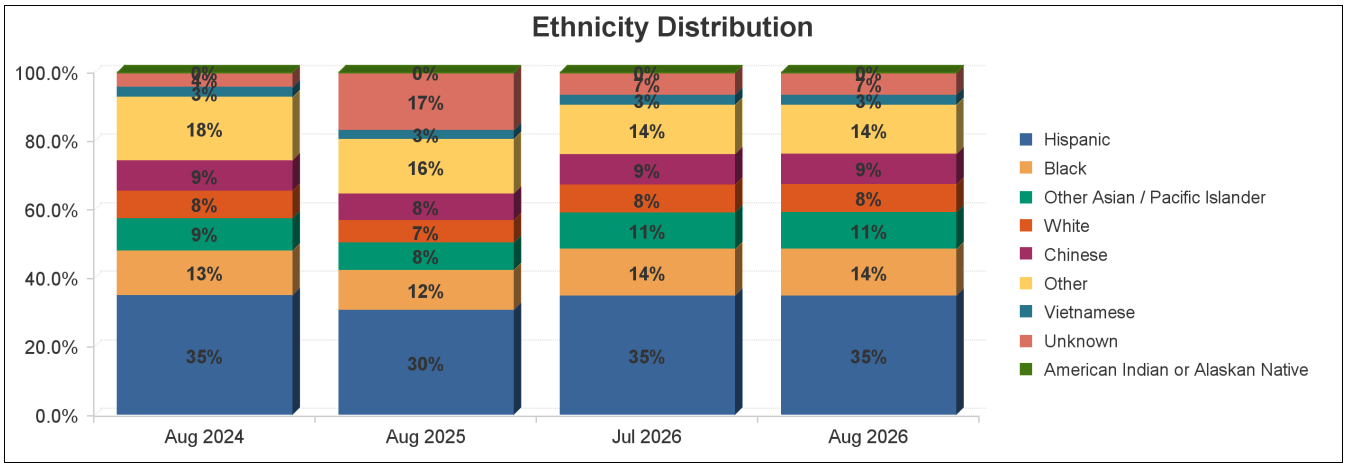
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
F	212,258	212,501	194,501	**194,361**	52%	52%	53%	53%	0%	-9%	0%
M	193,064	195,169	172,706	**172,464**	48%	48%	47%	47%	1%	-13%	0%
Total	**405,322**	**407,670**	**367,207**	**366,825**	**100%**	**100%**	**100%**	**100%**	**1%**	**-11%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024	Aug 2025	Jul 2026	Aug 2026	Aug 2024 to Aug 2025	Aug 2025 to Aug 2026	Jul 2026 to Aug 2026
Hispanic	141,075	124,198	127,298	**127,159**	35%	30%	35%	35%	-14%	2%	0%
Black	52,860	47,397	49,949	**50,050**	13%	12%	14%	14%	-12%	5%	0%
Other Asian / Pacific Islander	38,062	32,594	38,924	**38,975**	9%	8%	11%	11%	-17%	16%	0%
White	32,586	26,772	30,068	**30,093**	8%	7%	8%	8%	-22%	11%	0%
Chinese	35,869	31,878	32,573	**32,577**	9%	8%	9%	9%	-13%	2%	0%
Other	74,954	64,699	52,928	**52,592**	18%	16%	14%	14%	-16%	-23%	-1%
Vietnamese	11,804	10,438	10,634	**10,614**	3%	3%	3%	3%	-13%	2%	0%
Unknown	17,310	69,002	24,116	**24,041**	4%	17%	7%	7%	75%	-187%	0%
American Indian or Alaskan Native	802	692	717	**724**	0%	0%	0%	0%	-16%	4%	1%
Total	**405,322**	**407,670**	**367,207**	**366,825**	**100%**	**100%**	**100%**	**100%**	**1%**	**-11%**	**0%**



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

Medi-Cal By City

City	Aug 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	143,056	40%	21,473	36,214	15,632	69,737
HAYWARD	45,910	13%	10,772	12,166	5,181	17,791
FREMONT	34,508	10%	14,637	5,430	1,872	12,569
SAN LEANDRO	22,720	6%	6,056	3,595	2,852	10,217
UNION CITY	13,052	4%	5,285	2,225	734	4,808
ALAMEDA	12,559	3%	3,097	2,297	1,951	5,214
BERKELEY	14,610	4%	3,197	2,355	1,622	7,436
LIVERMORE	11,879	3%	1,973	317	1,912	7,677
NEWARK	8,117	2%	2,597	3,120	404	1,996
CASTRO VALLEY	10,080	3%	2,951	1,528	1,582	4,019
SAN LORENZO	5,512	2%	1,133	1,212	635	2,532
PLEASANTON	7,383	2%	2,287	254	770	4,072
DUBLIN	7,243	2%	2,519	269	829	3,626
EMERYVILLE	2,838	1%	509	632	506	1,191
ALBANY	2,239	1%	413	255	517	1,054
PIEDMONT	397	0%	92	147	53	105
SUNOL	85	0%	30	9	6	40
ANTIOCH	32	0%	8	6	6	12
Other	17,833	5%	3,504	3,473	2,457	8,399
Total	360,053	100%	**82,533**	**75,504**	**39,521**	**162,495**

Group Care By City

City	Aug 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,927	30%	352	441	0	1,134
HAYWARD	745	12%	346	198	0	201
FREMONT	733	11%	454	94	0	185
SAN LEANDRO	707	11%	278	111	0	318
UNION CITY	299	5%	173	56	0	70
ALAMEDA	338	5%	97	39	0	202
BERKELEY	164	3%	39	21	0	104
LIVERMORE	105	2%	30	1	0	74
NEWARK	164	3%	95	40	0	29
CASTRO VALLEY	238	4%	106	38	0	94
SAN LORENZO	180	3%	53	46	0	81
PLEASANTON	77	1%	30	3	0	44
DUBLIN	140	2%	56	5	0	79
EMERYVILLE	46	1%	9	10	0	27
ALBANY	26	0%	8	4	0	14
PIEDMONT	5	0%	0	2	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	8	4	0	12
Other	556	9%	185	100	0	271
Total	**6,475**	**100%**	**2,320**	**1,213**	**0**	**2,942**

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

D-SNP By City

City	Aug 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	111	37%	24	9	0	78
HAYWARD	31	10%	12	3	0	16
FREMONT	22	7%	16	0	0	6
SAN LEANDRO	21	7%	10	4	0	7
UNION CITY	6	2%	4	1	0	1
ALAMEDA	21	7%	6	5	0	10
BERKELEY	21	7%	2	0	0	19
LIVERMORE	12	4%	1	1	0	10
NEWARK	8	3%	7	1	0	0
CASTRO VALLEY	4	1%	1	2	0	1
SAN LORENZO	6	2%	3	0	0	3
PLEASANTON	6	2%	3	0	0	3
DUBLIN	8	3%	1	0	0	7
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	18	6%	10	1	0	7
Sum:			**2,320**	**1,213**	**0**	**2,942**

Total By City

City	Aug 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	144,983	40%	21,825	36,655	15,632	70,871
HAYWARD	46,655	13%	11,118	12,364	5,181	17,992
FREMONT	35,241	10%	15,091	5,524	1,872	12,754
SAN LEANDRO	23,427	6%	6,334	3,706	2,852	10,535
UNION CITY	13,351	4%	5,458	2,281	734	4,878
ALAMEDA	12,897	4%	3,194	2,336	1,951	5,416
BERKELEY	14,774	4%	3,236	2,376	1,622	7,540
LIVERMORE	11,984	3%	2,003	318	1,912	7,751
NEWARK	8,281	2%	2,692	3,160	404	2,025
CASTRO VALLEY	10,318	3%	3,057	1,566	1,582	4,113
SAN LORENZO	5,692	2%	1,186	1,258	635	2,613
PLEASANTON	7,460	2%	2,317	257	770	4,116
DUBLIN	7,383	2%	2,575	274	829	3,705
EMERYVILLE	2,884	1%	518	642	506	1,218
ALBANY	2,265	1%	421	259	517	1,068
PIEDMONT	402	0%	92	149	53	108
SUNOL	86	0%	31	9	6	40

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

ANTIOCH	56	0%	16	10	6	24
Other	18,389	5%	3,689	3,573	2,457	8,670
Total	366,528	100%	**84,853**	**76,717**	**39,521**	**165,437**



Human Resources

Anastacia Swift

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

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

Date: **October 9th, 2026**

Subject: **Human Resources Report**

Staffing

- As of October 1st, 2026, the Alliance had 629 full time employees and 0 part time employee.

- On October 1st, 2026, the Alliance had 22 open positions in which 3 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 19 positions open to date. The Alliance is actively recruiting for the remaining 19 positions and several of these positions are in the interviewing or job offer stage.

- Our current recruitment rate is 4%.

- Summary of open positions by division:

Division	Open Position October 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	3	1	2
Operations	13	2	11
Healthcare Analytics	0	0	0
Information Technology	4	0	4
Finance	1	0	1
Compliance	0	0	0
Human Resources	1	0	1
Executive	0	0	0
Total	22	3	19

Employee Recognition

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

  5 years:
  - Lani Y (Member Services)

  6 years:
  - Homaira M (Quality Management)
  - Heidi T (Quality Management)
  - Misha C (Quality Management)

  7 years:
  - Monique L (Utilization Management)
  - Ramces C (Claims)
  - Komal B (Utilization Management)
  - Gabby F (Grievance and Appeals)

8 years:

- Katherine E (Quality Management)
- Cynthia C (Member Services)
- Cynthia R (Claims)

9 years:

- Jennifer L (Facilities & Support Service)

10 years:

- Anthony T (Financial Planning & Analysis)
- Sankar R (IT Development)
- Pandiyarajan S (IT Development)
- Tami L (Operations Support)
- Ed D (IT Infrastructure)
- Sasi K (Information Technology)
- Natalie M (Utilization Management)

11 years:

- Smita K (IT Ops and Quality Apps Mgt)

13 years:

- Catie P (Case/Disease Management)
- Alexandra L (Grievance and Appeals)
- Hellai M (Quality Management)