ALAMEDA Alliance FOR HEALTH

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

Board of Governors

Regular Meeting

Friday, March 8th, 2024
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 South Loop Road, Alameda, CA 94502

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, March 8th, 2024
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502
and
11331 Brockway Road
Truckee, CA 96161

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 brmartinez@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 159517119#. 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 three (3) 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 March 8th, 2024, at 12:00 p.m. in Alameda County, California, by Rebecca Gebhart, Presiding Officer. This meeting is to take place in person and by video conference call)

2. ROLL CALL

3. AGENDA APPROVAL

4. INTRODUCTIONS

5. CLOSED SESSION

a) PUBLIC EMPLOYEE PERFORMANCE EVALUATION: CHIEF EXECUTIVE OFFICER (GOV. CODE SECTION 54957).

6. 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) **DECEMBER 5th, 2023, FINANCE COMMITTEE MEETING MINUTES**

b) **FEBRUARY 6th, 2024, FINANCE COMMITTEE MEETING MINUTES**

c) **DECEMBER 8th, 2023, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES**

d) **DECEMBER 8th, 2023, BOARD OF GOVERNORS MEETING MINUTES**

e) **JANUARY 26th, 2024, BOARD OF GOVERNORS RETREAT MINUTES**

7. BOARD MEMBER REPORTS

a) **BOARD CHAIR REPORT**

i. **FORM 700 SUBMISSION**

ii. **TRAININGS**

b) **COMPLIANCE ADVISORY COMMITTEE**

c) **FINANCE COMMITTEE**

8. CEO UPDATE

9. BOARD BUSINESS

a) **REVIEW AND APPROVE STAFF REPORT NOMINATING JAMES JACKSON FOR VICE CHAIR OF THE FINANCE COMMITTEE**

b) **COMPLIANCE PRESENTATION**

c) **REDETERMINATION PRESENTATION**

d) **REVIEW AND APPROVE SEPTEMBER 2023, DECEMBER 2023 AND JANUARY 2024 MONTHLY FINANCIAL STATEMENTS**

e) **FISCAL YEAR 2024 SECOND QUARTER FORECAST**

10. **STANDING COMMITTEE UPDATES**

    a) **PEER REVIEW AND CREDENTIALING COMMITTEE**

    b) **PHARMACY & THERAPEUTICS**

    c) **QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE**

    d) **COMMUNITY ADVISORY COMMITTEE**

11. **STAFF UPDATES**

12. **UNFINISHED BUSINESS**

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

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

15. **ADJOURNMENT**

NOTICE TO THE PUBLIC

The foregoing does not constitute the final agenda. The final agenda will be posted no later than 24 hours prior to the meeting date.

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) 747-6160.

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 Committee 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 a 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 Martinez, at (510) 747-6160 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 March 5th, 2024, by 12:00 p.m.

Brenda Martinez, Clerk of the Board

ALAMEDA Alliance FOR HEALTH

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

EXECUTIVE SUMMARY APPENDIX

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

ALAMEDA Alliance FOR HEALTH

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

PRESENTATIONS APPENDIX

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

ALAMEDA Alliance FOR HEALTH

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

SUPPORTING MATERIALS APPENDIX

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

ALAMEDA Alliance FOR HEALTH

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

Consent Calendar

ALAMEDA Alliance FOR HEALTH

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

Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

December 5th, 2023
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted in-person and by Teleconference.

Committee Members in-person: Dr. Rollington Ferguson, Dr. Michael Marchiano, Gil Riojas
Committee Members on Conference Call: James Jackson

Board of Governor members in-person and on Conference Call: Rebecca Gebhart, Andie Martinez Patterson

Alliance Staff in-person and on Conference Call: Matt Woodruff, Tiffany Cheang, Sasi Karaiyan, Richard Golfin III, Dr. Steve O'Brien, Anastacia Swift, Lao Paul Vang, Ruth Watson, Shulin Lin, Carol van Oosterwijk, Linda Ly, Feliz Rodriguez, Maryam Maleki, Brenda Martinez, Jeanette Murray, Brett Kish, Danube Serri, James Zhong Xu, Christine Corpus

CALL TO ORDER, ROLL CALL, AND INTRODUCTIONS

Dr. Ferguson called the Finance Committee meeting to order at 8:03 am. A Roll Call was then conducted.

Gil Riojas introduced Felix Rodriguez, our new Assistant Controller.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

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

a.) CEO UPDATE

- Final Budget
  - Thank you to the Finance Team for all their work preparing the final budget, and for all the work they did in regard to reporting back to the State about our rates.

Informational update to the Finance Committee. Vote not required.

b.) REVIEW AND APPROVE SEPTEMBER AND OCTOBER 2023 MONTHLY FINANCIAL STATEMENTS

SEPTEMBER 2023 Financial Statement Summary

Enrollment:

Enrollment continues to decrease, as expected.

By category of aid, the Child, Adults, and Optional Expansion are the three main drivers of those decreases. A little bit of a dip in our Seniors and Persons with Disabilities (SPD). The Duals category remains a bit flat, and our Group Care has also shown slight decreases over the last 12 months.

Net Income:

For the month ending September 30th, 2023, the Alliance reported a Net Income of $5.5 million (versus budgeted Net Income of $843,000). The favorable variance is attributed to higher than anticipated Revenue, lower than anticipated Administrative Expense, and higher than anticipated Total Other Income, and slightly offset by higher than anticipated Medical Expense. For the year-to-date, the Alliance recorded a Net Income of $17.6 million versus a budgeted Net Loss of $41,000.

Revenue:

For the month ending September 30th, 2023, actual Revenue was $137.4 million vs. our budgeted amount of $133.8 million. This slight positive variance is related to CalAIM incentive program. Our actual year-to-date Revenue is currently at $414.5 billion versus budgeted Revenue of $406.0 million.

Medical Expense:

Actual Medical Expenses for the month were $126.4 million, vs. our budgeted amount of $125.5 million. For the year-to-date, actual Medical Expenses were $382.2 million versus budgeted $385.7 million. Drivers leading to the favorable variance can be seen on the tables on pages 14 and 15, with further explanation on pages 15 and 16.

Medical Loss Ratio:

Our MLR ratio for this month was reported at 92.0%. Year-to-date MLR was at 92.2%.

Administrative Expense:

Actual Administrative Expenses for the month ending September 30th, 2023 were $7.1 million vs. our budgeted amount of $8.2 million. Our Administrative Loss Ratio (ALR) is 5.1% of our Revenue for the month, and 5.1% of Net Revenue for year-to-date.

Other Income / (Expense):

As of September 30th, 2023, our YTD interest income from investments show a gain of $6.6 million.

YTD claims interest expense is $177,000.

Tangible Net Equity (TNE):

The DMHC requires that we have $46.4 million in TNE, and we reported $341.6 million, so the excess of that is $295.2 million. As a percentage of 737%, that means we have over 7 times the amount that is required.

Cash and Cash Equivalents:

We reported $603.2 million in cash; $323.2 million is uncommitted. Our current ratio is above the minimum required at 1.64 compared to regulatory minimum of 1.0.

Capital Investments:

We have spent $559,000 in Capital Assets year-to-date. Our annual capital budget is $1.5 million.

OCTOBER 2023 Financial Statement Summary

Enrollment:

The Alliance experienced an increase in enrollment, despite ongoing redetermination efforts due to DHCS no longer assigning new members to Anthem, so all new members are Alliance members. Enrollment increased by 3,519 members to 354,067 members.

Net Income:

For the month ending October 31st, 2023, the Alliance reported a Net Income of $3.8 million (versus budgeted Net Loss of $4.6 million). The favorable variance is attributed to higher than anticipated Investment Income, and lower than anticipated Medical and Administrative Expenses. For the year-to-date, the Alliance recorded a Net Income of $21.4 million versus a budgeted Net Loss of $4.6 million.

Revenue:

For the month ending October 31st, 2023, actual Revenue was $135.7 million vs. our budgeted amount of $133.4 million. This slight positive variance is related to CalAIM incentive program, and a higher enrollment and higher proportion of members with higher rates. This was slightly offset by the anticipated unfavorable MOT Risk Corridor recoupment. Our actual year-to-date Revenue is currently at $277.1 billion versus budgeted Revenue of $272.1 million.

Medical Expense:

Actual Medical Expenses for the month were $126.8 million, vs. our budgeted amount of $128.7 million. For the year-to-date, actual Medical Expenses were $508.9 million versus budgeted $514.4 million. Drivers leading to the favorable variance can be seen on the tables on pages 50 and 51, with further explanation on pages 51 and 52.

Medical Loss Ratio:

Our MLR ratio for this month was reported at 93.4%. Year-to-date MLR was at 92.5%.

Administrative Expense:

Actual Administrative Expenses for the month ending October 31st, 2023 were $8.6 million vs. our budgeted amount of $10.1 million. Our Administrative Loss Ratio (ALR) is 6.4% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Other Income / (Expense):

As of October 31st, 2023, our YTD interest income from investments show a gain of $10.2 million.

YTD claims interest expense is $207,000.

Tangible Net Equity (TNE):

The DMHC requires that we have $49.7 million in TNE, and we reported $345.3 million, so the excess of that is $295.7 million. As a percentage we are at 695% and that means we still have over 6 times the amount that is required. You can see from the chart that our TNE started at about the mid 600% range over the last 12 months and peaked at 778%, so as mentioned previously, as our enrollment mix changes as we get new members, and as our expenses increase, that will increase the reserve amount required by the DMHC. So, as expected, we're seeing that our TNE excess actually decreased because of that increase in the requirement.

Cash and Cash Equivalents:

We reported $516.1 million in cash; $344.2 million is uncommitted. Our current ratio is above the minimum required at 1.75 compared to regulatory minimum of 1.0.

Capital Investments:

We have spent $662,000 in Capital Assets year-to-date. Our annual capital budget is $1.5 million.

Motion: A motion was made by Dr. Michael Marchiano, and seconded by Gil Riojas, to accept and approve the September 2023, and October 2023 Financial Statements.

Motion Passed

No opposed or abstained.

c.) REVIEW AND APPROVE FISCAL YEAR 2024 FINAL BUDGET

Gil Riojas gave a PowerPoint Presentation detailing the changes between the Preliminary Budget presented in June, and the Final Budget presented today.

Highlights of the differences between the Preliminary and Final budgets:

- Increase projected membership from 349,601 to 379,251
- Decrease in overall Net Income from $21.9 to $9.3 million
- Administrative Expense % decrease from 6.8% to 5.9%
- Medical Loss Ratio increase from 92.5% to 95.3%
- TNE Percent of Required decrease from 592% to 546%
- Decrease in FTEs from projected 658.9 to 643.4

Motion: A motion was made by Dr. Michael Marchiano, and seconded by Mr. James Jackson, to accept the Fiscal Year 2024 Final Budget.

Motion Passed

No opposed or abstained.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 8:59 a.m.

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

February 6th, 2024
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted in-person and by Teleconference.

Committee Members in-person: Dr. Rollington Ferguson, Yeon Park, Gil Riojas
Committee Members on Conference Call: James Jackson

Board of Governor members in-person and on Conference Call: Rebecca Gebhart

Alliance Staff in-person and on Conference Call: Matt Woodruff, Tiffany Cheang, Sasi Karaiyan, Anastacia Swift, Ruth Watson, Shulin Lin, Carol van Oosterwijk, Linda Ly, Maryam Maleki, Brenda Martinez, Jeanette Murray, Renan Ramirez, Danube Serri, James Zhong Xu, Christine Corpus

CALL TO ORDER, ROLL CALL, AND INTRODUCTIONS

Dr. Ferguson called the Finance Committee meeting to order at 8:00 am. A Roll Call was then conducted.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

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

a.) CEO UPDATE

Matt Woodruff provided updates to the committee on the following:

- Single Plan Model
    - Matt started off by thanking the team for all the work put forth into getting ready for the Single Plan Model and reported that we have done very well in managing our finances over the last 6 months. Matt explained that this is especially good because of all the changes with the Single Plan Model we anticipate over the *next* six months.

- Claims and Member Services Volume
    - We were within regulatory compliance, but not within *internal* compliance with our claims turnaround for the first time in at least 6 plus years.
        - We missed it by 2%, so we processed at 88% instead of 90%. Matt added that he believes that has to do with the sheer amount of volume that we received.
    - For Member Services, again, we hit the regulatory metrics, but we did not hit our internal metrics.
        - We were off by 9% on our speed to answer and off by 6% on our abandonment So we are the largest claims volume ever at the alliance.

    - In December 2023, we received 215,000 claims at the Alliance, and in January we received 298,000. So, we had an increase of about 83,000 claims for the month of January. As a result, we are looking at staffing, and determining if this increase is a one-time event.

- If you look overall at our membership, our membership went from 350,000 to 400,000. If everybody remembers, with Kaiser leaving, we lost the 51,000 Kaiser members, but then we gained 101,000 anthem and undocumented members.

- I mentioned the fact that we missed our Member services internal marks, but we hit regulatory.
  - In December we had almost 14,000 calls.
  - In January we were just a couple of calls short of 30,000, so we more than doubled the calls for Member services.
  - For the first six months of the year, we averaged one person a day coming on site asking questions, for January, we averaged 5 people per day. So, the volume is definitely increasing.
- Our Healthcare Services department had approximately 1200 authorizations that were requested in December from our membership, and in January, we had over 2700 authorizations that were requested.

So overall, our volumes have gone up tremendously with going into the Single Plan Model. We are looking to see what we can do from not just a staffing, but also a systems perspective. Sasi and his team are looking at all the systems and what we can do to try to enhance them and make all the data entry go smoother.

As a reminder, we hold ourselves to a higher standard than what is required for regulatory compliance. If you remember back in 2018 and 2019, we went through a national certification, and we were considered a call center of excellence, so we are still holding ourselves to those standards. When COVID hit, everything happened and now we are trying to get back to those standards.

Matt then addressed questions and commentary from the committee.

Informational update to the Finance Committee. Voting is not required.

b.) REVIEW AND APPROVE NOVEMBER AND DECEMBER 2023 MONTHLY FINANCIAL STATEMENTS

NOVEMBER 2023 Financial Statement Summary

Enrollment:

Enrollment decreased slightly by 1,541 members. DHCS is no longer assigning new members to Anthem, so all new members are being assigned to the Alliance. This helped to offset the continued redetermination disenrollments.

Net Income:

For the month ending November 30th, 2023, the Alliance reported a Net Income of $3.4 million (versus budgeted Net Loss of $1.0 million). The favorable variance is attributed to higher than anticipated Investment Income, and lower than anticipated Medical and Administrative Expense. For the year-to-date, the Alliance recorded a Net Income of $24.8 million versus a budgeted Net Income of $20.4 million.

Revenue:

For the month ending November 30th, 2023, actual Revenue was $137.8 million vs. our budgeted amount of $136.2 million. This slight positive variance is primarily due to the timing of revenue

recognition. Our actual year-to-date Revenue is currently at $688.0 million versus budgeted Revenue of $686.3 million.

Medical Expense:

Actual Medical Expenses for the month were $128.3 million, vs. our budgeted amount of $129.4 million. For the year-to-date, actual Medical Expenses were $637.2 million versus budgeted $638.4 million. Drivers leading to the favorable variance can be seen on the tables on pages 11 and 12, with further explanation on pages 12 and 13.

Medical Loss Ratio:

Our MLR ratio for this month was reported at 93.1%. Year-to-date MLR was at 92.6%.

Administrative Expense:

Actual Administrative Expenses for the month ending November 30th, 2023 were $7.9 million vs. our budgeted amount of $10.2 million. Our Administrative Loss Ratio (ALR) is 5.7% of our Revenue for the month, and 5.5% of Net Revenue for year-to-date.

Other Income / (Expense):

As of November 30th, 2023, our YTD interest income from investments show a gain of $12.0 million.

YTD claims interest expense is $253,000.

Tangible Net Equity (TNE):

The DMHC requires that we have $49.9 million in TNE, and we reported $348.8 million, so the excess of that is $298.9 million. As a percentage, we are at 699% of required, which remains very healthy.

Cash and Cash Equivalents:

We reported $480.5 million in cash; $310.7 million is uncommitted. Our current ratio is above the minimum required at 1.80 compared to regulatory minimum of 1.0.

Capital Investments:

We have spent $1.2 million in Capital Assets year-to-date. Our annual capital budget is $1.6 million.

DECEMBER 2023 Financial Statement Summary

Enrollment:

The Alliance experienced a slight decrease in enrollment due to ongoing redetermination efforts. Enrollment decreased by 546 members to 351,980 members.

Net Income:

For the month ending December 31st, 2023, the Alliance reported a Net Income of $10.6 million (versus budgeted Net Loss of $3.4 million). The favorable variance is attributed to higher than anticipated Revenue, higher than anticipated Other Income/Expense, and lower than anticipated Medical and Administrative Expenses. For the year-to-date, the Alliance recorded a Net Income of $35.4 million versus a budgeted Net Income of $17.0 million.

Revenue:

For the month ending December 31st, 2023, actual Revenue was $135.1 million vs. our budgeted amount of $132.8 million. The slight positive variance is primarily due to the timing of revenue

recognition. Our actual year-to-date Revenue is currently at $823.0 million versus budgeted Revenue of $819.0 million.

Medical Expense:

Actual Medical Expenses for the month were $122.2 million, vs. budgeted amount of $128.6 million. For the year-to-date, actual Medical Expenses were $759.4 million versus budgeted $767.0 million. Drivers leading to the favorable variance can be seen on the tables on pages 47 and 48, with further explanation on pages 48 and 49.

Medical Loss Ratio:

Our MLR ratio for this month was reported at 90.4%. Year-to-date MLR was at 92.3%.

Administrative Expense:

Actual Administrative Expenses for the month ending December 31st, 2023 were $7.0 million vs. our budgeted amount of $10.0 million. Our Administrative Loss Ratio (ALR) is 5.2% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Other Income / (Expense):

As of December 31st, 2023, our YTD interest income from investments show a gain of $16.8 million.

YTD claims interest expense is $294,000.

Tangible Net Equity (TNE):

The DMHC requires that we have $49.6 million in TNE, and we reported $359.3 million, so the excess of that is $309.7 million. As a percentage we are at 724% and that means we have over 7 times the amount that is required.

Cash and Cash Equivalents:

We reported $516.0 million in cash; $345.3 million is uncommitted. Our current ratio is above the minimum required at 1.82 compared to regulatory minimum of 1.0.

Capital Investments:

We have spent $1.1 million on Capital Assets year-to-date. Our annual capital budget is $1.6 million.

Motion: A motion was made by Yeon Park, and seconded by James Jackson, to accept and approve the November 2023, and December 2023 Financial Statements.

Motion Passed

No opposed or abstained.

c.) VICE CHAIR RESIGNATION

Matt Woodruff announced that current Vice-Chair Dr. Michael Marchiano has resigned from the Board entirely, and at the March Board of Governor's meeting, we will hold a vote for a new vice-chair. Mr. James Jackson has graciously agreed to put his name in to be the new vice chair, and again, that vote will take place at the March 8th Board meeting.

Informational update to the Finance Committee. Voting is not required.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 8:59 a.m.

ALAMEDA Alliance FOR HEALTH

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

Compliance Advisory Committee Meeting Minutes

COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes
Friday, December 8th, 2023
10:30 a.m. – 11:30 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

CALL TO ORDER

Committee Members Attendance: Byron Lopez, Richard Golfin III, Dr. Kelley Meade, Rebecca Gebhart

Committee Members Remote:

Committee Members Excused:

1. CALL TO ORDER

The regular Compliance Advisory Committee meeting was called to order by Dr. Kelley Meade at 10:30 am.

2. ROLL CALL

A roll call was taken of the Committee Members, quorum was confirmed.

3. AGENDA APPROVAL OR MODIFICATIONS

There were no modifications to the agenda.

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

None

5. CONSENT CALENDAR

a) October 13th, 2023, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

Motion: A motion was made by Richard Golfin, III and seconded by Byron Lopez to approve Consent Calendar Agenda Items (a).

Vote: Motion unanimously passed.

No opposition or abstentions.

6. COMPLIANCE MEMBER REPORTS

a) COMPLIANCE ACTIVITY REPORT

i. Plan Audits and State Regulatory Oversight

1. Written report attached.

ii. RGP Compliance Assessment Summary of Findings

- At the request of the Board of Governors (BOG), a compliance assessment was conducted in December 2022 due to leadership changes and growth demands.
- The goal was to provide insight into the maturity of the compliance program and provide suggestions for improvement.
- The assessment was conducted by a consulting firm, RGP, and was completed on May 22nd, 2023. In the report, the RGP addressed fourteen (14) areas of opportunity for assessing the Alliance, with the following observations:

1. Organizational Structure
   - The legal team reporting to the Chief Compliance officer as a conflict and a possible CAP from CMS.
   - The Compliance Department lacks experience with Medicaid, insurance, and health plan compliance which would aid the Department in remediating risk.
     i. AAH will take the following additional actions:
        - Continuing to encourage team members to participate in training and development courses is a proactive step towards motivating and encouraging the Compliance Department. By Q4 2024 the goal is to have 75% of management certified in Compliance, department staff goal is 30%.
        - Continue regular one-on-one meetings to discuss progress towards individual development goals.
        - Encourage team members to share knowledge gained from training.
        - Encourage team members to apply newly acquired skills and knowledge in their day-to-day work.
        - Provide opportunities for them to practice and reinforce what they have learned. (Possibly develop trainings and present at organization meetings)
2. Monitoring and Testing
   - The Compliance Department does not assist department managers in establishing routine audit and reporting procedures except in response to Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) audits and CAPs.
   - The Compliance Department has not developed or identified internal controls to detect significant instances of illegal, improper, or unethical conduct.
   - Compliance Program Effectiveness has not been established due to lack of audits and Delegation oversight is not robust.
   - Grievances and Appeals (G&A) lack monitoring and auditing.
     i. AAH will take the following additional actions:
        - By Q2 2024, the Compliance Health Plan Investigations department will develop a timeline and calendar for 1LOD (First Line of Defense) audits and will include these audits as part of the IAP (Internal Audit Process) which will be reviewed and approved at the Compliance Committee annually.

Additionally, our Internal Audit team will be meeting with SMEs to determine what their own department process audits are and review their P&Ps to determine if they are following their own processes.

3. Policy and Procedures (P&Ps)
   - P&Ps do not adhere to the processes, ignored details, some are no longer required, or are missing entirely.
   - The Code of Conduct should include business and social standards that address the complex problems of a sophisticated and complex organization.
   - Some policies should be removed if no longer needed or required.
     i. AAH will take the following additional actions:
        - Conduct trainings for new employees or on a as need basis on how to use Policy Tech
        - Update training materials and workflows to support the use of Policy Tech and Policy and Procedure development.
4. Hotline Triage
   - Hotline lacks confidentiality, follow-up timing, and coordination of ownership, and a decision tree is needed to separate compliance and non-compliance reporting, especially HR matters.
     i. AAH will take the following additional actions:
        - By Q2 2024 ensure that all stakeholders involved are trained and understand the protocols put in place, this can be done by having relevant stakeholders trained through reviewing desktop procedures and workflows. The Compliance Department is working on updating workflows and desktop procedures into Navex and will encourage other divisions to do the same. In regard to the HR Hotline, Compliance will consult with internal stakeholders on next steps.
5. Technology
   - Currently there is not an effective technology to support a robust Compliance Program for holding Audits, Assessments, reports, etc.
     i. AAH will take the following additional actions:
        - Compliance is working with IT and Analytics for additional technologies and reports to further enhance the Compliance Department.
        - The Compliance Department will look at making a repository for documents by analyzing current technologies such as Policy Tech, Smartsheet, and Teams folders, as well as other potential technologies.
6. Internal Audit
   - There is not a structured Internal Audit Program in place. A policy does exist for the creation of Internal Audit.
   - There is a disconnect between departments on how to support internal auditing.
   - Internal Audit procedure documentation should be improved.
     i. AAH will take the following additional actions:
        - Internal audit findings will continue to be reported at the Compliance Committee, and the process for reporting will be developed into a desktop

procedure. While reporting has now begun at the Compliance Committee, the desktop procedure, and associated reporting will be fully implemented by Q2 2024.

Question: Regarding the effective Compliance Committee, does that refer to the internal Compliance committee, and not the Compliance Advisory Committee?

Answer: Yes,

Question: Is there any reflection on the functions of the Compliance Advisory Committee and the intersection of Compliance with the Board of Governors?

Answer: That isn't part of the report. From my own experience, uh, my decade and 1/2 in this industry, I have not seen this set where we have the board delegated compliance committee, team routinely reporting to the board, sanction Compliance Advisory Committee.
That is a tremendous amount of transparency and ward engagement and I hope more plans follow this structure. It's pretty special, to have our board members sit and engage with the compliance team on a regular basis. Typically, it reports to watch larger, much larger committee that has everything brought in, and then it's a bullet point rather than its own dedicated a port committee.

7. Corporate Risk Assessment
- It was found that there's not an active risk management program and recommends initiating a health plan risk assessment.
    i. AAH will take the following additional actions by Q4 2024:
        - Stakeholder Engagement: actively involve stakeholders from various departments in the risk assessment process. Ensure their perspectives and expertise are considered in identifying and prioritizing risk.
        - Data collection and analysis: Gather relevant data and information to support the risk assessment process. This may include historical data and compliance documentation.
        - Document and Reporting: Document the entire risk assessment process, including identified risks, prioritization, and responsible parties. Provide regular reports to senior management and relevant stakeholders.
        - Continuous Monitoring: Implement a process for ongoing monitoring and review of risks, considering changes in industry trends, and regulatory landscape. Update the risk assessment as needed.

8. Regulatory Intake
- Quality Assurance (1LOD) struggles with coordination with Compliance (2LOD) in regulatory changes and impacts to the organization. In addition, there is not a tracking process for all the APLs and their impact.
    i. AAH will take the following additional actions:
        - Continue to team up and meet with IPD on ongoing projects and implementation processes.

9. Effective Compliance Committee
- The Compliance Organization Strategy relates to executing the Compliance Program and staffing-up as fast as possible. However, there is a need to create a strategy on how to support growth.
    i. AAH will take the following additional actions by Q3 2024:

- Regular Progress Updates: The Compliance Department will implement a system for periodic updates on Compliance projects, and audit projects between committee meetings. This could be in the form of monthly reports or dashboards.
- Issue Escalation Protocol: Establish a clear protocol for escalating any significant compliance issues or challenges that require immediate attention, outside of regular committee meetings.
- Cross functional Collaboration: Foster collaboration between compliance and other departments to ensure alignment with organizational goals and objectives. This could involve joint projects, and regular check-ins. This should also involve updating and approving of policies and procedures and using Navex Policy Tech as the only place Policies are being updated or developed.
- Feedback mechanism: Establish a mechanism for committee members to provide feedback on the effectiveness of the committee's initiatives and processes. This feedback loop can be used to make continuous improvements.

10. Delegation Oversight
    - Network management exists. However, a robust Delegation Oversight Program needs to be established.
        i. AAH will take the following additional actions:
            - By Q4 2024, continue to work on the Delegation Dashboard as a strategic move towards efficient task management.
            - Action Item: gather feedback from stakeholders on the outcomes of the dashboard and CAP process, the Compliance Department can then use that feedback to enhance reporting.

11. Training
    - The Alliance has Compliance Training, but the following information should be added to increase awareness:
        - Compliance's roles and responsibilities
        - Operation's role and responsibilities
        - External audit process including roles, responsibilities, and communication standards.
        i. AAH will take the following additional actions:
            - In Order to accomplish the following below, education will need to be created and distributed across the Alliance. This will need to be created by Q2 2024.
            - An overview of Internal Audits.
            - Roles and responsibilities for both Compliance and the Compliance related responsibilities for the rest of the organization.

12. Investigations/FWA/SIU
    - The lack of a robust Fraud, Waste, and Abuse (FWA) Plan along with lack of support from Compliance in G&A,
        i. AAH will take the following additional actions:

- Continued FWA training. Workflows will be created and shared to the organization to ensure timeliness of reporting FWA incidents to Compliance from other areas of the organization.

13. Vendor Risk Management
    - Vendor Management (VM) needs additional support from Compliance in validating Business Associate Agreements (BAAs) including updates, screening requirements, and support for First Tier, Downstream, and Related Entities.
        i. AAH will take the following additional actions:
            - Currently Privacy and Vendor Management work together. The Privacy office works closely with Vendor Management for completion of data protection agreements with vendors and various other Privacy / Vendor questions and concerns.
            - Data Sharing Agreements
            - Data Processing Agreement
            - Business Associate Agreements
            - Other activities
            - Recently the two departments have partnered with review of contracts and investigations when working through a vendor privacy/security incident.
            - Privacy was invited to weigh in on the development of the VM Playbook.
            - VM invited Privacy to a department meeting to review different agreement types and when to use them, Privacy's role in data agreements and how Privacy and VM can partner to protect the Alliance.

14. Quality Assurance
    - Quality Assurance (1LOD) conducts monitoring and auditing separate from the Compliance Department. Quality Assurance also speaks with regulators as a gap fill to support Compliance due to Compliance's staffing challenges.
    - Monitoring and auditing documents lacked formalized reporting and should outline collaborative reporting between both Quality Assurance and Compliance.
        i. AAH will take the following additional actions by Q2 2024:
            - Present the proposed 1LOD audit process to the Alliance's Compliance Committee for review and approval. This ensures that key stakeholders are engaged in the process and have an opportunity to provide input.
            - Implement a clear protocol for escalating any identified gaps or non-compliance with DHCS, DMHC, and NCQA requirements. This ensures prompt corrective action and reporting as needed.
            - By taking these additional actions, the Compliance Department can strengthen its regulatory compliance efforts, foster effective communication with regulators, and establish a robust audit process aligned with the organization's regulatory obligations.
    - Based on a review of this report and comparison with our current processes, Compliance agrees with 45% of the recommendations and disagrees with 55%. A total of 14% of the observation recommendations are complete and 86% are in progress. Our estimated completion date is to complete 8% of the

recommendations by Q4 of this year, 50% in Q2 2024, 8% in Q3 2024, and 34% in Q4 2024.

Question: What is the risk of disagreeing with this assessment if we agree with 45% of it?

Answer: We hired an external consultant to do a review, but they did not include all the information. We then reviewed their review with the information that wasn't included or was under development. In March, the external consultants completed their review. We were in post-audit in July, and several policies and procedures had been approved. I don't see any risk of disagreeing because we're demonstrating how the plan is doing.

Question: Is this undertaking voluntary and intended to enhance our audit and compliance program or is it a regulatory matter?

Answer: This is not a regulatory matter. This is how we look at ourselves to make sure we're ready for the next things. This is part of the seven elements of an effective compliance program, and so to bolster our abilities to maintain and manage compliance at our plan, we wanted a third-party assessment that comes in and tells us we normally wouldn't agree or disagree.

b) DELEGATION ACTIVITY AND OVERSIGHT

None

c) MEDI-CAL PROGRAM UPDATES

None

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a) 2024 Compliance Advisory Committee Calendar

8. STAFF UPDATES

None

9. UNFINISHED BUSINESS

None

10. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

None

11. ADJOURNMENT

Chair Dr. Kelley Meade adjourned the meeting at 11:30 am.

ALAMEDA Alliance FOR HEALTH

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

Board of Governors Meeting Minutes

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, December 8th, 2023
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: Rebecca Gebhart (Chair), Aarondeep Basrai, Colleen Chawla, Andrea Ford, Byron Lopez, Dr. Marty Lynch, Dr. Michael Marchiano, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Supervisor Lena Tam

Board of Governors Remote (Traditional Brown Act): Dr. Noha Aboelata (Vice-Chair)

Board of Governors Excused: Dr. Rollington Ferguson, James Jackson, Yeon Park, Andrea Schwab-Galindo, Dr. Evan Seevak, Natalie Williams

Alliance Staff Present: Matthew Woodruff, Richard Golfin III, Dr. Steve O'Brien, Gil Riojas, Anastacia Swift, Ruth Watson, Sasi Karaiyan, Tiffany Cheang, Michelle Lewis, Lao Paul Vang

Chair Gebhart called the regular Board of Governors meeting to order at 12:01 p.m.

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL OR MODIFICATIONS

There were no modifications to the agenda.

4. INTRODUCTIONS

Chair Gebhart and Matt Woodruff introduced and welcomed three new board members to the Alliance Board of Governors: Colleen Chawla, Director of Alameda County Health Care Services Agency, represents the Health Care Services Agency Seat; Andrea Ford, Agency Director of Alameda Social Services Agency, represents the Social Services Agency Seat; Andie Martinez Patterson, CEO of Alameda Health Consortium and Community Health Center Network, represents the Community Health Center Network Seat.

5. CONSENT CALENDAR

a) OCTOBER 10th, 2023, FINANCE COMMITTEE MEETING MINUTES

b) OCTOBER 13th, 2023, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

c) OCTOBER 13th, 2023, BOARD OF GOVERNORS MEETING MINUTES

Motion: A motion was made by Supervisor Lena Tam and seconded by Dr. Marty Lynch to approve the Consent Calendar.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Andrea Ford, Byron Lopez, Dr. Marty Lynch, Dr. Michael Marchiano, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

Dr. Kelley Meade gave an update on the Compliance Advisory Committee meeting that took place on December 8, 2023. The committee discussed the results of a voluntary consultant report of our internal audit process for the plan. The consultant worked with the plan from December 22nd to May 23rd for six months during a crucial time for the plan. The purpose of this engagement was to assess the maturity of the compliance process and identify any opportunities for improvement. Grace St. Clair, Katie Sisto, and Roberta Robertson thoroughly reviewed each issue and provided feedback. They only agreed with about 45% of the items in the report, but wherever they disagreed, there was substantial evidence to support that the processes and procedures were in place at the plan. The committee applauded the internal audit team for their report. The committee also suggested additional training and an opportunity for corporate risk assessment with an outside agency. An RFP will go out to look at corporate risk assessment for the future, and that will be the work of 2024. There were 14 items in total, and a project plan and timeline were created for 2024 to resolve or improve them.

b) FINANCE COMMITTEE

Chief Financial Officer, Gil Riojas, provided an update on the Finance Committee meeting held on December 5, 2023. The Committee reviewed the financial results and details for September and October and spent a lot of time discussing the final budget. The September financial report showed a little over $5 million in net income, while the October report showed about $3.8 million in net income. Currently, our Final Budget is projected to have a net income of about $9.1 million for the year.

7. CEO UPDATE

In the CEO Update, Matthew Woodruff shared the following updates:

- Key Performance Indicators
    - Regulatory and Non-Regulatory Metrics:
        - The Plan is meeting all the regulatory and non-regulatory metrics. Non-regulatory metrics refer to our internal standards which we hold ourselves to a higher level of accountability, sometimes higher than the requirements set by the State. Our long-term care expenses have exceeded our estimates due to retroactive costs, staffing, and additional ancillary expenses that were difficult to quantify. Therefore, we have decided to adjust our final budget to reflect the current expenses.

Question: In regards to long-term ancillary coverage, we had no prior experience with the medical expenses of these members since they were not previously part of our network. However, the estimated costs we had projected earlier turned out to be lower than the actual costs. Is my understanding of the situation correct?

Answer: We had no prior experience in handling such claims since the state was dealing with them for the first time. We anticipated having around 1500-1600 members based on our knowledge and projections, yet we only ended up with 1400 members. We knew the per-day cost we would have to pay, but there were other costs that we had to consider, such as hospital, radiology, and DME costs. We had to contract with various companies for these expenses. Additionally, there were retroactive costs involved. The retroactivity referred to the center sending in a cost report, which the State would take about 6-9 months to review. Then, they would calculate the rate retroactively to the beginning of when they received the report, and we would owe the facilities the difference.

- Program Implementations:
    - Final Budget Discussion
        - Final budget net income is projected at around $9 million.
        - The staffing is going to increase from 517 to 643, which is in the budget. This increase is primarily due to the arrival of approximately 110,000 new members on January 1, 2024. Matt has praised the HR Department for their efforts in hiring 101 employees in the first five months of this fiscal year and is working hard to get all the staffing ready.

Question: Will we receive information about hospital utilization from the undocumented population that will be covered?

Answer: We have information about the HealthPAC members who are transferring, and most of them will be assigned to CHCN and AHS. Our priority is to enroll them back into CHCN and AHS. However, we are expecting around 16,000 individuals that we have limited information on, and we will need to process them.

Pay Equity Salary Survey

- We completed Step One of our pay equity salary survey and adjusted 29 out of 508 employees based on gender equitability. Overall, we believe that The Alliance has performed well.
- Next step the Alliance will rerun the data to finalize the changes made on November 17, 2024.

Board Retreat

- The agenda is set, and the retreat is scheduled for January 26, 2024, at Garré Winery in Livermore. Chair Gebhart expressed gratitude to Dr. Marty Lynch for his help with the committee and to Matthew for preparing the agenda.

Recruiting Incentives for our Network

- Matthew thanked all the board members who sent feedback. An updated program will be distributed at the end of the month for review.

Question: In relation to the workforce recruitment approved in the budget by the Finance Committee, when will it roll out, and how will The Alliance communicate this opportunity to contracted providers?

Answer: Our aim is to begin the implementation of this plan during the first quarter of the calendar year. However, we haven't communicated this information yet as we are still finalizing the process, which would require the board's approval. Once this is done, we will communicate the details to everyone.

8. BOARD BUSINESS

a) REVIEW AND APPROVE RESOLUTION 2023-10 UPDATING THE CONFLICT OF INTEREST CODE

Chair Gebhart briefly explained the main revision made to the resolution. Counsel has determined that there are more positions within the plan that need to disclose their potential conflicts of interest because they have the ability to influence the spending decisions. Counsel has reviewed everyone's roles and has already included the CEO and senior leadership team as disclosures. Now, additional individuals have been identified as requiring disclosures.

Motion: A motion was made by Supervisor Lena Tam and seconded by Dr. Kelley Meade to approve Resolution 2023-10, updating the Conflict of Interest Code.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Andrea Ford, Byron Lopez, Dr. Marty Lynch, Dr. Michael Marchiano, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

b) REVIEW AND APPROVE RESOLUTION 2023-11 CHANGING MAC TO CAC

Matthew Woodruff has explained that The Alliance has had a member advisory committee for a considerable period. The Alliance's contract "the Contract" with the Department of Health Care Services (DHCS) requires the Plan to establish a Community Advisory Committee to comply with the contract. Although this is an existing committee within the Alliance, the name of the committee needs to be changed from Member Advisory Committee (MAC) to Community Advisory Committee (CAC). Further changes have been made to the Community Advisory Committee's charter in order to reflect the enhanced requirements in the Contract with the Board's review and approval.

The resolution is simply about changing the name of the committee. Furthermore, in the past, the CEO would work together with the Healthcare Services team to appoint members to the committee. However, as of January, this responsibility will be shifted to this body. This body will now approve all members appointed to the Community Advisory Committee. The team has 180 days to select members after January 1, 2024. Matthew will work with Rebecca and others to develop procedures that are compliant with the nominating process.

Motion: A motion was made by Aaron Basrai and seconded by Supervisor Lena Tam to approve Resolution 2023-11, changing MAC to CAC.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Andrea Ford, Byron Lopez, Dr. Marty Lynch, Dr. Michael Marchiano, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

c) REVIEW AND APPROVE OCTOBER 2023 MONTHLY FINANCIAL STATEMENTS

Chief Financial Officer Gil Riojas provided the following updates on the October 2023 Financials:

Executive Summary

- For the month ended October 31st, 2023, the Alliance had an enrollment of 354,067 members, a Net Income of $3.8 million and 695% of the required Tangible Net Equity (TNE).

Gil informed us that there was an unexpected increase in enrollment this month. However, we received some information last month which provided us with a better understanding of the enrollment trends. Our TNE, which is the reserve amount required by the Department of Managed Health Care, decreased from the previous month.

Enrollment

- Total enrollment has increased by 3,519 members since September 2023.
- Total enrollment decreased by 7,618 members since June 2023

Over the past few months, our enrollment has been decreasing at a rate of approximately 3,000 to 4,000 members per month. However, this month, we saw a reversal of that trend and had an increase of about 3,500 members compared to the previous month.

Enrollment and Profitability by Program and Category of Aid

- There has been a reversal in the trend for Medi-Cal Child, Medi-Cal Adult and Medi-Cal ACA Optional Expansion from a decline to an increase. Medi-Cal SPD has gone up slightly as well.
- Medi-Cal Duals, those that are eligible for both Medi-Cal and Medicare, remain flat.
- Group Care, which is our commercial line of business and our business with the County, has seen a steady decline over the last 12 months.

Net Income

- For the month ended October 31st, 2023
  - Actual Net Income $3.8 million.
  - Budgeted Net Loss of $4.6 million.

- For the fiscal YTD ended October 31st, 2023
  - Actual Net Income $21.4 million.
  - Budgeted Net Loss of $4.6 million.

- The favorable variance of $8.3 million in the current month is primarily due to:
  - Favorable $2.7 million higher than anticipated Total Other Income/Expense.
  - Favorable $2.3 million higher than anticipated Revenue.
  - Favorable $1.9 million lower than anticipated Medical Expense.
  - Favorable $1.5 million lower than anticipated Administrative Expense.

Revenue

- For the month ended October 31st, 2023
  - Actual Revenue: $135.7 million.
  - Budgeted Revenue: $133.4 million.

Gil reported that our revenue is on track with expectations.

Medical Expense

- For the month ended October 31st, 2023
  - Actual Medical Expense: $126.8 million.
  - Budgeted Medical Expense: $128.7 million.

- For the fiscal YTD ended October 31st, 2023
  - Actual Medical Expense: $508.9 million.
  - Budgeted Medical Expense: $514.4 million.

Medical Loss Ratio (MLR)

The Medical Loss Ratio was 93.4% for the month and 92.5% on a year-to-date basis.

Administrative Expense

- For the month ended October 31st, 2023
  - Actual Administrative Expense: $8.6 million.
  - Budgeted Administrative Expense: $10.1 million.

- For the fiscal YTD ended October 31st, 2023
  - Actual Administrative Expense: $29.8 million.
  - Budgeted Administrative Expense: $32.7 million.

Other Income/ (Expense)

Other Income and expenses are comprised of investment income and claims interest.

- Fiscal year-to-date net investments show a gain of $10.2 million.

Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) requires us to have approximately $50 million in TNE. We've reported an actual TNE of about $345 million, and the excess amount we have is about $296 million, which represents about 696% of what is required by the DMHC.

Gil explained that the TNE had reached its peak in May and has been on a downward trend over the last few months. As we move away from Kaiser and shift towards the single plan model, we will be adding more fee-for-service members. This will increase the requirement for TNE, which in turn will lower our TNE percentage.

Comment: Chair Gebhart highlighted an important issue for board members to understand. She explained that even if the same amount of dollars are obligated, the TNE will go down because the fee for service members have a higher risk. Therefore, the requirement to put aside more is higher, resulting in a lower TNE percentage. This should not be a cause for alarm for those who monitor the TNE percentage as a measure of the organization's health.

During the discussion, Gil shared another perspective on the matter. He explained that the State also considers our TNE and expects us to use it to manage new programs and enrollments effectively. Thus, although our reserve may seem high, it will be utilized for upcoming expenses, including Medicare, new enrollment, and programs. This way, our TNE will help us withstand significant changes that may happen in the next few years.

Chair Gebhart also mentioned that during previous meetings, the auditors explained that the state capitalizes on managed care plans with TNE. This means that the state is aware of what's happening and prepares the plans to be better equipped to handle new responsibilities. So, it's essential to keep this in mind when considering the significance of TNE.

Question: Does this mean that with capitalization, as seen in the example of CalAIM, new expectations are being placed on us? Will these new responsibilities eventually affect the rates? It doesn't seem actuarially sound to assume that the rates can remain the same when new responsibilities are added.

Answer: Part of determining the rates for our services depends on how we collect and report our data to the State. It is important that we capture all the necessary data in encounters and claims. However, there are certain areas where the State relies on us to use our TNE to manage certain expenses, such as community support. Although these expenses are not currently included in our rates, we have enough TNE to manage them. Our concern is how long we can continue to do so without support from the State. Our aim is to have the State include these expenses in our rates in the future. This will ensure that all expenses are captured, which is not currently the case. Our advocacy is focused on having these expenses included in our rates in the coming years.

Question: If a penalty is incurred, will the fine be paid from the reserves?

Answer: Yes. If there are fines and penalties, the reserve amount that we have will help us pay those fines without destabilizing the plan.

Capital Investment

- Fiscal year-to-date capital assets acquired: $662,000.
- Annual capital budget: $1.5 million.

Motion: A motion was made by Dr. Kelley Meade and seconded by Dr. Michael Marchiano to approve the October Financial Statements.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Andrea Ford, Byron Lopez, Dr. Marty Lynch, Dr. Michael Marchiano, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

d) REVIEW AND APPROVE FISCAL YEAR 2024 FINAL BUDGET

Gil Riojas presented the Fiscal Year 2024 Final Budget and praised his team for their hard work and dedication. He acknowledged their efforts over the several months it took to complete the budget, including the many late hours they put in. Gil expressed his gratitude to the budget team for their successful completion of the task.

Highlights of the presentation included:

Material Areas of Uncertainty

- Material changes in enrollment are estimates, DHCS has not sent Plan specific enrollment projections. We are keeping a close eye on this and will update our budget and forecast accordingly in the future.
- Draft rates were received this week. Overall, it seems like the rates are favorable. However, because of the favorable rates, there is more work to be done in terms of managing the increased revenue. This means that although the revenue is increasing, the responsibility of managing it also increases. Those new programs that we'll need to implement starting in calendar year 2024, but generally, it was favorable to what we expected.
- The ratio of members with Satisfactory versus Unsatisfactory Immigration Status may vary from DHCS projections.
- The responsibility for long-term care services transitioned from fee-for-service Medi-Cal in February; thus, AAH still has limited LTC experience. Emerging data shows that costs for Long-term Care have been higher than anticipated.
- Medical Expenses include assumptions regarding the relative acuity of new populations, existing members, and departing members. These assumptions will need time to develop and validate.
- The Alliance may be required to contract with many out-of-area providers in order to maintain continuity of care for members transitioning from Anthem.
- Contract changes for hospitals and delegated providers in projections have not been finalized.

Question: Could you explain the current immigration status rates and their impact on stakeholders? This is an important issue that you are trying to address with the State.

Answer: The state is paying us different rates for members with Satisfactory Immigration Status and those with Unsatisfactory Immigration Status (UIS). However, the rates for UIS members were significantly lower than expected. Despite the direction given by the State, the actual rates were lower than anticipated, causing concern because they were considerably lower than the rates for Satisfactory Immigration Status members. When we reviewed the draft information from the State, they allowed us to provide feedback on it. One area we pushed back on was the rates, as we requested more justification for the low rates and argued that they should be higher. The State listened to our advocacy, as well as that of other plans, and we believe that the rates will be higher because of it in the future. While we were initially unhappy with the rates, we are now somewhat satisfied with the draft rate information we received this week.

Question: Had Medi-Cal providers been paid the same rates for all beneficiaries in prior years as they are being paid now?

Answer: The State had an issue with receiving federal funds from CMS due to incorrect enrollment reporting. They included individuals with Unsatisfactory Immigration Status to CMS and receiving payments for them. However, such reporting is not appropriate at the federal level, so the State had to rectify the situation by going back and correcting it for many years. Consequently, the State is now responsible for paying UIS rates for future periods, which is a significant shift in how they have been paid in the past. Rates are now different for different populations, and the reporting requirements have also increased. The State now requires information on both Satisfactory Immigration Status and Unsatisfactory Immigration Status, which has led to higher rates.

Highlights

- In our initial budget report, we had projected a net income of $22 million dollars. However, based on the draft rates we received in October, our net income has decreased to $9.3 million. It is important to note that this figure is subject to change with updated rates, and we hope that it will improve. However, this was the estimated net income we had at the time of preparing the report.
- Our Tangible Net Equity percentage is decreasing as more members join. Currently, we have a TNE of around 700%, but by the end of the fiscal year, we anticipate it to be around 546%. This is due to the higher requirement for new members.
- We expect our enrollment to peak at 404,000 members in January.
- Total revenue includes approximately $120 million of pass-through funding. Revenue managed by AAH is approximately $1.7 billion.
- PMPM Fee-for-Service and Capitated Medical Expense decreases by 2.0%.
- $18.9 million in net savings are included for claims avoidance and recovery activities.
- As we grow, our clinical expenses are growing as well.
- Staffing includes 643 full-time equivalent employees by June 30, 2024. This includes 438 Administrative employees and 205 Clinical employees.

Enrollment

- FY 2024 member months of 4,484,000 are 4.3% higher than the Preliminary Budget.
- The number of projected members at the end of the year has increased by 30,000.
- Increases to assumptions have been made to the number of members transitioning on January 1, 2024. This includes members transitioning from Anthem and new undocumented members aged 26-49 years old.
- Disenrollments have been slightly more moderate than anticipated.

Revenue

- 98% of Revenue for Medi-Cal, 2% for Group Care.
- PMPM draft Medi-Cal rates are lower than anticipated. They are 0.6% lower than CY 2023 and 3.5% lower than Preliminary budget. This is driven by lower UIS rates in the ACA OE, SPD, and Dual Categories of Aid.
- ECM rates increased by 1.6% versus Preliminary.

Medical Expense

- 98% of Expense for Medi-Cal, 2% for Group Care.
- Medical loss ratio is 95.3%, an increase of 2.8% over the Preliminary Budget.

Capital Expenditures

- Full Year budget of $1.6 million in capitalized purchases for Information Technology and Facilities. This is an increase of $110,000 from the Preliminary Budget.

Staffing: Full-time Employees at Year-end

- 643 FTE, we anticipate being hired by the end of the fiscal year. Although we have approved approximately 702 positions, it is unlikely that all of them will be hired by the end of the fiscal year. However, we have been growing consistently over the past few years and expect to continue doing so.

Question: Long-term care is expensive. Have we identified the factors driving up costs? Did we underestimate the budget?

Answer: In our preliminary budget for long-term care, we used the rate information from the State. The State assumed that our long-term care costs would be X, and so we made a similar assumption for our expenses. However, it turns out that our expenses are higher than the revenue we're getting from the State. We are now using our experience from the first few months of this fiscal year to determine how we need to increase our expected expenses for long-term care. Our hope is that in the two-year rate cycle, the State will catch up, and our long-term care rates in future periods will reflect higher expenses. We report this information to the State, including the data and encounters. We are currently managing the situation and are trying to understand what the drivers of the higher expenses are.

Motion: A motion was made by Dr. Marty Lynch and seconded by Dr. Michael Marchiano to approve the Fiscal Year 2024 Final Budget.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Andrea Ford, Byron Lopez, Dr. Marty Lynch, Dr. Michael Marchiano, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

e) BEHAVIORAL HEALTH INSOURCING UPDATE

Dr. O'Brien and Ruth Watson presented an update on Behavioral Health Insourcing. Dr. O'Brien pointed out that the information in the presentation was prepared by the two senior directors of Behavioral Health, Laura Grossmann-Hicks on the operation side and Dr. Peter Curry on the Healthcare Services side as well as Dr. Sanjay Bhatt, who overseas it from the Healthcare Services side with a lot of input from Gia Degrano in Member Services and Jennifer Karmelich in Grievance and Appeals.

Highlights

Mental Health

- Utilization
    - Pre-Insourcing
    - Post-Insourcing
- Strengths/Challenges
- Network Gaps
- Network Development Actions
- Grievances

BHT/ABA

- Beacon Waitlist
- Utilization
    - Pre-Insourcing
    - Post-Insourcing

- BHT Utilization Data (April-October 2023)
- Network Development Strategy
- Network Expansion Opportunities
- Grievances
    - Pre-Insourcing
    - Post-Insourcing
    - Member Grievances
    - Clinical Grievances with AAH team
    - Operations Grievances
    - Access to Care Grievances
- Strengths/Challenges
- Take Away

Informational item only.

Question: Could you clarify if Anthem and Beacon have different provider pools?

Answer: We have found that there are different providers in the general network we received from Anthem, not just for Behavioral Health. They have contracted with providers outside the county to fill in gaps, which is not something we traditionally do. We make an effort to stay within the county, but we are considering contracting with providers in contiguous counties. We are currently looking into their Behavioral Health network, and there may be providers they contract with that we do not. We are working to ensure that we have access to as much of their network as possible. This is one of our major initiatives that we are focusing on before the end of the year.

Question: What information do you ask for and receive during a 10-minute intake call? What is the purpose of this call?

Answer: This is a form issued by the State where we ask individuals about their needs, in order to understand them better and refer them to the appropriate provider. The State covers mild to moderate cases, while severe cases are covered by the State. It is mandatory for everyone to use the same screening tool for assessment purposes, as the State requires it. The questions asked in the tool are mandated by the State.

Question: Can you clarify how the Kaiser shift will affect us? Will Kaiser members still be able to access the same providers in the community, or will they need to take any action? Also, how does the shift of Kaiser members impact the network adequacy overall?

Answer: Going forward, Kaiser will handle it through their network. We won't have connectivity, and they won't be our members anymore in January.

Question: It seems that there are different subpopulations who are going through the referral process. Are there any differences in the way the process works for people who are part of the Beacon population, the old Alliance population legacy, and the other subpopulations? Are they all following the same process or is there any variation?

Answer: We have now merged all the processes into one. Although Beacon is no longer in the picture, we inherited it and wanted to ensure that people who were waiting for a response were

contacted. We have designed a special process for them, and based on the feedback we have received, it has been well received.

Comment: Jody Moore suggested that we reach out to UC Santa Barbara's autism clinic for guidance on finding solutions to our challenges. They are recognized for their expertise in Applied Behavior Analysis (ABA), and we can benefit from their knowledge to address the problems we are facing. It is not necessary to reinvent the wheel because the clinic has extensive experience in dealing with similar issues.

Question: How does Behavioral Health Care coordination work with our complex care management, ECM, and standard case management care coordination for at-risk members?

Answer: The Behavioral Health team comprises autism providers, nurse care managers, and social workers who collaborate with the autism team to provide case management care coordination. They are also closely integrated with the rest of the case management team to ensure that individuals with needs beyond their mental health requirements are connected to other services, community support, ECM, and so on.

9. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE

Dr. O'Brien gave an update on the Peer Review and Credentialing Committee's meeting held on November 21st. 192 providers were credentialed, including 163 behavioral health providers who are almost all autism providers. There were also 41 providers who were recredentialed.

b) QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE

Dr. O'Brien gave an update on the Quality Improvement Health Equity Committee meeting held on November 13th. The committee reviewed the new QIHEC charter and Kaiser trilogy documents. CFMG presented an excellent and very interesting update on their HEDIS work, which included a review of quality sanctions and the impact on rates and our plan of action. Finally, they reviewed the pay-for-performance program.

10. STAFF UPDATES

There were no staff updates.

11. UNFINISHED BUSINESS

None.

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

14. ADJOURNMENT

Chair Gebhart adjourned the meeting at 1:59 p.m.

Respectfully Submitted by: Brenda Martinez, Clerk of the Board

BOARD OF GOVERNORS
Retreat Meeting Minutes
Friday, January 26th, 2024
10:00 a.m. – 3:30 p.m.

Video Conference Call and

Garré Winery
7986 Tesla Road
Livermore, CA 94550

1. MEET AND GREET – LIGHT BREAKFAST

2. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Dr. Noha Aboelata (Vice-Chair), Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford (arrived at 11:28 a.m.) Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, Yeon Park, Dr. Evan Seevak, Supervisor Lena Tam

Board of Governors Remote: None

Board of Governors Excused: James Jackson, Dr. Michael Marchiano, Jody Moore, Natalie Williams

Alliance Staff Present: Matthew Woodruff, Tiffany Cheang, Richard Golfin III, Sasi Karaiyan, Dr. Steve O'Brien, Gil Riojas, Anastacia Swift, Lao Paul Vang, Ruth Watson

The Board retreat was called to order at 10:00 a.m.

3. ROLL CALL

Roll call was taken, and a quorum was established.

4. WELCOME AND INTRODUCTIONS

There were no modifications to the agenda.

5. MEDICARE

Betsy Seals, CEO and founder of Rebellis, and Jeff Fox, operating partner with Chicago Pacific Founders, provided a presentation on the operational effects of Medicare that included a discussion on CMS Industry Overview, Overview of Current D-SNP in California, Board Brilliance, and Alliance readiness.

Informational Item only.

6. FINANCE TRAINING

Gil Riojas, Chief Financial Officer, gave a presentation on how the board members can effectively monitor The Plan's finances. The presentation covered the following topics:

- Understanding the different components of the financial statements
- The most important financial concepts/metrics to be aware of
- Interpreting the financial metrics to gauge our performance
- Analyzing Tangible Net Equity (TNE) as an important metric
- Comparing our financial reserves with those of other plans

Informational Item only.

7. LUNCH

8. HEALTH EQUITY AND QUALITY

A presentation that included key information on changes and the current state of the Single Plan Model, Quality Focus, and Rise of Equity Focus was provided.

Informational Item only.

9. BREAKOUT SESSIONS

During the breakout sessions, the board members and the leadership team divided themselves into three small groups. They engaged in 25-minute in-depth discussions and brainstorming sessions to explore and develop ideas related to the following topics:

<u>Behavioral Health/Applied Behavioral Analytics:</u>

- Community College Training
    - ABA Workforce Development
- Other Trainings paraprofessionals can do
- ABA goes to homes more often?
    - Can we incentivize
- In Service's to the Board of Governors
    - Regional Center
    - Include County Agencies
    - First 5

Mental Health

- ED follow up
    - Improvement
    - Use of technology

- ACBH Role
    - Data
    - Providers
    - Contacts

Autism Spectrum

- What else can we do with
    - LEA's
- Superintendent
    - Include in the process
- Board Seat
    - Do we create on in the future?

<u>Older Adult Services</u>

- Transportation – Appointments/Ability to Drive
- Members do not know about the benefit
    - Cannot pick up prescription
    - Easy to arrange for providers
- Caregivers – quality for IHSS but cannot get quality caregivers
    - Training – Caregivers/Family
    - Specific areas
        - Understand dementia – cannot take it personal
        - Prescription management
- Network Adequacy – specialty referrals
    - Ortho
    - Rheumatologist
    - Can we make it easier for outside providers to get a pipeline into AHS or Highland
    - How do we access other systems for Spec.
        - UCSF
- Care Coordination
    - What is available – members and providers
- Cultural Competency – impacts older adults
    - How do they access services
    - Language – different experience – how to figure out the system
    - A higher percentage do not understand the system
- Improve the quality of caretakers in the Registry
    - Members cannot express that name
    - Family members cannot get paid as IHSS providers
        - Undocumented family (legislative pending)
        - Current Regs pending

- Case Management and coordination of all Benefits
    - Medical/Behavioral Health/CS/etc.
    - Not sure we do enough case management to close the gaps
- AAH creates a portal – the member is not a part of AHS.
    - Can docs get into Highland
        - Community access
        - Long wait times for appointments
- Loneliness/Isolation – (12 hours/day alone) depression
- Access to technology
    - YouTube videos, etc.
    - Facebook/Games

- Adequate Behavioral Health – any type of Providers
    - Access problems
- DSNP – successfully – Network/Prescriptions/Special Payment/Risk sharing
- Deprescribing – Prescription management in general
- Medication reconciliation
    - The patient is unaware of the medication they are taking.
- Mail Delivery of prescription – for key meds
- Member satisfaction now vs with DSNP (Baseline)
- End-of-life care – Hospice
- Palliative care
    - Is the benefit used?
- The Members are unaware of their benefits
    - How to navigate
    - IHSS training or family
- Related Services – Legal/Housing/LTSS/Food (options)
    - Ethnically appropriate

<u>Pediatric Services</u>

Priority Focus

- Access – member outreach
    - Public marketing campaign
- Outreach to non/under utilizers
    - Focus on getting kids in
    - Question PYP for non-utilizers
    - Texting via providers
- Quality
    - POC lead testing (consider expert consultation)
    - Connect providers to quality
- First 5 (leverage their expertise)
- School partnerships
- Question model
    - Question partnerships

- Set priorities of what to focus on first
- Look at other models
    - Consortium center that does multiple screening tasks

10. COMPLIANCE DISCUSSION

Due to time constraints, the Compliance presentation was postponed to the March 8th board meeting.

Motion: A motion was made by Dr. Marty Lynch and seconded by Yeon Park to move the Compliance training to the March 8th Board meeting.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, Yeon Park, Andrea Schwab Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

11. ANNOUNCEMENTS

There were no staff updates.

12. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

13. ADJOURNMENT

The Board retreat was adjourned at 3:28 p.m.

Respectfully Submitted by: Brenda Martinez, Clerk of the Board

ALAMEDA Alliance FOR HEALTH

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

CEO Update

Matthew Woodruff

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

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

Date: **March 8th, 2024**

Subject: **CEO Report**

- **Financials:**
  - **February 2024:** Net Operating Performance by Line of Business for the month of January 2023 and Year-To-Date (YTD):

	February	YTD
Medi-Cal	($7.4M)	$26.6M
Group Care	($648K)	$751K
Total	($8.0M)	$27.4M

  - **Revenue was $166.7 million in January 2024 and $989.8 million Year-to-Date (YTD)**.
    - Medical expenses were $168.6 million in January and $928.1 million for the fiscal year-to-date; the medical loss ratio is 101.2% for the month and 93.8% for the fiscal year-to-date.
    - Administrative expenses were $8.3 million in January and $53.8 million year-to-date; the administrative loss ratio is 5.0% of net revenue for the month and 5.4% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 612% of the required DMHC minimum, representing $293.9 million in excess TNE.
  - **Total enrollment in January 2024 was 400,518**, an increase of 48,538 Medi-Cal members compared to December.
- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - All Regulatory Metrics were met.
  - **Non-Regulatory Metrics:**
    - The member services team did not meet internal metrics for service. The team's speed to answer was at 79%, and the abandonment rate was at 9%, compared to internal metrics of 80% and 5%, respectively.

- **Program Implementations:**
  - **Single Plan Model**
    - Good news. The Alliance enrollment as of January 25th, 2024, is 400,518.
    - Member Services had their second largest call volume in its history, almost surpassing 24,000 calls, compared to nearly 30,000 calls in January.
    - Member Services had their second largest Walk-In volume in its history, with 64 members coming onsite for help. That equates to over 3 members onsite per day. For comparison, we averaged just 1 per day for the first six months of the Fiscal year.
    - The Health Care Services Department had its second largest volume of authorizations ever in February 2024. The team received over 7,637 authorization requests in February, compared to 8,519 in January 2024. These numbers encompass authorizations for all categories, not just outpatient.
  - **Pay Equity Salary Survey**
    - We will continue to include updates as the Alliance works through the entire process.
  - **Recruiting Incentives for our Network**
    - Process and application currently under development.
  - **Proposed Board of Governors Community Investment Program**
    - Process and application currently under development.
- **Medicare Overview**
  - **<u>D-SNP Readiness</u>**

    Alameda Alliance for Health (AAH) Medicare Advantage Duals Special Needs Plan (DNSP) will begin serving members on January 1st, 2026.

    Key milestones and dates the Alliance is working toward for January 1st, 2026, include the following:
    - D-SNP Feasibility Study (ProForma) – January 2024 - completed
    - Core System (Claims, Medical Management, Grievance & Appeals) Review – January 2024 – completed
    - DHCS & DMHC Material Modification Submission 1 – March 1st, 2024 - completed
    - DHCS & DMHC Material Modification Submission 2 (Financials) – April 15th, 2024
    - Provider Network Development and Recruitment – February 2024 thru February 2025

- CMS Notice of Intent to Apply – November 2024
- CMS Application (Model of Care (MOC), Provider Network, & DMHC Approval) – February 2025
- CMS Formulary and Bid Submission (Benefit Determination) – June 2025
- Operational Readiness Assessment, Training, and Audit – June through December 2025
- Annual Enrollment Period – October thru December 2025

- **Accomplishments in Greater Detail**

2023 Q2 (May)

- In May 2023, AAH entered into a Consultant Services Agreement with Rebellis Group to provide the Subject Matter Expertise (SME) to support the development of the D-SNP program.

2023 Q3 (July thru September)

- In July 2023, AAH and Rebellis completed the project kickoff, introducing D-SNP to AAH project stakeholders and the Executive Team, and began the review and development of the project plan, defining the work and timeline required to meet the project milestones and the successful launch of D-SNP on January 1st, 2026.
- Rebellis, with the support of AAH stakeholders, began the development of the Proforma.
- Rebellis met with AAH IT and Business stakeholders to evaluate the viability of our Claims (HEALTHsuite), Medical Management (TruCare), and Grievance & Appeals (QualitySuite) systems to support D-SNP.

2023 Q4 (October thru December)

- AAH received the initial draft Proforma for review and feedback.
- AAH received the Final DRAFT System Evaluation for review, feedback, and AAH's decision on the platforms to support Claims, Medical Management, and Grievance and Appeals.

2024 Q1 (January thru March)

- Tome Meyers, Executive Director of Medicare, started March 4th, 2024, and serves as the Project Driver supporting Ruth Watson as the project's Executive Sponsor.
- Executive Leadership confirmed the decision to use the existing Claims (HEALTHsuite), Medical Management (TruCare), and Grievance & Appeals (QualitySuite) platforms for D-SNP and for IT to initiate discussions with each system vendor (Ram and Zyter) to evaluate and confirm the enhancements available to support D-SNP.
- Completed user training and provided user access to Rebellis Academy, the online, self-directed training content for Medicare Advantage and Part D organizations (including DSNP) offered by Rebellis Group.
- Completed the DHCS & DMHC Material Modification Submission 1 as required by March 1st, 2024.

- **Next Steps**

  2024 Q2 (April thru June)

  AAH and Rebellis will complete the kickoff and initial review and development for the following:

  - Review of current Policy & Procedures (all business areas).
  - Model of Care. The Model of Care includes four parts, MOC 1 Description of the SNP Population, MOC 2 Care Coordination, MOC 3 Provider Network, MOC 4 Quality Measurement & Performance Measurement. The initial focus is on MOC part 1.
  - Clinical services for Utilization Management, Quality, Stars, and HEDIS.
  - Sales and Marketing Planning.
  - Product Management with a focus on Benefit Pre-Planning.
  - Member Experience with a focus on Member Call Center Planning.
  - Oversight of Rebellis Academy user training.
  - DHCS & DMHC Material Modification Submission 2 (Financials) for submission by April 15th, 2024.
  - Receipt and review of the Quest GeoAccess report for network adequacy required to support the development of the Provider Network Recruitment / Engagement Strategy.

ALAMEDA Alliance FOR HEALTH

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

Executive Dashboard

OPERATIONS DASHBOARD

MARCH 2024

3/4/2024 10:08:06 AM

Financials

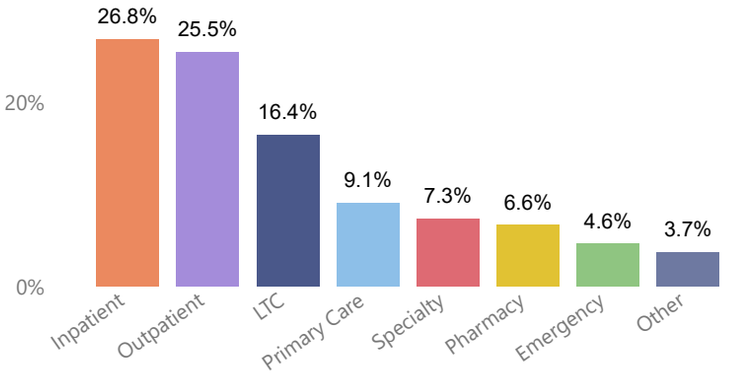
Income & Expenses

	JANUARY 2024	FISCAL YTD
REVENUE	$ 166.7 M	$ 989.8 M
MEDICAL EXPENSE	$ (168.6) M	$ (928.1) M
ADMIN EXPENSE	$ (8.3) M	$ (53.0) M
OTHER	$ 2.2 M	$ 18.7 M
NET INCOME	$ (8.0) M	$ 27.4 M

Gross Margin %

6.2%

Medical Expenses



Liquid Reserves

MLR Net %

93.8%

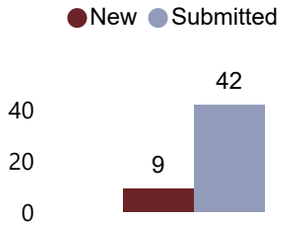
TNE %

611.8%

TNE $

$351.3M

Reinsurance Cases



Balance Sheet

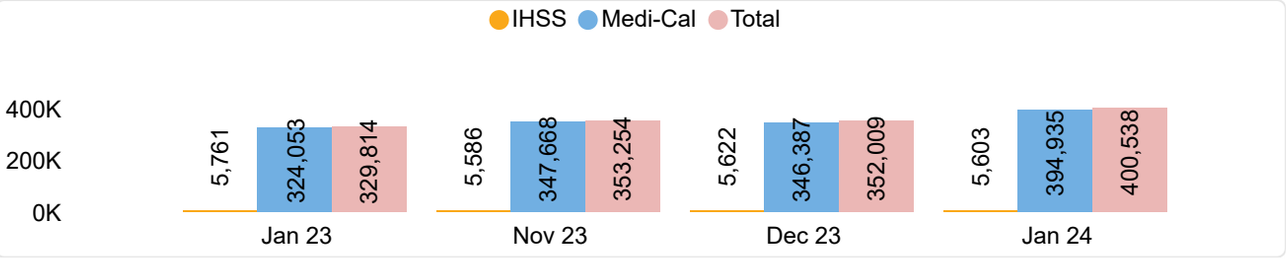
Cash Equivalents	$524.1M
Pass-Through Liabilities	$173.3M
Uncommitted Cash	$350.8M
Working Capital	$336.0M

Current Ratio

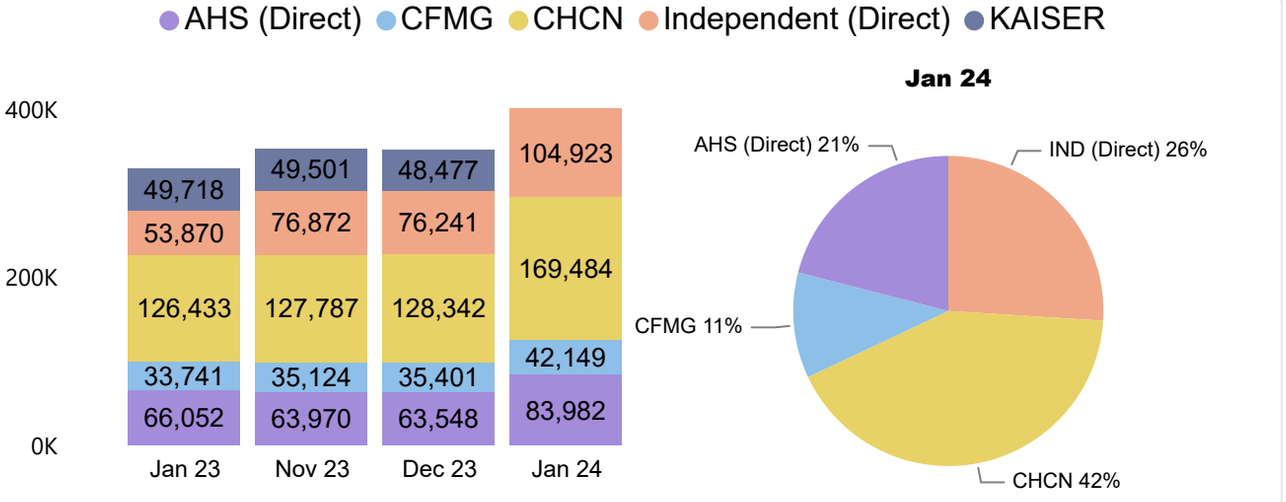
1.71

Membership

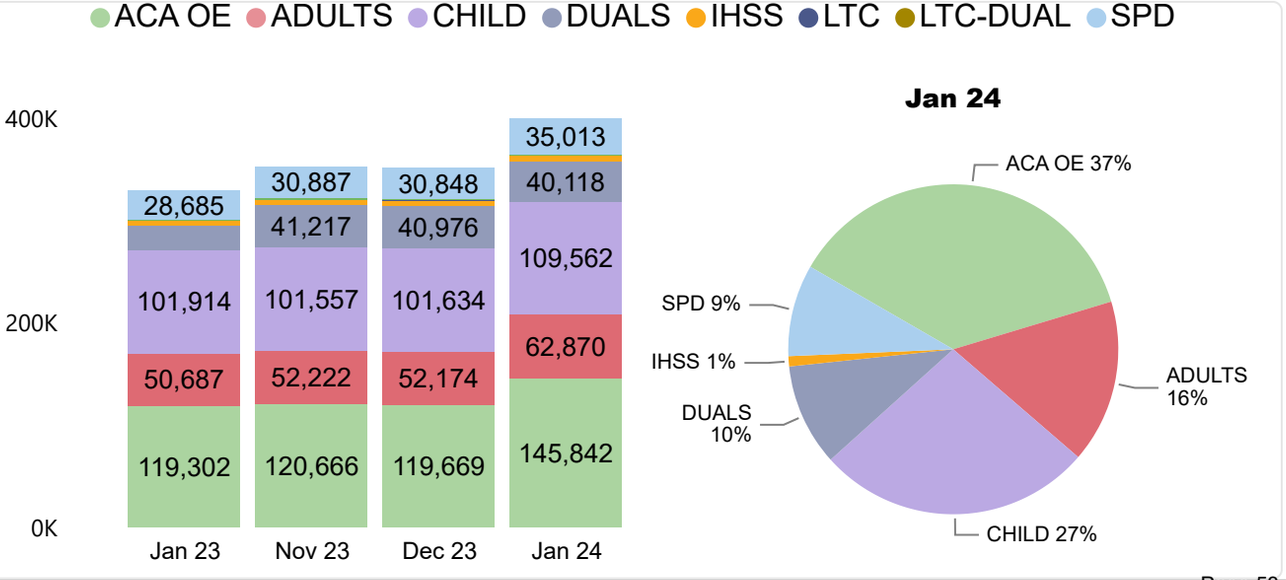
By Plan



By Network



By Category



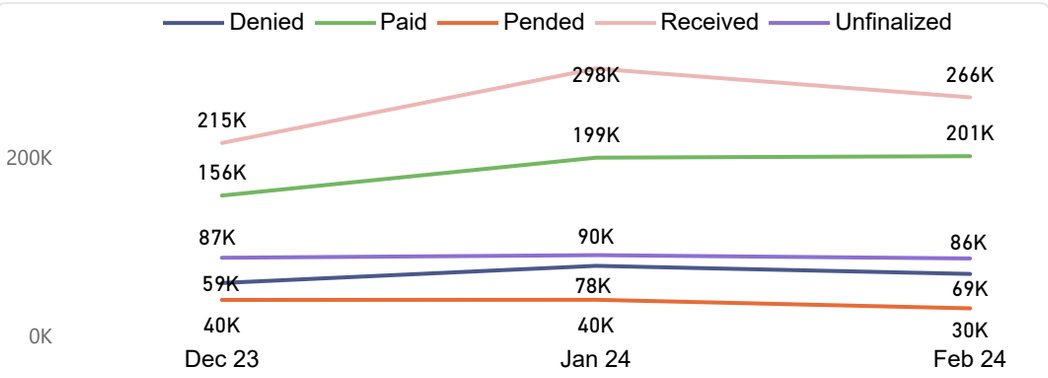
OPERATIONS DASHBOARD

MARCH 2024

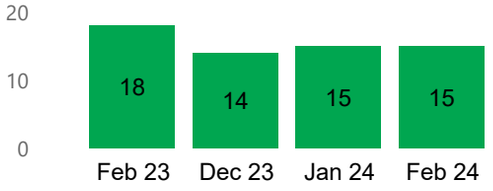
3/4/2024 10:08:06 AM

Claims

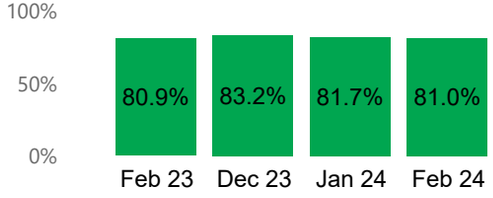
Claims Processing



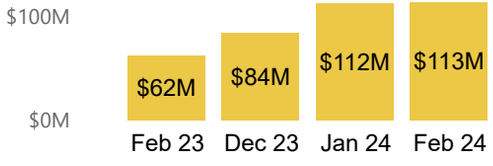
Average Payment TAT (Days)



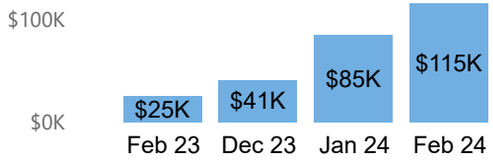
Auto Adjudication Rate (%)



Claims Paid ($)

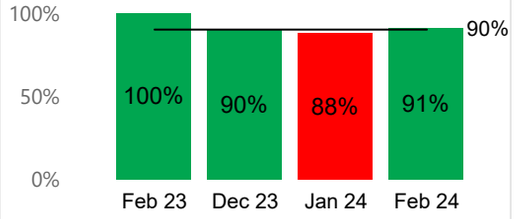


Interest Paid ($)

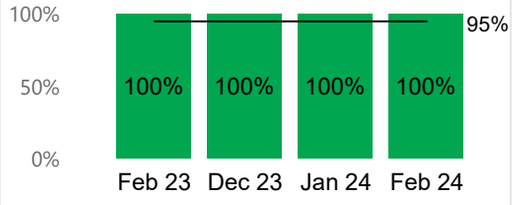


Claims Compliance

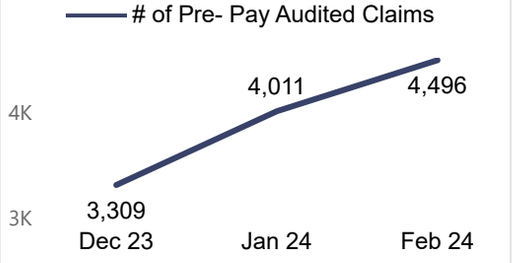
Processed 30 Cal Days (%)



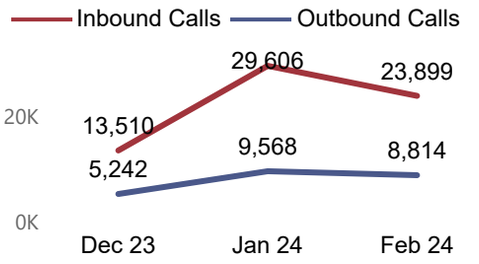
Processed 45 Work Days (%)



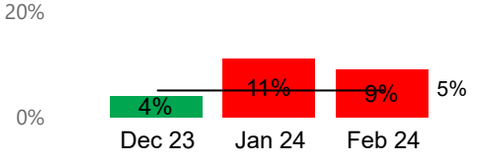
Claims Auditing



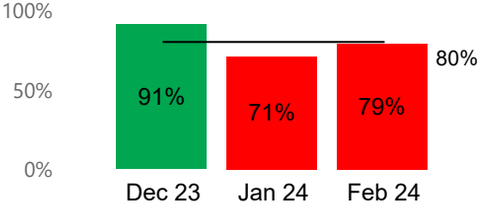
Member Services



Abandoned Call Rate (%)

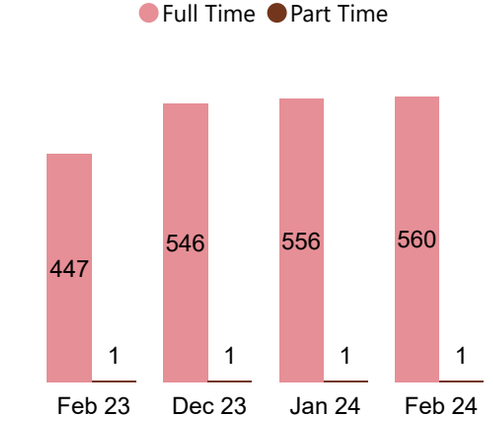


Calls Answered in 30 Seconds (%)



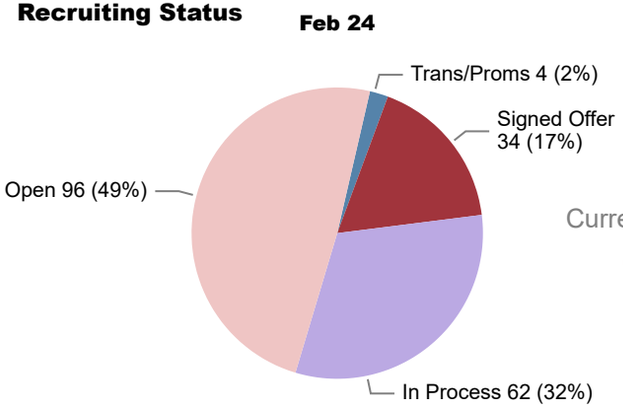
Average Call Times	Dec 23	Jan 24	Feb 24
Wait Time	00:23	01:26	00:58
Call Duration	06:42	06:58	06:49

Human Resources



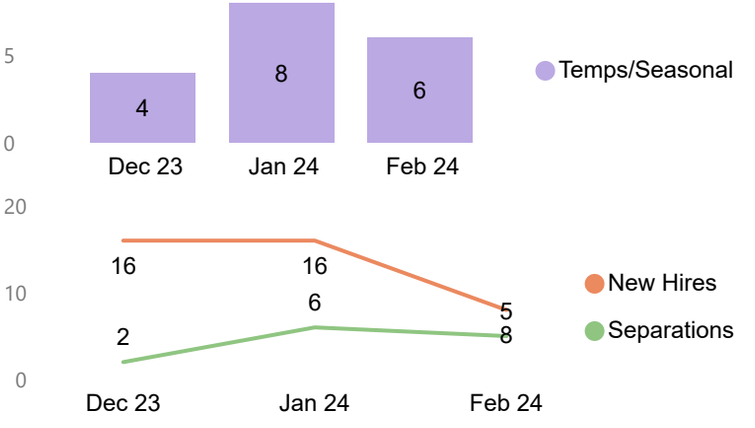
Recruiting Status

Feb 24



Current Vacancy

15%



OPERATIONS DASHBOARD

MARCH 2024

3/4/2024 10:08:06 AM

Provider Services

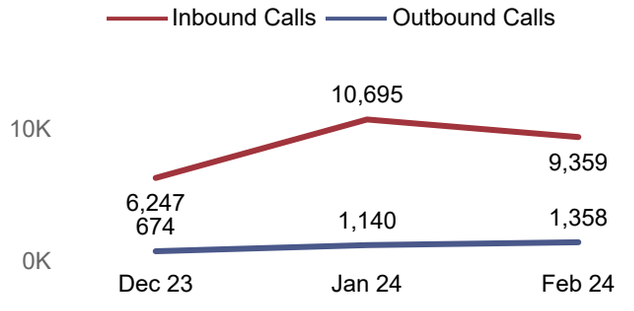
Provider Network

Hospital	17
Specialist	9,855
Primary Care Physician	789
Skilled Nursing Facility	104
Urgent Care	7
Health Centers (FQHCs and Non-FQHCs)	68
TOTAL	**10,840**

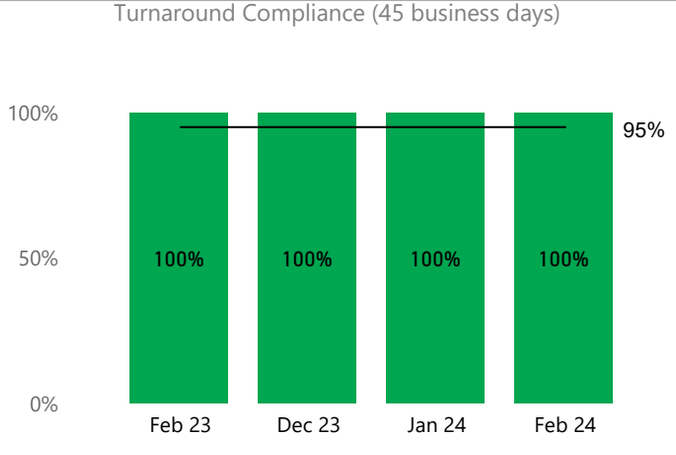
Provider Credentialing

3,226

Provider Call Center

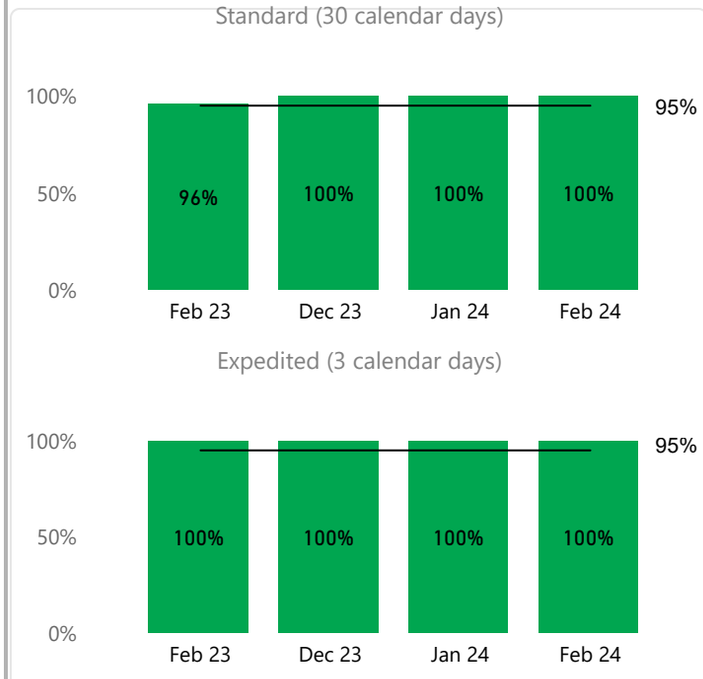


Provider Disputes & Resolutions

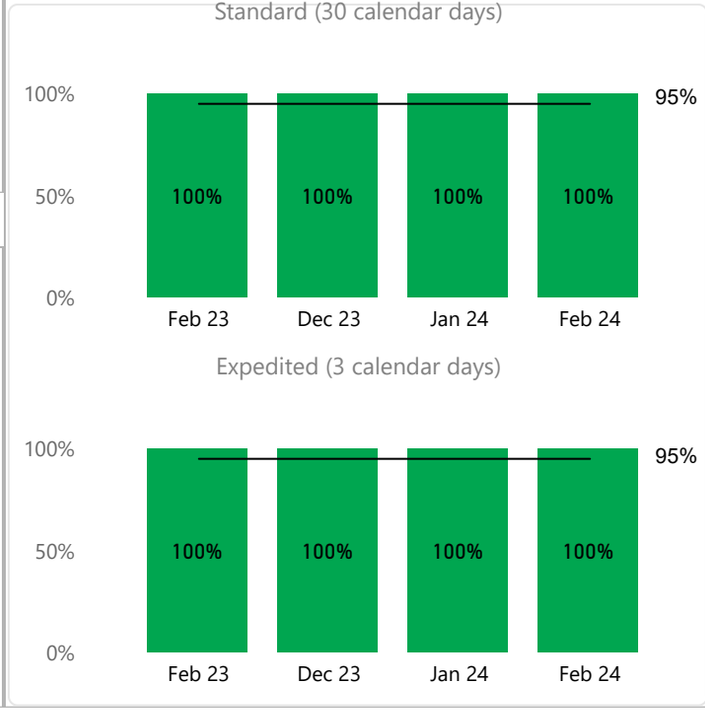


Compliance

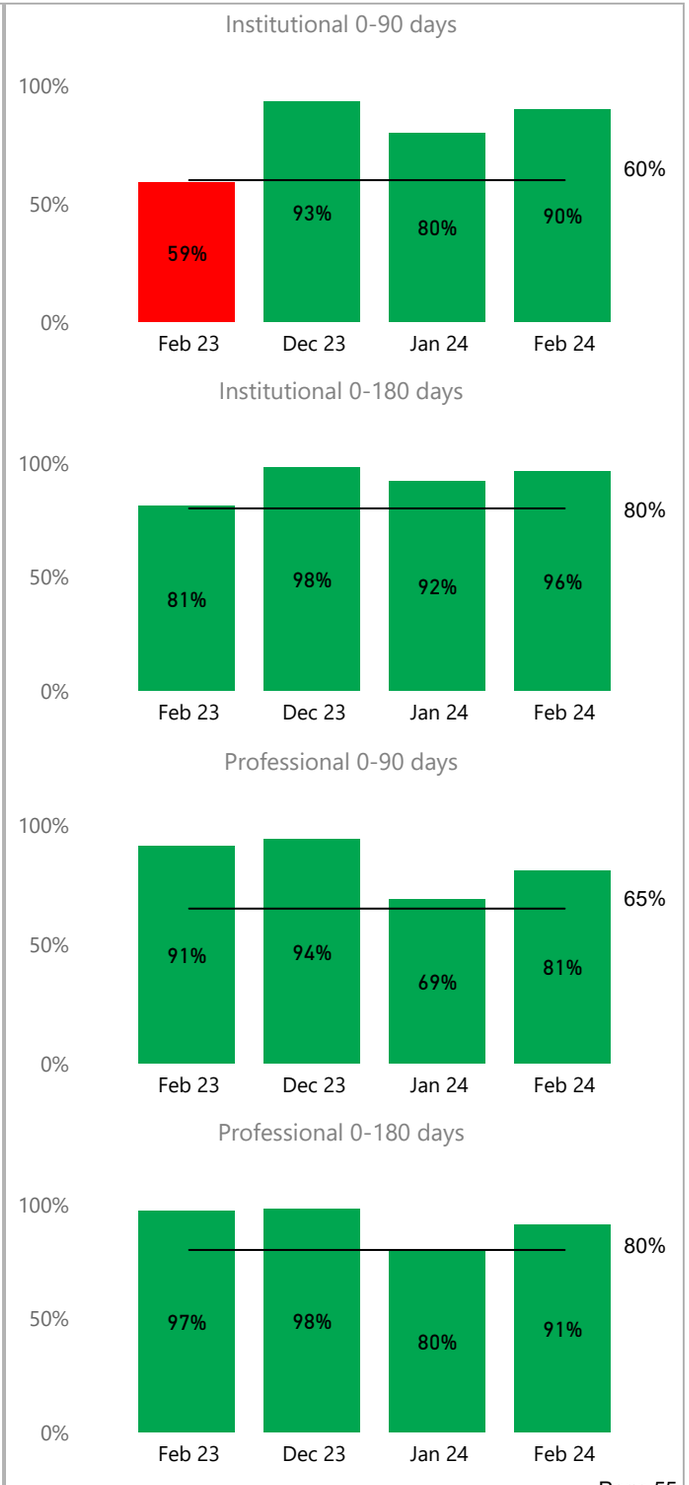
Member Grievances



Member Appeals



Encounter Data



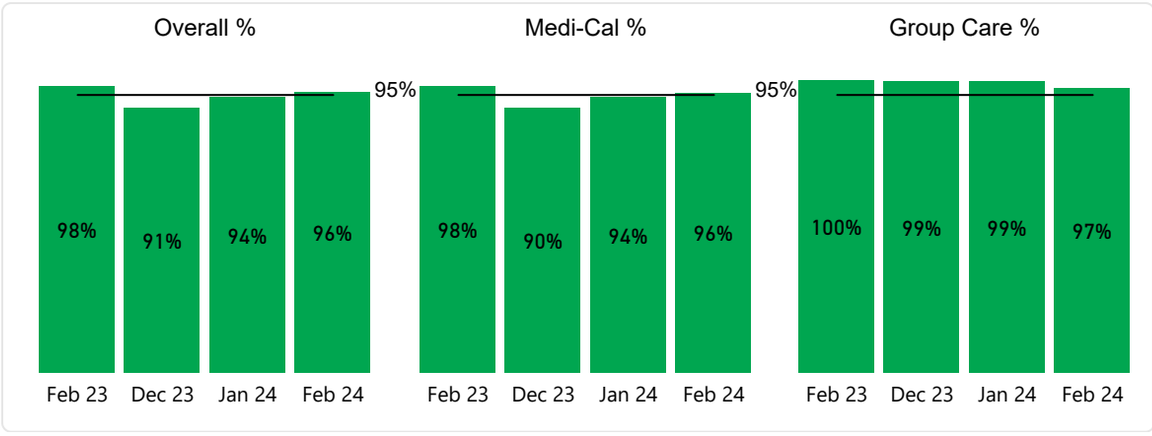
OPERATIONS DASHBOARD

MARCH 2024

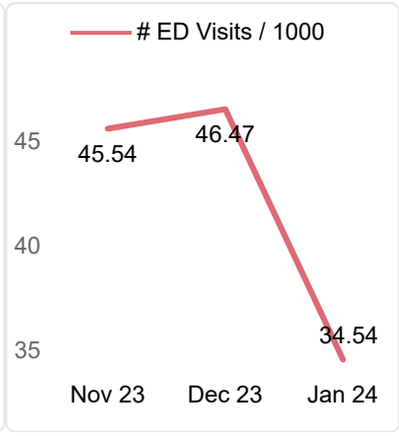
3/4/2024 10:08:06 AM

Health Care Services

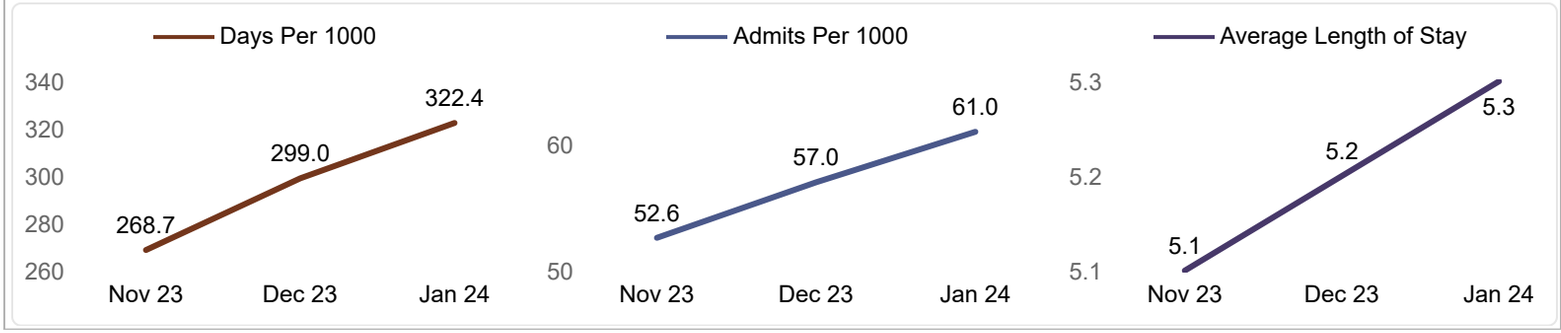
Authorization Turnaround



ED Utilization

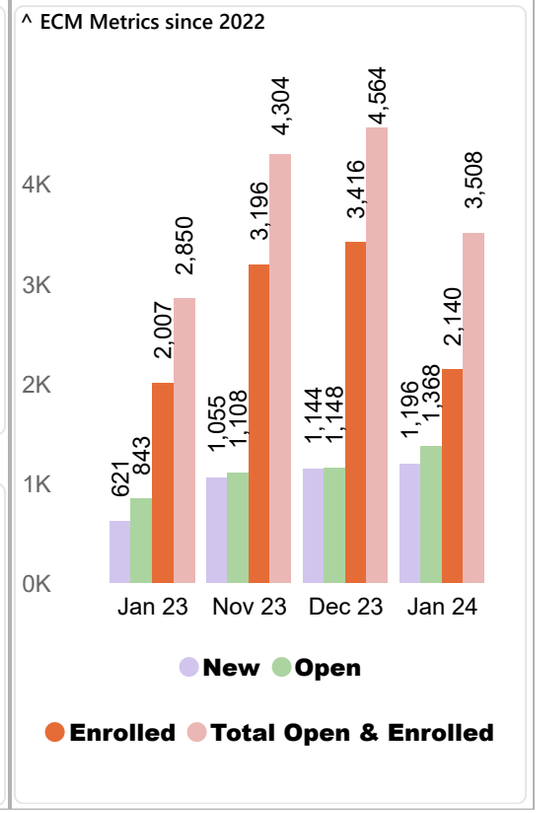


Inpatient Utilization

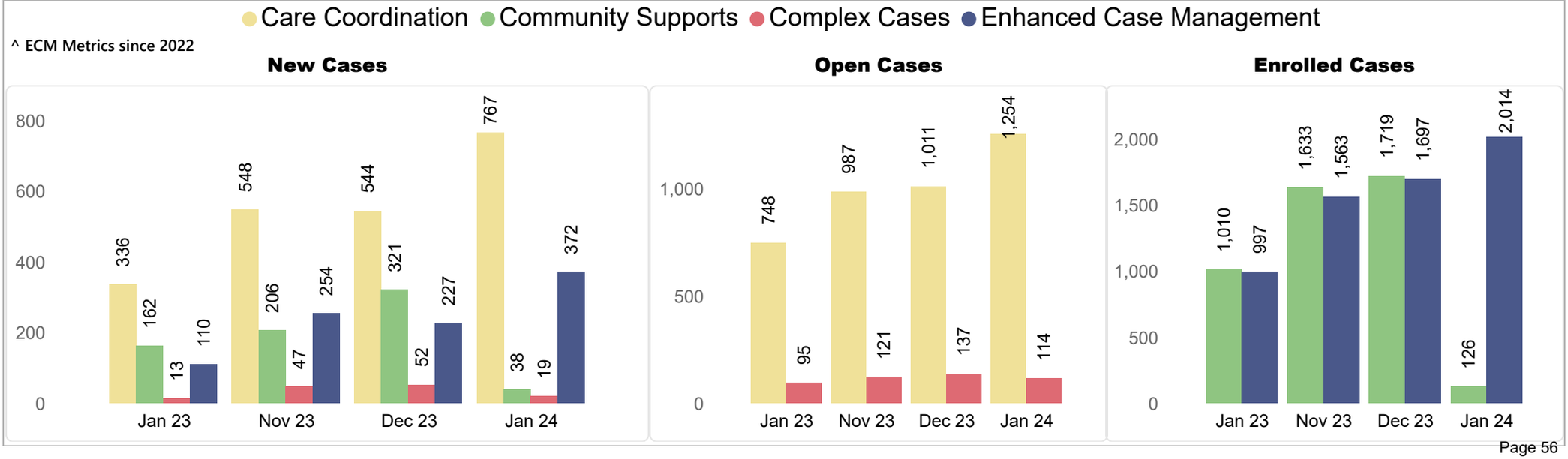


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Feb 23	Dec 23	Jan 24	Feb 24
HEALTHsuite System	100.0%	100.0%	100.0%	100.0%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Feb 23	Dec 23	Jan 24	Feb 24
Denial Rate Excluding Partial Denials (%)	3.8%	3.9%	3.1%	3.9%
Overall Denial Rate (%)	4.2%	4.1%	3.4%	4.1%
Partial Denial Rate (%)	0.4%	0.3%	0.3%	0.3%

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

Pharmacy Authorizations

Authorizations	Feb 23	Dec 23	Jan 24	Feb 24
Approved Prior Authorizations	36	22	30	35
Closed Prior Authorizations	75	58	107	91
Denied Prior Authorizations	18	27	43	36
Total Prior Authorizations	129	107	180	162

ALAMEDA Alliance FOR HEALTH

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

Legislative Tracking

2024 Legislative Tracking List

The 2024 California State Legislative Session is moving full steam ahead. The deadline to introduce new bills passed on February 16th and a total of 2,124 bills were introduced this legislative year. The following is a list of state bills tracked by the Public Affairs and Compliance Departments. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership.

AB 4 **(Arambula D) Covered California: expansion.**
Current Text: Amended: 7/13/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. on 7/13/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

Summary: Current federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Current state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Current law requires the Exchange to apply for a federal waiver to allow persons otherwise not able to obtain coverage through the Exchange because of their immigration status to obtain coverage from the Exchange. This bill would delete that requirement and would instead require the Exchange to administer a program to allow persons otherwise not able to obtain coverage by reason of immigration status to enroll in health insurance coverage in a manner as substantially similar to other Californians as feasible given existing federal law and rules.

AB 47 **(Boerner D) Pelvic floor physical therapy coverage.**
Current Text: Introduced: 12/5/2022 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, to provide coverage for pelvic floor physical therapy after pregnancy. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

AB 55 **(Rodriguez D) Medi-Cal: workforce adjustment for ground ambulance transports.**
Current Text: Amended: 4/27/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

Summary: Current law requires, with exceptions, that Medi-Cal reimbursement to providers of emergency medical transports be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. Under current law, those increased payments are funded solely from a quality assurance fee (QAF), which emergency medical transport providers are required to pay based on a specified formula, and from federal reimbursement and any other

related federal funds. Current law sets forth separate provisions for increased Medi-Cal reimbursement to providers of ground emergency medical transportation services that are owned or operated by certain types of public entities. This bill would establish, for dates of service on or after July 1, 2024, a workforce adjustment, serving as an additional payment, for each ground ambulance transport performed by a provider of medical transportation services, excluding the above-described public entity providers. The bill would vary the rate of adjustment depending on the point of pickup and whether the service was for an emergency or nonemergency, with the workforce adjustment being equal to 80% of the lowest maximum allowance established by the federal Medicare Program reduced by the fee-for-service payment schedule amount, as specified.

AB 236 **(Holden D) Health care coverage: provider directories.**
Current Text: Amended: 1/22/2024 html pdf
Status: 1/30/2024-Read third time. Passed. Ordered to the Senate. (Ayes 59. Noes 9.) In Senate. Read first time. To Com. on RLS. for assignment.
Location: 1/30/2024-S. RLS.

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Current law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2025, unless specified criteria applies. The bill would require a plan or insurer to arrange care and provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the contracted amount for those services.

AB 365 **(Aguiar-Curry D) Medi-Cal: diabetes management.**
Current Text: Amended: 9/8/2023 html pdf
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/12/2023)(May be acted upon Jan 2024)
Location: 9/14/2023-S. 2 YEAR

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

Summary: Would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program for the treatment of diabetes when medically necessary, subject to utilization controls. The bill would require the State Department of Health Care Services, by July 1, 2024, to review, and update as appropriate, coverage policies for continuous glucose monitors, as specified. The bill would authorize the department to require a manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. The bill would limit its implementation to the extent that any necessary federal approvals are obtained and federal financial participation is available.

AB 412 **(Soria D) Distressed Hospital Loan Program.**
Current Text: Amended: 4/24/2023 html pdf
Status: 6/14/2023-Referred to Com. on HEALTH.

Location: 6/14/2023-S. HEALTH

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

Summary: The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority to, among other things, make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions, as defined, for financing or refinancing the acquisition, construction, or remodeling of health facilities. This bill would create the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. The bill would require, subject to an appropriation by the Legislature, the Department of Health Care Access and Information to administer the program and would require the department to enter into an interagency agreement with the authority to implement the program. The bill would require the department, in collaboration with the State Department of Health Care Services, the Department of Managed Health Care, and the State Department of Public Health, to develop a methodology to evaluate an at-risk hospital's potential eligibility for state assistance from the program, as specified.

AB 488 **(Nguyen, Stephanie D) Medi-Cal: skilled nursing facilities: vision loss.**
Current Text: Introduced: 2/7/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: Current law requires the State Department of Health Care Services, subject to any necessary federal approvals, for managed care rating periods that begin between January 1, 2023, and December 31, 2026, inclusive, to establish and implement the Workforce and Quality Incentive Program under which a network provider furnishing skilled nursing facility services to a Medi-Cal managed care enrollee may earn performance-based directed payments from the Medi-Cal managed care plan with which they contract, as specified. Current law, subject to an appropriation, requires the department to set the amounts of those directed payments under a specified formula. Current law requires the department to establish the methodology or methodologies, parameters, and eligibility criteria for the directed payments, including the milestones and metrics that network providers of skilled nursing facility services must meet in order to receive a directed payment from a Medi-Cal managed care plan, with at least 2 of these milestones and metrics tied to workforce measures. This bill would require that the measures and milestones include program access, staff training, and capital improvement measures aimed at addressing the needs of skilled nursing facility residents with vision loss.

AB 564 **(Villapudua D) Medi-Cal: claim or remittance forms: signature.**
Current Text: Amended: 4/5/2023 html pdf
Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/14/2023)(May be acted upon Jan 2024)
Location: 7/14/2023-S. 2 YEAR

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

Summary: Current 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. Current law requires the Director of Health Care Services to develop and implement standards for the timely processing and payment of each claim type. Current law requires that the standards be sufficient to meet minimal federal requirements for the timely processing of claims. Current law states the intent of the Legislature that claim forms for use by physicians and hospitals be the same as claim forms in general use by other payors, as specified. This bill would require the department to allow a provider to submit an electronic signature for a claim or remittance form under the Medi-Cal program, to the extent not in conflict with federal law.

AB 586 **(Calderon D) Medi-Cal: community supports: climate change or environmental remediation devices.**
Current Text: Amended: 3/30/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the State Department of Health Care Services is authorized to approve include, among other things, housing deposits, environmental accessibility adaptations or home modifications, and asthma remediation. This bill would add climate change or environmental remediation devices to the above-described list of community supports. For purposes of these provisions, the bill would define "climate change or environmental remediation devices" as coverage of devices and installation of those devices, as necessary, to address health-related complications, barriers, or other factors linked to extreme weather, poor air quality, or climate events, including air conditioners, electric heaters, air filters, or backup power sources, among other specified devices for certain purposes.

AB 815 **(Wood D) Health care coverage: provider credentials.**
Current Text: Amended: 4/20/2023 html pdf
Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/7/2023)(May be acted upon Jan 2024)
Location: 7/14/2023-S. 2 YEAR

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

Summary: Would require the California Health and Human Services Agency to create and maintain a provider credentialing board, with specified membership, to certify private and public entities for purposes of credentialing physicians and surgeons in lieu of a health care service plan's or health insurer's credentialing process. The bill would require the board to convene by July 1, 2024, develop criteria for the certification of public and private credentialing entities by January 1, 2025, and develop an application process for certification by July 1, 2025.

AB 1022 **(Mathis R) Medi-Cal: Program of All-Inclusive Care for the Elderly.**
Current Text: Introduced: 2/15/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: Current federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center so that they may continue living in the community. Federal law authorizes states to implement PACE as a Medicaid state option. Current state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal state plan. Current law requires the department to develop and pay capitation rates to entities contracted through the PACE program using actuarial methods and that reflect the level of care associated with the specific populations served pursuant to the contract. Current law authorizes a PACE organization approved by the department to use video telehealth to conduct initial assessments and annual reassessments for eligibility for enrollment in the PACE program. This bill, among other things relating to the PACE program, would require those capitation rates to also reflect the frailty level and risk associated with those populations. The bill would

also expand an approved PACE organization's authority to use video telehealth to conduct all assessments, as specified.

AB 1091 **(Wood D) Health Care Consolidation and Contracting Fairness Act of 2023.**
Current Text: Introduced: 2/15/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: This bill, the Health Care Consolidation and Contracting Fairness Act of 2023, would prohibit a contract issued, amended, or renewed on or after January 1, 2024, between a health care service plan or health insurer and a health care provider or health facility from containing terms that, among other things, restrict the plan or insurer from steering an enrollee or insured to another provider or facility or require the plan or insurer to contract with other affiliated providers or facilities. The bill would authorize the appropriate regulating department to refer a plan's or insurer's contract to the Attorney General, and would authorize the Attorney General or state entity charged with reviewing health care market competition to review a health care practitioner's or health facility's entrance into a contract that contains specified terms. 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.

AB 1092 **(Wood D) Health care service plans: consolidation.**
Current Text: Amended: 6/28/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

Summary: Current law requires a health care service plan that intends to merge with, consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, an entity, to give notice to, and secure prior approval from, the Director of the Department of Managed Health Care. Current law authorizes the director to disapprove the transaction or agreement if the director finds it would substantially lessen competition in health care service plan products or create a monopoly in this state. Current law authorizes the director to conditionally approve the transaction or agreement, contingent upon the health care service plan's agreement to fulfill one or more conditions to benefit subscribers and enrollees of the health care service plan, provide for a stable health care delivery system, and impose other conditions specific to the transaction or agreement, as specified. This bill would additionally require a health care service plan that intends to acquire or obtain control of an entity, as specified, to give notice to, and secure prior approval from, the director. Because a willful violation of this provision would be a crime, the bill would impose a state-mandated local program.

AB 1110 **(Arambula D) Public health: adverse childhood experiences.**
Current Text: Amended: 7/10/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

Summary: Would, subject to an appropriation and until January 1, 2027, require the office and the State Department of Health Care Services, while administering the ACEs Aware initiative and in collaboration with subject matter experts, to review available literature on ACEs, as defined, and ancestry or ethnicity-based data disaggregation practices in ACEs screenings, develop guidance for culturally and linguistically competent ACEs screenings through improved data

collection methods, post the guidance on the department's internet website and the ACEs Aware internet website, and make the guidance accessible, as specified.

AB 1157 **(Ortega D) Rehabilitative and habilitative services: durable medical equipment and services.**
Current Text: Amended: 7/13/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

Summary: Current law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under existing law, essential health benefits includes, among other things, rehabilitative and habilitative services. Current law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define "durable medical equipment" to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.

AB 1282 **(Lowenthal D) Mental health: impacts of social media.**
Current Text: Amended: 9/1/2023 html pdf
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/11/2023)(May be acted upon Jan 2024)
Location: 9/14/2023-S. 2 YEAR

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

Summary: Would require the Mental Health Services Oversight and Accountability Commission to report to specified policy committees of the Legislature, on or before July 1, 2025, a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. The bill would require the report to include, among other things, (1) the degree to which individuals negatively impacted by social media are accessing and receiving mental health services and (2) recommendations to strengthen children and youth resiliency strategies and California's use of mental health services to reduce the negative outcomes that may result from untreated mental illness, as specified. The bill would require the commission to explore, among other things, the persons and populations that use social media and the negative mental health risks associated with social media and artificial intelligence, as defined.

AB 1313 **(Ortega D) Older individuals: case management services.**
Current Text: Amended: 4/27/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 7/3/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered

1st House	2nd House				

Summary: The Mello-Granlund Older Californians Act requires the California Department of Aging to designate various private nonprofit or public agencies as area agencies on aging to work within a planning and service area and provide a broad array of social and nutritional services. Under the act, the department's mission is to provide leadership to those agencies in developing systems of home- and community-based services that maintain individuals in their own homes or least restrictive homelike environments. This bill would, until January 1, 2030, and subject to an appropriation, require the department to establish a case management services pilot program. Under the bill, the purpose of the program would be to expand statewide the local capacity of supportive services programs by providing case management services to older individuals who need assistance to maintain health and economic stability. The bill would require the Counties of Alameda, Marin, and Sonoma to participate in the pilot program.

AB 1338 **(Petrie-Norris D) Medi-Cal: community supports.**
Current Text: Amended: 4/20/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under current law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, recuperative care, respite, day habilitation programs, and medically supportive food and nutrition services.

AB 1359 **(Schiavo D) Paid sick days: health care employees.**
Current Text: Amended: 6/26/2023 html pdf
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/11/2023)(May be acted upon Jan 2024)
Location: 9/14/2023-S. 2 YEAR

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

Summary: The Healthy Workplaces, Healthy Families Act of 2014 entitles employees who satisfy specified requirements to sick leave. The act generally entitles an employee who, on or after July 1, 2015, works in California for the same employer for 30 or more days within a year to paid sick leave, subject to various use and accrual limits. The act also authorizes an employer to limit an employee's use of accrued paid sick days to 24 hours or 3 days in each year of employment, calendar year, or 12-month period. This bill would grant an employee of a covered health care facility health care worker sick leave, as those terms are defined. The bill would permit accrued leave, and would prescribe for the use and carryover of that leave, including permitting health care worker sick leave to carry over to the following year of employment for those employees, subject to certain conditions. The bill would prohibit a covered health care facility from limiting an employee's use of health care worker sick leave.

AB 1450 **(Jackson D) Behavioral health: behavioral health and wellness screenings: notice.**
Current Text: Amended: 1/3/2024 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: Current law requires the Medical Board of California, in determining its continuing education requirements,

to consider including a course in integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues and exposure to trauma in children and young adults and their appropriate care and treatment. Current law requires a physician and surgeon to provide notice to patients at an initial office visit regarding a specified database. Current law requires the State Department of Public Health to license and regulate health facilities, including general acute care hospitals. Current law requires a general acute care hospital to establish and adopt written policies and procedures to screen patients who are 12 years of age and older for purposes of detecting a risk for suicidal ideation and behavior. 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. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would require a physician and surgeon, a general acute care hospital, a health care service plan, and a health insurer to provide to each legal guardian of a patient, enrollee, or insured, 10 to 18 years of age, a written or electronic notice regarding the benefits of a behavioral health and wellness screening. The bill would require the providers to provide the notice at least once every 2 years in the preferred method of the legal guardian.

AB 1608 **(Patterson, Joe R) Medi-Cal: managed care plans.**
Current Text: Amended: 1/3/2024 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: The Lanterman Developmental Disabilities Services Act makes the State Department of Developmental Services responsible for providing various services and supports to individuals with developmental disabilities, and for ensuring the appropriateness and quality of those services and supports. Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes, reduce health disparities, and increase flexibility. Current law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with specified requirements and the CalAIM Terms and Conditions. Existing law, if the department standardizes those populations subject to mandatory enrollment, exempts certain dual and non-dual beneficiary groups, as defined, from that mandatory enrollment. This bill would additionally exempt dual and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage.

AB 1644 **(Bonta D) Medi-Cal: medically supportive food and nutrition services.**
Current Text: Amended: 4/27/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

Summary: Would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, upon issuance of final guidance by the State Department of Health Care Services. The bill would require medically supportive food and nutrition interventions to be covered when determined to be medically necessary by a health care provider or health care plan, as specified. In order to qualify for coverage under the Medi-Cal program, the bill would require a patient to be offered at least 3 of 6 specified medically supportive food and nutrition interventions and for the interventions to be provided for a minimum duration of 12 weeks, as specified. The bill would only provide coverage for nutrition support interventions when paired with the provision of food through one of the 3 offered interventions. The bill would require a health care provider to match the acuity of a patient's condition to the

intensity and duration of the medically supportive food and nutrition intervention and include culturally appropriate foods whenever possible.

AB 1690 **(Kalra D) Universal health care coverage.**
Current Text: Introduced: 2/17/2023 html pdf
Status: 2/1/2024-Died at Desk.
Location: 1/18/2024-A. DEAD

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

Summary: Would state the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program that benefits every resident of the state.

AB 1698 **(Wood D) Medi-Cal.**
Current Text: Introduced: 2/17/2023 html pdf
Status: 2/1/2024-Died at Desk.
Location: 1/18/2024-A. DEAD

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

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would make specified findings and would express the intent of the Legislature to enact future legislation relating to Medi-Cal.

AB 1783 **(Essayli R) Health care: immigration.**
Current Text: Introduced: 1/3/2024 html pdf
Status: 1/4/2024-From printer. May be heard in committee February 3.
Location: 1/3/2024-A. PRINT

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

Summary: Would state the intent of the Legislature to enact legislation to remove all taxpayer funding for health care for illegal immigrants from the California State Budget.

AB 1842 **(Reyes D) Health care coverage: Medication-assisted treatment.**
Current Text: Introduced: 1/16/2024 html pdf
Status: 1/29/2024-Referred to Com. on HEALTH.
Location: 1/29/2024-A. HEALTH

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

Summary: Current law authorizes health care service plans and health insurers that cover prescription drugs to utilize reasonable medical management practices, including prior authorization and step therapy, consistent with applicable law. This bill would prohibit a medical service plan and a health insurer from subjecting a naloxone product or another opioid antagonist approved by the United States Food and Drug Administration, or a buprenorphine product or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder, to prior authorization or step therapy. 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.

AB 1895 **(Weber D) Public health: maternity ward closures.**
Current Text: Introduced: 1/23/2024 html pdf
Status: 1/24/2024-Introduced measure version corrected. From printer. May be heard in committee February 23.
Location: 1/23/2024-A. PRINT

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

Summary: Would express the intent of the Legislature to enact legislation to address maternity ward closures.

AB 1926 **(Connolly D) Health care coverage: chronic digestive diseases and inherited metabolic disorders.**
Current Text: Introduced: 1/25/2024 html pdf
Status: 2/5/2024-Referred to Com. on HEALTH.
Location: 2/5/2024-A. HEALTH

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

Summary: Would require a health care service plan contract or disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after July 1, 2025, to provide coverage for formulas, as defined, for the treatment of other chronic digestive diseases and inherited metabolic disorders, as specified. The bill would specify that these provisions do not apply to Medi-Cal managed care plans to the extent that the services are excluded from coverage under the contract between the Medi-Cal managed care plan and the State Department of Health Care Services. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 1943 **(Weber D) Health information.**
Current Text: Introduced: 1/29/2024 html pdf
Status: 2/20/2024-Referred to Coms. on HEALTH and P. & C.P.
Location: 2/20/2024-A. HEALTH

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

Summary: Current law requires the Center for Data Insights and Innovation to develop tools and education related to improvement of consumer access to care, quality of care, and addressing the disparities in quality of care related to socioeconomic status. Current law also establishes the State Department of Health Care Services and requires the department, among other things, to administer the Medi-Cal program. This bill would require the department, in collaboration with the California Health and Human Services Agency, to collect appropriate data and identify indicators for tracking telehealth outcomes associated with impacting individual patient outcomes and overall population health. The bill would require the department to use the data collected to measure health outcomes of populations, as specified.

AB 1970 **(Jackson D) Mental Health: Black Mental Health Navigator Certification Pilot Program.**
Current Text: Introduced: 1/30/2024 html pdf
Status: 2/12/2024-Referred to Com. on HEALTH.
Location: 2/12/2024-A. HEALTH

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

Summary: Would, commencing July 1, 2025, establish, until June 30, 2028, the Black Mental Health Navigator Certification Pilot Program, to be administered by the State Department of Health Care Services, to provide comprehensive training in mental health resources and awareness, as specified. This bill would require the department to collect specific data and submit a report to the Legislature and the relevant policy committees on or before December 31, 2028. The bill would make those provisions contingent upon appropriation and would repeal those provisions on January 1, 2030.

AB 1975 **(Bonta D) Medi-Cal: medically supportive food and nutrition interventions.**
Current Text: Introduced: 1/30/2024 html pdf
Status: 2/12/2024-Referred to Com. on HEALTH.
Location: 2/12/2024-A. HEALTH

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

Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the State Department of Health Care Services is authorized to approve include, among other things, medically supportive food and nutrition services, including medically tailored meals. This bill would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, through both the fee-for-service and managed care delivery systems, effective July 1, 2026, subject to federal approval and the issuance of final guidance by the department. The bill would require those interventions to be covered if determined to be medically necessary by a health care provider or health care plan, as specified. The bill would require the provision of interventions for 12 weeks, or longer if deemed medically necessary. The bill would require a Medi-Cal managed care plan to offer at least 3 of 6 listed interventions, with certain conditions for a 7th intervention.

AB 1977 **(Ta R) Health care coverage: behavioral diagnoses.**
Current Text: Introduced: 1/30/2024 html pdf
Status: 2/12/2024-Referred to Com. on HEALTH.
Location: 2/12/2024-A. HEALTH

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

Summary: Would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from requiring an enrollee or insured previously diagnosed with pervasive developmental disorder or autism to be reevaluated or receive a new behavioral diagnosis to maintain coverage for behavioral health treatment for their condition. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2028 **(Ortega D) Medical loss ratios.**
Current Text: Introduced: 2/1/2024 html pdf
Status: 2/12/2024-Referred to Com. on HEALTH.
Location: 2/12/2024-A. HEALTH

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

Summary: The federal Patient Protection and Affordable Care Act requires a health insurance issuer to comply with minimum medical loss ratios (MLRs) and to provide an annual rebate to each insured if the MLR of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as specified. Current law requires health care service plans and health insurers that issue, sell, renew, or offer a contract or policy, excluding specialized dental and vision contracts and policies, to comply with a minimum MLR of 85% and provide specified rebates. Current law requires a health care service plan or health insurer that issues, sells, renews, or offers a contract or policy covering dental services to annually report MLR information to the appropriate department. This bill would require a health care service plan or health insurer that issues, sells, renews, or offers a specialized dental health care service plan contract or specialized dental health insurance policy to comply with a minimum MLR of 85% and to provide a specified rebate to an enrollee or insured.

AB 2043 **(Boerner D) Medi-Cal: nonmedical and nonemergency medical transportation.**
Current Text: Introduced: 2/1/2024 html pdf
Status: 2/12/2024-Referred to Com. on HEALTH.

Location: 2/12/2024-A. HEALTH

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

Summary: Would require the State Department of Health Care Services to require Medi-Cal managed care plans that are contracted to provide nonemergency medical transportation or nonmedical transportation to contract with public paratransit service operators who are enrolled Medi-Cal providers, for the purpose of establishing reimbursement rates for those transportation trips provided by a public paratransit service operator. The bill would require that the rates be based on the department's fee-for-service rates for the transportation service, as specified.

AB 2105 **(Lowenthal D) Coverage for PANDAS and PANS.**
Current Text: Introduced: 2/5/2024 html pdf
Status: 2/20/2024-Referred to Com. on HEALTH.
Location: 2/20/2024-A. HEALTH

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name. 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.

AB 2110 **(Arambula D) Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.**
Current Text: Introduced: 2/5/2024 html pdf
Status: 2/20/2024-Referred to Com. on HEALTH.
Location: 2/20/2024-A. HEALTH

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

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

AB 2115 **(Haney D) Controlled substances: clinics.**
Current Text: Introduced: 2/5/2024 html pdf

Status: 2/26/2024-Referred to Coms. on B. & P. and HEALTH.
Location: 2/26/2024-A. B.&P.

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

Summary: The Pharmacy Law provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy and makes a violation of the act a crime. Under current law, specified clinics, including surgical clinics, may purchase drugs at wholesale for administration or dispensing to the clinic's patients. Current law requires these clinics to maintain certain records and to obtain a license from the board. Current law prohibits specified substances from being dispensed by a nonprofit or free clinic, as defined. This bill would authorize a nonprofit or free clinic to dispense a narcotic drug for the purpose of relieving acute withdrawal symptoms while arrangements are being made for referral for treatment, as described, and would require the clinic dispensing the narcotic to be subject to specified labeling and recordkeeping requirements.

AB 2198 **(Flora R) Health information.**
Current Text: Introduced: 2/7/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Current law requires health care service plans and health insurers to establish and maintain specified application programming interfaces (API), including patient access API, for the benefit of enrollees, insureds, and contracted providers. This bill would exclude dental or vision benefits from the above-described API requirements.

AB 2200 **(Kalra D) Guaranteed Health Care for All.**
Current Text: Introduced: 2/7/2024 html pdf
Status: 2/8/2024-From printer. May be heard in committee March 9.
Location: 2/7/2024-A. PRINT

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

Summary: Would, under the California Guaranteed Health Care for All Act, create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The bill would make specified persons eligible to enroll as CalCare members during the implementation period, and would provide for automatic enrollment. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds.

AB 2237 **(Aguiar-Curry D) Foster children and youth: transfer of specialty mental health services.**
Current Text: Introduced: 2/8/2024 html pdf
Status: 2/9/2024-From printer. May be heard in committee March 10.
Location: 2/8/2024-A. PRINT

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

Summary: Current law requires the State Department of Health Care Services to issue policy guidance on the conditions for, and exceptions to, presumptive transfer of responsibility for providing or arranging for specialty mental health services to a foster youth from the county of original jurisdiction to the county in which the foster youth resides, as

prescribed. On a case-by-case basis, and when consistent with the medical rights of children in foster care, existing law authorizes the waiver of presumptive transfer, with the responsibility for the provision of specialty mental health services remaining with the county of original jurisdiction if certain exceptions exist. Under current law, the county probation agency or the child welfare services agency is responsible for determining whether waiver of the presumptive transfer is appropriate, with notice provided to the person requesting the exception. Under current law, in the case of placement of foster children in short-term residential therapeutic programs, community treatment facilities, or group homes, or in the case of admission of foster children to children's crisis residential programs, the county of original jurisdiction is required to retain responsibility and presumptive transfer provisions apply only if certain circumstances exist. This bill would declare the intent of the Legislature to enact legislation requiring, when jurisdiction of a child or youth is being transferred from one county to another, the transfer county to assume financial responsibility for purposes of ensuring that the child or youth receives, or continues to receive, timely access to specialty mental health services when the child or youth has been transferred from the county of original jurisdiction, while the transfer county conducts its investigation and casework transfer process, if specified conditions are met, including, but not limited to, that the child or youth has been identified by the county of original jurisdiction as high risk or coming from a vulnerable population. The bill also would declare the Legislature's intent to enact related provisions, including requiring the State Department of Health Care Services and the State Department of Social Services to collaborate to create a system of standardized communication between counties that respects the procedures of the receiving county and the needs of the child that is without mental health services, and requiring the State Department of Social Services to establish care teams to help counties coordinate and expedite the transfer between counties.

AB 2250 **(Weber D) Social determinants of health: screening and outreach.**
Current Text: Introduced: 2/8/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use specified tools or protocols when documenting patient responses to questions asked in these screenings. The bill would require a health care service plan or health insurer to provide physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or community health workers in counties where the plan or insurer has enrollees or insureds, as specified. The bill would authorize the respective departments to adopt guidance to implement its provisions. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2258 **(Zbur D) Health care coverage: cost sharing.**
Current Text: Introduced: 2/8/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Would prohibit a group or individual nongrandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement for items or services that are integral to the provision of the above-described preventive care services and screenings. The bill would require those contracts and policies to cover items and services for those preventive care services and screenings, including home test kits for sexually transmitted diseases and specified cancer screenings. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2271 **(Ortega D) Coverage for naloxone hydrochloride.**
Current Text: Introduced: 2/8/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Under current law, the pharmacist service of furnishing naloxone hydrochloride is a covered Medi-Cal benefit. The Medi-Cal program also covers certain medications to treat opioid use disorders as part of narcotic treatment program services, or as part of medication-assisted treatment services within the Drug Medi-Cal Treatment Program, as specified. Under this bill, prescription or nonprescription naloxone hydrochloride or another drug approved by the FDA for the complete or partial reversal of an opioid overdose would be a covered benefit under the Medi-Cal program. The bill would require a health care service plan contract or health insurance policy, as specified, to include coverage for the same medications under the same conditions. The bill would prohibit a health care service plan contract or health insurance policy from imposing any cost-sharing requirements for that coverage exceeding $10 per package of medication, and would prohibit a high deductible health plan from imposing cost sharing, as specified.

AB 2303 **(Carrillo, Juan D) Health and care facilities: prospective payment system rate increase.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Current law provides that federally qualified health center services and rural health clinic services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis and at a per-visit prospective payment system rate, as defined. Current law establishes 5 separate minimum wage schedules for covered health care employees, as defined, depending on the nature of the employer and includes increases beginning on June 1, 2024. Current law generally requires the State Department of Public Health to license, regulate, and inspect health and care facilities. This bill would require the State Department of Health Care Services, on or before April 1, 2025, to submit a request for approval to the federal Centers for Medicare and Medicaid Services to authorize a waiver for specified health care facilities to request a change in its prospective payment system rate.

AB 2319 **(Wilson D) California Dignity in Pregnancy and Childbirth Act.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Would make a legislative finding that the Legislature recognizes all birthing people, including nonbinary persons and persons of transgender experience. The bill would extend the evidence-based implicit bias training requirements to also include hospitals that provide perinatal or prenatal care, as defined. The bill would require an implicit bias program to include recognition of intersecting identities and the potential associated biases. The bill would require initial basic training for the implicit bias program to be completed by June 1, 2025, for current health care providers, and within 6 months of their start date for new health care providers, unless exempted. The bill would require, by February 1 of each year, that a facility provide the department with proof of compliance, with specified requirements. The bill would authorize the department to issue an administrative penalty if it determines that a facility has violated these provisions, and would require the department to annually post on its internet website a list of facilities that did not submit timely proof of compliance and have been issued administrative penalties. The bill would specify that, for these purposes, each health care provider that does not complete the required training constitutes a separate violation. The bill would vest the State Department of Public Health with full administrative power, authority, and jurisdiction to implement and enforce the California Dignity in Pregnancy and Childbirth Act. The bill would require the department to solicit participation and adopt regulations to further the purposes of the act, as specified.

AB 2332 **(Connolly D) Corrections: health care.**
Current Text: Introduced: 2/12/2024 html pdf

Status: 2/13/2024-From printer. May be heard in committee March 14.
Location: 2/12/2024-A. PRINT

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

Summary: Would state the intent of the Legislature to enact legislation to improve inmate health outcomes in state prisons.

AB 2339 **(Aguiar-Curry D) Medi-Cal: telehealth.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Under current law, subject to federal approval, in-person, face-to-face contact is not required under Medi-Cal when covered health care services are provided by video synchronous interaction, asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. Current law defines “asynchronous store and forward” as the transmission of a patient’s medical information from an originating site to the health care provider at a distant site. This bill would expand that definition, for purposes of the above-described Medi-Cal provisions, to include asynchronous electronic transmission initiated directly by patients, including through mobile telephone applications.

AB 2340 **(Bonta D) Medi-Cal: EPSDT services.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Under current law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered under Medi-Cal for an individual under 21 years of age in accordance with certain federal provisions. Under current law, for an individual under 21 years of age, a service is medically necessary if the service meets the standards set forth in one of those federal EPSDT provisions, including the correction or amelioration of defects and physical and mental illnesses and conditions discovered by the screening services, whether or not those services are covered under the state plan. Current law sets forth other provisions on medical necessity standards for covered benefits provided in a Medi-Cal behavioral health delivery system. This bill would prohibit limits on EPSDT services when those services are medically necessary. The bill would require a Medi-Cal managed care plan to cover all medically necessary EPSDT services, unless otherwise carved out of the contract between the managed care plan and the State Department of Health Care Services, regardless of whether those services are covered under the Medi-Cal State Plan. The bill would establish definitions for “EPSDT services” and “medically necessary” by making references to the above-described provisions. The bill would specify that EPSDT services also include all age-specific assessments and services listed under the most current periodicity schedule by the American Academy of Pediatrics (AAP) and Bright Futures, and any other medically necessary assessments and services that exceed those listed by AAP and Bright Futures.

AB 2342 **(Lowenthal D) Medi-Cal: critical access hospitals: islands.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Under current law, a hospital designated by the State Department of Health Care Services as a critical access hospital, and certified as such by the Secretary of the United States Department of Health and Human Services under the

federal Medicare rural hospital flexibility program, is eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons. Current law conditions those payments on receipt of federal financial participation and an appropriation in the annual Budget Act for the nonfederal share of those payments, with supplemental payments being apportioned among critical access hospitals based on their number of Medi-Cal outpatient visits. This bill, subject to appropriation and the availability of federal funding, would require the department to provide an annual supplemental payment, for services covered under Medi-Cal, to each critical access hospital that operates on an island that is located more than 10 miles offshore of the mainland coast of the state but is still within the jurisdiction of the state. The bill would specify the formula of the payment amount, which would be in addition to any supplemental payment described above.

AB 2352 **(Irwin D) Psychiatric advance directives.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 2/13/2024-From printer. May be heard in committee March 14.
Location: 2/12/2024-A. PRINT

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

Summary: Current law establishes the requirements for executing a written advance health care directive that is legally sufficient to direct health care decisions. Current law provides a form that an individual may use or modify to create an advance health care directive. The statutory form includes a space to designate an agent to make health care decisions, as well as optional spaces to designate a first alternate agent and 2nd alternate agent. Current law defines "health care decision," as specified. Current law authorizes an individual to provide an "individual health care instruction" as the individual's authorized written or oral direction regarding a health care decision for the individual. Current law confirms that the provisions relating to execution of advance health directives do not prohibit the execution of a voluntary standalone psychiatric advance directive. This bill would declare the intent of the Legislature to enact legislation relating to psychiatric advance directives.

AB 2356 **(Wallis R) Medi-Cal: monthly maintenance amount: personal and incidental needs.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Qualified individuals under the Medi-Cal program include medically needy persons and medically needy family persons who meet the required eligibility criteria, including applicable income requirements. Current law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Current law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $50, and would require that the amount be increased annually, as specified. The bill would make these changes subject to receipt of necessary federal approvals.

AB 2376 **(Bains D) Medi-Cal.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 2/13/2024-From printer. May be heard in committee March 14.
Location: 2/12/2024-A. PRINT

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

Summary: Would state the intent of the Legislature to enact legislation to allow for acute care hospitals that accept Medi-Cal coverage to directly bill for inpatient detox services and Medically Assisted Treatment for substance abuse issues, as specified.

AB 2446 **(Ortega D) Medi-Cal: diapers.**
Current Text: Introduced: 2/13/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Would add to the schedule of Medi-Cal benefits diapers for infants or toddlers with certain conditions, such as a urinary tract infection and colic, among others. The bill would establish diapers as a covered benefit for a child greater than 3 years of age with a condition that contributes to incontinence. The bill would require the department to seek any and all available federal funding to implement this provision and would implement these provision only to the extent that the State Department of Health Care Services obtains any necessary federal approvals or waivers.

AB 2449 **(Ta R) Health care coverage: qualified autism service providers.**
Current Text: Introduced: 2/13/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Current law requires a health care service plan contract or health insurance policy to provide coverage for behavioral health treatment provided for pervasive developmental disorder or autism and requires a plan or policy to maintain an adequate network of qualified autism service providers. Under current law, a "qualified autism service provider" means, among other things, a person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies. This bill would clarify that the Qualified Applied Behavior Analysis Credentialing Board is also a national entity that may certify a qualified autism service provider, and would authorize the certification to be accredited by the American National Standards Institute.

AB 2466 **(Carrillo, Wendy D) Mental health.**
Current Text: Introduced: 2/13/2024 html pdf
Status: 2/14/2024-From printer. May be heard in committee March 15.
Location: 2/13/2024-A. PRINT

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

Summary: Current law establishes various state and local programs for the provision of mental health services within the jurisdiction of the State Department of Health Care Services, the State Department of Public Health, the California Behavioral Health Planning Council, the Department of Health Care Access and Information, and county public health or behavioral health departments, among other entities. Those programs, services, and provisions include, among others, the Mental Health Services Act, the Lanterman-Petris-Short Act, the Children and Youth Behavioral Health Initiative, the Behavioral Health Continuum Infrastructure Program, the Licensed Mental Health Service Provider Education Program, and Medi-Cal specialty mental health services. This bill would state the intent of the Legislature to enact legislation relating to mental health.

AB 2556 **(Jackson D) Behavioral health and wellness screenings: notice.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 2/15/2024-From printer. May be heard in committee March 16.
Location: 2/14/2024-A. PRINT

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

Summary: Would require a health care service plan or insurer to provide to each legal guardian of a patient, enrollee, or insured, 10 to 18 years of age, a written or electronic notice regarding the benefits of a behavioral health and wellness screening, as defined. The bill would require a health care service plan or insurer to provide the notice at least once every 2 years in the preferred method of the legal guardian. Because a violation of the bill's requirements relative to a health care service plan would be crimes, the bill would impose a state-mandated local program.

AB 2668 **(Berman D) Coverage for cranial prostheses.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 2/15/2024-From printer. May be heard in committee March 16.
Location: 2/14/2024-A. PRINT

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to cover cranial prostheses, as defined, for individuals experiencing permanent or temporary medical hair loss. The bill would require a licensed provider to prescribe the cranial prosthesis for an individual's course of treatment for a diagnosed health condition, chronic illness, or injury, as specified. The bill would limit coverage to once every 12 months and $750 for each instance of coverage. The bill would not apply these provisions to a specialized health care service plan or specialized health insurance policy. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2699 **(Carrillo, Wendy D) Health care service plans: provider directories.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 2/15/2024-From printer. May be heard in committee March 16.
Location: 2/14/2024-A. PRINT

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

Summary: The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans. Current law requires plans to publish and maintain provider directories, as specified. This bill would make technical, nonsubstantive changes to those provisions.

AB 2701 **(Villapudua D) Medi-Cal: dental cleanings and examinations.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 2/15/2024-From printer. May be heard in committee March 16.
Location: 2/14/2024-A. PRINT

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

Summary: Under current law, one dental prophylaxis cleaning per year and one initial dental examination by a dentist are covered Medi-Cal benefits for beneficiaries 21 years of age or older. Under current law, 2 dental prophylaxis cleanings per year and 2 periodic dental examinations per year are covered Medi-Cal benefits for beneficiaries under 21 years of age. Current law conditions implementation of those provisions on receipt of any necessary federal approvals and the availability of federal financial participation and funding in the annual Budget Act. This bill would restructure those provisions so that 2 cleanings and 2 examinations per year, as specified, would be covered Medi-Cal benefits for all beneficiaries, regardless of age.

AB 2703 **(Aguiar-Curry D) Federally qualified health centers and rural health clinics: psychological associates.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 2/15/2024-From printer. May be heard in committee March 16.
Location: 2/14/2024-A. PRINT

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

Summary: Current law requires the State Department of Health Care Services to seek any necessary federal approvals and issue appropriate guidance to allow a federally qualified health center (FQHC) or a rural health clinic (RHC) to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when certain conditions are met, including, among others, that the FQHC or RHC is otherwise authorized to bill for services provided by the supervising practitioner as a separate visit. This bill would add a psychological associate to those provisions, requiring the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill for an encounter between a patient and a psychological associate under those conditions. The bill would make conforming changes with regard to supervision by a licensed psychologist as required by the Board of Psychology.

AB 2726 **(Flora R) Health care coverage: access to specialty care.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 2/15/2024-From printer. May be heard in committee March 16.
Location: 2/14/2024-A. PRINT

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

Summary: Would state that it is the intent of the Legislature to enact legislation to increase access to specialty care to support whole-person care among California's most medically complex patients facing significant adverse social drivers of health.

AB 2753 **(Ortega D) Rehabilitative and habilitative services: durable medical equipment and services.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 2/16/2024-From printer. May be heard in committee March 17.
Location: 2/15/2024-A. PRINT

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

Summary: Current law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under current law, essential health benefits include, among other things, rehabilitative and habilitative services. Current law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define "durable medical equipment" to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.

AB 2843 **(Petrie-Norris D) Health care coverage: rape and sexual assault.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 2/16/2024-From printer. May be heard in committee March 17.
Location: 2/15/2024-A. PRINT

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

Summary: Would require a health care service plan or health insurance policy that is issued, amended, renewed, or

delivered on or after January 1, 2025, to provide coverage without cost sharing for emergency room medical care and follow-up health care treatment for an enrollee or insured who is treated following a rape or sexual assault. The bill would prohibit a health care service plan or health insurer from requiring, as a condition of providing coverage, (1) an enrollee or insured to file a police report, (2) charges to be brought against an assailant, (3) or an assailant to be convicted of rape or sexual assault. 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 2956 **(Boerner D) Medi-Cal eligibility: redetermination.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/17/2024-From printer. May be heard in committee March 18.
Location: 2/16/2024-A. PRINT

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

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their Medi-Cal eligibility. Current law conditions implementation of the redetermination provisions on the availability of federal financial participation and receipt of any necessary federal approvals. Under current law, if a county has facts clearly demonstrating that a Medi-Cal beneficiary cannot be eligible for Medi-Cal due to an event, such as death or change of state residency, Medi-Cal benefits are terminated without a redetermination. Existing law requires the department, subject to federal funding, to extend continuous eligibility to children 19 years of age or younger for a 12-month period, as specified. Under current law, operative on January 1, 2025, or the date that the department certifies that certain conditions have been met, a child is continuously eligible for Medi-Cal up to 5 years of age. Under those provisions, a redetermination is prohibited during this time, unless certain circumstances apply, including, voluntary disenrollment, death, or change of state residency. This bill would require the department to seek federal approval to extend continuous eligibility to individuals over 19 years of age. Under the bill, subject to federal funding, and except as described above with regard to death, change of state residency, or other events, an individual would remain eligible from the date of a Medi-Cal eligibility determination until the end of a 12-month period, as specified.

AB 2976 **(Jackson D) Mental health care.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/17/2024-From printer. May be heard in committee March 18.
Location: 2/16/2024-A. PRINT

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

Summary: Current law establishes various state and local programs for the provision of mental health services within the jurisdiction of the State Department of Health Care Services, the State Department of Public Health, the California Behavioral Health Planning Council, the Department of Health Care Access and Information, and county public health or behavioral health departments, among other entities. This bill would state the intent of the Legislature to enact legislation relating to access to mental health care.

AB 3129 **(Wood D) Health care system consolidation.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/17/2024-From printer. May be heard in committee March 18.
Location: 2/16/2024-A. PRINT

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

Summary: Current law requires a nonprofit corporation that operates or controls a health facility or other facility that provides similar health care to provide written notice to, and to obtain the written consent of, the Attorney General prior

to entering into any agreement or transaction to sell, transfer, lease, exchange, option, convey, or otherwise dispose of the asset, or to transfer control, responsibility, or governance of the asset or operation, to a for-profit corporation or entity, to a mutual benefit corporation or entity, or to a nonprofit corporation, as specified. This bill would require a private equity group or a hedge fund, as defined, to provide written notice to, and obtain the written consent of, the Attorney General prior to a change of control or an acquisition between the private equity group or hedge fund and a health care facility or provider group, as those terms are defined, except as specified. The bill would require the notice to be submitted at the same time that any other state or federal agency is notified pursuant to state or federal law, and otherwise at least 90 days before the change in control or acquisition. The bill would authorize the Attorney General to extend that 90-day period under certain circumstances. The bill would additionally require a private equity group or hedge fund to provide advance written notice to the Attorney General prior to a change of control or acquisition between a private equity group or hedge fund and a nonphysician provider, or a provider with specified annual revenue.

AB 3149 **(Garcia D) Community health workers.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/17/2024-From printer. May be heard in committee March 18.
Location: 2/16/2024-A. PRINT

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

Summary: Current law requires the Department of Health Care Access and Information to, on or before July 1, 2023, develop statewide requirements for community health worker certificate programs in consultation with stakeholders, including, but not limited to, the State Department of Health Care Services, the State Department of Public Health, community health workers, Promotores and Promotores de Salud, or representative organizations. Current law defines "community health worker" as, among other things, a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. This bill would state the intent of the Legislature to enact legislation related to community health workers.

AB 3156 **(Patterson, Joe R) Medi-Cal: managed care plans.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/17/2024-From printer. May be heard in committee March 18.
Location: 2/16/2024-A. PRINT

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

Summary: The Lanterman Developmental Disabilities Services Act makes the State Department of Developmental Services responsible for providing various services and supports to individuals with developmental disabilities, and for ensuring the appropriateness and quality of those services and supports. Pursuant to that law, the department contracts with regional centers to provide services and supports to persons with developmental disabilities. Current law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes, reduce health disparities, and increase flexibility. Current law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with specified requirements and the CalAIM Terms and Conditions. If the department standardizes those populations subject to mandatory enrollment, exempts certain dual and non-dual beneficiary groups, as defined, from that mandatory enrollment. This bill would express the intent of the Legislature to enact legislation to exempt dual and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage from mandatory enrollment in a Medi-Cal managed care plan.

AB 3215 **(Soria D) Medi-Cal: mental health services for children.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/17/2024-From printer. May be heard in committee March 18.
Location: 2/16/2024-A. PRINT

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

Summary: Would express the intent of the Legislature to enact legislation to expand access to behavioral mental health services to children receiving Medi-Cal benefits.

AB 3221 **(Pellerin D) Department of Managed Health Care: review of records.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/17/2024-From printer. May be heard in committee March 18.
Location: 2/16/2024-A. PRINT

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

Summary: 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. Current law requires the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director of the department during normal business hours. This bill would instead require the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director, including through electronic means. The bill would require a plan and other specified entities to furnish in electronic media records, books, and papers that are possessed in electronic media and to conduct a diligent review of records, books, and papers and make every effort to furnish those responsive to the director's request. The bill would require records, books, and papers to be furnished in a format that is digitally searchable, to the greatest extent feasible.

AB 3245 **(Patterson, Joe R) Coverage for colorectal cancer screening.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/17/2024-From printer. May be heard in committee March 18.
Location: 2/16/2024-A. PRINT

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

Summary: Current law generally requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage without cost sharing for a colorectal cancer screening test, and for a colorectal cancer screening examination in specified circumstances, assigned either a grade of A or a grade of B by the United States Preventive Services Task Force. This bill would additionally require that coverage if the test or screening examination is assigned either a grade of A or a grade of B by another accredited or certified guideline agency.

SB 70 **(Wiener D) Prescription drug coverage.**
Current Text: Amended: 6/29/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/16/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

Summary: Current law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law prohibits a health care service plan contract that covers prescription drug benefits or a specified health insurance policy from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which it was approved by the federal Food and Drug Administration if specified conditions are met. Current law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. This bill

would additionally prohibit limiting or excluding coverage of a drug, dose of a drug, or dosage form of a drug that is prescribed for off-label use if the drug has been previously covered for a chronic condition or cancer, as specified, regardless of whether or not the drug, dose, or dosage form is on the plan's or insurer's formulary. The bill would prohibit a health care service plan contract or health insurance policy from requiring additional cost sharing not already imposed for a drug that was previously approved for coverage.

SB 238 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 6/19/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/23/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

Summary: Current law provides for the regulation of disability insurers by the Department of Insurance. Current law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill, commencing July 1, 2024, would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified. The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts.

SB 282 **(Eggman D) Medi-Cal: federally qualified health centers and rural health clinics.**
Current Text: Amended: 3/13/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/16/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

Summary: Under current law of the Medi-Cal program, to the extent that federal financial participation is available, federally qualified health center (FQHC) and rural health clinic (RHC) services are reimbursed on a per-visit basis, as specified. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and a physician or other specified health care professionals. Under existing law, "visit" also includes an encounter using video or audio-only synchronous interaction or an asynchronous store and forward modality, as specified. This bill would authorize reimbursement for a maximum of 2 visits that take place on the same day at a single site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit, as defined. The bill would require the department, by July 1, 2024, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting those provisions. The bill would include a licensed acupuncturist within those health care professionals covered under the definition of a "visit." The bill would also make a change to the provision relating to physicians and would make other technical changes.

SB 294 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 1/11/2024 html pdf
Status: 1/29/2024-Read third time. Passed. (Ayes 31. Noes 7.) Ordered to the Assembly. In Assembly. Read first time. Held at Desk.
Location: 1/29/2024-A. DESK

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

Summary: Would, commencing July 1, 2025, require a health care service plan or a disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified.

SB 339 **(Wiener D) HIV preexposure prophylaxis and postexposure prophylaxis.**
Current Text: Chaptered: 2/6/2024 html pdf
Status: 2/6/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 1, Statutes of 2024.
Location: 2/6/2024-S. CHAPTERED

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

Summary: The Pharmacy Law provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. Current law authorizes a pharmacist to furnish at least a 30-day supply of HIV preexposure prophylaxis, and up to a 60-day supply of those drugs if certain conditions are met. Current law also authorizes a pharmacist to furnish postexposure prophylaxis to a patient if certain conditions are met. This bill would authorize a pharmacist to furnish up to a 90-day course of preexposure prophylaxis, or preexposure prophylaxis beyond a 90-day course, if specified conditions are met. The bill would require the California State Board of Pharmacy to adopt emergency regulations to implement these provisions by October 31, 2024.

SB 363 **(Eggman D) Facilities for inpatient and residential mental health and substance use disorder: database.**
Current Text: Amended: 5/18/2023 html pdf
Status: 9/1/2023-September 1 hearing: Held in committee and under submission.
Location: 8/23/2023-A. APPR. SUSPENSE FILE

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

Summary: Would require, by January 1, 2026, the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a real-time, internet-based database to collect, aggregate, and display information about beds in specified types of facilities, such as chemical dependency recovery hospitals, acute psychiatric hospitals, and mental health rehabilitation centers, among others, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the database to include a minimum of specific information, including the contact information for a facility's designated employee, the types of diagnoses or treatments for which the bed is appropriate, and the target populations served at the facility, and have the capacity to, among other things, enable searches to identify beds that are appropriate for individuals in need of inpatient or residential mental health or substance use disorder treatment.

SB 424 **(Durazo D) Medi-Cal: Whole Child Model program.**

Current Text: Amended: 5/25/2023 html pdf

Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/8/2023)(May be acted upon Jan 2024)

Location: 7/14/2023-A. 2 YEAR

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

Summary: Current law establishes the California Children's Services (CCS) Program, administered by the State Department of Health Care Services and a designated agency of each county, to provide medically necessary services for persons under 21 years of age who have any of specified medical conditions and who meet certain financial eligibility requirements. Current law establishes the Medi-Cal program, which is administered by the department and under which qualified low-income individuals receive health care services. Current law requires the department to establish a statewide Whole Child Model program stakeholder advisory group that includes specified persons, including CCS case managers, and to consult with that advisory group on prescribed matters. Current law terminates the advisory group on December 31, 2023. This bill would extend the operation of the advisory group until December 31, 2026.

SB 427 **(Portantino D) Health care coverage: antiretroviral drugs, drug devices, and drug products.**

Current Text: Amended: 9/8/2023 html pdf

Status: 2/26/2024-From inactive file. Ordered to third reading.

Location: 2/26/2024-A. THIRD READING

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

Summary: Would prohibit a health care service plan or health insurer from subjecting antiretroviral drugs, drug devices, or drug products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of HIV/AIDS, to prior authorization or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the plan or insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, drug device, or drug product without cost sharing pursuant to an exception request. The bill would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, drug devices, or drug products, including by supplying participating providers directly with a drug, drug device, or drug product, as specified.

SB 516 **(Skinner D) Health care coverage: prior authorization.**

Current Text: Amended: 9/13/2023 html pdf

Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. on 9/14/2023)(May be acted upon Jan 2024)

Location: 9/14/2023-A. 2 YEAR

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

Summary: Would, on or after January 1, 2026, prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly

approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

SB 551 **(Portantino D) Beverage containers: recycling.**
Current Text: Amended: 2/12/2024 html pdf
Status: 2/22/2024-Re-referred to Com. on NAT. RES. pursuant to Assembly Rule 96.
Location: 2/22/2024-A. NAT. RES.

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

Summary: The California Beverage Container Recycling and Litter Reduction Act requires plastic beverage containers sold by a beverage manufacturer, as specified, to contain a specified average percentage of postconsumer recycled plastic per year. The act requires the manufacturer of a beverage sold in a plastic beverage container subject to the California Redemption Value to report to the Department of Resources Recycling and Recovery certain information about the amounts of virgin plastic and postconsumer recycled plastic used for plastic beverage containers subject to the California Redemption Value for sale in the state in the previous calendar year. Current law provides that a violation of the act or a regulation adopted pursuant to the act is a crime. This bill would authorize certain beverage manufacturers to submit with other beverage manufacturers a consolidated report that identifies the postconsumer recycled plastic content for beverage containers and the amounts of virgin plastic and postconsumer recycled plastic used in beverage containers, as specified. The bill would require the consolidated report to be submitted under penalty of perjury.

SB 729 **(Menjivar D) Health care coverage: treatment for infertility and fertility services.**
Current Text: Amended: 8/14/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/23/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

Summary: Would require large and small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after January 1, 2024, to provide coverage for the diagnosis and treatment of infertility and fertility services. With respect to large group health care service plan contracts and disability insurance policies, the bill would require coverage for a maximum of 3 completed oocyte retrievals, as specified. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and disability insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and policyholders. The bill would prohibit a health care service plan or disability insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified. The bill would make these requirements inapplicable to a religious employer, as defined, and specified contracts and policies.

SB 966 **(Wiener D) Pharmacy benefits.**
Current Text: Introduced: 1/24/2024 html pdf
Status: 2/14/2024-Referred to Coms. on B., P. & E. D. and HEALTH.
Location: 2/14/2024-S. B., P. & E.D.

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

Summary: The Pharmacy Law establishes the California State Board of Pharmacy in the Department of Consumer Affairs to license and regulate the practice of pharmacy. The Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), a violation of which is a crime, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. The Knox-Keene Act requires a pharmacy benefit manager under contract

with a health care service plan to, among other things, register with the Department of Managed Health Care. Current law provides for the regulation of health insurers by the Department of Insurance. Current law imposes requirements on audits of pharmacy services provided to beneficiaries of a health benefit plan, as specified, and prohibits those audit provisions from being construed to suggest or imply that the Department of Consumer Affairs or the California State Board of Pharmacy has any jurisdiction or authority over those audit provisions. This bill would delete the latter provision relating to the construction and jurisdiction over those provisions by the department and the board. This bill would require a pharmacy benefit manager, as defined by the bill, to apply for and obtain a license from the California State Board of Pharmacy to operate as a pharmacy benefit manager. The bill would establish application qualifications and requirements and would establish an unspecified fee for initial licensure and renewal.

SB 980 **(Wahab D) Medi-Cal: dental crowns and implants.**
Current Text: Introduced: 1/29/2024 html pdf
Status: 3/1/2024-Set for hearing March 20.
Location: 2/14/2024-S. HEALTH

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

Summary: Would provide Medi-Cal coverage, for persons 13 years of age or older, for laboratory-processed crowns on teeth when a lesser service would not suffice because of extensive coronal destruction and a crown is medically necessary to restore the tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria.

SB 999 **(Cortese D) Health coverage: mental health and substance use disorders.**
Current Text: Introduced: 2/1/2024 html pdf
Status: 3/1/2024-Set for hearing March 20.
Location: 2/14/2024-S. HEALTH

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

Summary: Current law requires a health care service plan or disability insurer, as specified, to base medical necessity determinations and the utilization review criteria the plan or insurer, and any entity acting on the plan's or insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders, on current generally accepted standards of mental health and substance use disorder care. This bill would require a health care service plan and a disability insurer, and an entity acting on a plan's or insurer's behalf, to ensure compliance with specific requirements for utilization review, including maintaining telephone access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conducting peer-to-peer discussions regarding specific patient issues related to treatment.

SB 1008 **(Bradford D) Obesity Treatment Parity Act.**
Current Text: Introduced: 2/1/2024 html pdf
Status: 2/14/2024-Referred to Com. on HEALTH.
Location: 2/14/2024-S. HEALTH

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

Summary: Would require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include comprehensive coverage for the treatment of obesity in the same manner as any other illness, condition, or disorder. The bill would prohibit an individual or group health care service plan contract or health insurance policy from requiring more than 6 months of intensive behavioral therapy prior to granting access to other treatment options. The bill would also require that at least one FDA-approved antiobesity medication within the class of the relevant United States Pharmacopeia therapeutic category appear on, and be covered under, tier one of the health care service plan's or insurer's drug formulary.

SB 1017 **(Eggman D) Available facilities for inpatient and residential mental health or substance use disorder treatment.**
Current Text: Introduced: 2/5/2024 html pdf
Status: 3/1/2024-Set for hearing March 20.
Location: 2/14/2024-S. HEALTH

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

Summary: Current law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. This bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a solution to collect, aggregate, and display information about beds in specified types of facilities, including licensed community care facilities and licensed residential alcoholism or drug abuse recovery or treatment facilities, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the solution to be operational by January 1, 2026, or the date the State Department of Health Care Services communicates to the Department of Finance in writing that the solution has been implemented to meet these provisions, whichever date is later.

SB 1112 **(Menjivar D) Medi-Cal: families with subsidized childcare.**
Current Text: Introduced: 2/13/2024 html pdf
Status: 3/1/2024-Set for hearing March 20.
Location: 2/21/2024-S. HEALTH

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

Summary: Current law establishes a system of childcare and development services, administered by the State Department of Social Services, for children from infancy to 13 years of age. Current law authorizes, upon departmental approval, the use of appropriated funds for alternative payment programs to allow for maximum parental choice. Current law requires the department to contract with local contracting agencies for alternative payment programs so that services are provided throughout the state. Current 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, through managed care or fee-for-service delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered Medi-Cal benefits for individuals under 21 years of age. This bill, subject to any necessary federal approvals and the availability of federal funding, would require the State Department of Health Care Services and the State Department of Social Services to enter into a memorandum of understanding to facilitate coordination between Medi-Cal managed care plans and alternative payment agencies.

SB 1120 **(Becker D) Health care coverage: utilization review.**
Current Text: Introduced: 2/13/2024 html pdf
Status: 3/1/2024-Set for hearing March 20.
Location: 2/21/2024-S. HEALTH

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

Summary: Current law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Current law authorizes the Director of the Department of Managed Health Care or the Insurance Commissioner to assess an administrative penalty to a health care service plan or health insurer, as applicable, for failure to comply with those requirements. This bill would require a

health care service plan or health insurer to ensure that a licensed physician supervises the use of artificial intelligence decisionmaking tools when those tools are used to inform decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees or insureds.

SB 1131 **(Gonzalez D) Medi-Cal providers.**
Current Text: Introduced: 2/13/2024 html pdf
Status: 2/21/2024-Referred to Com. on HEALTH.
Location: 2/21/2024-S. HEALTH

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

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, services provided by a certified nurse practitioner are covered under the Medi-Cal program to the extent authorized by federal law, and existing law requires the department to permit a certified nurse practitioner to bill Medi-Cal independently for their services. This bill would similarly make services provided by a licensed physician assistant covered under the Medi-Cal program and would require the department to permit a certified nurse practitioner to bill Medi-Cal independently for their services.

SB 1180 **(Ashby D) Health care coverage: emergency medical services.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 2/21/2024-Referred to Com. on HEALTH.
Location: 2/21/2024-S. HEALTH

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include coverage for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program. The bill would require those plans and policies to require an enrollee or insured who receives covered services from a noncontracting program to pay no more than the same cost-sharing amount they would pay for the same covered services received from a contracting program. The bill would specify the reimbursement process and amount for a noncontracting program. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would also make services provided by these programs covered benefits under the Medi-Cal program. This bill contains other related provisions and other existing laws.

SB 1213 **(Atkins D) Health care programs: cancer.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 2/29/2024-Referred to Com. on HEALTH.
Location: 2/29/2024-S. HEALTH

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

Summary: Current law requires the State Department of Health Care Services to perform various health functions, including providing breast and cervical cancer screening and treatment for low-income individuals. Current law provides that an individual is eligible to receive treatment services if, among other things, the individual has a family income at or below 200% of the federal poverty level as determined by the provider performing the screening and diagnosis. This bill would provide that an individual is eligible to receive treatment services if the individual has a family income at or below 300% of the federal poverty level as determined by the provider performing the screening and diagnosis.

SB 1236 **(Blakespear D) Medicare supplement coverage: open enrollment periods.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 2/29/2024-Referred to Com. on HEALTH.
Location: 2/29/2024-S. HEALTH

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

Summary: Current federal law provides for the issuance of Medicare supplement policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program for the hospital, medical, or surgical expenses of persons eligible for the Medicare Program, including coverage of Medicare deductible, copayment, or coinsurance amounts, as specified. Current law, among other provisions, requires supplement benefit plans to be uniform in structure, language, designation, and format with the standard benefit plans, as prescribed. Current law prohibits an issuer from denying or conditioning the offering or effectiveness of any Medicare supplement contract, policy, or certificate available for sale in this state, or discriminating in the pricing of a contract, policy, or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. This bill, on and after January 1, 2025, would prohibit an issuer of Medicare supplement coverage in this state from denying or conditioning the issuance or effectiveness of any Medicare supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for coverage is submitted during an open enrollment period, as specified in the bill. The bill would entitle an individual enrolled in Medicare Part B to a 90-day annual open enrollment period beginning on January 1 of each year, as specified, during which period the bill would require applications to be accepted for any Medicare supplement coverage available from an issuer, as specified.

SB 1258 **(Dahle R) Medi-Cal: unrecovered payments: interest rate.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 2/29/2024-Referred to Com. on HEALTH.
Location: 2/29/2024-S. HEALTH

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

Summary: Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

SB 1268 **(Nguyen R) Health insurance.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 2/29/2024-Referred to Com. on RLS.
Location: 2/15/2024-S. RLS.

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

Summary: Current law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Existing law authorizes the establishment of a health authority in specified counties for the delivery of medical care and services in that county. Current law makes the health authority subject to specified provisions, including certain notification and reporting requirements, commencing on the date that the health authority first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and until the time that the health authority is in compliance with all the requirements regarding tangible net equity applicable to a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975.

SB 1269 **(Padilla D) Safety net hospitals.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 3/1/2024-Set for hearing March 20.
Location: 2/29/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoe	Chaptered

1st House	2nd House	Conc.		d	

Summary: Would establish a definition for “safety net hospital” and would state the intent of the Legislature that this definition serve as a recommended definition for policymakers to elect to utilize when crafting policy aimed at focusing on or supporting those hospitals. Under the bill, the definition would not be construed as affecting existing or new references to safety net hospitals, unless future legislation or other action expressly makes reference to this definition, as specified.

SB 1290 **(Roth D) Health care coverage: essential health benefits.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 2/29/2024-Referred to Com. on HEALTH.
Location: 2/29/2024-S. HEALTH

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

Summary: Would express the intent of the Legislature to review California’s essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year. This bill contains other related provisions and other existing laws.

SB 1300 **(Cortese D) Health facility closure: public notice: inpatient psychiatric and maternity services.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 2/29/2024-Referred to Com. on HEALTH.
Location: 2/29/2024-S. HEALTH

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

Summary: Current law requires the State Department of Public Health to license, regulate, and inspect health facilities, as specified, including general acute care hospitals. A violation of these provisions is a crime. Under existing law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Current law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Current regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. Current law requires a health facility to provide 90 days of public notice of the proposed closure or elimination of a supplemental service, and 120 days of public notice of the proposed closure or elimination of an acute psychiatric hospital.This bill would change the notice period required before proposed closure or elimination of the supplemental service of inpatient psychiatric service or maternity service from 90 days to 120 days. By changing the definition of a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 1339 **(Allen D) Health and care facilities.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/29/2024-Referred to Com. on RLS.
Location: 2/16/2024-S. RLS.

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

Summary: Current law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, defined to include, among other types of health facilities, an acute psychiatric hospital. Current law requires the State Department of Health Care Services to license and establish regulations for psychiatric residential treatment facilities. This bill would state the intent of the Legislature to enact legislation to ensure that licensed facilities that receive referred behavioral health patients have their licenses checked to ensure that these licensed facilities are capable of providing the appropriate level of care.

SB 1354 **(Wahab D) Health facilities: payment source.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/29/2024-Referred to Com. on HEALTH.
Location: 2/29/2024-S. HEALTH

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

Summary: Would require a long-term health care that participates as a provider under the Medi-Cal program to provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source.

SB 1355 **(Wahab D) Medi-Cal: in-home supportive services: redetermination.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/20/2024-From printer. May be acted upon on or after March 18.
Location: 2/16/2024-S. RLS.

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

Summary: Current law provides for 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 supportive services in order to permit them to remain in their own homes. Existing law authorizes certain Medi-Cal beneficiaries to receive IHSS as a covered Medi-Cal benefit. This bill would, to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized, require an IHSS recipient to be continuously eligible for Medi-Cal for 3 years, and would prohibit a redetermination of Medi-Cal eligibility before 3 years, except as specified. The bill would make the implementation of its provisions contingent upon the department obtaining all necessary federal approvals, the department determining that systems have been programmed to implement these provisions, and the Legislature has appropriated funding to implement these provisions after a determination that ongoing General Fund resources are available to support the ongoing implementation of these provisions. To the extent the bill would increase county duties in administrating the IHSS program, the bill would impose a state-mandated local program.

SB 1397 **(Eggman D) Behavioral health crisis services: reporting.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/29/2024-Referred to Com. on HEALTH.
Location: 2/29/2024-S. HEALTH

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

Summary: Current law requires a health care service plan contract or disability insurance policy to provide coverage for medically necessary treatment of mental health and substance use disorders, including behavioral health crisis services that are provided by an in-network or out-of-network 988 center, mobile crisis team, or other provider, as specified. Current law requires a health care service plan or disability insurer to reimburse a 988 center, mobile crisis team, or other provider for emergency and nonemergency behavioral health crisis services and care pursuant to these provisions. This bill would authorize a county to report to the Department of Managed Health Care or the Department of Insurance a complaint about a health care service plan's or a health insurer's failure to make a good faith effort to contract or enter into an agreement with the county to obtain reimbursement for behavioral health crisis services, or to timely reimburse the county for services the plan or insurer is required to cover by state or federal law, and would require the respective department to timely investigate the complaint.

SB 1423 **(Dahle R) Medi-Cal: critical access hospitals.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/29/2024-Referred to Com. on HEALTH.
Location: 2/29/2024-S. HEALTH

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

Summary: Under current law, each hospital designated by the State Department of Health Care Services as a critical access hospital, and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, is eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons. Current law conditions those payments on receipt of federal financial participation and an appropriation in the annual Budget Act for the nonfederal share of those payments, with supplemental payments being apportioned among critical access hospitals based on their number of Medi-Cal outpatient visits. This bill would remove the provisions relating to supplemental payments and would instead require the reimbursement to a critical access hospital for Medi-Cal covered outpatient services at a rate equal to the actual cost to the hospital of providing the services or the amount charged by the hospital for the services, whichever is less. The bill would also require reimbursement to those hospitals, under the same terms, for swing-bed services, relating to beds licensed for general acute care that may be used as skilled nursing beds.

SB 1428 **(Atkins D) Health care coverage: triggering events.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/29/2024-Referred to Com. on HEALTH.
Location: 2/29/2024-S. HEALTH

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

Summary: Current law requires a health care service plan or a health insurer to allow an individual to enroll in or change individual health benefit plans as a result of specified triggering events, including a loss of minimum essential coverage, as defined, gaining a dependent or becoming a dependent, or being mandated to be covered as a dependent pursuant to a valid state or federal court order. Current law allows an individual 60 days from the date of a triggering event to apply for subsequent coverage. This bill would allow an individual 60 days before or after the date of a triggering event to apply for subsequent coverage. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

SB 1492 **(Menjivar D) Medi-Cal reimbursement rates: private duty nursing.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/29/2024-Referred to Com. on HEALTH.
Location: 2/29/2024-S. HEALTH

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

Summary: Under current law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Current law sets forth requirements for private duty nursing and home health care under the Medi-Cal program. Current law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department to provide full-scope Medi-Cal services. Under current law, proceeds from the MCO provider tax may be used, upon appropriation by the Legislature, for the increased costs incurred as a result of reimbursement requirements, among other things. This bill would provide that, for the above-described reimbursement purposes, private duty nursing services provided to a child under 21 years of age by a home health agency are considered specialty care services.

Total Measures: 105

Total Tracking Forms: 105

ALAMEDA Alliance FOR HEALTH

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

Board Business

TO: Alameda Alliance for Health Board of Governors

FROM: Matt Woodruff, CEO

DATE: March 8th, 2024

SUBJECT: Nomination of James Jackson to Vice Chair of the Finance Committee

RECOMMENDED ACTION

To approve a motion to appoint Mr. James Jackson to the Vice Chair of the Alameda Alliance Finance Committee.

DISCUSSION

Dr. Michael Marchiano resigned from the Board of Governors and as Vice Chair of the Finance Committee, effective January 26, 2024. Mr. James Jackson has been nominated to fill the Vice Chair vacancy within the Finance Committee.

FISCAL IMPACT

This action will not have a fiscal impact.

ATTACHMENTS

N/A

Compliance Division Plan Updates

Internal Audit Activities for CY 2023 & CY2024

As Presented to the Alameda Alliance Board of Governors

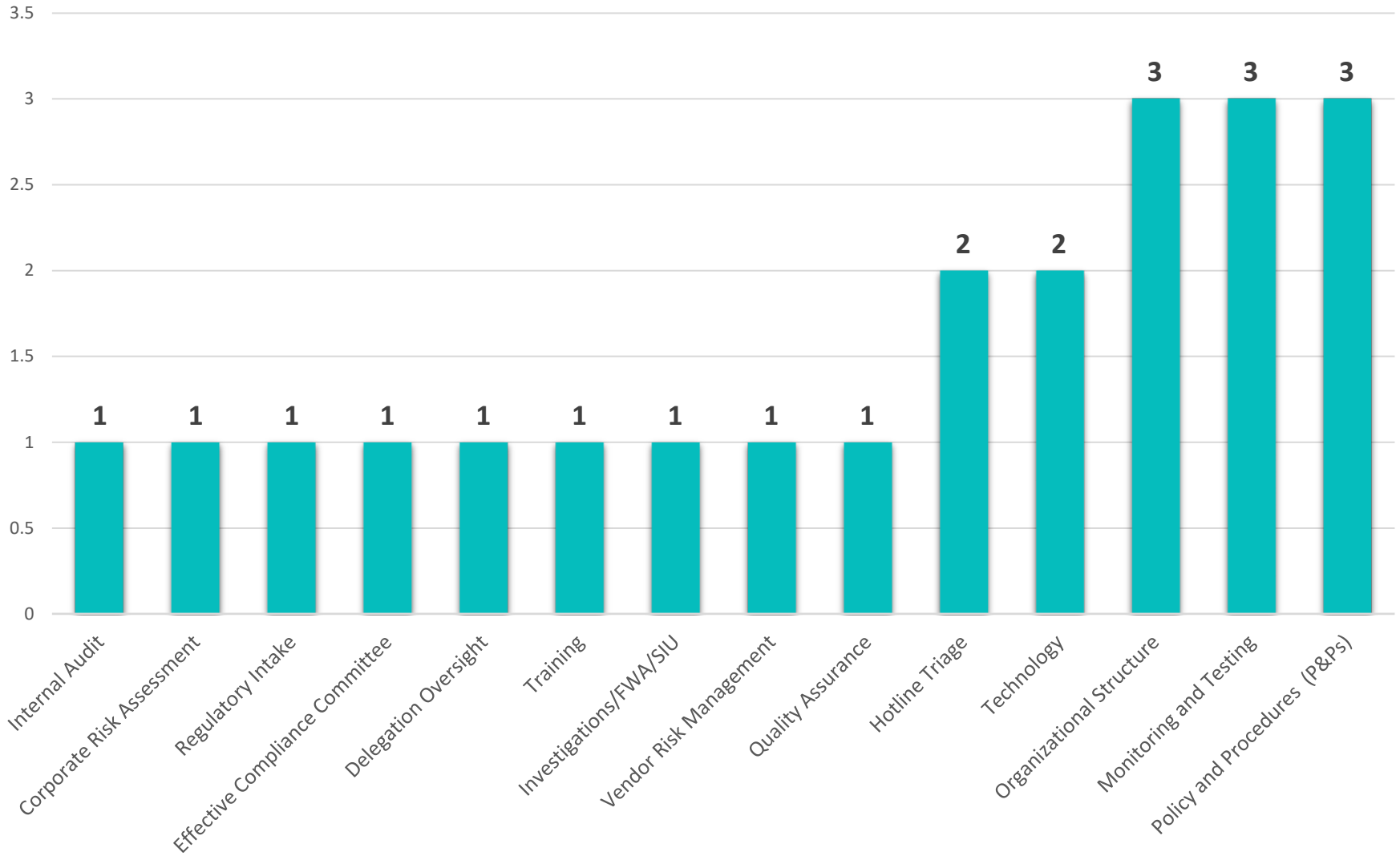
Presented by: Richard Golfin III
Chief Compliance & Privacy Officer
March 8th, 2024

Compliance Risk Assessment

Third-Party Compliance Risk Assessment (CRA)

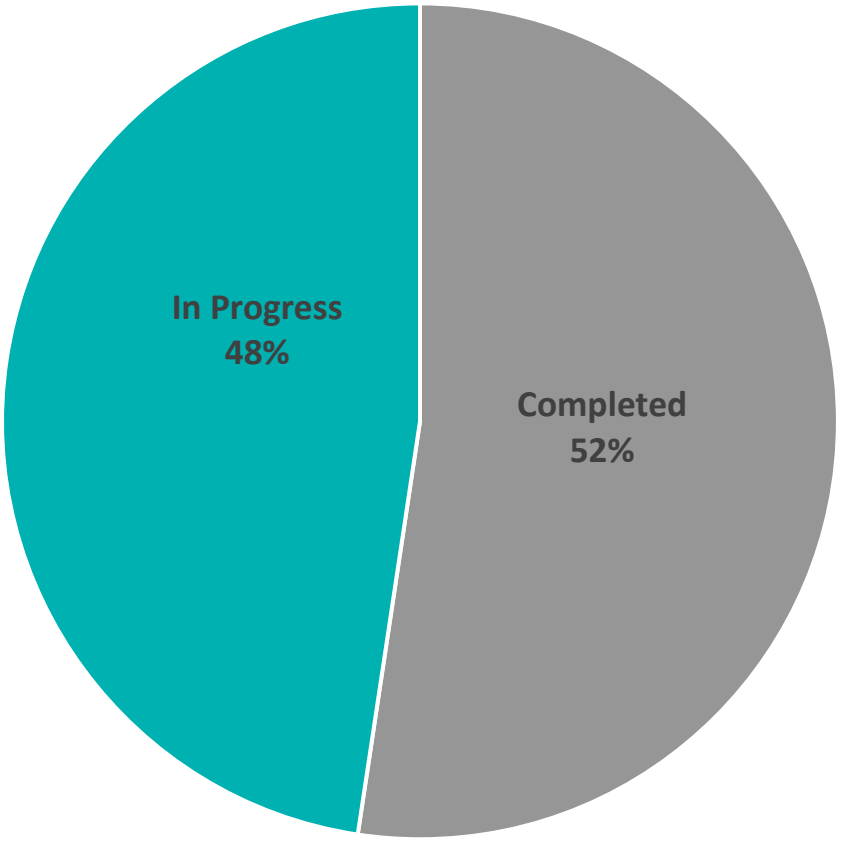
- The CRA was conducted from December 2022, through May 2023 by RGP (third-party consultant), and includes 22 findings and recommendations covering the following areas: internal audits, risk management, communication/training, policies/procedures, workflows and reporting.
- The CRA did not account for programs and policies in development. The Plan conducted it secondary review of RGP's findings against current processes to ensure the most accurate and up-to-date information available at the Alliance.
- After internal assessment, the Compliance Division agrees with 50% of RGP's recommendations and developed additional actions beyond RGP's recommendations to mature the compliance program.
- All recommendations will be implemented by the end of Q4 2024.

Findings by Area of Opportunity (22)

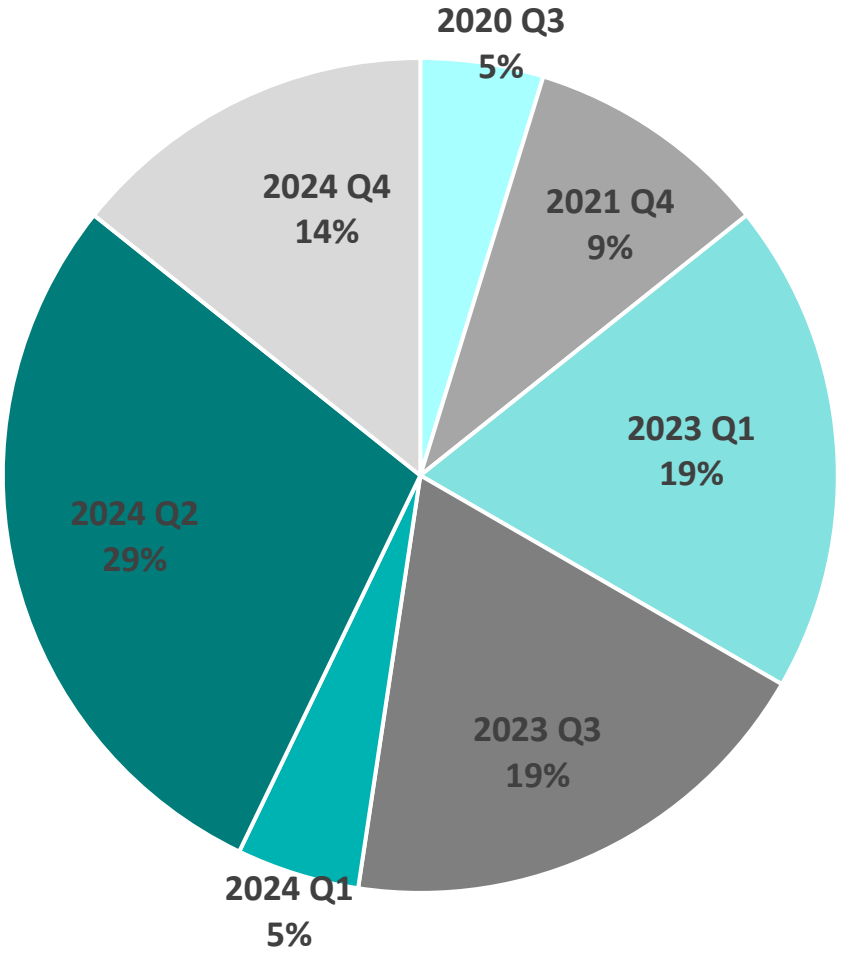


AAH Internal Audit Status

In Process vs. Completed



Estimated Completion



Recommendations Completed

Completed	Quantity	Description
2020 Q3	1	• 7.1 Compliance Committee meeting minutes already include the information recommended by RGP.
2021 Q4	2	• 9.2 Compliance implemented Policy Tech which is the Alliance's policy repository. • 12.1 Policy Tech houses both finalized policies and in development. It also tracks each policy's approval process. Also, new and revised policies plus requests to retire policies are submitted to the Compliance Committee for final approval on a quarterly basis.
2023 Q1	4	• 2.2 The Internal Audit Plan is the auditing program for the Alliance. • 2.3 The Internal Audit Plan includes a tracking process for audit findings. • 5.1 Regulatory Affairs is the regulatory intake program for the Alliance and partnered with Integrated Planning Division to develop a more robust implementation process. • 12.2 The Code of Conduct governs the manner employees conduct business and establishes ethical standards. It was last updated and approved on February 10, 2023.
2023 Q3	4	• 1.1 Legal now reports to the Chief Executive Officer. • 6.1 Compliance developed triage protocols for complaints received through the Compliance Hotline. • 8.1 The Alliance has a robust delegation oversight program which includes the Delegation Oversight Committee (DOC). DOC meets on a quarterly basis to review and discuss the compliance status for the Alliance's delegated and subcontracted networks. • 11.1 The Alliance has multiple processes in place for investigating and reporting FWA; developed workflows for referrals; tracking cases through Ethics Point; and implemented Fraud Shield.

Recommendations In Progress

Estimated Completion	Quantity	Description

2024 Q1	1	• 12.3 Policy and Procedure (P&P) Development
		  • Legal plans to submit the Conflict of Interest Code (LGL-003) P&P to the Administrative Oversight Committee for approval in April 2024.
		  • Regulatory Affairs and Compliance (RAC) has drafted a P&P for communicating with regulators to ensure employees understand RAC is the primary source for communication with regulators. The P&P will be completed by the end of March 2024.

2024 Q2	1	• 10.1 The New Employee Orientation (NEO) Compliance Training is being revised.
		  • An overview of Internal Audits was added.
		  • The following is being drafted and will be added:
		  • How Compliance interacts with other Departments (e.g., Operations)
		  • Roles and responsibilities for both Compliance and the Compliance related responsibilities for the rest of the organization
		  • An overview of the Compliance Plan
		  • Compliance is partnering with Human Resources to add the NEO Compliance Training to HR's onboarding process.

California State Auditor's Report for CalOptima

ALAMEDA Alliance FOR HEALTH

California State Auditor's (CSA) Report for CalOptima

- In May 2023, the CSA completed an audit of CalOptima's budget, services, programs, and organizational changes.
- Compliance compared the Alliance to the CSA audit report on CalOptima to meet the Alliance's goal to identify risk and improve operations.
- Compliance found the Alliance is compliant with the findings for CalOptima, but provided recommendations to improve the following areas:
  - Financial transparency
  - FWA Investigations
  - Hiring: Best Practices
  - Monitoring Effective Use of Funds
  - Surplus Funds
  - Timely Access
- The recommendations have been shared with the impacted areas on December 15, 2023, and responses were due January 18, 2024.
- Compliance reviewed responses and requested additional information . Upon receipt, the audit will be closed and may revisit the audit in the future.

Kaiser and DMHC Behavioral Health Settlement Agreement

ALAMEDA Alliance FOR HEALTH

Kaiser and DMHC Behavioral Health Settlement Agreement

- DMHC entered into a settlement agreement with Kaiser regarding Kaiser's violation of timely access and clinical standards by canceling and inadequately providing behavioral health appointments.
- The Compliance Division is comparing Plan internal operations to the settlement agreement to identify potential areas for improvement and bolster risk mitigation.
  - This will be known as the Alameda Alliance Kaiser Behavioral Health Comparison Audit (AAH BHCA).
  - Kaiser's violations include, but are not limited to, a shortage of high-level facilities, insufficient oversight of medical groups, failure to make proper out-of-network referrals, and inadequate handling of enrollee grievances.
  - Evaluation will include eight (8) audit areas over 66 points of interest.
- In March 2024, the Compliance will reach out to various departments and teams to begin collaboration on this audit.
- Compliance will present the results of the audit at the October 2024 Board of Governors meeting.

2023 AAH Documentation Audit

ALAMEDA Alliance FOR HEALTH

2023 AAH Documentation Audit

- As part of the Compliance Department initiatives to ensure compliance and improve operations, various Alliance documents were reviewed for compliance with policies and regulatory requirements, and to enhance transparency through accessible information.
- Documents reviewed included the Notice of Privacy Practices, Website Privacy Statement, Conflict of Interest Code, Bylaws, and more.
- Compliance worked with audited areas to address findings and discuss recommendations.

Status of Recommendations

Document	Status
Notice of Privacy Practices	Recommendations were implemented by the Privacy Office in February 2024 and the documents are being finalized for posting on the Alliance's website.
Website Privacy Statement	Recommendations were implemented by the Privacy Office in February 2024. The revisions are pending review and approval by C&O as they are the owners of this document.
Bylaws	Compliance met with Legal on February 27, 2024. Legal will provide an update on its response to the recommendations on March 7, 2024.
Conflict of Interest Code	
Rosters, Charters, and Org Chart for the Operational and Standing Committees	

Compliance Division Summary

ALAMEDA Alliance FOR HEALTH

Compliance Division Summary

- Compliance Division has grown 200% in the past 10 years.
- Primary Objective: To ensure that the Alliance is operating in compliance with regulatory standards.
- Due to growth, Internal Audits has been able to leverage internal audits and develop advanced reporting internally and to government agencies.
  - Increased proactivity to risk identification and CAP mitigation.
  - Development of the Internal Audit Plan (Approved Q1 2023).
- Next Steps: Build an Enterprise Risk Management (ERM) program which is a holistic and strategic approach to identify, assess, prioritize, and manage risks across all facets of the Alliance.
  - Compliance will leverage ERM data to ensure the organization operates with resilience, compliance and the ability to deliver high-quality healthcare services.
  - ERM will provide a framework for assessing the effectiveness of existing controls and will help to systematically identify, evaluate and prioritize potential risks that could impact the achievement of an organization's objectives.

Questions?

ALAMEDA Alliance FOR HEALTH

Alameda County Social Services (ACSSA) Medi-Cal Re-Evaluations

Alameda Alliance Board of Governance
March 8, 2024

Andrea Ford, Agency Director, ACSSA

Tammy Lue, Medi-Cal Program Specialist, ACSSA-WBA

Juan Ventanilla, Medi-Cal Program Specialist, ACSSA-WBA

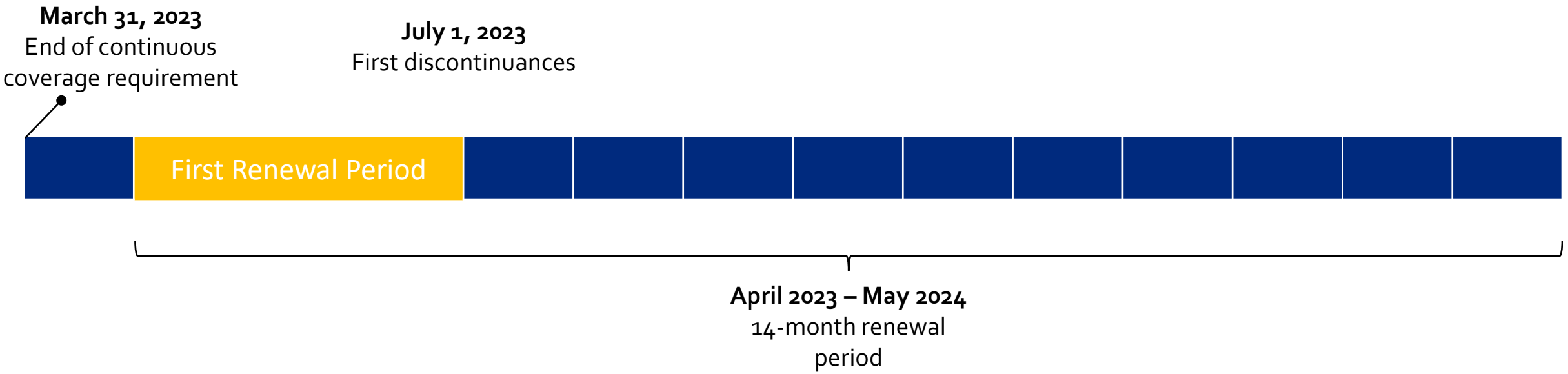
Alameda County
Social Services Agency

Overview

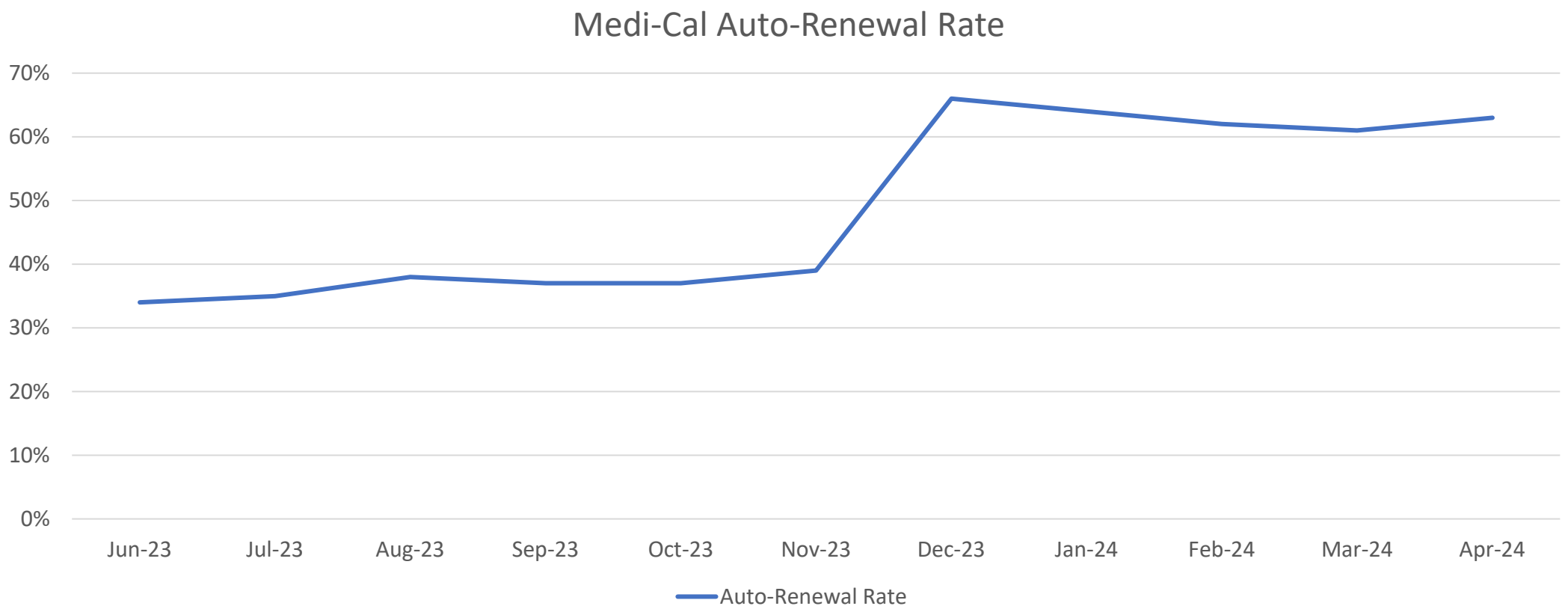
1. Continuous Coverage Unwinding
2. Medi-Cal Re-Evaluation Data
3. ACSSA Plan for Re-Evaluation Process
4. Medi-Cal Re-Evaluation Waivers
5. Alameda Alliance & ACSSA Collaboration

Continuous Coverage Unwinding

Continuous Coverage Unwinding



Medi-Cal Re-Evaluation (RE) Data



Medi-Cal Re-Evaluation Data – cont.

- # of packets sent: 113,283
- # of REs received: 68,580
  - # of REs processed: 45,660
  - # of REs not processed: 22,920
- # of REs not received: 44,703
- # of cases discontinued: 34,934
  - # of cases discontinued for no RE: 27,911

*data as of 02/05/2024

ACSSA Plan for Re-Evaluation Process

- An Internal workgroup was created to develop creative solutions for tackling outstanding renewals.
- ACSSA has also launched its Re-Evaluation Medi-Cal Campaign entitled "Medi-Cal: Thinking Ahead for the Win"
  - Guidance is continually being updated with policy changes regarding renewal processing during the continuous coverage unwinding.
  - A series of workshops is being conducted to familiarize SSA staff with the changes in policy updates and business process due to the continuous coverage unwinding.

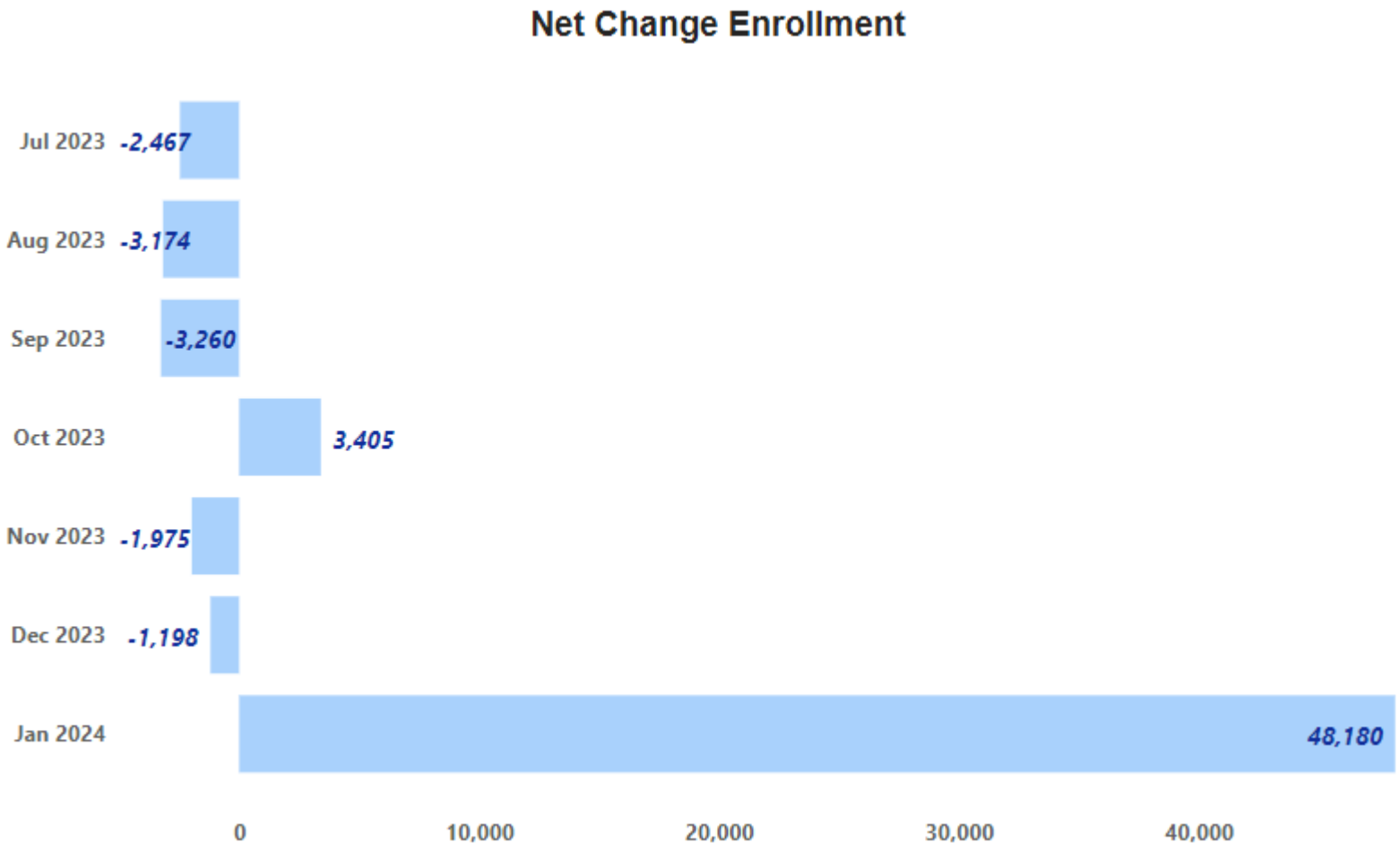
ACSSA Plan for Re-Evaluation Process – cont.

Medi-Cal Re-Evaluation Waivers

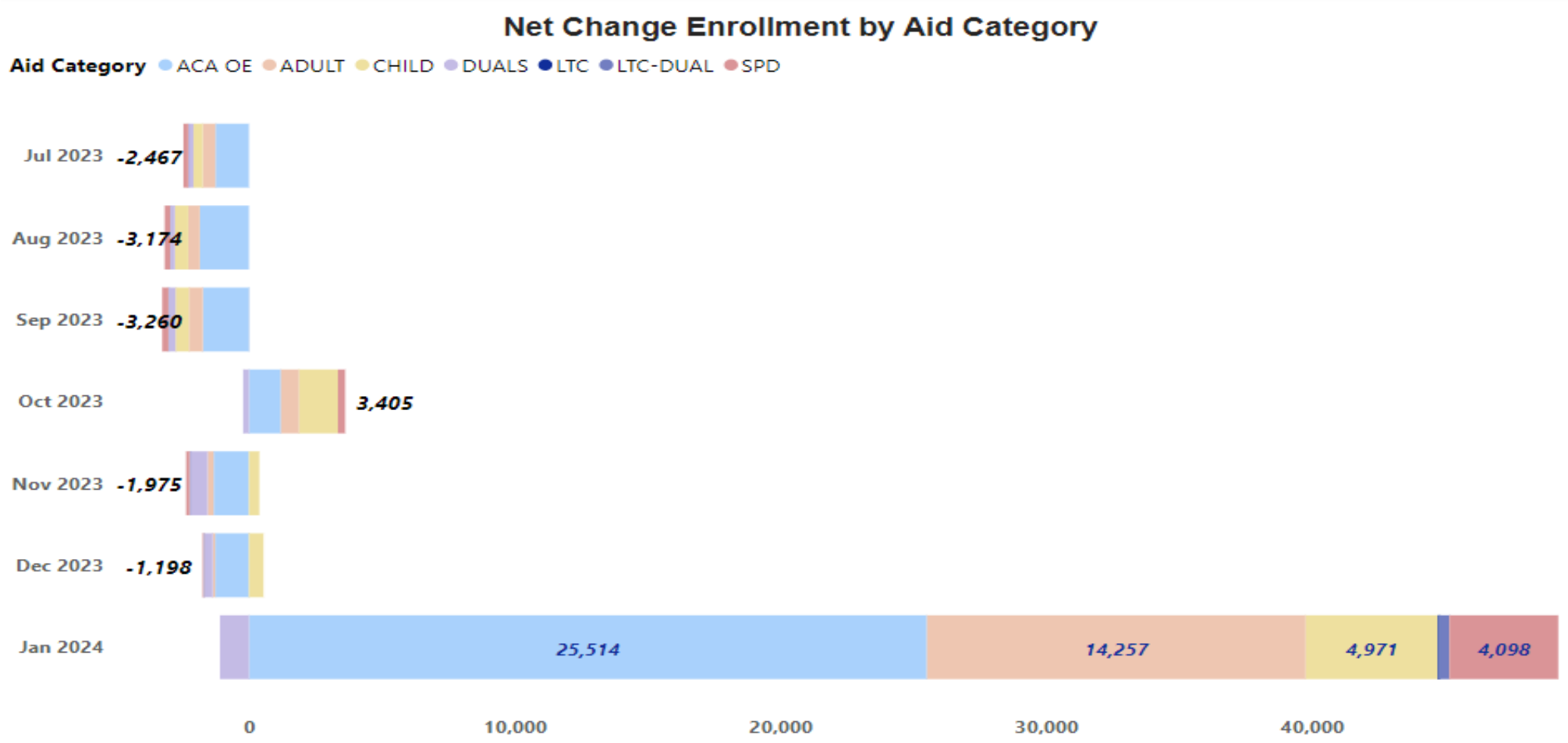
- **Reasonable Compatibility Threshold Increase:** Threshold for the Medi-Cal auto-renewal process has increased to 20%.
- **Hard-to-Reach Population Waiver:** The renewal can be processed if information about a hard-to-reach individual is received, and enough information is available to complete a re-evaluation.
- **Reasonable Explanation:** Ability to provide verification through verbal or written explanation that resolves the discrepancy between self-attested income and income received through electronic data sources.
- **100% FPL Waiver:** The renewal can be processed if the most recent income determination was at or below 100% FPL, no electronic data is received, and no contradictory information is on file.
- **Stable Income Waiver:** The renewal can be processed if the most recent income determination was no earlier than 12 months prior to March 2019, if the individual only receives stable income, and no contradictory information is on file.

Alameda Alliance & ACSSA Collaboration

Alameda Alliance Net Change Enrolllment



Alameda Alliance Net Change Enrolllment



Alameda Alliance Net Change by Aid Category

Aid Category	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	**Total**
ACA OE	-1,264	-1,849	-1,735	1,203	-1,330	-1,271	25,514	**19,268**
ADULT	-480	-434	-526	689	-228	-88	14,257	**13,190**
CHILD	-344	-506	-502	1,455	390	546	4,971	**6,010**
DUALS	-189	-159	-254	-209	-648	-319	-1,091	**-2,869**
LTC	-5	-4	4	-1	-5	-4	79	**64**
LTC-DUAL	-5	-11	-16	-4	-25	-22	352	**269**
SPD	-180	-211	-231	272	-129	-40	4,098	**3,579**
Total	**-2,467**	**-3,174**	**-3,260**	**3,405**	**-1,975**	**-1,198**	**48,180**	**39,511**

Thank You!

FY 2024 Second Quarter Forecast

Presented to the Alameda Alliance Board of Governors

March 8th, 2024

Highlights

- 2024 Projected Net Income of $19.1 million.
- Projected excess Tangible Net Equity at 6/30/24 of $350.1 million is 681% of required TNE.
- Year-end enrollment is 381,000. Enrollment peaked at 401,000 in January 2024.
- The Forecast now includes MCO Tax Revenue and Expense as the Plan is at-risk for differences in MCO Revenue received vs. MCO Tax owed. The Forecast reflects a deficit of $13.4 million for Calendar Year 2023.
- Forecast also includes $10 million in accruals for a retroactive 2023 Medi-Cal rate acuity adjustment, and a $4 million reserve for Fiscal Year 2015 ACA OE Medical Loss Ratio payback.
- Medi-Cal Targeted Rate Increase (TRI) Revenue and Expense is also now included at approximately $40 million each.
- Medi-Cal base rates received in December are also higher than estimated, due to favorable acuity adjustments and an increase in the administrative load.
- Expenses for Long-Term Care are projected to be approximately $15 million higher than originally anticipated.
- There are 417 Administrative FTEs and 209 Clinical FTEs at year-end; 17 lower than budget.
- Operating Expenses, other than Staffing, are lower by $5.7 million, largely due to decreased consultant expense.

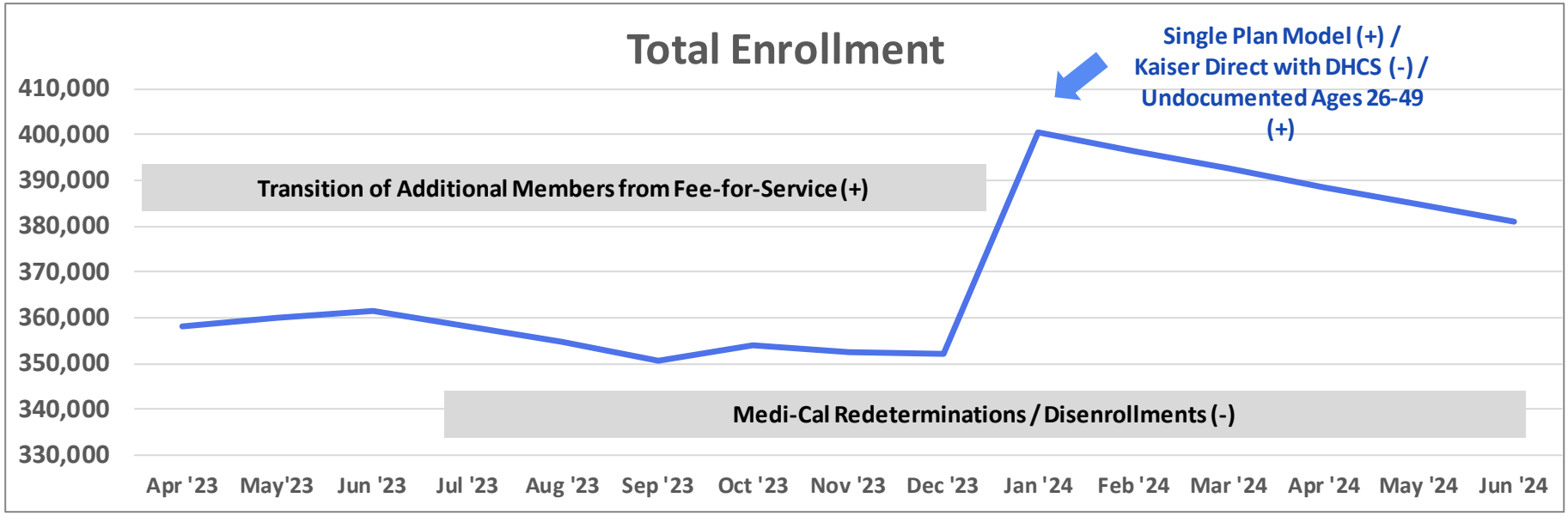
Material Areas of Uncertainty

- The Alliance enrolled over 100,000 new members in January. There is a lack of historical data on which to base medical expense projections.
- Authorizations for Long-Term Care are significantly higher than anticipated. It is unclear how much additional expense will be generated from the authorizations.
- DHCS has adopted the practice of changing Medi-Cal capitation rates retro-actively. Final Calendar Year 2023 rates are expected in the next few months. Adjustments to Calendar Year 2024 rates are expected mid-year. Changes could be either positive or negative.
- Enrollment changes may be impacted by the County redetermination process.

FY 2024 Q2 Forecast
Comparison to Budget

$ in Thousands	FY 2024 Q2 Forecast				FY 2024 Budget				Variance F/(U)			
	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total
Enrollment at Year-End	**375,514**	**5,533**	**0**	**381,047**	**379,251**	**5,493**	**0**	**384,744**	**(3,737)**	**40**	**0**	**(3,697)**
Member Months	**4,398,988**	**67,165**	**0**	**4,466,153**	**4,416,822**	**66,886**	**0**	**4,483,708**	**(17,834)**	**279**	**0**	**(17,555)**
Premium Revenue	1,751,691	30,710	0	1,782,402	1,746,538	30,585	0	1,777,123	5,153	126	0	5,279
MCO Tax Revenue	605,411	0	0	605,411	0	0	0	0	605,411	0	0	605,411
Operating Margin	**2,357,102**	**30,710**	**0**	**2,387,812**	**1,746,538**	**30,585**	**0**	**1,777,123**	**610,564**	**126**	**0**	**610,690**
Medical Expense	1,655,931	27,899	0	1,683,830	1,665,425	27,800	0	1,693,225	9,494	(98)	0	9,396
Gross Margin	**701,171**	**2,812**	**0**	**703,983**	**81,113**	**2,785**	**0**	**83,897**	**620,058**	**27**	**0**	**620,085**
Administrative Expense	94,509	1,835	608	96,952	101,608	2,009	613	104,230	7,100	174	5	7,278
MCO Tax Expense	618,876	0	0	618,876	0	0	0	0	(618,876)	0	0	(618,876)
Other Income / (Expense)	30,440	510	0	30,951	29,104	485	0	29,589	1,337	25	0	1,362
Net Income / (Loss)	**$18,227**	**$1,487**	**($608)**	**$19,106**	**$8,608**	**$1,261**	**($613)**	**$9,256**	**$9,619**	**$226**	**$5**	**$9,850**
Admin. Expense % of Revenue	**5.4%**	**6.0%**		**5.4%**	**5.8%**	**6.6%**		**5.9%**	**0.4%**	**0.6%**		**0.4%**
Medical Loss Ratio	**94.5%**	**90.8%**		**94.5%**	**95.4%**	**90.9%**		**95.3%**	**0.8%**	**0.1%**		**0.8%**
TNE at Year-End				**$410,304**				**$333,213**				**$77,092**
TNE Percent of Required at YE				**681%**				**546%**				**135%**

Enrollment by Month



Staffing: Full-time Employees at Year-end

Administrative FTEs	FY24 Q2 Forecast	FY24 Budget	Increase/ Decrease
Administrative Vacancy	(54.7)	(46.5)	(8.2)
Operations	10.0	10.0	0.0
Executive	2.0	2.0	0.0
Finance	36.0	36.0	0.0
Healthcare Analytics	17.0	17.0	0.0
Claims	50.0	50.0	0.0
Information Technology	15.0	15.0	0.0
IT Infrastructure	8.0	8.0	0.0
Apps Mgmt., IT Quality & Process Imp.	18.0	18.0	0.0
IT Development	17.0	17.0	0.0
IT Data Exchange	9.0	9.0	0.0
IT-Ops and Quality Apps Mgt.	13.0	14.0	(1.0)
Member Services	99.0	111.0	(12.0)
Provider Services	38.0	38.0	0.0
Credentialing	7.0	7.0	0.0
Health Plan Operations	1.0	1.0	0.0
Human Resources	12.0	12.0	0.0
Vendor Management	8.0	8.0	0.0
Legal Services	5.0	5.0	0.0
Facilities & Support Services	7.0	7.0	0.0
Marketing & Communication	14.0	14.0	0.0
Privacy and SIU	16.0	17.0	(1.0)
Regulatory Affairs & Compliance	10.0	9.0	1.0
Grievance and Appeals	27.0	27.0	0.0
Integrated Planning	0.0	0.0	0.0
State Directed & Special Programs	7.0	7.0	0.0
Portfolio Mgmt. & Svc Excellence	14.0	14.0	0.0
Workforce Development	9.0	9.0	0.0
Diversity and Health Equity	3.0	3.0	0.0
Total Administrative FTEs	**417.3**	**438.5**	**(21.2)**

Clinical FTEs	FY24 Q2 Forecast	FY24 Budget	Increase/ Decrease
Clinical Vacancy	(12.2)	(12.2)	0.1
Quality Analytics	4.0	4.0	0.0
Utilization Management	84.9	79.9	5.0
Case/Disease Management	55.0	57.0	(2.0)
Medical Services	5.0	5.0	0.0
Quality Management	38.0	38.0	0.0
HCS Behavioral Health	21.0	20.0	1.0
Pharmacy Services	9.2	9.2	0.0
Regulatory Readiness	4.0	4.0	0.0
Total Clinical FTEs	**208.9**	**204.8**	**4.1**

Total FTEs	**626.3**	**643.4**	**(17.2)**

**FTE = Full-Time Equivalent Personnel working approximately 2,080 hours per year. Includes Temporary Employees.*

ALAMEDA Alliance FOR HEALTH

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

Finance

Gil Riojas

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

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

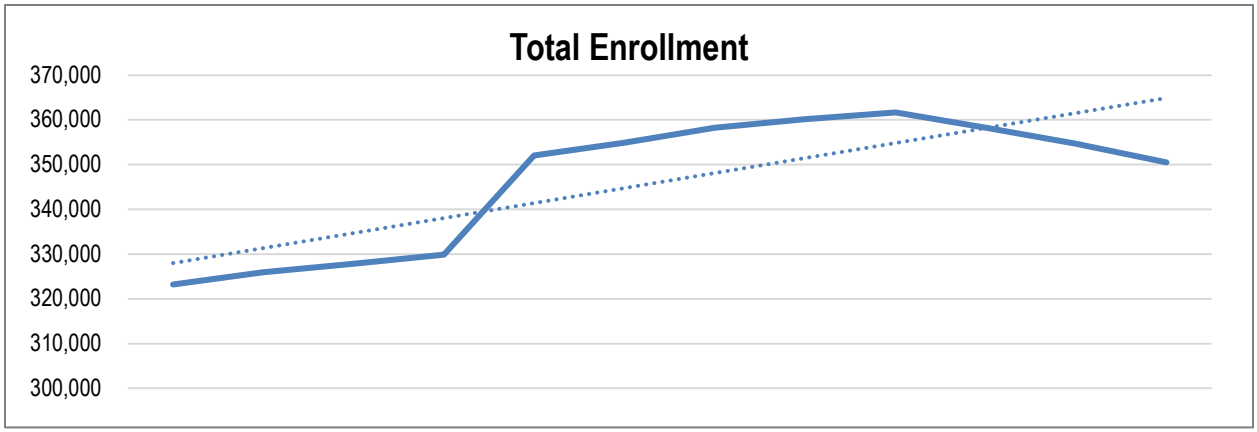
Date: **March 8th, 2024**

Subject: **Finance Report –September 2023 Financials**

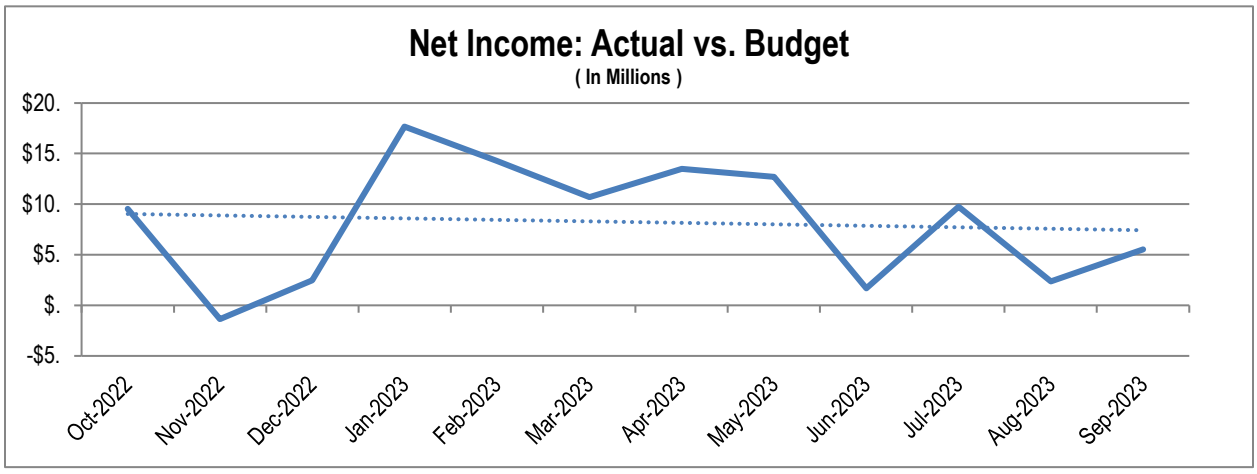
Executive Summary

For the month ended September 30th, 2023, the Alliance continued a decrease in enrollment related to redetermination efforts. Enrollment decreased by 4,123 members to 350,548 members. Net Income of $5.5 million was reported in September. The Plan's medical expenses represented 92.0% of revenue. Alliance reserves increased to 737% of required and remain well above minimum requirements.

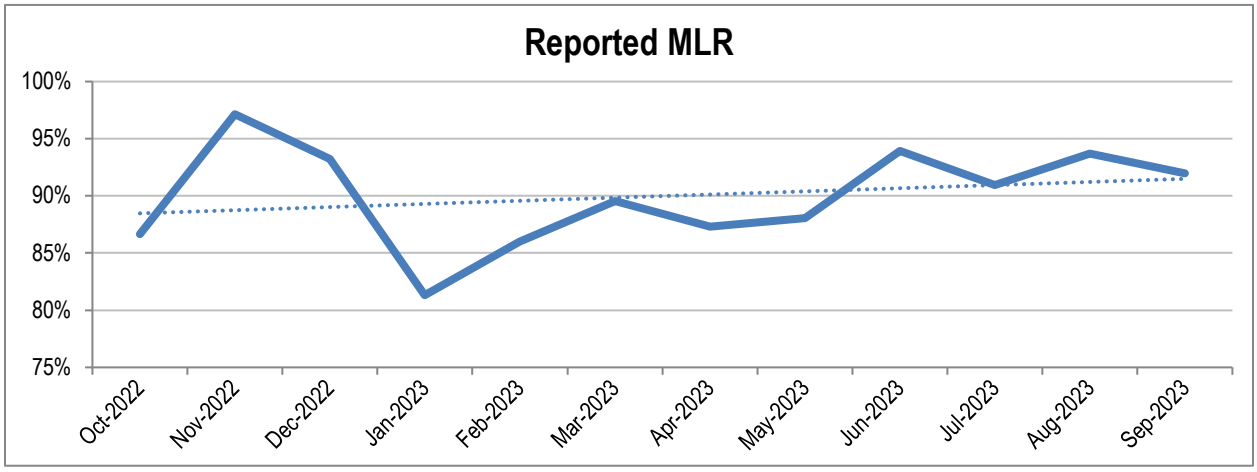
Enrollment – Enrollment continues to decline. In September, enrollment fell by 4,123 members due to redetermination. We anticipate an increase in enrollment in October as Anthem can no longer enroll members.



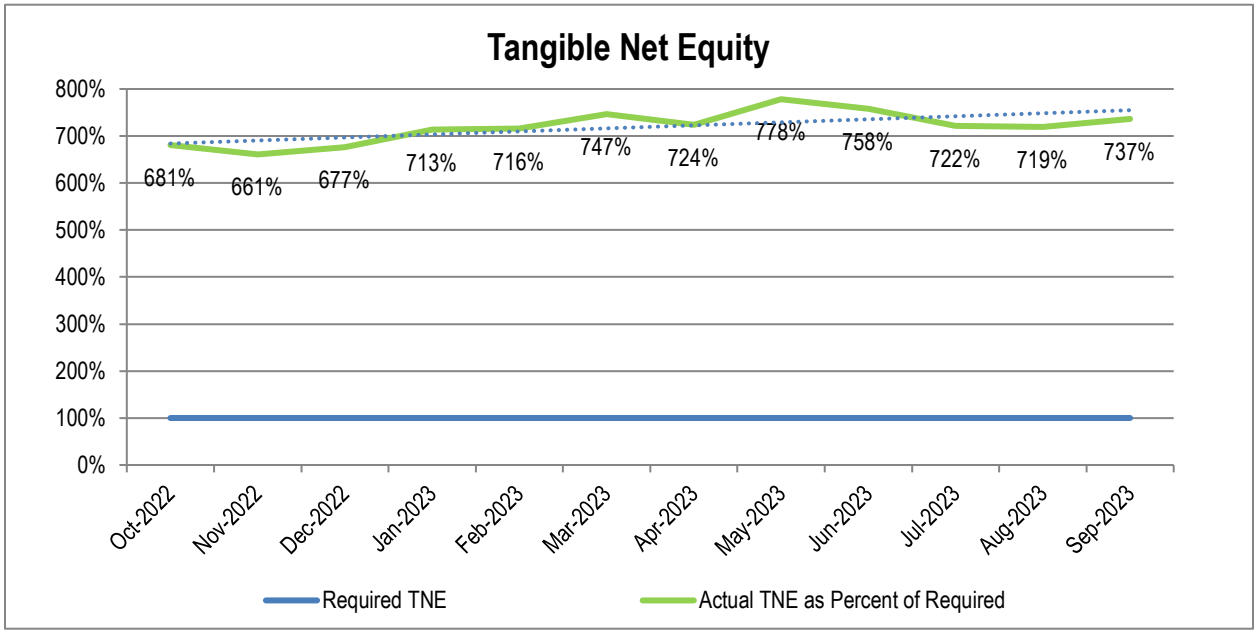
Net Income - For the month ended September 30th, 2023, actual Net Income was $5.5 million vs. budgeted Net Income of $843,000. Fiscal year-to-date actual Net Income was $17.6 million vs. Budgeted Net Loss of $41,000.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 92.0% for the month and 92.2% for the fiscal year-to-date. MLR percentages above 95% may result in net losses for the plan.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $46.4M in reserves, we reported $341.6M. We had our first increase after seeing three months of slight decreases in reserves.



The Alliance continues to benefit from increased non-operating income. For September we reported returns of $1.6M, and year-to-date $6.6M, in the investment portfolio.

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

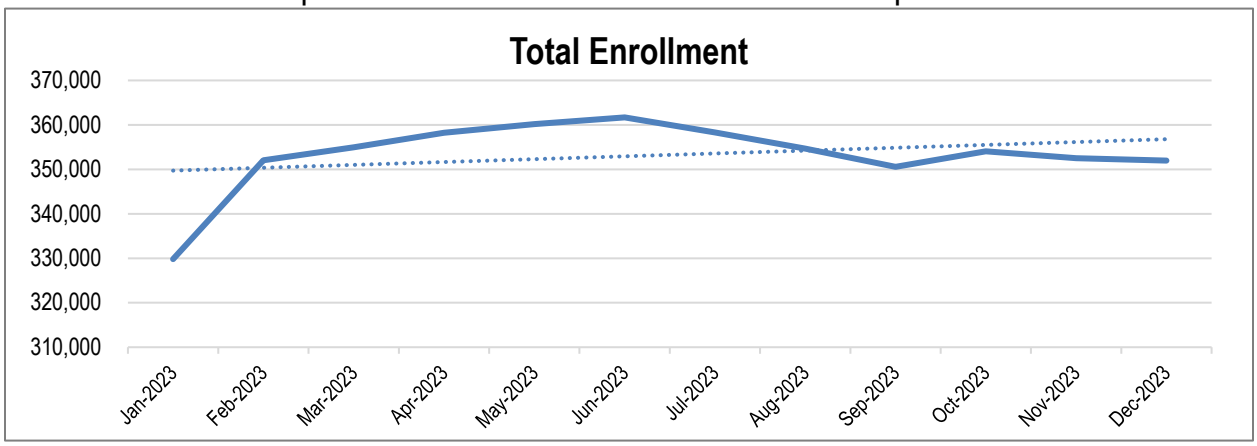
From: **Gil Riojas, Chief Financial Officer**

Date: **March 8th, 2024**

Subject: **Finance Report – December 2023 Financials**

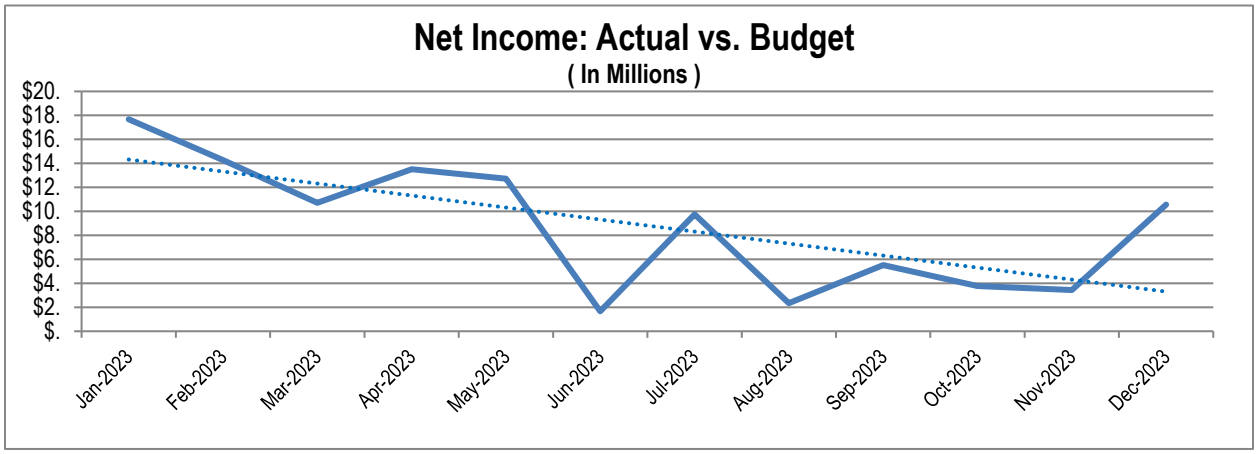
Executive Summary

For the month ended December 31st, 2023, the Alliance experienced a decrease in enrollment due to ongoing redetermination efforts. Enrollment decreased by 546 members since November 2023, to 351,980 members. Net Income of $10.6 million was reported in December. The Plan's December medical expenses represented 90.4% of revenue. Alliance reserves increased to 724% of required and remain well above minimum requirements.



Enrollment – In December, enrollment decreased slightly by 546 members. DHCS is no longer assigning new members to Anthem, so all new members are Alliance members, which continues to help offset continued redetermination disenrollments.

Net Income – For the month ended December 31st, 2023, actual Net Income was $10.6 million vs. budgeted Net Loss of $3.4 million. Fiscal year-to-date actual Net Income was $35.4 million vs. Budgeted Net Income of $17.0 million. The favorable variance of $13.9 million in the current month is due to higher than anticipated Revenue, higher than anticipated Other Income/Expense, and lower than anticipated Medical and Administrative Expenses.



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

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

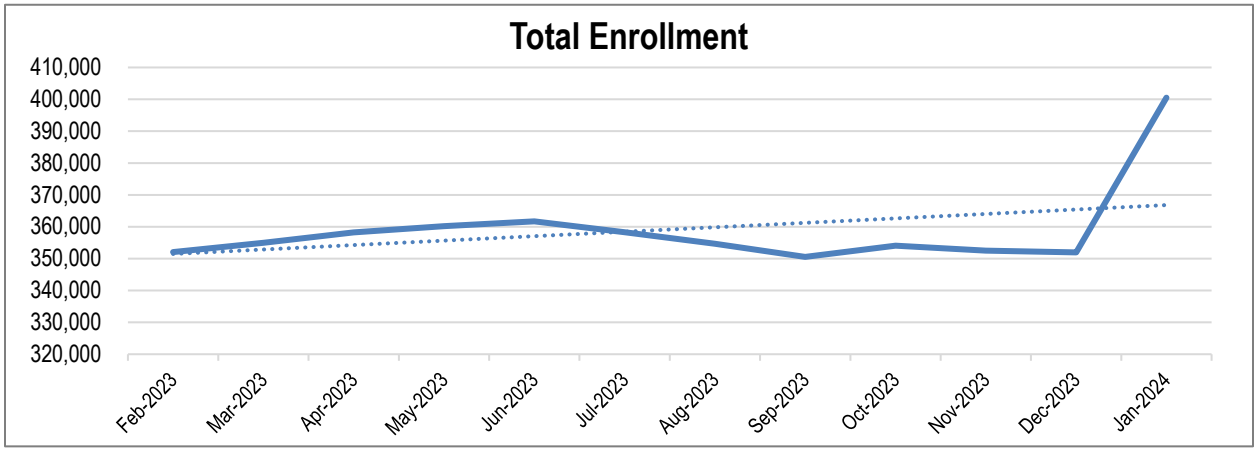
Date: **March 8th, 2024**

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

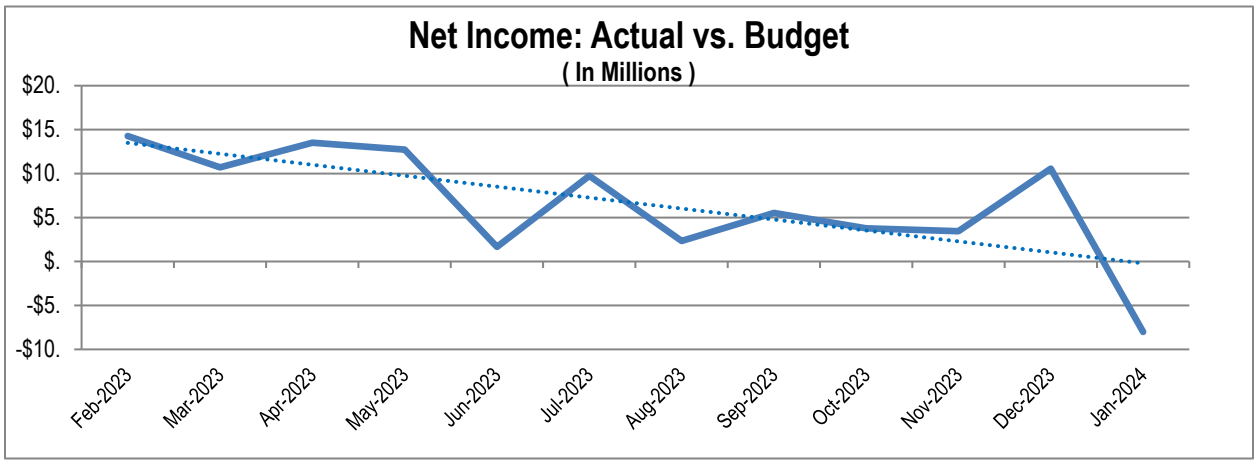
Executive Summary

For the month ended January 31st, 2024, the Alliance experienced a significant increase in enrollment and now reports over 400K members. Net Loss of $8.0 million was reported in January. The Plan's January medical expenses represented 101.2% of revenue. Alliance reserves decreased to 612% of required and remain well above minimum requirements.

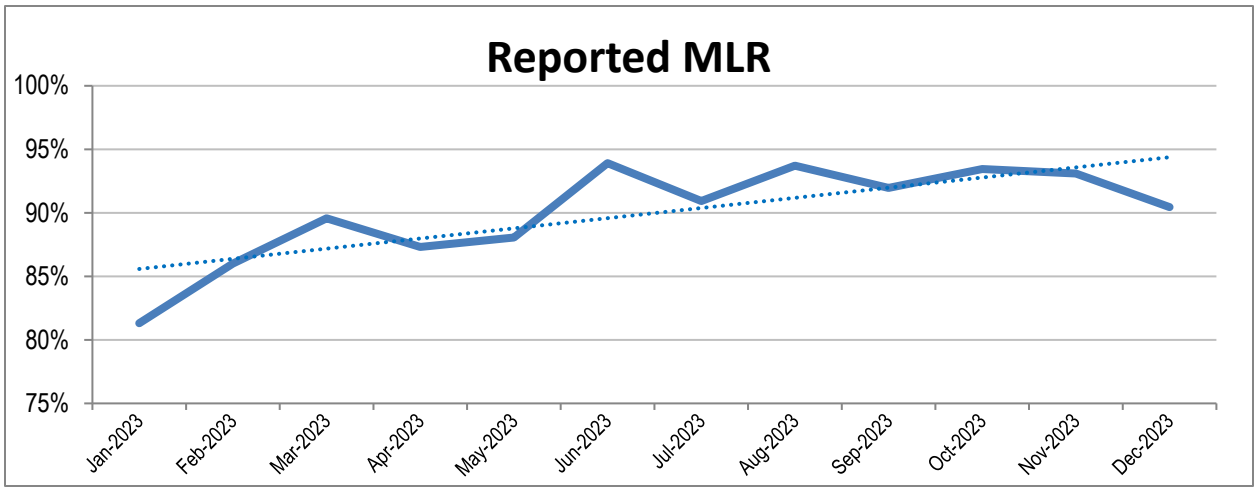
Enrollment – In January, Enrollment increased by 48,538 members primarily due to the transition to Single Plan Model and the expansion of full-scope Medi-Cal to residents 26-49 regardless of immigration status. This increase was slightly offset by Kaiser's transition to a direct contract with the State.



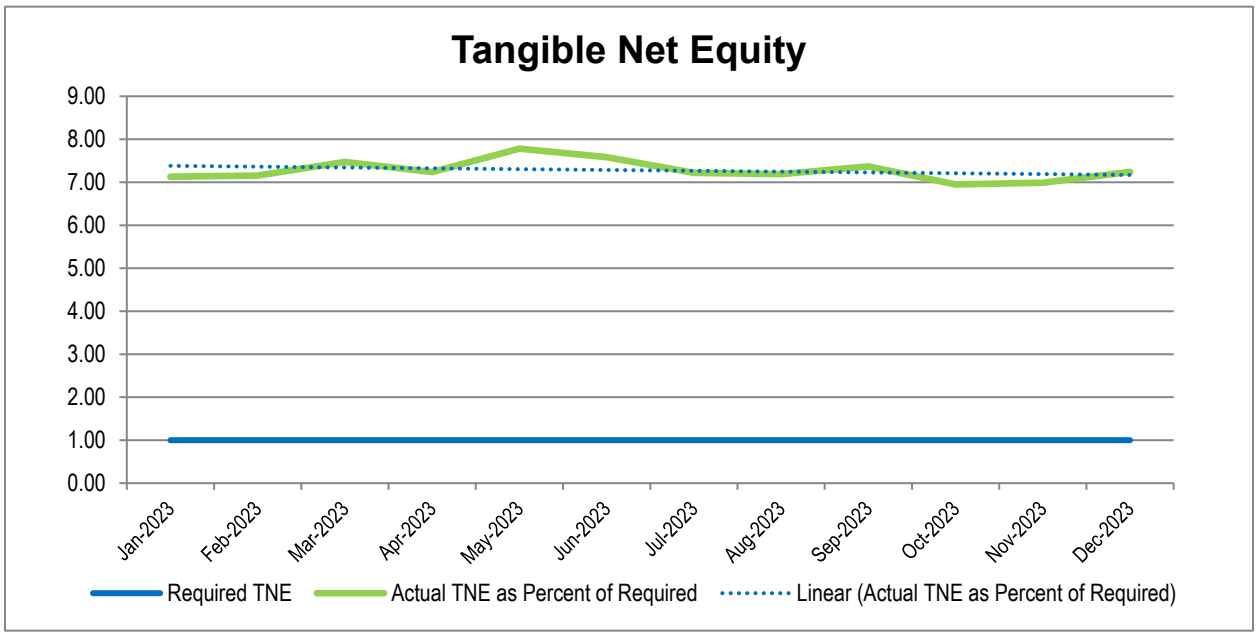
Net Income – For the month ended January 31st, 2024, actual Net Loss was $8.0 million vs. budgeted Net Loss of $316k. Fiscal year-to-date actual Net Income was $27.4 million vs. Budgeted Net Income of $16.7 million. The unfavorable IBNP impact of $10.6 million for prior period medical expenses led to unfavorable Medical Expense variance of $7.9 million. This was slightly offset by higher than anticipated Revenue.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 90.4% for the month and 92.3% for the fiscal year-to-date. MLR percentages above 95% may result in net losses for the plan.

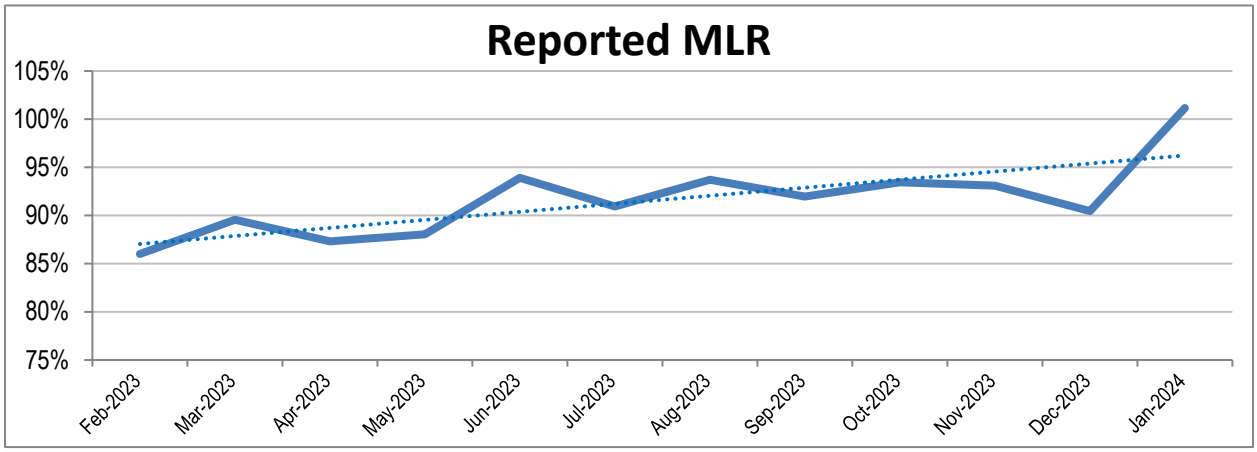


Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $49.6M in reserves, we reported $359.3M. Our overall TNE remains healthy at 724%.

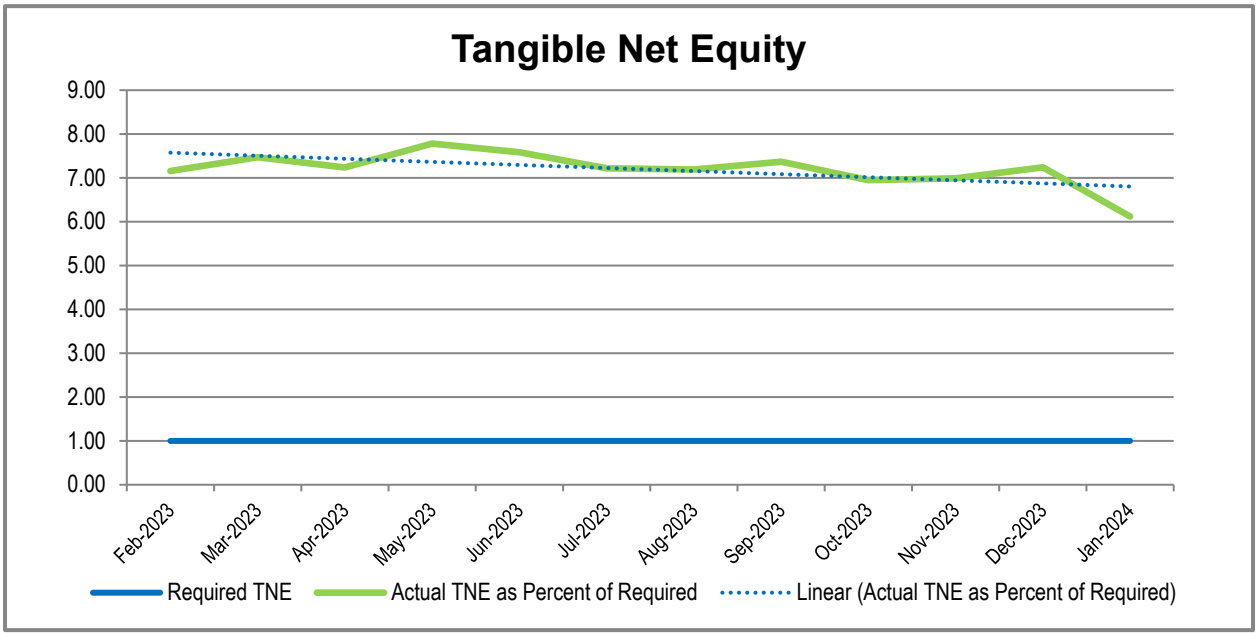


The Alliance continues to benefit from increased non-operating income. For December we reported returns of just over $4.7M, and year-to-date $16.8M, in the investment portfolio.

Medical Loss Ratio (MLR) – The Medical Loss Ratio was 101.2% for the month and 93.8% for the fiscal year-to-date. MLR percentages above 95% may result in net losses for the plan.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $57.4M in reserves, we reported $351.3M. Our overall TNE remains healthy at 612%.



The Alliance continues to benefit from increased non-operating income. For January we reported returns of $2.3M, and year-to-date $19.1M, in the investment portfolio.

Finance

Supporting Documents

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

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

Date: **March 8th, 2024**

Subject: **Finance Report – September 2023**

Executive Summary

- For the month ended September 30th, 2023, the Alliance had enrollment of 350,548 members, a Net Income of $5.5 million and 737% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$137,393	$414,488
Medical Expense	126,354	382,168
Admin. Expense	7,059	21,161
Other Inc. / (Exp.)	1,534	6,445
Net Income	**$5,514**	**$17,605**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	$5,769	$16,834
Group Care	(255)	771
	$5,514	**$17,605**

*Includes consulting cost for Medicare implementation.

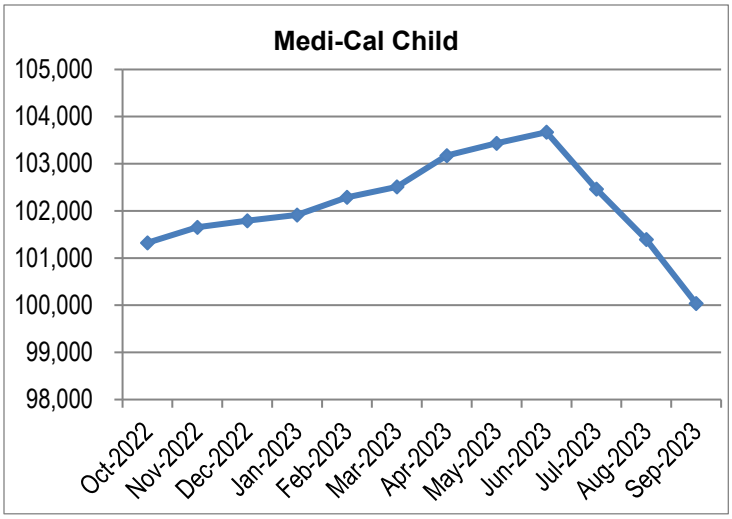
Enrollment

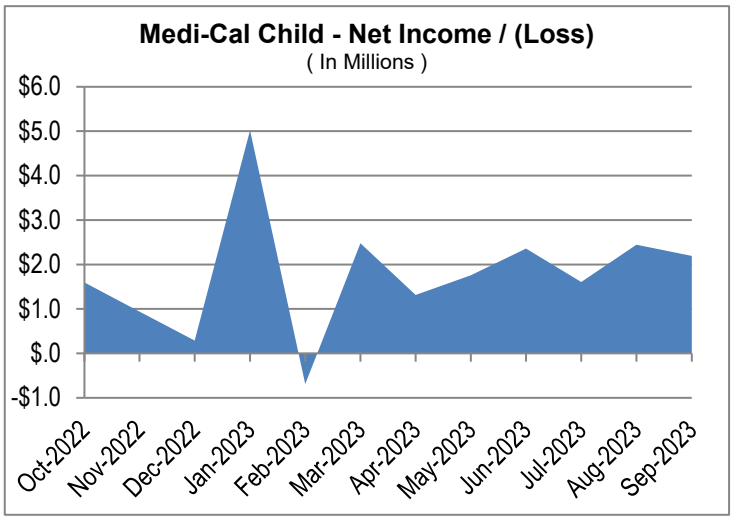
- Total enrollment decreased by 4,123 members since August 2023.
- Total enrollment decreased by 11,137 members since June 2023.

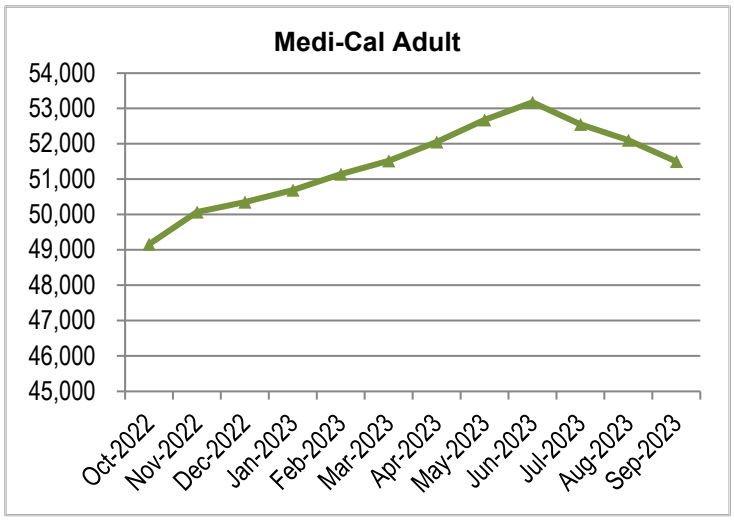
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

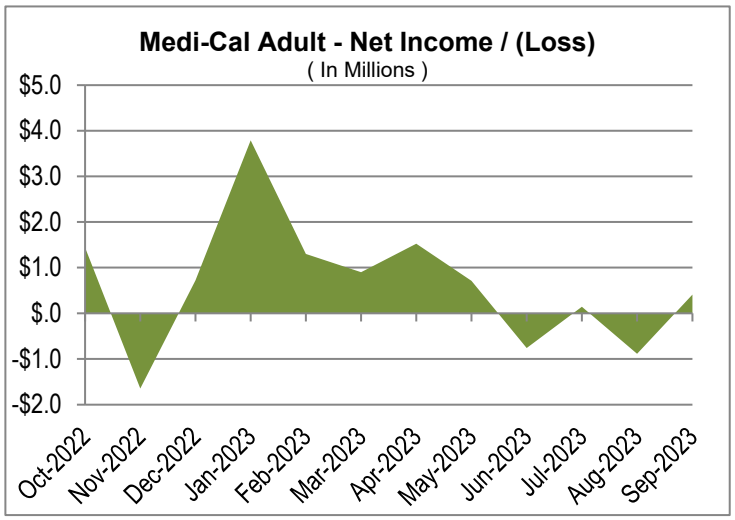
Enrollment					Member Months			
September 2023					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
51,499	49,772	1,727	3.5%	Adult	156,151	152,327	3,824	2.5%
100,038	102,632	(2,594)	-2.5%	Child	303,894	309,264	(5,370)	-1.7%
30,592	31,371	(779)	-2.5%	SPD	92,487	94,059	(1,572)	-1.7%
41,629	42,304	(675)	-1.6%	Duals	125,032	126,912	(1,880)	-1.5%
120,016	117,258	2,758	2.4%	ACA OE	365,542	360,610	4,932	1.4%
139	145	(6)	-4.1%	LTC	418	435	(17)	-3.9%
1,004	983	21	2.1%	LTC Duals	3,056	2,949	107	3.6%
344,917	**344,465**	**452**	**0.1%**	**Medi-Cal Total**	**1,046,580**	**1,046,556**	**24**	**0.0%**
5,631	5,669	(38)	-0.7%	Group Care	16,945	17,007	(62)	-0.4%
350,548	**350,134**	**414**	**0.1%**	**Total**	**1,063,525**	**1,063,563**	**(38)**	**0.0%**

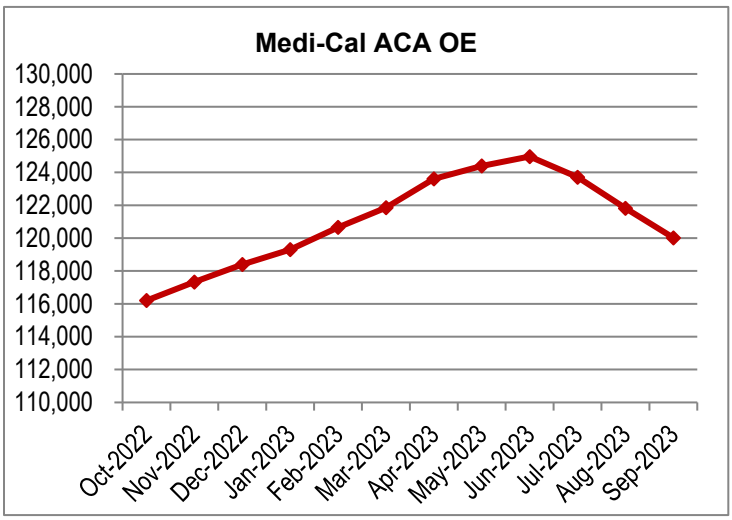
Enrollment and Profitability by Program and Category of Aid

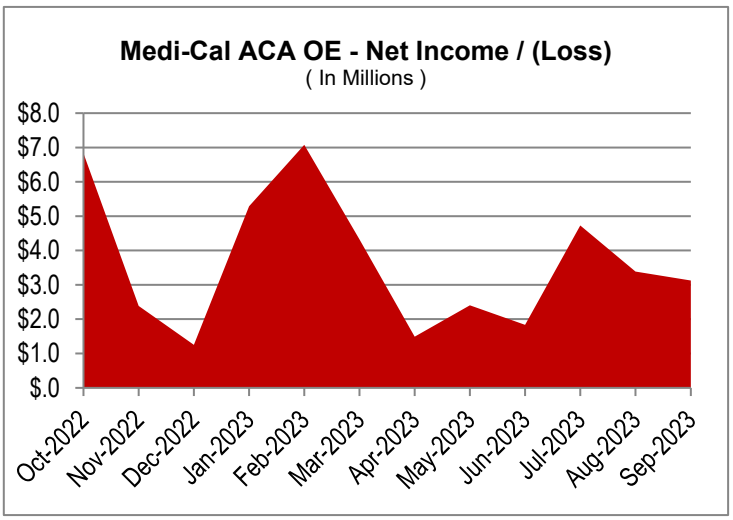




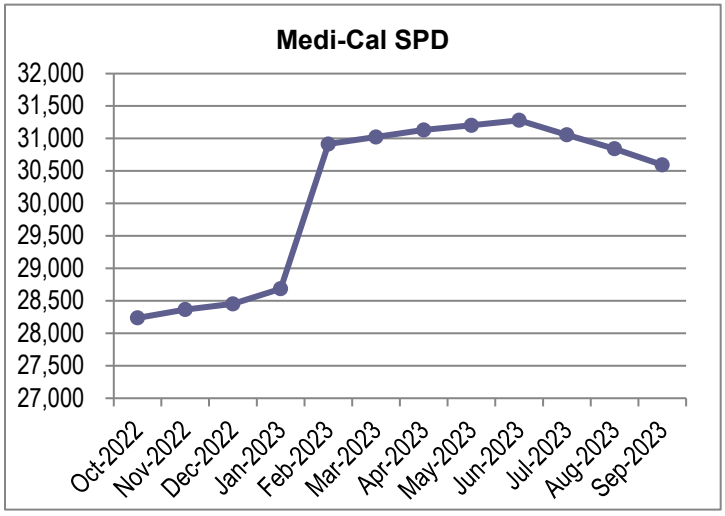


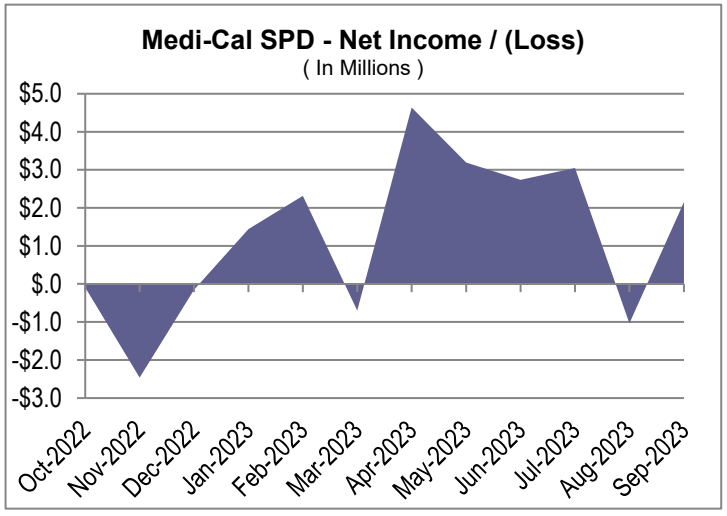


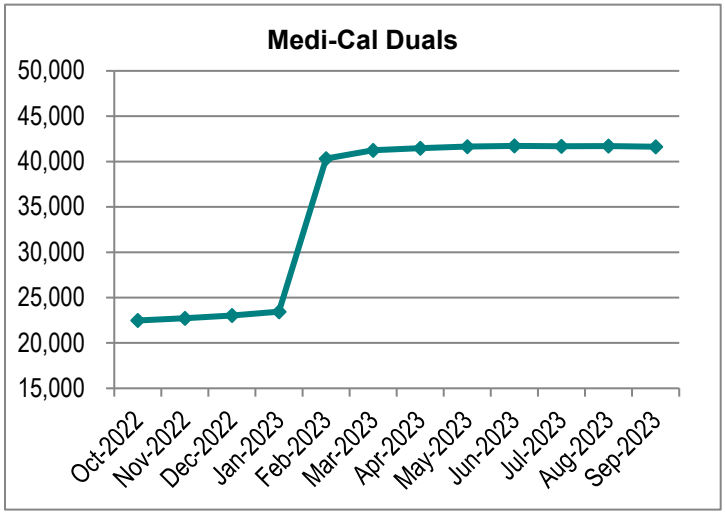


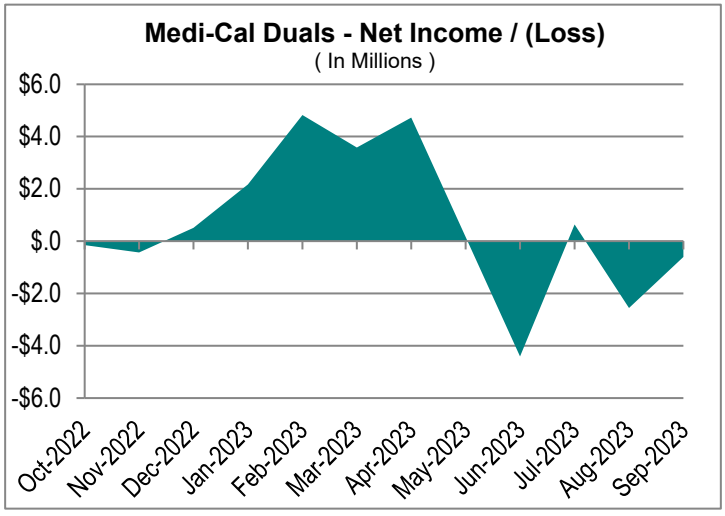


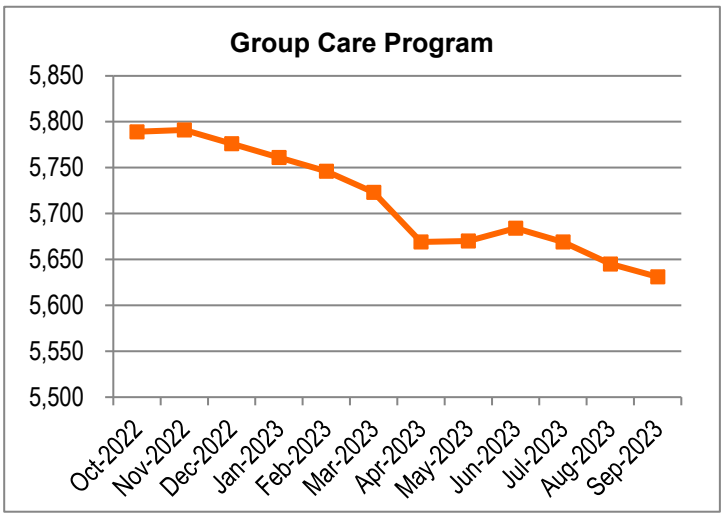
Enrollment and Profitability by Program and Category of Aid

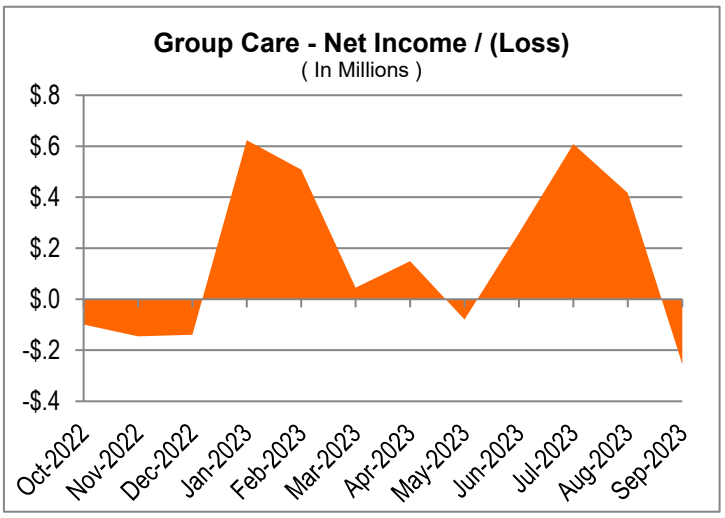




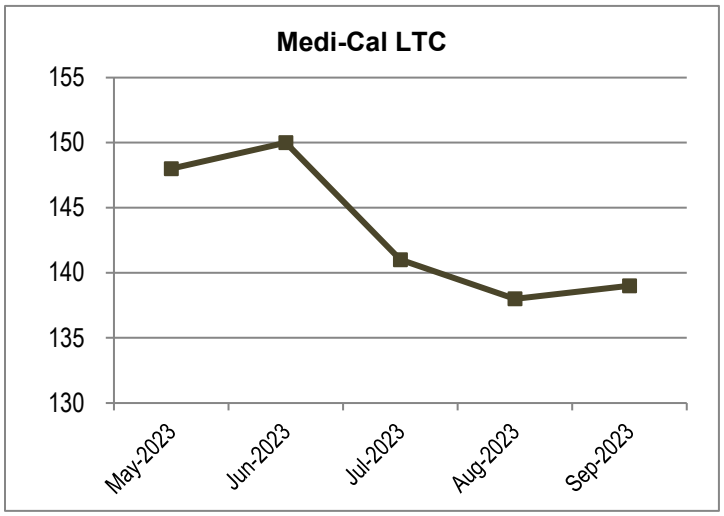


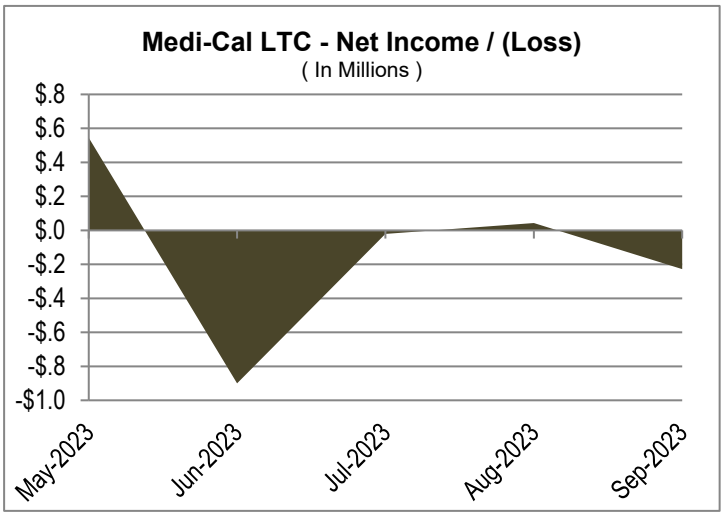


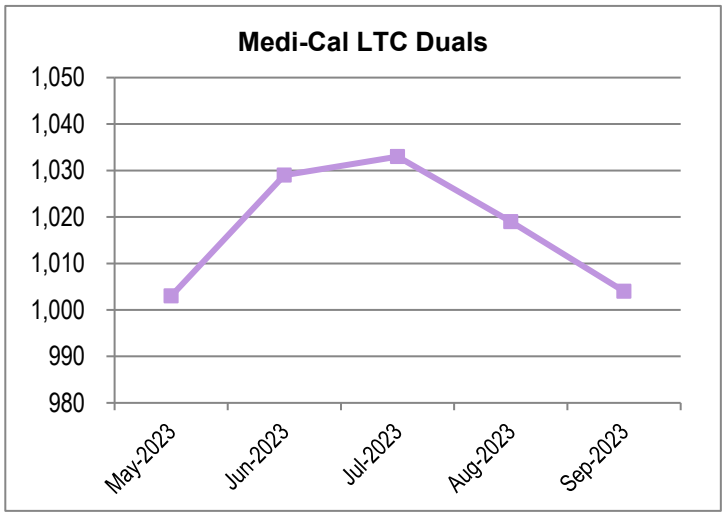


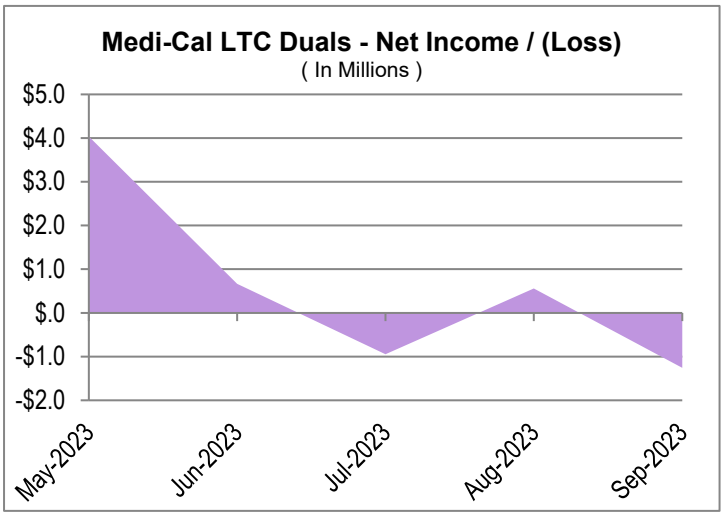


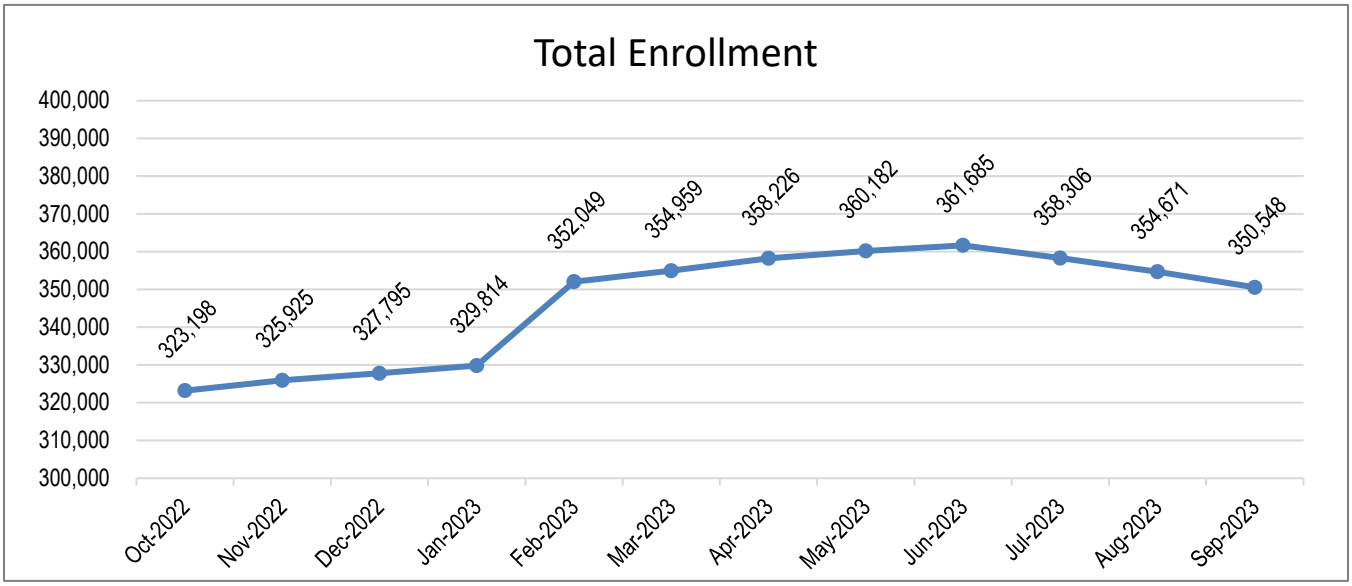
Enrollment and Profitability by Program and Category of Aid

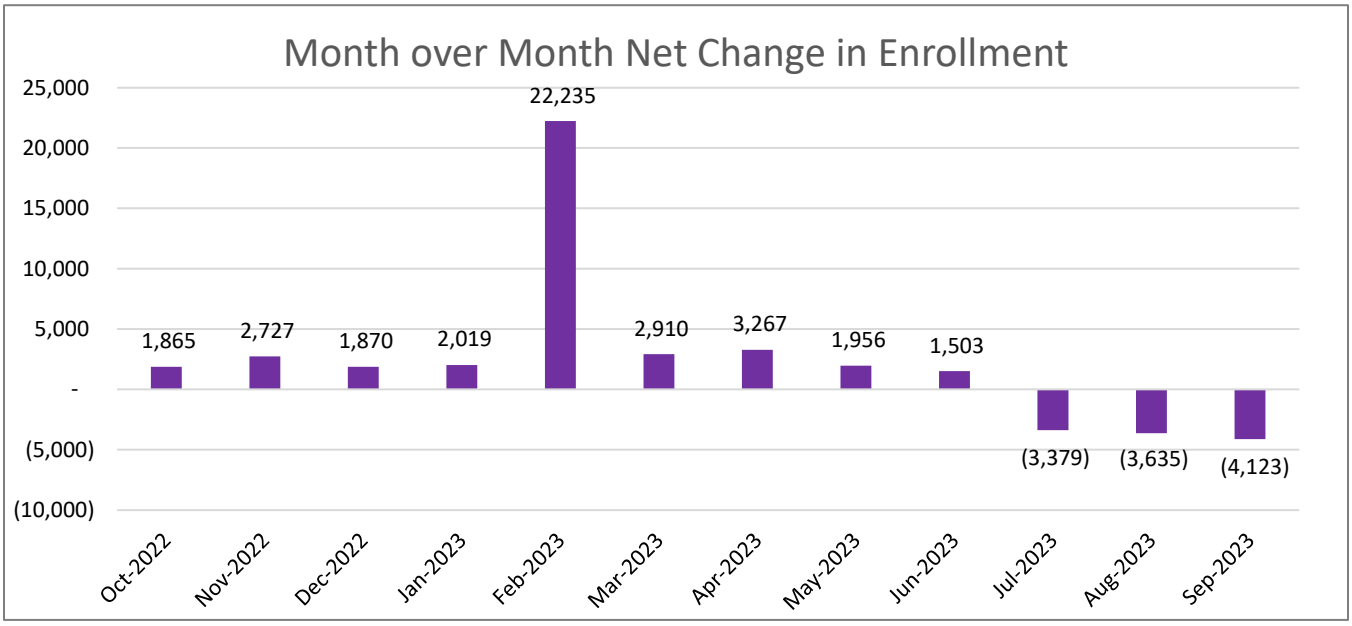










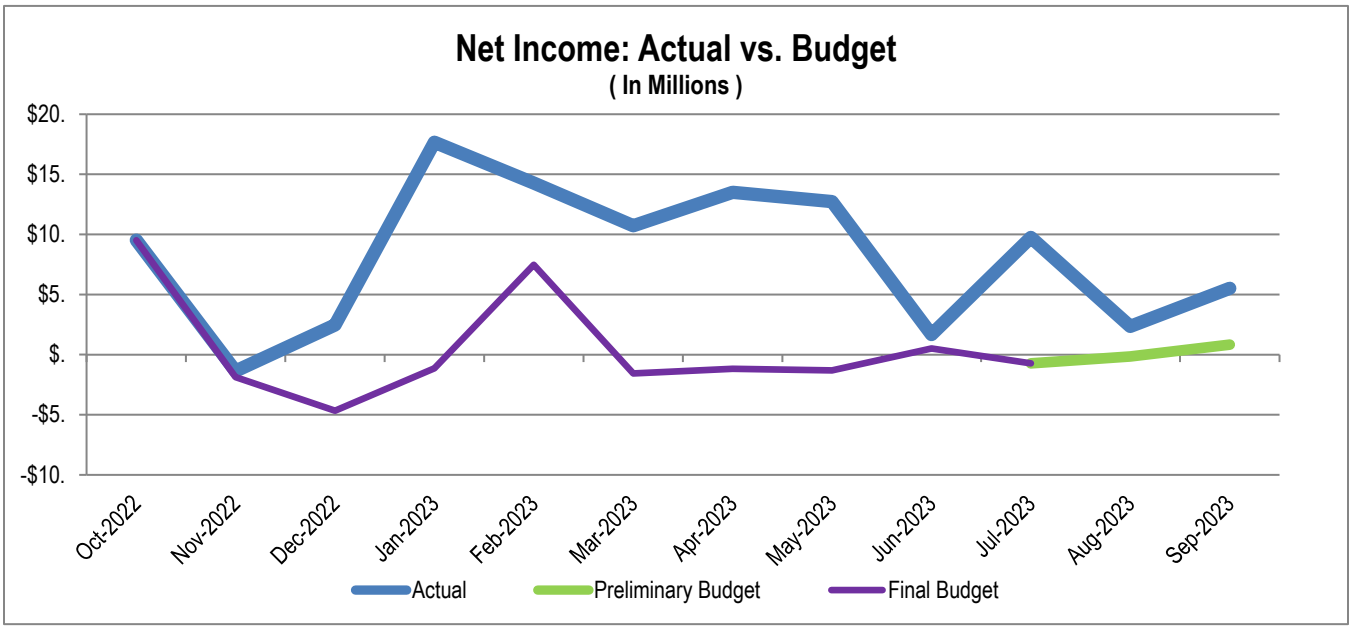


- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started in July 2023.

Net Income

- For the month ended September 30th, 2023
  - Actual Net Income $5.5 million.
  - Budgeted Net Income $843,000.

- For the fiscal YTD ended September 30th, 2023
  - Actual Net Income $17.6 million.
  - Budgeted Net Loss $41,000.

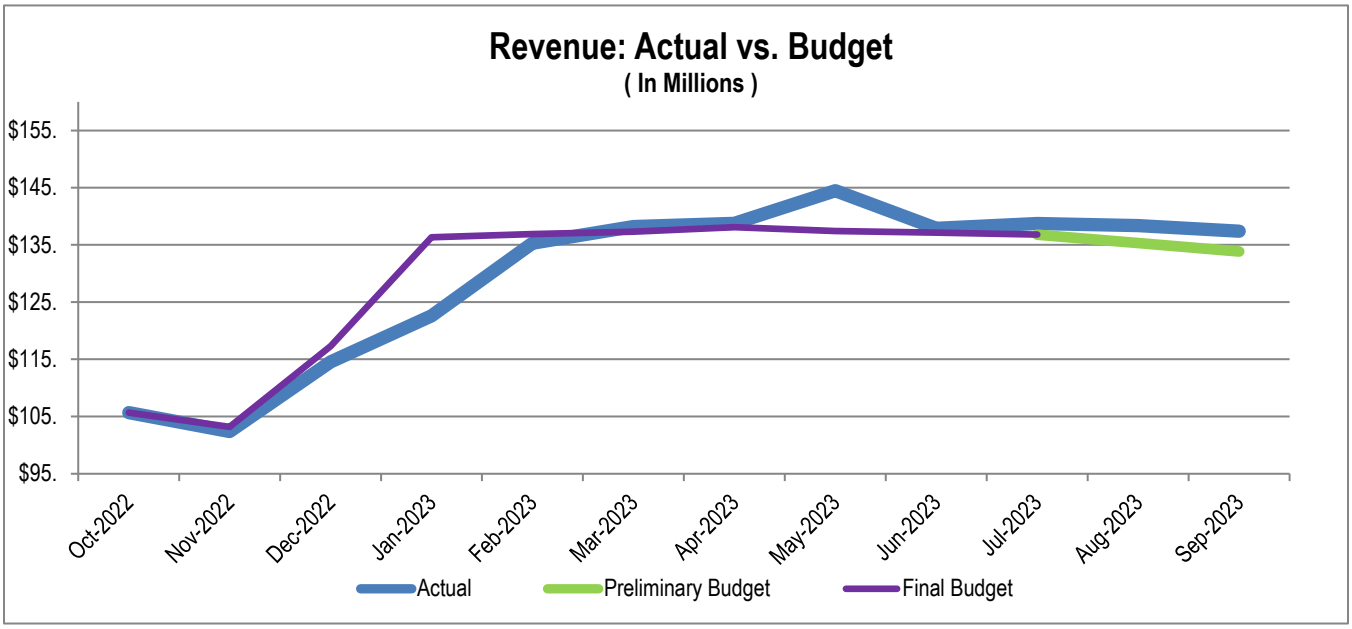


- The favorable variance of $4.7 million in the current month is primarily due to:
  - Favorable $3.5 million higher than anticipated Revenue.
  - Favorable $1.2 million lower than anticipated Administrative Expense.
  - Favorable $764,000 higher than anticipated Total Other Income/Expense
  - Unfavorable $822,000 higher than anticipated Medical Expense.

Revenue

- For the month ended September 30th, 2023
  - Actual Revenue: $137.4 million.
  - Budgeted Revenue: $133.8 million.

- For the fiscal YTD ended September 30th, 2023
  - Actual Revenue: $414.5 million.
  - Budgeted Revenue: $406.0 million.

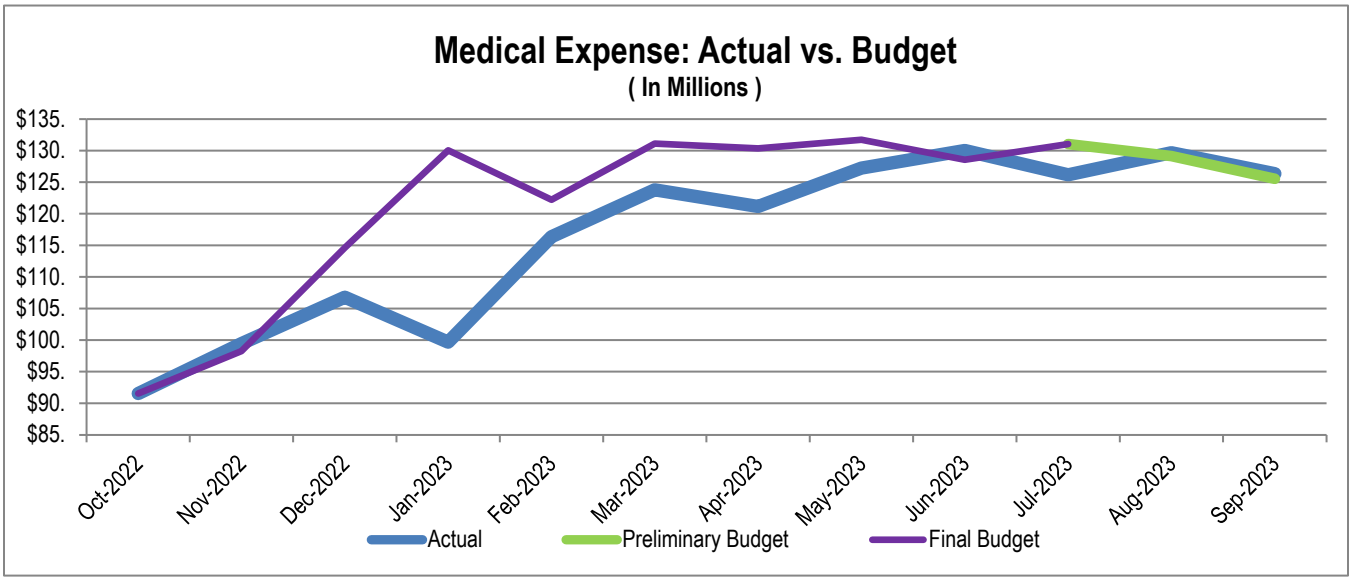


- For the month ended September 30th, 2023, the favorable revenue variance of $3.5 million is primarily due to timing of revenue recognition:
  - Favorable $2.1 million CalAIM Incentive Program revenue (IPP, HHIP, and SBHIP). The majority of this revenue has corresponding CalAIM Incentive expenses.
  - Favorable $733,000 capitation revenue due to higher proportion of members with higher rates and enrollment variance.

Medical Expense

- For the month ended September 30th, 2023
  - Actual Medical Expense: $126.4 million.
  - Budgeted Medical Expense: $125.5 million.
- For the fiscal YTD ended September 30th, 2023

- Actual Medical Expense: $382.2 million.
- Budgeted Medical Expense: $385.7 million.



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

- For September, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $791,000. Year to date, the estimate for prior years increased by $7.7 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)
Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$77,504,232	$0	$77,504,232	$78,953,770	$1,449,538	1.8%
Primary Care FFS	$16,731,723	$31,469	$16,763,192	$15,564,319	($1,167,404)	-7.5%
Specialty Care FFS	$15,666,342	($506,614)	$15,159,728	$16,717,671	$1,051,329	6.3%
Outpatient FFS	$23,717,397	$781,842	$24,499,239	$25,135,739	$1,418,342	5.6%
Ancillary FFS	$30,986,839	$1,945,058	$32,931,897	$36,315,646	$5,328,807	14.7%
Pharmacy FFS	$25,484,601	($419,576)	$25,065,025	$26,762,502	$1,277,901	4.8%
ER Services FFS	$16,676,729	$328,538	$17,005,266	$18,122,800	$1,446,072	8.0%
Inpatient Hospital & SNF FFS	$92,606,790	$6,168,620	$98,775,409	$105,449,967	$12,843,177	12.2%
Long Term Care FFS	$59,819,949	($675,597)	$59,144,352	$46,518,592	($13,301,357)	-28.6%
Other Benefits & Services	$13,700,412	$0	$13,700,412	$15,345,256	$1,644,844	10.7%
Net Reinsurance	$619,196	$0	$619,196	$800,776	$181,580	22.7%
Provider Incentive	$1,000,000	$0	$1,000,000	$0	($1,000,000)	-
	$374,514,211	**$7,653,740**	**$382,167,951**	**$385,687,039**	**$11,172,829**	**2.9%**

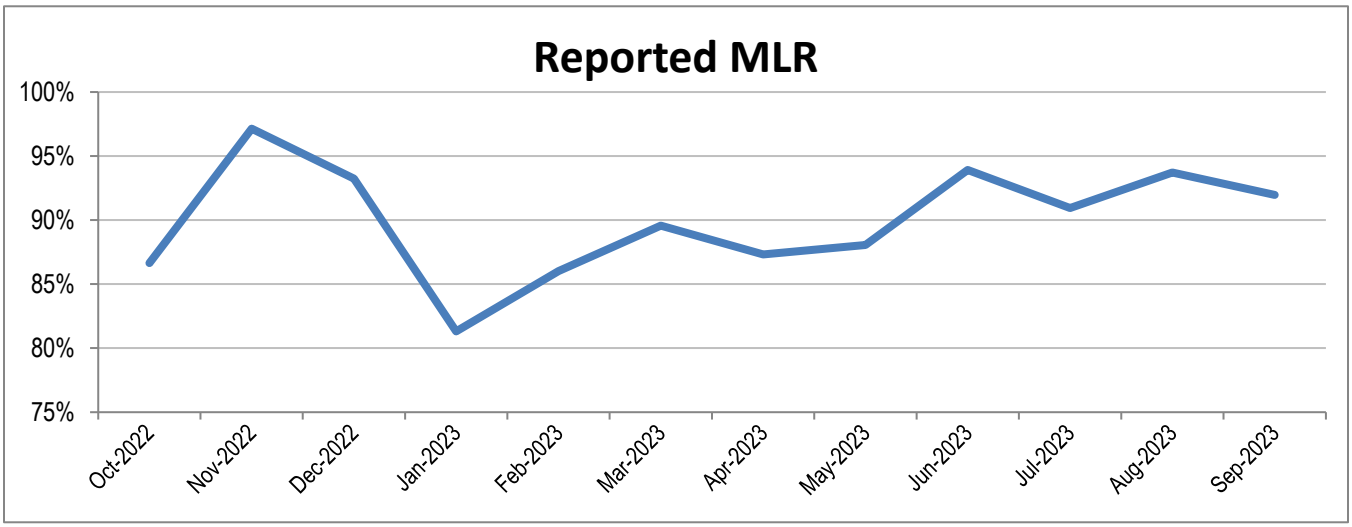
Medical Expense - Actual vs. Budget (Per Member Per Month) Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$72.87	$0.00	$72.87	$74.24	$1.36	1.8%
Primary Care FFS	$15.73	$0.03	$15.76	$14.63	($1.10)	-7.5%
Specialty Care FFS	$14.73	($0.48)	$14.25	$15.72	$0.99	6.3%
Outpatient FFS	$22.30	$0.74	$23.04	$23.63	$1.33	5.6%
Ancillary FFS	$29.14	$1.83	$30.96	$34.15	$5.01	14.7%
Pharmacy FFS	$23.96	($0.39)	$23.57	$25.16	$1.20	4.8%
ER Services FFS	$15.68	$0.31	$15.99	$17.04	$1.36	8.0%
Inpatient Hospital & SNF FFS	$87.08	$5.80	$92.88	$99.15	$12.07	12.2%
Long Term Care FFS	$56.25	($0.64)	$55.61	$43.74	($12.51)	-28.6%
Other Benefits & Services	$12.88	$0.00	$12.88	$14.43	$1.55	10.7%
Net Reinsurance	$0.58	$0.00	$0.58	$0.75	$0.17	22.7%
Provider Incentive	$0.94	$0.00	$0.94	$0.00	($0.94)	-
	$352.14	**$7.20**	**$359.34**	**$362.64**	**$10.49**	**2.9%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $11.2 million favorable to budget. On a PMPM basis, medical expense is 2.9% favorable to budget. For per-member-per-month expense:
    - Capitated Expense is slightly under budget, largely driven by favorable FQHC expense.
    - Primary Care Expense unfavorable compared to budget across all populations except for Duals, driven generally by unfavorable unit cost.
    - Specialty Care expenses are below budget, driven by favorable Dual population utilization.
    - Outpatient Expense is under budget, generally due to favorable dialysis utilization and facility other unit cost in the Dual category of aid.
    - Ancillary Expense is under budget mostly due to favorable unit cost in the SPD, ACA OE and Dual populations.
    - Pharmacy Expense is under budget, mostly due to favorable Non-PBM expense, driven by favorable utilization in the Adult, ACA OE and Dual populations.
    - Emergency Room Expense is under budget, driven by favorable unit cost in the SPD, ACA OE, Child and Dual populations.
    - Inpatient Expense is under budget, mostly driven by favorable utilization in the SPD, ACA OE, LTC Duals, Child and Duals populations offset by unfavorable utilization and unit cost in the Adult population.
    - Long Term Care expense is over budget, mostly due to unfavorable utilization in the ACA OE COA and unfavorable SPD, Dual and LTC Dual unit cost.
    - Other Benefits & Services is under budget, due to favorable Cal AIM Incentive, community relations and other purchased services expense.

- Net Reinsurance year-to-date is favorable because more recoveries were received than budgeted.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 92.0% for the month and 92.2% for the fiscal year-to-date.



Administrative Expense

- For the month ended September 30th, 2023
  - Actual Administrative Expense: $7.1 million.
  - Budgeted Administrative Expense: $8.2 million.

- For the fiscal YTD ended September 30th, 2023
  - Actual Administrative Expense: $21.2 million.
  - Budgeted Administrative Expense: $22.6 million.

Summary of Administrative Expense (In Dollars)
For the Month and Fiscal Year-to-Date
Favorable/(Unfavorable)

Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$4,359,631	$4,400,692	$41,061	0.9%	Employee Expense	$13,325,693	$12,723,756	($601,937)	-4.7%
64,368	51,767	(12,601)	-24.3%	Medical Benefits Admin Expense	1,002,822	156,419	(846,404)	-541.1%
838,472	1,584,597	746,126	47.1%	Purchased & Professional Services	2,846,607	4,416,036	1,569,429	35.5%
1,796,967	2,204,806	407,839	18.5%	Other Admin Expense	3,985,804	5,345,989	1,360,185	25.4%
$7,059,439	$8,241,863	$1,182,424	14.3%	Total Administrative Expense	$21,160,926	$22,642,199	$1,481,273	6.5%

The year-to-date variances include:

- Delayed timing of start dates for Consulting for new projects and Computer Support Services.
- Delays in annual renewals of various administrative licenses.

The Administrative Loss Ratio (ALR) is 5.1% of net revenue for the month and 5.1% of net revenue year-to-date.

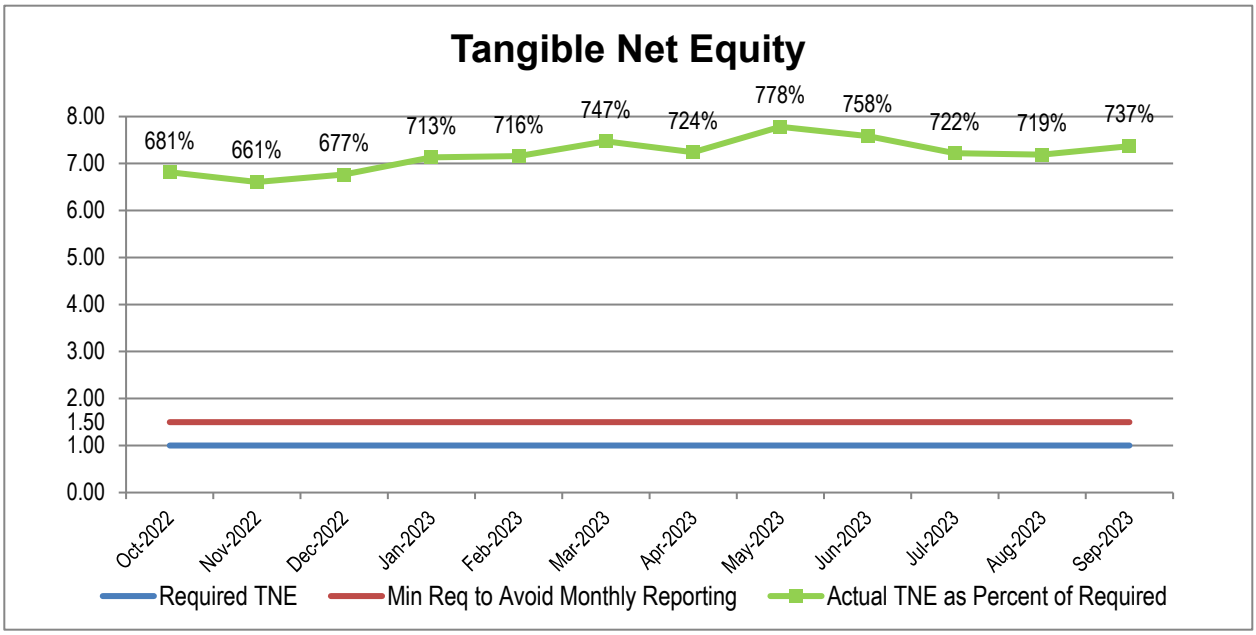
Other Income / (Expense)

Other Income & Expense is comprised of investment income and claims interest.

- Fiscal year-to-date net investments show a gain of $6.6 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $177,000.

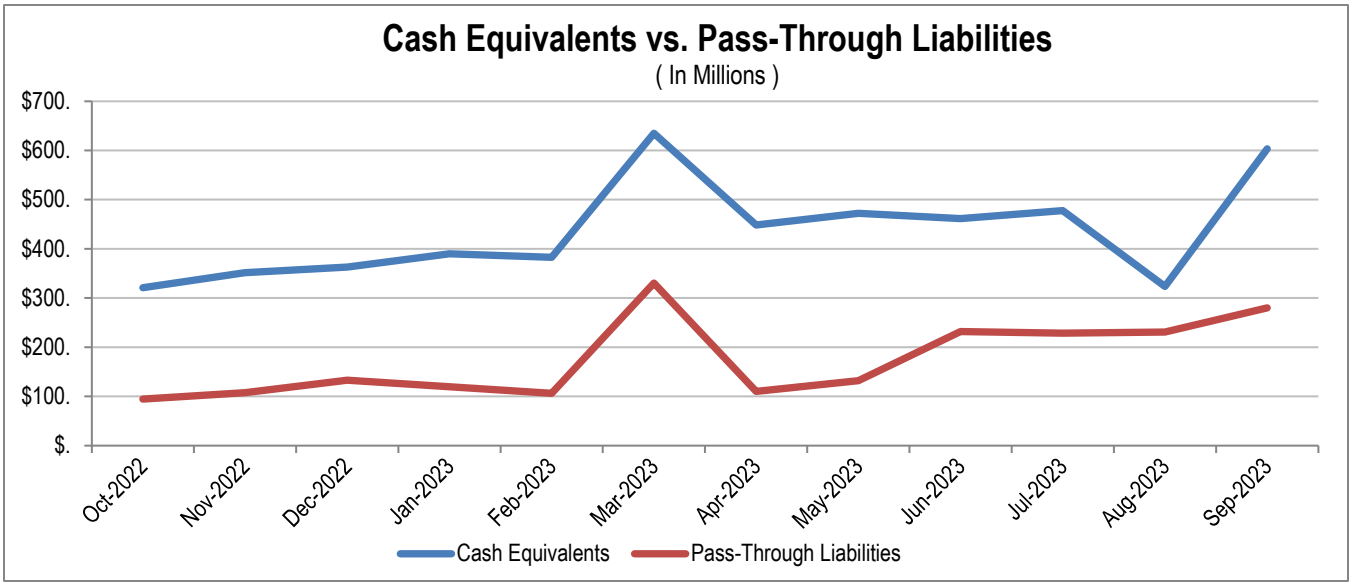
Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to consumers. TNE is a calculation of a company's total tangible assets minus the company's total liabilities. The Alliance exceeds DMHC's required TNE.
    - Required TNE $46.4 million
    - Actual TNE $341.6 million
    - Excess TNE $295.2 million
    - TNE % of Required TNE 737%



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

- Key Metrics
  - Cash & Cash Equivalents $603.2 million
  - Pass-Through Liabilities $280.0 million
  - Uncommitted Cash $323.2 million
  - Working Capital $325.2 million
  - Current Ratio 1.64 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $559,000
- Annual capital budget: $1.5 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.

ALAMEDA ALLIANCE FOR HEALTH

STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET (MEDICAL EXPENSE BY PAYMENT TYPE)
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED SEPTEMBER 30, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
344,917	344,465	452	0.1%	1 - Medi-Cal	1,046,580	1,046,556	24	0.0%
5,631	5,669	(38)	(0.7%)	2 - GroupCare	16,945	17,007	(62)	(0.4%)
350,548	**350,134**	**414**	**0.1%**	**3 - TOTAL MEMBER MONTHS**	**1,063,525**	**1,063,563**	**(38)**	**0.0%**
				REVENUE				
$137,393,488	**$133,846,030**	**$3,547,458**	**2.7%**	**4 - TOTAL REVENUE**	**$414,488,324**	**$405,978,335**	**$8,509,990**	**2.1%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$25,830,192	$25,968,019	$137,826	0.5%	5 - Capitated Medical Expense	$77,504,232	$78,953,770	$1,449,538	1.8%
				Fee for Service Medical Expenses:				
$29,983,310	$34,059,467	$4,076,158	12.0%	6 - Inpatient Hospital FFS Expense	$98,775,409	$105,449,967	$6,674,558	6.3%
$5,157,344	$5,076,472	($80,871)	(1.6%)	7 - Primary Care Physician FFS Expense	$16,763,192	$15,564,320	($1,198,873)	(7.7%)
$5,321,869	$5,405,449	$83,580	1.5%	8 - Specialty Care Physician Expense	$15,159,728	$16,717,671	$1,557,943	9.3%
$9,497,264	$11,884,177	$2,386,913	20.1%	9 - Ancillary Medical Expense	$32,931,897	$36,315,646	$3,383,748	9.3%
$7,896,295	$8,121,539	$225,243	2.8%	10 - Outpatient Medical Expense	$24,499,239	$25,135,739	$636,500	2.5%
$6,346,241	$5,863,374	($482,868)	(8.2%)	11 - Emergency Expense	$17,005,266	$18,122,800	$1,117,534	6.2%
$9,172,766	$8,662,001	($510,766)	(5.9%)	12 - Pharmacy Expense	$25,065,025	$26,762,502	$1,697,477	6.3%
$20,836,998	$15,362,577	($5,474,421)	(35.6%)	13 - Long Term Care FFS Expense	$59,144,352	$46,518,592	($12,625,760)	(27.1%)
$94,212,087	$94,435,056	$222,969	0.2%	14 - Total Fee for Service Expense	$289,344,110	$290,587,238	$1,243,128	0.4%
$5,122,794	$4,864,427	($258,367)	(5.3%)	15 - Other Benefits & Services	$13,700,412	$15,345,255	$1,644,843	10.7%
$188,506	$263,805	$75,298	28.5%	16 - Reinsurance Expense	$619,196	$800,776	$181,580	22.7%
$1,000,000	$0	($1,000,000)	0.0%	17 - Risk Pool Distribution	$1,000,000	$0	($1,000,000)	0.0%
$126,353,580	**$125,531,306**	**($822,273)**	**(0.7%)**	**18 - TOTAL MEDICAL EXPENSES**	**$382,167,951**	**$385,687,039**	**$3,519,088**	**0.9%**
$11,039,908	**$8,314,724**	**$2,725,184**	**32.8%**	**19 - GROSS MARGIN**	**$32,320,374**	**$20,291,296**	**$12,029,078**	**59.3%**
				ADMINISTRATIVE EXPENSES				
$4,359,631	$4,400,692	$41,061	0.9%	20 - Personnel Expense	$13,325,693	$12,723,756	($601,937)	(4.7%)
$64,368	$51,767	($12,601)	(24.3%)	21 - Benefits Administration Expense	$1,002,822	$156,419	($846,404)	(541.1%)
$838,472	$1,584,597	$746,126	47.1%	22 - Purchased & Professional Services	$2,846,607	$4,416,036	$1,569,429	35.5%
$1,796,967	$2,204,806	$407,839	18.5%	23 - Other Administrative Expense	$3,985,804	$5,345,989	$1,360,185	25.4%
$7,059,439	**$8,241,863**	**$1,182,425**	**14.3%**	**24 - TOTAL ADMINISTRATIVE EXPENSES**	**$21,160,926**	**$22,642,199**	**$1,481,273**	**6.5%**
$3,980,470	**$72,861**	**$3,907,609**	**5,363.1%**	**25 - NET OPERATING INCOME / (LOSS)**	**$11,159,448**	**($2,350,904)**	**$13,510,351**	**574.7%**
				OTHER INCOME / EXPENSES				
$1,533,865	**$770,000**	**$763,865**	**99.2%**	**26 - TOTAL OTHER INCOME / (EXPENSES)**	**$6,445,281**	**$2,310,000**	**$4,135,281**	**179.0%**
$5,514,335	**$842,861**	**$4,671,474**	**554.2%**	**27 - NET INCOME / (LOSS)**	**$17,604,729**	**($40,904)**	**$17,645,632**	**43,139.6%**
5.1%	**6.2%**	**1.1%**	**17.7%**	**28 - ADMIN EXP % OF REVENUE**	**5.1%**	**5.6%**	**0.5%**	**8.9%**

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED SEPTEMBER 30, 2023

	9/30/2023	8/31/2023	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$9,185,850	$4,648,471	$4,537,379	97.61%
Short-Term Investments	593,964,784	318,754,308	275,210,477	86.34%
Interest Receivable	450,138	545,674	(95,537)	-17.51%
Other Receivables - Net	213,845,802	431,590,802	(217,745,000)	-50.45%
Prepaid Expenses	5,501,708	5,211,393	290,315	5.57%
Prepaid Inventoried Items	58,330	88,105	(29,775)	-33.79%
CalPERS Net Pension Asset	(5,286,448)	(5,286,448)	0	0.00%
Deferred CalPERS Outflow	14,099,056	14,099,056	0	0.00%
TOTAL CURRENT ASSETS	**$831,819,219**	**$769,651,361**	**$62,167,859**	**8.08%**
OTHER ASSETS:				
Long-Term Investments	7,027,564	9,319,265	(2,291,701)	-24.59%
Restricted Assets	350,000	350,000	0	0.00%
Lease Asset - Office Space (Net)	1,252,769	1,315,408	(62,638)	-4.76%
Lease Asset - Office Equipment (Net)	147,375	150,650	(3,275)	-2.17%
SBITA Asset-GASB 96 (Net)	5,309,802	5,558,937	(249,136)	-4.48%
TOTAL OTHER ASSETS	**$14,087,510**	**$16,694,260**	**($2,606,750)**	**-15.61%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,129,539	10,113,570	15,969	0.16%
Furniture And Equipment	12,398,056	12,288,567	109,489	0.89%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally-Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	38,254,044	38,128,585	125,458	0.33%
Less: Accumulated Depreciation	(32,645,422)	(32,589,321)	(56,100)	0.17%
NET PROPERTY AND EQUIPMENT	**$5,608,622**	**$5,539,264**	**$69,358**	**1.25%**
TOTAL ASSETS	**$851,515,352**	**$791,884,885**	**$59,630,467**	**7.53%**
CURRENT LIABILITIES:				
Accounts Payable	919,537	1,123,528	(203,991)	-18.16%
Other Accrued Expenses	17,980,983	16,930,498	1,050,485	6.20%
Interest Payable	106,591	90,276	16,315	18.07%
Pass-Through Liabilities	279,960,963	230,640,982	49,319,980	21.38%
Claims Payable	31,022,471	33,593,308	(2,570,837)	-7.65%
IBNP Reserves	156,895,226	151,339,847	5,555,379	3.67%
Payroll Liabilities	7,080,789	7,037,647	43,142	0.61%
CalPERS Deferred Inflow	5,004,985	5,004,985	0	0.00%
Risk Sharing	4,629,337	3,628,337	1,001,000	27.59%
Provider Grants/ New Health Program	(11,640)	(11,640)	0	0.00%
ST Lease Liability - Office Space	836,760	830,487	6,273	0.76%
ST Lease Liability - Office Equipment	39,300	39,300	0	0.00%
SBITA ST Liability-GASB 96	2,195,220	2,220,459	(25,239)	-1.14%
TOTAL CURRENT LIABILITIES	**$506,660,520**	**$452,468,013**	**$54,192,507**	**11.98%**
LONG TERM LIABILITIES:				
LT Lease Liability - Office Space	597,778	670,878	(73,100)	-10.90%
LT Lease Liability - Office Equipment	108,075	111,350	(3,275)	-2.94%
SBITA LT Liability -GASB 96	2,587,208	2,587,208	0	0.00%
TOTAL LONG TERM LIABILITIES	**$3,293,061**	**$3,369,436**	**($76,375)**	**-2.27%**
TOTAL LIABILITIES	**$509,953,581**	**$455,837,450**	**$54,116,132**	**11.87%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	323,116,808	323,116,808	0	0.00%
Year-to Date Net Income / (Loss)	17,604,729	12,090,394	5,514,335	45.61%
TOTAL NET WORTH	**$341,561,770**	**$336,047,435**	**$5,514,335**	**1.64%**
TOTAL LIABILITIES AND NET WORTH	**$851,515,352**	**$791,884,885**	**$59,630,467**	**7.53%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 9/30/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,573,291	$7,746,391	$15,502,066	$7,746,390
Total	2,573,291	7,746,391	15,502,066	7,746,390
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	134,820,138	406,741,724	820,731,713	406,741,724
Premium Receivable	216,879,405	85,191,635	(44,864,854)	85,191,635
Total	351,699,543	491,933,359	775,866,859	491,933,359
Investment & Other Income Cash Flows				
Other Revenue (Grants)	95,474	290,670	350,447	290,670
Investment Income	1,499,508	6,406,441	11,928,366	6,406,442
Interest Receivable	95,537	264,438	43,377	264,438
Total	1,690,519	6,961,549	12,322,190	6,961,550
Medical & Hospital Cash Flows				
Total Medical Expenses	(126,353,580)	(382,167,951)	(760,618,250)	(382,167,950)
Other Receivable	865,596	1,184,048	1,340,186	1,184,048
Claims Payable	(2,570,838)	(7,677,453)	(7,782,754)	(7,677,453)
IBNP Payable	5,555,379	(7,609,177)	5,298,421	(7,609,177)
Risk Share Payable	1,001,000	(977,846)	(990,582)	(977,846)
Health Program	0	(11,640)	(139,180)	(11,640)
Other Liabilities	0	(1)	0	0
Total	(121,502,443)	(397,260,020)	(762,892,159)	(397,260,018)
Administrative Cash Flows				
Total Administrative Expenses	(7,120,496)	(21,412,546)	(42,277,801)	(21,412,547)
Prepaid Expenses	(260,540)	(659,320)	1,885,831	(659,320)
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	845,984	774,586	2,667,948	774,586
Other Accrued Liabilities	16,315	46,556	97,790	46,556
Payroll Liabilities	43,142	1,150,902	(1,347,025)	1,150,902
Net Lease Assets/Liabilities (Short term & Long term)	219,708	219,366	(545,266)	219,366
Depreciation Expense	56,100	168,297	353,127	168,297
Total	(6,199,787)	(19,712,159)	(39,165,396)	(19,712,160)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**228,261,123**	**89,669,120**	**1,633,560**	**89,669,121**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 9/30/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	2,291,701	4,532,973	16,231,620	4,532,973
	2,291,701	4,532,973	16,231,620	4,532,973
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	49,320,492	48,122,073	(48,846,246)	48,122,073
Restricted Cash	0	0	0	0
	49,320,492	48,122,073	(48,846,246)	48,122,073
Fixed Asset Cash Flows				
Depreciation expense	56,100	168,297	353,127	168,297
Fixed Asset Acquisitions	(125,459)	(558,947)	(673,018)	(558,947)
Change in A/D	(56,100)	(168,297)	(353,127)	(168,297)
	(125,459)	(558,947)	(673,018)	(558,947)
Total Cash Flows from Investing Activities	**51,486,734**	**52,096,099**	**(33,287,644)**	**52,096,099**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**279,747,857**	**141,765,219**	**(31,654,084)**	**141,765,220**
Rounding	0	0	0	(1)
Cash @ Beginning of Period	323,402,777	461,385,415	634,804,718	461,385,415
Cash @ End of Period	**$603,150,634**	**$603,150,634**	**$603,150,634**	**$603,150,634**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 9/30/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$5,514,335	$17,604,730	$45,616,543	$17,604,728
Add back: Depreciation	56,100	168,297	353,127	168,297
Receivables				
Premiums Receivable	216,879,405	85,191,635	(44,864,854)	85,191,635
Interest Receivable	95,537	264,438	43,377	264,438
Other Receivable	865,596	1,184,048	1,340,186	1,184,048
Total	217,840,538	86,640,121	(43,481,291)	86,640,121
Prepaid Expenses	(260,540)	(659,320)	1,885,831	(659,320)
Trade Payables	845,984	774,586	2,667,948	774,586
Claims Payable, IBNR & Risk Share				
IBNP	5,555,379	(7,609,177)	5,298,421	(7,609,177)
Claims Payable	(2,570,838)	(7,677,453)	(7,782,754)	(7,677,453)
Risk Share Payable	1,001,000	(977,846)	(990,582)	(977,846)
Other Liabilities	0	(1)	0	0
Total	3,985,541	(16,264,477)	(3,474,915)	(16,264,476)
Unearned Revenue				
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	16,315	46,556	97,790	46,556
Payroll Liabilities	43,142	1,150,902	(1,347,025)	1,150,902
Net Lease Assets/Liabilities (Short term & Long term)	219,708	219,366	(545,266)	219,366
Health Program	0	(11,640)	(139,180)	(11,640)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	279,165	1,405,184	(1,933,681)	1,405,184
Cash Flows from Operating Activities	**$228,261,123**	**$89,669,121**	**$1,633,562**	**$89,669,120**
Difference (rounding)	0	1	2	(1)

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 9/30/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$351,699,543	$491,933,359	$775,866,859	$491,933,359
Commercial Premium Revenue	2,573,291	7,746,391	15,502,066	7,746,390
Other Income	95,474	290,670	350,447	290,670
Investment Income	1,595,045	6,670,879	11,971,743	6,670,880
Cash Paid To:				
Medical Expenses	(121,502,443)	(397,260,020)	(762,892,159)	(397,260,018)
Vendor & Employee Expenses	(6,199,787)	(19,712,159)	(39,165,396)	(19,712,160)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	228,261,123	89,669,120	1,633,560	89,669,121
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	(125,459)	(558,947)	(673,018)	(558,947)
Net Cash Provided By (Used In) Financing Activities	(125,459)	(558,947)	(673,018)	(558,947)
Cash Flows from Investing Activities:				
Changes in Investments	2,291,701	4,532,973	16,231,620	4,532,973
Restricted Cash	49,320,492	48,122,073	(48,846,246)	48,122,073
Net Cash Provided By (Used In) Investing Activities	51,612,193	52,655,046	(32,614,626)	52,655,046
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**279,747,857**	**141,765,219**	**(31,654,084)**	**141,765,220**
Cash @ Beginning of Period	323,402,777	461,385,415	634,804,718	461,385,415
Subtotal	$603,150,634	$603,150,634	$603,150,634	$603,150,635
Rounding	0	0	0	(1)
Cash @ End of Period	**$603,150,634**	**$603,150,634**	**$603,150,634**	**$603,150,634**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$5,514,335	$17,604,730	$45,616,543	$17,604,728
Depreciation	56,100	168,297	353,127	168,297
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	217,840,538	86,640,121	(43,481,291)	86,640,121
Prepaid Expenses	(260,540)	(659,320)	1,885,831	(659,320)
Trade Payables	845,984	774,586	2,667,948	774,586
Claims payable & IBNP	3,985,541	(16,264,477)	(3,474,915)	(16,264,476)
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	279,165	1,405,184	(1,933,681)	1,405,184
Subtotal	228,261,123	89,669,121	1,633,562	89,669,120
Rounding	0	(1)	(2)	1
Cash Flows from Operating Activities	**$228,261,123**	**$89,669,120**	**$1,633,560**	**$89,669,121**
Rounding Difference	0	(1)	(2)	1

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF SEPTEMBER 2023

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments	100,038	51,499	30,592	120,016	41,629	139	1,004	344,917	5,631	-	350,548
Net Revenue	$13,319,281	$16,961,878	$35,744,300	$47,054,103	$12,097,155	$1,490,689	$8,152,793	$134,820,198	$2,573,290	$0	$137,393,488
Medical Expense	$10,780,360	$15,977,445	$31,834,013	$42,196,698	$12,170,912	$1,643,132	$9,046,464	$123,649,024	$2,704,555	$0	$126,353,580
Gross Margin	$2,538,920	$984,433	$3,910,287	$4,857,405	($73,758)	($152,443)	($893,671)	$11,171,173	($131,265)	$0	$11,039,908
Administrative Expense	$434,959	$735,099	$2,262,841	$2,209,642	$682,648	$97,972	$466,112	$6,889,273	$150,165	$20,000	$7,059,439
Operating Income / (Expense)	$2,103,961	$249,335	$1,647,445	$2,647,764	($756,406)	($250,415)	($1,359,784)	$4,281,900	($281,430)	($20,000)	$3,980,470
Other Income / (Expense)	$88,646	$160,972	$502,673	$477,416	$149,969	$22,325	$105,115	$1,507,116	$26,750	$0	$1,533,865
Net Income / (Loss)	$2,192,607	$410,307	$2,150,119	$3,125,179	($606,437)	($228,090)	($1,254,669)	$5,789,016	($254,681)	($20,000)	$5,514,335
PMPM Metrics:											
Revenue PMPM	$133.14	$329.36	$1,168.42	$392.07	$290.59	$10,724.38	$8,120.31	$390.88	$456.99	$0.00	$391.94
Medical Expense PMPM	$107.76	$310.25	$1,040.60	$351.59	$292.37	$11,821.09	$9,010.42	$358.49	$480.30	$0.00	$360.45
Gross Margin PMPM	$25.38	$19.12	$127.82	$40.47	($1.77)	($1,096.71)	($890.11)	$32.39	($23.31)	$0.00	$31.49
Administrative Expense PMPM	$4.35	$14.27	$73.97	$18.41	$16.40	$704.83	$464.26	$19.97	$26.67	$0.00	$20.14
Operating Income / (Expense) PMPM	$21.03	$4.84	$53.85	$22.06	($18.17)	($1,801.55)	($1,354.37)	$12.41	($49.98)	$0.00	$11.35
Other Income / (Expense) PMPM	$0.89	$3.13	$16.43	$3.98	$3.60	$160.61	$104.70	$4.37	$4.75	$0.00	$4.38
Net Income / (Loss) PMPM	$21.92	$7.97	$70.28	$26.04	($14.57)	($1,640.94)	($1,249.67)	$16.78	($45.23)	$0.00	$15.73
Ratio:											
Medical Loss Ratio	80.9%	94.2%	89.1%	89.7%	100.6%	110.2%	111.0%	91.7%	105.1%	0.0%	92.0%
Gross Margin Ratio	19.1%	5.8%	10.9%	10.3%	-0.6%	-10.2%	-11.0%	8.3%	-5.1%	0.0%	8.0%
Administrative Expense Ratio	3.3%	4.3%	6.3%	4.7%	5.6%	6.6%	5.7%	5.1%	5.8%	0.0%	5.1%
Net Income Ratio	16.5%	2.4%	6.0%	6.6%	-5.0%	-15.3%	-15.4%	4.3%	-9.9%	0.0%	4.0%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE SEPTEMBER 2023

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	303,894	156,151	92,487	365,542	125,032	418	3,056	1,046,580	16,945	-	1,063,525
Net Revenue	$40,382,409	$50,915,610	$107,960,793	$141,855,669	$36,330,169	$4,483,507	$24,813,777	$406,741,934	$7,746,391	$0	$414,488,324
Medical Expense	$33,039,363	$49,691,908	$99,295,695	$126,008,205	$37,429,322	$4,502,730	$25,560,463	$375,527,686	$6,640,265	$0	$382,167,951
Gross Margin	$7,343,046	$1,223,702	$8,665,098	$15,847,464	($1,099,153)	($19,224)	($746,686)	$31,214,248	$1,106,126	$0	$32,320,374
Administrative Expense	$1,476,186	$2,227,566	$6,581,024	$6,639,980	$2,063,621	$281,796	$1,340,688	$20,610,862	$450,064	$100,000	$21,160,926
Operating Income / (Expense)	$5,866,860	($1,003,865)	$2,084,074	$9,207,483	($3,162,774)	($301,019)	($2,087,374)	$10,603,385	$656,062	($100,000)	$11,159,448
Other Income / (Expense)	$378,630	$671,052	$2,078,567	$2,032,093	$629,820	$94,166	$446,458	$6,330,787	$114,494	$0	$6,445,281
Net Income / (Loss)	$6,245,490	($332,813)	$4,162,641	$11,239,577	($2,532,954)	($206,853)	($1,640,915)	$16,934,172	$770,557	($100,000)	$17,604,729
PMPM Metrics:											
Revenue PMPM	$132.88	$326.07	$1,167.31	$388.07	$290.57	$10,726.09	$8,119.69	$388.64	$457.15	$0.00	$389.73
Medical Expense PMPM	$108.72	$318.23	$1,073.62	$344.72	$299.36	$10,772.08	$8,364.03	$358.81	$391.87	$0.00	$359.34
Gross Margin PMPM	$24.16	$7.84	$93.69	$43.35	($8.79)	($45.99)	($244.33)	$29.82	$65.28	$0.00	$30.39
Administrative Expense PMPM	$4.86	$14.27	$71.16	$18.16	$16.50	$674.15	$438.71	$19.69	$26.56	$0.00	$19.90
Operating Income / (Expense) PMPM	$19.31	($6.43)	$22.53	$25.19	($25.30)	($720.14)	($683.04)	$10.13	$38.72	$0.00	$10.49
Other Income / (Expense) PMPM	$1.25	$4.30	$22.47	$5.56	$5.04	$225.28	$146.09	$6.05	$6.76	$0.00	$6.06
Net Income / (Loss) PMPM	$20.55	($2.13)	$45.01	$30.75	($20.26)	($494.86)	($536.95)	$16.18	$45.47	$0.00	$16.55
Ratio:											
Medical Loss Ratio	81.8%	97.6%	92.0%	88.8%	103.0%	100.4%	103.0%	92.3%	85.7%	0.0%	92.2%
Gross Margin Ratio	18.2%	2.4%	8.0%	11.2%	-3.0%	-0.4%	-3.0%	7.7%	14.3%	0.0%	7.8%
Administrative Expense Ratio	3.7%	4.4%	6.1%	4.7%	5.7%	6.3%	5.4%	5.1%	5.8%	0.0%	5.1%
Net Income Ratio	15.5%	-0.7%	3.9%	7.9%	-7.0%	-4.6%	-6.6%	4.2%	9.9%	0.0%	4.2%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED September 30, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$4,359,631	$4,400,692	$41,061	0.9%	Personnel Expenses	$13,325,693	$12,723,756	($601,937)	(4.7%)
64,368	51,767	(12,601)	(24.3%)	Benefits Administration Expense	1,002,822	156,419	(846,404)	(541.1%)
838,472	1,584,597	746,126	47.1%	Purchased & Professional Services	2,846,607	4,416,036	1,569,429	35.5%
457,705	269,502	(188,203)	(69.8%)	Occupancy	1,515,776	772,433	(743,342)	(96.2%)
607,821	714,913	107,091	15.0%	Printing Postage & Promotion	1,000,736	1,233,393	232,657	18.9%
703,338	1,200,150	496,813	41.4%	Licenses Insurance & Fees	1,392,987	3,291,554	1,898,567	57.7%
28,103	20,242	(7,861)	(38.8%)	Supplies & Other Expenses	76,305	48,609	(27,697)	(57.0%)
$2,699,807	$3,841,171	$1,141,364	29.7%	Total Other Administrative Expense	$7,835,233	$9,918,443	$2,083,210	21.0%
$7,059,439	$8,241,863	$1,182,425	14.3%	Total Administrative Expenses	$21,160,926	$22,642,199	$1,481,273	6.5%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED September 30, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
2,956,225	2,939,751	(16,474)	(0.6%)	Salaries & Wages	8,950,014	8,426,928	(523,086)	(6.2%)
316,864	313,239	(3,625)	(1.2%)	Paid Time Off	981,829	888,099	(93,730)	(10.6%)
2,268	3,895	1,627	41.8%	Incentives	8,693	10,115	1,422	14.1%
45,611	52,923	7,312	13.8%	Payroll Taxes	140,678	240,629	99,952	41.5%
15,463	13,567	(1,897)	(14.0%)	Overtime	86,758	41,400	(45,358)	(109.6%)
241,706	248,237	6,531	2.6%	CalPERS ER Match	785,799	710,792	(75,007)	(10.6%)
663,296	546,054	(117,242)	(21.5%)	Employee Benefits	1,995,261	1,623,340	(371,921)	(22.9%)
199	0	(199)	0.0%	Personal Floating Holiday	2,978	0	(2,978)	0.0%
5,885	33,874	27,989	82.6%	Employee Relations	5,319	79,273	73,954	93.3%
15,830	20,450	4,620	22.6%	Work from Home Stipend	46,840	58,600	11,760	20.1%
209	5,735	5,526	96.4%	Transportation Reimbursement	1,143	15,052	13,909	92.4%
9,738	17,682	7,943	44.9%	Travel & Lodging	28,518	46,144	17,626	38.2%
29,941	144,560	114,619	79.3%	Temporary Help Services	222,341	403,987	181,646	45.0%
15,634	49,695	34,061	68.5%	Staff Development/Training	38,043	161,302	123,259	76.4%
40,762	11,031	(29,731)	(269.5%)	Staff Recruitment/Advertising	31,480	18,094	(13,386)	(74.0%)
$4,359,631	**$4,400,692**	**$41,061**	**0.9%**	**Total Employee Expenses**	**$13,325,693**	**$12,723,756**	**($601,937)**	**(4.7%)**
				Benefit Administration Expense				
25,637	21,808	(3,829)	(17.6%)	RX Administration Expense	68,146	65,424	(2,722)	(4.2%)
0	0	0	0.0%	Behavioral Hlth Administration Fees	817,710	0	(817,710)	0.0%
38,732	29,959	(8,772)	(29.3%)	Telemedicine Admin Fees	116,967	90,995	(25,972)	(28.5%)
$64,368	**$51,767**	**($12,601)**	**(24.3%)**	**Total Benefit Administration Expenses**	**$1,002,822**	**$156,419**	**($846,404)**	**(541.1%)**
				Purchased & Professional Services				
176,092	561,236	385,145	68.6%	Consulting Services	715,284	1,634,773	919,489	56.2%
359,026	619,047	260,022	42.0%	Computer Support Services	1,042,390	1,527,998	485,608	31.8%
11,875	12,500	625	5.0%	Professional Fees-Accounting	35,625	37,500	1,875	5.0%
0	33	33	100.0%	Professional Fees-Medical	0	100	100	100.0%
133,965	139,997	6,032	4.3%	Other Purchased Services	553,888	482,810	(71,078)	(14.7%)
34	717	683	95.2%	Maint.& Repair-Office Equipment	2,656	2,151	(505)	(23.5%)
1,180	0	(1,180)	0.0%	Maint.&Repair-Computer Hardware	1,180	0	(1,180)	0.0%
52,402	114,160	61,758	54.1%	HMS Recovery Fees	247,186	324,860	77,674	23.9%
3,765	43,854	40,089	91.4%	Hardware (Non-Capital)	116,575	119,188	2,613	2.2%
35,356	41,702	6,346	15.2%	Provider Relations-Credentialing	68,783	125,106	56,323	45.0%
64,777	51,350	(13,427)	(26.1%)	Legal Fees	63,039	161,550	98,511	61.0%
$838,472	**$1,584,597**	**$746,126**	**47.1%**	**Total Purchased & Professional Services**	**$2,846,607**	**$4,416,036**	**$1,569,429**	**35.5%**
				Occupancy				
56,100	60,874	4,774	7.8%	Depreciation	168,297	163,704	(4,593)	(2.8%)
62,638	74,147	11,509	15.5%	Building Lease	185,756	222,441	36,685	16.5%
6,772	5,870	(902)	(15.4%)	Leased and Rented Office Equipment	16,992	17,610	618	3.5%
15,273	14,700	(573)	(3.9%)	Utilities	82,373	32,200	(50,173)	(155.8%)
45,972	86,510	40,538	46.9%	Telephone	247,517	259,530	12,013	4.6%
21,814	27,401	5,587	20.4%	Building Maintenance	67,435	76,948	9,513	12.4%
249,136	0	(249,136)	0.0%	SBITA Amortization Expense-GASB 96	747,407	0	(747,407)	0.0%
$457,705	**$269,502**	**($188,203)**	**(69.8%)**	**Total Occupancy**	**$1,515,776**	**$772,433**	**($743,342)**	**(96.2%)**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED September 30, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Printing Postage & Promotion				
40,285	32,753	(7,533)	(23.0%)	Postage	117,140	99,358	(17,782)	(17.9%)
11,594	5,300	(6,294)	(118.8%)	Design & Layout	13,656	16,300	2,645	16.2%
54,452	45,987	(8,465)	(18.4%)	Printing Services	203,761	129,825	(73,936)	(57.0%)
9,577	6,910	(2,667)	(38.6%)	Mailing Services	31,548	20,730	(10,818)	(52.2%)
10,293	6,480	(3,813)	(58.8%)	Courier/Delivery Service	30,476	19,230	(11,245)	(58.5%)
4,006	1,250	(2,756)	(220.5%)	Promotional Products	4,193	1,250	(2,943)	(235.5%)
0	3,150	3,150	100.0%	Promotional Services	1,450	3,450	2,000	58.0%
455,608	540,417	84,809	15.7%	Community Relations	542,700	845,250	302,550	35.8%
22,006	72,667	50,661	69.7%	Translation - Non-Clinical	55,813	98,000	42,187	43.0%
$607,821	**$714,913**	**$107,091**	**15.0%**	**Total Printing Postage & Promotion**	**$1,000,736**	**$1,233,393**	**$232,657**	**18.9%**
				Licenses Insurance & Fees				
0	250,000	250,000	100.0%	Regulatory Penalties	0	500,000	500,000	100.0%
26,306	28,000	1,694	6.0%	Bank Fees	80,699	84,000	3,301	3.9%
75,060	89,100	14,040	15.8%	Insurance	225,179	267,299	42,120	15.8%
486,443	693,923	207,480	29.9%	Licenses, Permits and Fees	799,056	1,991,076	1,192,020	59.9%
115,529	139,128	23,599	17.0%	Subscriptions & Dues	288,054	449,179	161,125	35.9%
$703,338	**$1,200,150**	**$496,813**	**41.4%**	**Total Licenses Insurance & Postage**	**$1,392,987**	**$3,291,554**	**$1,898,567**	**57.7%**
				Supplies & Other Expenses				
22,569	4,584	(17,985)	(392.3%)	Office and Other Supplies	31,061	12,452	(18,609)	(149.4%)
0	0	0	0.0%	Furniture and Equipment	350	0	(350)	0.0%
2,735	3,700	965	26.1%	Ergonomic Supplies	9,959	9,100	(859)	(9.4%)
2,799	6,641	3,842	57.9%	Commissary-Food & Beverage	10,084	20,807	10,722	51.5%
0	0	0	0.0%	Miscellaneous Expense	20,000	0	(20,000)	0.0%
0	4,850	4,850	100.0%	Member Incentive Expense	4,850	4,850	0	0.0%
0	100	100	100.0%	Covid-19 IT Expenses	0	300	300	100.0%
0	367	367	100.0%	Covid-19 Non IT Expenses	0	1,100	1,100	100.0%
$28,103	**$20,242**	**($7,861)**	**(38.8%)**	**Total Supplies & Other Expense**	**$76,305**	**$48,609**	**($27,697)**	**(57.0%)**
$7,059,439	**$8,241,863**	**$1,182,425**	**14.3%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$21,160,926**	**$22,642,199**	**$1,481,273**	**6.5%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED JUNE 30, 2024

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Catalyst 9300 - Catalyst Switches	IT-FY24-01	$ -		**$ -**	$ 50,000	$ 50,000
	Cisco Catalyst 8500 - Routers	IT-FY24-02	$ -		**$ -**	$ 60,000	$ 60,000
	Cisco AP-9166 - Access Point	IT-FY24-03	$ -		**$ -**	$ 10,000	$ 10,000
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 426,371	$ 100	**$ 426,471**	$ 310,000	$ (116,471)
	PURE Storage array	IT-FY24-05	$ -		**$ -**	$ 300,000	$ 300,000
	PKI management	IT-FY24-06	$ -		**$ -**	$ 20,000	$ 20,000
	IBM Power Hardware Upgrade	IT-FY24-07	$ -		**$ -**	$ 405,000	$ 405,000
	Misc Hardware	IT-FY24-08	$ 7,119		**$ 7,119**	$ 15,000	$ 7,881
	Network / AV Cabling	IT-FY24-09	$ -	$ 107,600	**$ 107,600**	$ 30,000	$ (77,600)
Hardware Subtotal			**$ 433,489**	**$ 107,701**	**$ 541,190**	**$ 1,200,000**	**$ 658,810**
2. Software:							
	Zerto renewal and Tier 2 add	AC-FY24-01	$ -		**$ -**	$ 126,000	$ 126,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 126,000**	**$ 126,000**
3. Building Improvement:							
	Appliances over 1k new/replacement (all buildings/suites)	FA-FY24-01	**$ -**	$ -	**$ -**	$ -	$ -
	ACME Security: Readers, HID boxes, Cameras, Doors (planned/unplanned	FA-FY24-02	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	HVAC: Replace VAV boxes, duct work, replace old equipment	FA-FY24-03	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	Electrical work for projects, workstations requirement	FA-FY24-04	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	1240 Interior blinds replacement	FA-FY24-05	**$ -**	$ -	**$ -**	$ 25,000	$ 25,000
	EV Charging stations, if not completed in FY23 and carried over to FY24	FA-FY24-06	**$ -**	$ 15,969	**$ 15,969**	$ 50,000	$ 34,031
Building Improvement Subtotal			**$ -**	**$ 15,969**	**$ 15,969**	**$ 125,000**	**$ 109,031**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)	FA-FY24-17	$ -	$ 1,789	**$ 1,789**	$ 20,000	$ 18,211
	Replace, reconfigure, re-design workstations	FA-FY24-18	$ -		**$ -**	20,000.00	$ 20,000
Furniture & Equipment Subtotal			**$ -**	**$ 1,789**	**$ 1,789**	**$ 40,000**	**$ 38,211**
GRAND TOTAL			**$ 433,489**	**$ 125,458**	**$ 558,947**	**$ 1,491,000**	**$ 932,053**

5. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 9/30/23	**$ 38,254,044**
Fixed Assets @ Cost - 6/30/23	**$ 37,695,096**
Fixed Assets Acquired YTD	**$ 558,947**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2024

TANGIBLE NET EQUITY (TNE)

	Jul-23	Aug-23	QTR. END Sep-23
Current Month Net Income / (Loss)	$9,746,933	$2,343,460	$5,514,335
YTD Net Income / (Loss)	$9,746,933	$12,090,393	$17,604,728
Actual TNE			
Net Assets	$333,703,974	$336,047,435	$341,561,770
Subordinated Debt & Interest	$0	$0	$0
Total Actual TNE	**$333,703,974**	**$336,047,435**	**$341,561,770**
Increase/(Decrease) in Actual TNE	$9,746,933	$2,343,460	$5,514,335
Required TNE[(1)]	**$46,228,233**	**$46,744,204**	**$46,352,062**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$69,342,350	$70,116,307	$69,528,093
TNE Excess / (Deficiency)	$287,475,741	$289,303,231	$295,209,708
Actual TNE as a Multiple of Required	**7.22**	**7.19**	**7.37**

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

LIQUID TANGIBLE NET EQUITY

Net Assets	$333,703,974	$336,047,435	$341,561,770
Fixed Assets at Net Book Value	(5,169,098)	(5,539,264)	(5,608,622)
Net Lease Assets/Liabilities/Interest	(711,429)	(475,037)	(1,115,074)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$328,184,876**	**$330,158,171**	**$335,603,148**
Liquid TNE as Multiple of Required	**7.10**	**7.06**	**7.24**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2024

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

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	102,463	101,393	100,038										303,894
Adult	52,550	52,102	51,499										156,151
SPD	31,055	30,840	30,592										92,487
ACA OE	123,707	121,819	120,016										365,542
Duals	41,688	41,715	41,629										125,032
MCAL LTC	141	138	139										418
MCAL LTC Duals	1,033	1,019	1,004										3,056
Medi-Cal Program	352,637	349,026	344,917										1,046,580
Group Care Program	5,669	5,645	5,631										16,945
Total	**358,306**	**354,671**	**350,548**										**1,063,525**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)										(3,632)
Adult	(624)	(448)	(603)										(1,675)
SPD	(225)	(215)	(248)										(688)
ACA OE	(1,260)	(1,888)	(1,803)										(4,951)
Duals	(43)	27	(86)										(102)
MCAL LTC	(9)	(3)	1										(11)
MCAL LTC Duals	4	(14)	(15)										(25)
Medi-Cal Program	(3,364)	(3,611)	(4,109)										(11,084)
Group Care Program	(15)	(24)	(14)										(53)
Total	**(3,379)**	**(3,635)**	**(4,123)**										**(11,137)**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	29.1%	29.1%	29.0%										29.0%
Adult % of Medi-Cal	14.9%	14.9%	14.9%										14.9%
SPD % of Medi-Cal	8.8%	8.8%	8.9%										8.8%
ACA OE % of Medi-Cal	35.1%	34.9%	34.8%										34.9%
Duals % of Medi-Cal	11.8%	12.0%	12.1%										11.9%
Medi-Cal Program % of Total	98.4%	98.4%	98.4%										98.4%
Group Care Program % of Total	1.6%	1.6%	1.6%										1.6%
Total	**100.0%**	**100.0%**	**100.0%**										**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2024

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

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027	72,504										220,078
Alameda Health System	66,089	65,344	64,133										195,566
	140,636	138,371	136,637										415,644
Delegated:													
CFMG	34,810	34,649	34,144										103,603
CHCN	130,230	129,183	127,430										386,843
Kaiser	52,630	52,468	52,337										157,435
Delegated Subtotal	217,670	216,300	213,911										647,881
Total	**358,306**	**354,671**	**350,548**										**1,063,525**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(939)	(2,265)	(1,734)										(4,938)
Delegated:													
CFMG	(441)	(161)	(505)										(1,107)
CHCN	(1,721)	(1,047)	(1,753)										(4,521)
Kaiser	(278)	(162)	(131)										(571)
Delegated Subtotal	(2,440)	(1,370)	(2,389)										(6,199)
Total	**(3,379)**	**(3,635)**	**(4,123)**										**(11,137)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	39.3%	39.0%	39.0%										39.1%
Delegated:													
CFMG	9.7%	9.8%	9.7%										9.7%
CHCN	36.3%	36.4%	36.4%										36.4%
Kaiser	14.7%	14.8%	14.9%										14.8%
Delegated Subtotal	60.7%	61.0%	61.0%										60.9%
Total	**100.0%**	**100.0%**	**100.0%**										**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2024	PRELIMINARY BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program by Category of Aid:													
Child	103,544	103,088	102,632	102,175	101,718	101,260	107,566	107,077	106,587	106,097	105,607	105,116	1,252,467
Adult	51,779	50,776	49,772	48,768	47,763	46,758	49,018	47,940	46,861	45,781	44,701	43,620	573,537
SPD	31,335	31,353	31,371	31,389	31,407	31,425	35,606	35,627	35,648	35,669	35,690	35,711	402,231
ACA OE	123,148	120,204	117,258	114,310	111,361	108,410	138,802	134,913	131,022	127,129	123,234	119,336	1,469,127
Duals	42,304	42,304	42,304	42,304	42,304	42,304	44,536	44,536	44,536	44,536	44,536	44,536	521,040
MCAL LTC	145	145	145	145	145	145	175	175	175	175	175	175	1,920
MCAL LTC Duals	983	983	983	983	983	983	1,107	1,107	1,107	1,107	1,107	1,107	12,540
Medi-Cal Program	353,238	348,853	344,465	340,074	335,681	331,285	376,810	371,375	365,936	360,494	355,050	349,601	4,232,862
Group Care Program	5,669	5,669	5,669	5,669	5,669	5,669	5,669	5,669	5,669	5,669	5,669	5,669	68,028
Total	**358,907**	**354,522**	**350,134**	**345,743**	**341,350**	**336,954**	**382,479**	**377,044**	**371,605**	**366,163**	**360,719**	**355,270**	**4,300,890**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	1,335	(456)	(456)	(457)	(457)	(458)	6,306	(489)	(490)	(490)	(490)	(491)	2,907
Adult	1,459	(1,003)	(1,004)	(1,004)	(1,005)	(1,005)	2,260	(1,078)	(1,079)	(1,080)	(1,080)	(1,081)	(6,700)
SPD	(576)	18	18	18	18	18	4,181	21	21	21	21	21	3,800
ACA OE	3,641	(2,944)	(2,946)	(2,948)	(2,949)	(2,951)	30,392	(3,889)	(3,891)	(3,893)	(3,895)	(3,898)	(171)
Duals	(3,158)	0	0	0	0	0	2,232	0	0	0	0	0	(926)
MCAL LTC	(8)	0	0	0	0	0	30	0	0	0	0	0	22
MCAL LTC Duals	(201)	0	0	0	0	0	124	0	0	0	0	0	(77)
Medi-Cal Program	2,492	(4,385)	(4,388)	(4,391)	(4,393)	(4,396)	45,525	(5,435)	(5,439)	(5,442)	(5,444)	(5,449)	(1,145)
Group Care Program	(120)	0	0	0	0	0	0	0	0	0	0	0	(120)
Total	**2,372**	**(4,385)**	**(4,388)**	**(4,391)**	**(4,393)**	**(4,396)**	**45,525**	**(5,435)**	**(5,439)**	**(5,442)**	**(5,444)**	**(5,449)**	**(1,265)**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	29.3%	29.6%	29.8%	30.0%	30.3%	30.6%	28.5%	28.8%	29.1%	29.4%	29.7%	30.1%	29.6%
Adult % (Medi-Cal)	14.7%	14.6%	14.4%	14.3%	14.2%	14.1%	13.0%	12.9%	12.8%	12.7%	12.6%	12.5%	13.5%
SPD % (Medi-Cal)	8.9%	9.0%	9.1%	9.2%	9.4%	9.5%	9.4%	9.6%	9.7%	9.9%	10.1%	10.2%	9.5%
ACA OE % (Medi-Cal)	34.9%	34.5%	34.0%	33.6%	33.2%	32.7%	36.8%	36.3%	35.8%	35.3%	34.7%	34.1%	34.7%
Duals % (Medi-Cal)	12.0%	12.1%	12.3%	12.4%	12.6%	12.8%	11.8%	12.0%	12.2%	12.4%	12.5%	12.7%	12.3%
MCAL LTC % (Medi-Cal)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
MCAL LTC Duals % (Medi-Cal)	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Medi-Cal Program % of Total	98.4%	98.4%	98.4%	98.4%	98.3%	98.3%	98.5%	98.5%	98.5%	98.5%	98.4%	98.4%	98.4%
Group Care Program % of Total	1.6%	1.6%	1.6%	1.6%	1.7%	1.7%	1.5%	1.5%	1.5%	1.5%	1.6%	1.6%	1.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2024	PRELIMINARY BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted	141,664	139,841	138,017	136,193	134,368	132,542	175,235	172,548	169,859	167,168	164,475	161,781	1,833,691
Delegated:													
CFMG	34,754	34,568	34,382	34,196	34,010	33,824	44,249	43,997	43,745	43,493	43,241	42,989	467,448
CHCN	130,622	128,908	127,193	125,475	123,756	122,035	162,995	160,499	158,001	155,502	153,003	150,500	1,698,489
Kaiser	51,867	51,205	50,542	49,879	49,216	48,553	0	0	0	0	0	0	301,262
Delegated Subtotal	217,243	214,681	212,117	209,550	206,982	204,412	207,244	204,496	201,746	198,995	196,244	193,489	2,467,199
Total	**358,907**	**354,522**	**350,134**	**345,743**	**341,350**	**336,954**	**382,479**	**377,044**	**371,605**	**366,163**	**360,719**	**355,270**	**4,300,890**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	8,226	(1,823)	(1,824)	(1,824)	(1,825)	(1,826)	42,693	(2,687)	(2,689)	(2,691)	(2,693)	(2,694)	28,343
Delegated:													
CFMG	684	(186)	(186)	(186)	(186)	(186)	10,425	(252)	(252)	(252)	(252)	(252)	8,919
CHCN	(4,995)	(1,714)	(1,715)	(1,718)	(1,719)	(1,721)	40,960	(2,496)	(2,498)	(2,499)	(2,499)	(2,503)	14,883
Kaiser	(1,543)	(662)	(663)	(663)	(663)	(663)	0	0	0	0	0	0	(4,857)
Delegated Subtotal	(5,854)	(2,562)	(2,564)	(2,567)	(2,568)	(2,570)	51,385	(2,748)	(2,750)	(2,751)	(2,751)	(2,755)	18,945
Total	**2,372**	**(4,385)**	**(4,388)**	**(4,391)**	**(4,393)**	**(4,396)**	**94,078**	**(5,435)**	**(5,439)**	**(5,442)**	**(5,444)**	**(5,449)**	**47,288**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	39.5%	39.4%	39.4%	39.4%	39.4%	39.3%	45.8%	45.8%	45.7%	45.7%	45.6%	45.5%	42.6%
Delegated:													
CFMG	9.7%	9.8%	9.8%	9.9%	10.0%	10.0%	11.6%	11.7%	11.8%	11.9%	12.0%	12.1%	10.9%
CHCN	36.4%	36.4%	36.3%	36.3%	36.3%	36.2%	42.6%	42.6%	42.5%	42.5%	42.4%	42.4%	39.5%
Kaiser	14.5%	14.4%	14.4%	14.4%	14.4%	14.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.0%
Delegated Subtotal	60.5%	60.6%	60.6%	60.6%	60.6%	60.7%	54.2%	54.2%	54.3%	54.3%	54.4%	54.5%	57.4%
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 2024

	Variance Jul-23	Variance Aug-23	Variance Sep-23	Variance Oct-23	Variance Nov-23	Variance Dec-23	Variance Jan-24	Variance Feb-24	Variance Mar-24	Variance Apr-24	Variance May-24	Variance Jun-24	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	(1,081)	(1,695)	(2,594)										(5,370)
Adult	771	1,326	1,727										3,824
SPD	(280)	(513)	(779)										(1,572)
ACA OE	559	1,615	2,758										4,932
Duals	(616)	(589)	(675)										(1,880)
MCAL LTC	(4)	(7)	(6)										(17)
MCAL LTC Duals	50	36	21										107
Medi-Cal Program	(601)	173	452										24
Group Care Program	0	(24)	(38)										(62)
Total	**(601)**	**149**	**414**										**(38)**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	(1,028)	(1,470)	(1,380)										(3,878)
Delegated:													
CFMG	56	81	(238)										(101)
CHCN	(392)	275	237										120
Kaiser	763	1,263	1,795										3,821
Delegated Subtotal	427	1,619	1,794										3,840
Total	**(601)**	**149**	**414**										**(38)**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED SEPTEMBER 30, 2023

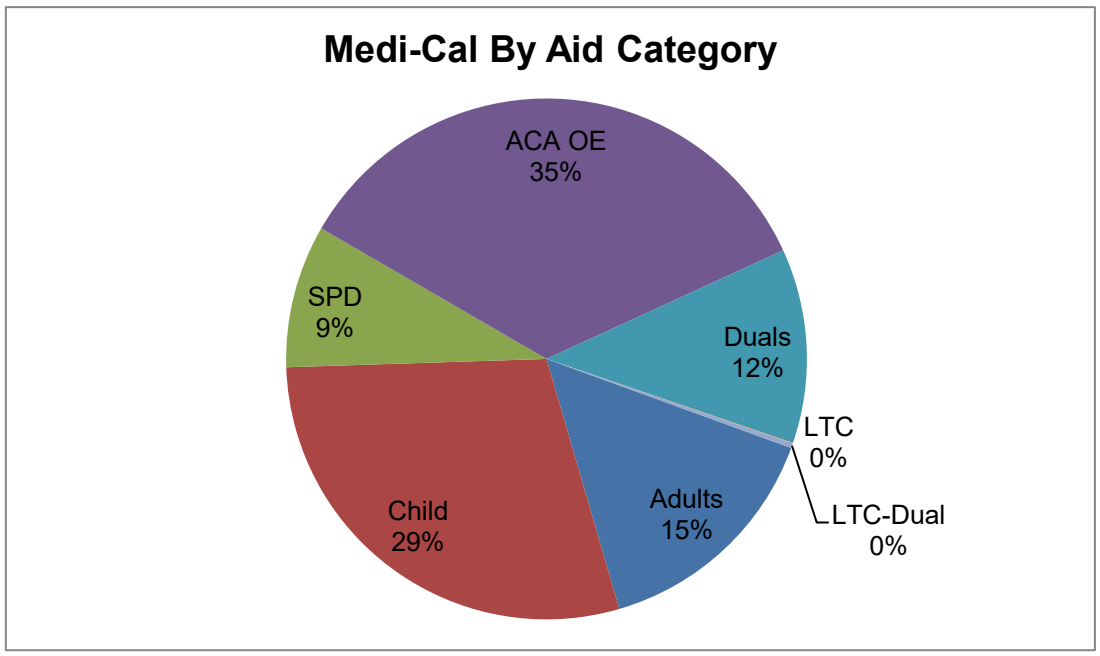
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,152,331	$1,156,491	$4,160	0.4%	PCP Capitation	$3,490,159	$3,487,774	($2,385)	(0.1%)
4,362,747	4,600,634	237,887	5.2%	PCP Capitation FQHC	13,144,794	13,990,487	845,693	6.0%
296,765	298,607	1,842	0.6%	Specialty-Capitation	898,204	900,683	2,479	0.3%
3,801,148	3,974,772	173,624	4.4%	Specialty-Capitation FQHC	11,449,089	12,109,933	660,844	5.5%
489,854	487,632	(2,222)	(0.5%)	Laboratory Capitation	1,477,737	1,478,920	1,184	0.1%
251,366	252,058	692	0.3%	Vision Cap	759,237	764,918	5,680	0.7%
86,366	86,966	600	0.7%	CFMG Capitation	261,401	262,315	914	0.3%
188,343	197,903	9,560	4.8%	Anc IPA Admin Capitation FQHC	567,425	602,202	34,776	5.8%
14,143,702	13,546,530	(597,172)	(4.4%)	Kaiser Capitation	42,461,343	41,213,256	(1,248,087)	(3.0%)
344,752	599,313	254,562	42.5%	Maternity Supplemental Expense	847,903	1,834,902	986,999	53.8%
712,819	767,113	54,293	7.1%	DME Cap	2,146,941	2,308,381	161,440	7.0%
$25,830,192	**$25,968,019**	**$137,826**	**0.5%**	**5 - TOTAL CAPITATED EXPENSES**	**$77,504,232**	**$78,953,770**	**$1,449,538**	**1.8%**
				FEE FOR SERVICE MEDICAL EXPENSES:				
(213,784)	0	213,784	0.0%	IBNR Inpatient Services	(5,849,216)	0	5,849,216	0.0%
(6,413)	0	6,413	0.0%	IBNR Settlement (IP)	(175,476)	0	175,476	0.0%
(17,102)	0	17,102	0.0%	IBNR Claims Fluctuation (IP)	(467,936)	0	467,936	0.0%
27,171,564	34,059,467	6,887,904	20.2%	Inpatient Hospitalization FFS	94,874,633	105,449,967	10,575,334	10.0%
1,847,010	0	(1,847,010)	0.0%	IP OB - Mom & NB	5,866,854	0	(5,866,854)	0.0%
34,610	0	(34,610)	0.0%	IP Behavioral Health	859,899	0	(859,899)	0.0%
1,167,426	0	(1,167,426)	0.0%	IP Facility Rehab FFS	3,666,650	0	(3,666,650)	0.0%
$29,983,310	**$34,059,467**	**$4,076,158**	**12.0%**	**6 - Inpatient Hospital & SNF FFS Expense**	**$98,775,409**	**$105,449,967**	**$6,674,558**	**6.3%**
(7,169)	0	7,169	0.0%	IBNR PCP	(501,187)	0	501,187	0.0%
(215)	0	215	0.0%	IBNR Settlement (PCP)	(15,037)	0	15,037	0.0%
(574)	0	574	0.0%	IBNR Claims Fluctuation (PCP)	(40,094)	0	40,094	0.0%
1,653,958	1,730,418	76,460	4.4%	Primary Care Non-Contracted FF	5,888,438	5,362,440	(525,997)	(9.8%)
312,325	182,320	(130,006)	(71.3%)	PCP FQHC FFS	1,711,389	565,977	(1,145,412)	(202.4%)
2,289,357	3,163,734	874,377	27.6%	Prop 56 Physician Exp	6,955,661	9,635,902	2,680,241	27.8%
14,041	0	(14,041)	0.0%	Prop 56 Hyde Exp	42,645	0	(42,645)	0.0%
78,544	0	(78,544)	0.0%	Prop 56 Trauma Exp	238,884	0	(238,884)	0.0%
94,634	0	(94,634)	0.0%	Prop 56 Develop. Screening Exp	287,442	0	(287,442)	0.0%
722,442	0	(722,442)	0.0%	Prop 56 Family Planning Exp	2,195,052	0	(2,195,052)	0.0%
$5,157,344	**$5,076,472**	**($80,871)**	**(1.6%)**	**7 - Primary Care Physician FFS Expense**	**$16,763,192**	**$15,564,320**	**($1,198,873)**	**(7.7%)**
520,416	0	(520,416)	0.0%	IBNR Specialist	(1,069,623)	0	1,069,623	0.0%
295,879	0	(295,879)	0.0%	Psychiatrist FFS	706,352	0	(706,352)	0.0%
2,128,118	5,335,191	3,207,073	60.1%	Specialty Care FFS	7,152,333	16,499,701	9,347,368	56.7%
210,552	0	(210,552)	0.0%	Specialty Anesthesiology	571,653	0	(571,653)	0.0%
927,911	0	(927,911)	0.0%	Specialty Imaging FFS	3,454,504	0	(3,454,504)	0.0%
19,257	0	(19,257)	0.0%	Obstetrics FFS	50,879	0	(50,879)	0.0%
228,945	0	(228,945)	0.0%	Specialty IP Surgery FFS	929,523	0	(929,523)	0.0%
510,133	0	(510,133)	0.0%	Specialty OP Surgery FFS	1,887,119	0	(1,887,119)	0.0%
360,387	0	(360,387)	0.0%	Spec IP Physician	1,396,618	0	(1,396,618)	0.0%
63,027	70,258	7,231	10.3%	SCP FQHC FFS	198,027	217,970	19,942	9.1%
15,611	0	(15,611)	0.0%	IBNR Settlement (SCP)	(32,089)	0	32,089	0.0%
41,633	0	(41,633)	0.0%	IBNR Claims Fluctuation (SCP)	(85,569)	0	85,569	0.0%
$5,321,869	**$5,405,449**	**$83,580**	**1.5%**	**8 - Specialty Care Physician Expense**	**$15,159,728**	**$16,717,671**	**$1,557,943**	**9.3%**
(217,528)	0	217,528	0.0%	IBNR Ancillary	857,667	0	(857,667)	0.0%
(6,526)	0	6,526	0.0%	IBNR Settlement (ANC)	25,731	0	(25,731)	0.0%
(17,401)	0	17,401	0.0%	IBNR Claims Fluctuation (ANC)	68,613	0	(68,613)	0.0%
21,135	0	(21,135)	0.0%	IBNR Transportation FFS	22,194	0	(22,194)	0.0%
1,033,157	0	(1,033,157)	0.0%	Behavioral Health Therapy FFS	3,859,502	0	(3,859,502)	0.0%
947,920	0	(947,920)	0.0%	Psychologist & Other MH Prof.	2,988,892	0	(2,988,892)	0.0%
234,689	0	(234,689)	0.0%	Acupuncture/Biofeedback	864,511	0	(864,511)	0.0%
84,218	0	(84,218)	0.0%	Hearing Devices	300,058	0	(300,058)	0.0%
24,913	0	(24,913)	0.0%	Imaging/MRI/CT Global	127,289	0	(127,289)	0.0%
41,246	0	(41,246)	0.0%	Vision FFS	124,161	0	(124,161)	0.0%
10	0	(10)	0.0%	Family Planning	30	0	(30)	0.0%
400,657	0	(400,657)	0.0%	Laboratory-FFS	1,454,559	0	(1,454,559)	0.0%
88,339	0	(88,339)	0.0%	ANC Therapist	315,472	0	(315,472)	0.0%
805,862	0	(805,862)	0.0%	Transportation (Ambulance)-FFS	2,991,881	0	(2,991,881)	0.0%
1,548,419	0	(1,548,419)	0.0%	Transportation (Other)-FFS	4,423,311	0	(4,423,311)	0.0%
1,500,868	0	(1,500,868)	0.0%	Hospice	4,488,952	0	(4,488,952)	0.0%
1,032,319	0	(1,032,319)	0.0%	Home Health Services	3,937,301	0	(3,937,301)	0.0%
3,390	9,311,550	9,308,160	100.0%	Other Medical-FFS	3,390	28,660,800	28,657,411	100.0%
(46,125)	0	46,125	0.0%	Medical Refunds through HMS	(21,971)	0	21,971	0.0%
(369,752)	0	369,752	0.0%	Medical Refunds	(378,711)	0	378,711	0.0%
12,131	0	(12,131)	0.0%	DME & Medical Supplies	36,992	0	(36,992)	0.0%
0	0	0	0.0%	GEMT FFS	(373,988)	0	373,988	0.0%
1,427,859	1,441,031	13,172	0.9%	ECM Base/Outreach FFS Anc.	4,335,295	4,364,234	28,939	0.7%
23,794	76,791	52,996	69.0%	CS Housing Deposits FFS Ancillary	72,360	235,731	163,371	69.3%
196,657	502,571	305,914	60.9%	CS Housing Tenancy FFS Ancillary	631,846	1,497,876	866,030	57.8%
42,695	91,872	49,177	53.5%	CS Housing Navigation Services FFS Ancillary	132,170	274,410	142,240	51.8%
67,397	131,064	63,667	48.6%	CS Medical Respite FFS Ancillary	184,769	402,341	217,572	54.1%

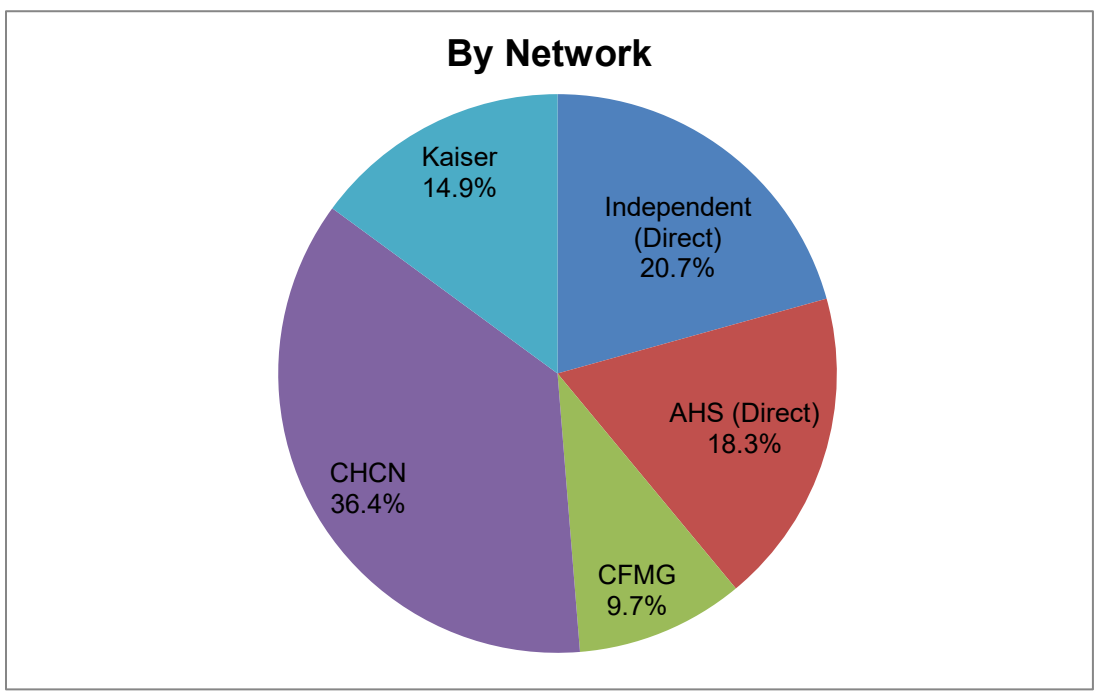
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED SEPTEMBER 30, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
24,423	82,827	58,404	70.5%	CS Medically Tailored Meals FFS Ancillary	54,113	246,844	192,731	78.1%
42	10,119	10,077	99.6%	CS Asthma Remediation FFS Ancillary	132	49,510	49,378	99.7%
0	10,002	10,002	100.0%	MOT Wrap Around (Non Medical MOT Cost)	0	30,006	30,006	100.0%
0	6,164	6,164	100.0%	CS Home Modifications FFS Ancillary	0	12,544	12,544	100.0%
0	108,278	108,278	100.0%	CS Personal Care & Homemaker Services FFS Ancillary	0	220,335	220,335	100.0%
0	20,988	20,988	100.0%	CS Caregiver Respite Services FFS Ancillary	0	42,709	42,709	100.0%
588,634	0	(588,634)	0.0%	Community Based Adult Services (CBAS)	1,393,908	0	(1,393,908)	0.0%
0	7,646	7,646	100.0%	CS Pilot LTC Diversion Expense	0	22,937	22,937	100.0%
3,823	3,823	0	0.0%	CS Pilot LTC Transition Expense	11,468	11,468	0	0.0%
0	79,452	79,452	100.0%	Justice Involved Pilot	0	243,902	243,902	100.0%
$9,497,264	**$11,884,177**	**$2,386,913**	**20.1%**	**9 - Ancillary Medical Expense**	**$32,931,897**	**$36,315,646**	**$3,383,748**	**9.3%**
634,153	0	(634,153)	0.0%	IBNR Outpatient	339,070	0	(339,070)	0.0%
19,024	0	(19,024)	0.0%	IBNR Settlement (OP)	10,170	0	(10,170)	0.0%
50,731	0	(50,731)	0.0%	IBNR Claims Fluctuation (OP)	27,126	0	(27,126)	0.0%
1,491,189	8,121,539	6,630,349	81.6%	Out Patient FFS	5,000,516	25,135,739	20,135,224	80.1%
1,744,319	0	(1,744,319)	0.0%	OP Ambul Surgery FFS	5,546,485	0	(5,546,485)	0.0%
1,494,270	0	(1,494,270)	0.0%	OP Fac Imaging Services FFS	5,068,419	0	(5,068,419)	0.0%
(4,978)	0	4,978	0.0%	Behav Health FFS	(57,669)	0	57,669	0.0%
571,150	0	(571,150)	0.0%	OP Facility Lab FFS	1,621,679	0	(1,621,679)	0.0%
140,944	0	(140,944)	0.0%	OP Facility Cardio FFS	466,038	0	(466,038)	0.0%
76,514	0	(76,514)	0.0%	OP Facility PT/OT/ST FFS	204,306	0	(204,306)	0.0%
1,678,978	0	(1,678,978)	0.0%	OP Facility Dialysis FFS	6,273,101	0	(6,273,101)	0.0%
$7,896,295	**$8,121,539**	**$225,243**	**2.8%**	**10 - Outpatient Medical Expense Medical Expense**	**$24,499,239**	**$25,135,739**	**$636,500**	**2.5%**
557,641	0	(557,641)	0.0%	IBNR Emergency	(312,999)	0	312,999	0.0%
16,730	0	(16,730)	0.0%	IBNR Settlement (ER)	(9,388)	0	9,388	0.0%
44,612	0	(44,612)	0.0%	IBNR Claims Fluctuation (ER)	(25,037)	0	25,037	0.0%
679,709	0	(679,709)	0.0%	Special ER Physician FFS	2,359,743	0	(2,359,743)	0.0%
5,047,549	5,863,374	815,824	13.9%	ER Facility	14,992,947	18,122,800	3,129,854	17.3%
$6,346,241	**$5,863,374**	**($482,868)**	**(8.2%)**	**11 - Emergency Expense**	**$17,005,266**	**$18,122,800**	**$1,117,534**	**6.2%**
378,100	0	(378,100)	0.0%	IBNR Pharmacy	(395,309)	0	395,309	0.0%
11,342	0	(11,342)	0.0%	IBNR Settlement (RX)	(11,863)	0	11,863	0.0%
30,249	0	(30,249)	0.0%	IBNR Claims Fluctuation (RX)	(31,624)	0	31,624	0.0%
502,762	378,159	(124,603)	(32.9%)	Pharmacy FFS	1,443,567	1,129,521	(314,046)	(27.8%)
109,425	8,253,412	8,143,987	98.7%	Pharmacy Non-PBM FFS-Other Anc	422,753	25,541,367	25,118,614	98.3%
5,906,891	0	(5,906,891)	0.0%	Pharmacy Non-PBM FFS-OP FAC	16,355,745	0	(16,355,745)	0.0%
173,261	0	(173,261)	0.0%	Pharmacy Non-PBM FFS-PCP	495,895	0	(495,895)	0.0%
2,076,173	0	(2,076,173)	0.0%	Pharmacy Non-PBM FFS-SCP	6,862,069	0	(6,862,069)	0.0%
6,537	0	(6,537)	0.0%	Pharmacy Non-PBM FFS-FQHC	30,768	0	(30,768)	0.0%
8,085	0	(8,085)	0.0%	Pharmacy Non-PBM FFS-HH	23,087	0	(23,087)	0.0%
(59)	0	59	0.0%	RX Refunds HMS	(63)	0	63	0.0%
(30,000)	30,429	60,429	198.6%	Pharmacy Rebate	(130,000)	91,614	221,614	241.9%
$9,172,766	**$8,662,001**	**($510,766)**	**(5.9%)**	**12 - Pharmacy Expense**	**$25,065,025**	**$26,762,502**	**$1,697,477**	**6.3%**
3,353,018	0	(3,353,018)	0.0%	IBNR LTC	76,480	0	(76,480)	0.0%
100,591	0	(100,591)	0.0%	IBNR Settlement (LTC)	2,295	0	(2,295)	0.0%
268,240	0	(268,240)	0.0%	IBNR Claims Fluctuation (LTC)	6,118	0	(6,118)	0.0%
14,015,674	0	(14,015,674)	0.0%	LTC Custodial Care	50,020,309	0	(50,020,309)	0.0%
3,099,475	15,362,577	12,263,102	79.8%	LTC SNF	9,039,150	46,518,592	37,479,443	80.6%
$20,836,998	**$15,362,577**	**($5,474,421)**	**(35.6%)**	**13 - Long Term Care FFS Expense**	**$59,144,352**	**$46,518,592**	**($12,625,760)**	**(27.1%)**
$94,212,087	**$94,435,056**	**$222,969**	**0.2%**	**14 - TOTAL FFS MEDICAL EXPENSES**	**$289,344,110**	**$290,587,238**	**$1,243,128**	**0.4%**
0	(225,263)	(225,263)	100.0%	Clinical Vacancy	0	(483,125)	(483,125)	100.0%
67,876	88,802	20,926	23.6%	Quality Analytics	309,399	289,156	(20,243)	(7.0%)
735,765	742,695	6,930	0.9%	Health Plan Services Department Total	2,114,465	2,099,303	(15,162)	(0.7%)
492,733	533,153	40,420	7.6%	Case & Disease Management Department Total	1,517,742	1,493,196	(24,546)	(1.6%)
2,892,597	2,601,821	(290,776)	(11.2%)	Medical Services Department Total	6,455,619	8,737,832	2,282,213	26.1%
492,185	652,929	160,744	24.6%	Quality Management Department Total	2,004,643	1,868,097	(136,546)	(7.3%)
242,089	253,393	11,304	4.5%	HCS Behavioral Health Department Total	715,065	746,037	30,972	4.2%
119,434	156,162	36,728	23.5%	Pharmacy Services Department Total	395,355	414,208	18,853	4.6%
80,115	60,734	(19,381)	(31.9%)	Regulatory Readiness Total	188,124	180,552	(7,572)	(4.2%)
$5,122,794	**$4,864,427**	**($258,367)**	**(5.3%)**	**15 - Other Benefits & Services**	**$13,700,412**	**$15,345,255**	**$1,644,843**	**10.7%**
(860,060)	(791,414)	68,646	(8.7%)	Reinsurance Recoveries	(2,569,060)	(2,402,328)	166,732	(6.9%)
1,048,566	1,055,218	6,652	0.6%	Reinsurance Premium	3,188,256	3,203,104	14,848	0.5%
$188,506	**$263,805**	**$75,298**	**28.5%**	**16- Reinsurance Expense**	**$619,196**	**$800,776**	**$181,580**	**22.7%**
1,000,000	0	(1,000,000)	0.0%	P4P Risk Pool Provider Incenti	1,000,000	0	(1,000,000)	0.0%
$1,000,000	**$0**	**($1,000,000)**	**0.0%**	**17 - Risk Pool Distribution**	**$1,000,000**	**$0**	**($1,000,000)**	**0.0%**
$126,353,580	**$125,531,306**	**($822,273)**	**(0.7%)**	**18 - TOTAL MEDICAL EXPENSES**	**$382,167,951**	**$385,687,039**	**$3,519,088**	**0.9%**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend							
Category of Aid	**Sep 2023**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	51,499	15%	9,645	9,863	796	21,587	9,608
Child	100,038	29%	7,116	9,252	30,908	33,581	19,181
SPD	30,592	9%	9,880	4,437	1,110	12,845	2,320
ACA OE	120,016	35%	17,844	37,127	1,328	47,018	16,699
Duals	41,629	12%	24,685	2,581	2	9,832	4,529
LTC	139	0%	139	-	-	-	-
LTC-Dual	1,004	0%	1,004	-	-	-	-
Medi-Cal	344,917		70,313	63,260	34,144	124,863	52,337
Group Care	5,631		2,191	873	-	2,567	-
Total	**350,548**	**100%**	**72,504**	**64,133**	**34,144**	**127,430**	**52,337**
Medi-Cal %	98.4%		97.0%	98.6%	100.0%	98.0%	100.0%
Group Care %	1.6%		3.0%	1.4%	0.0%	2.0%	0.0%
	Network Distribution		*20.7%*	*18.3%*	*9.7%*	*36.4%*	*14.9%*
			% Direct:	**39%**		**% Delegated:**	**61%**

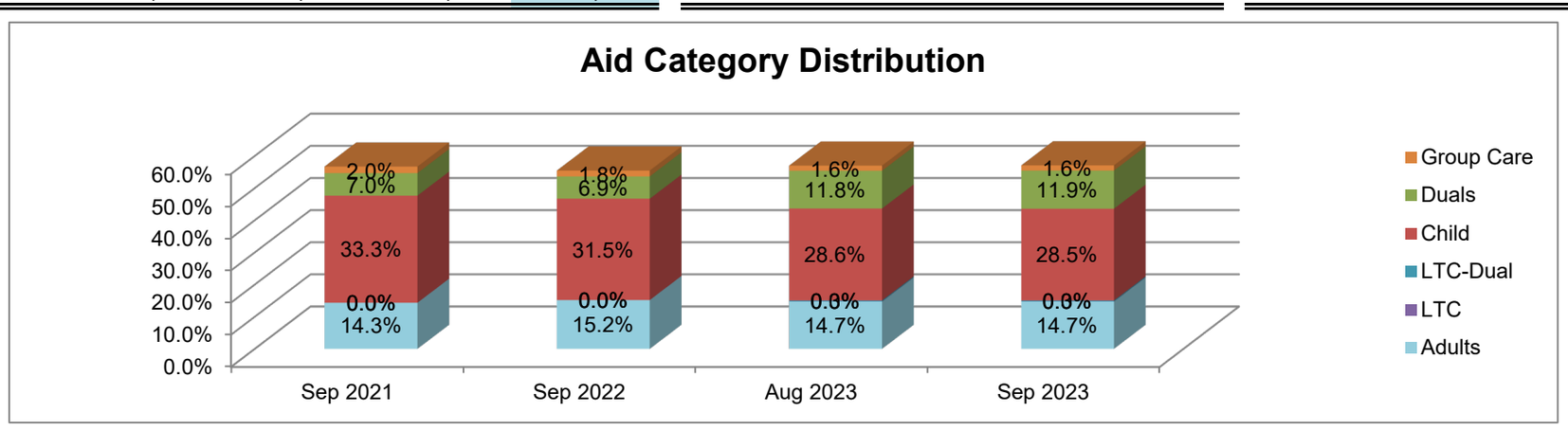




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

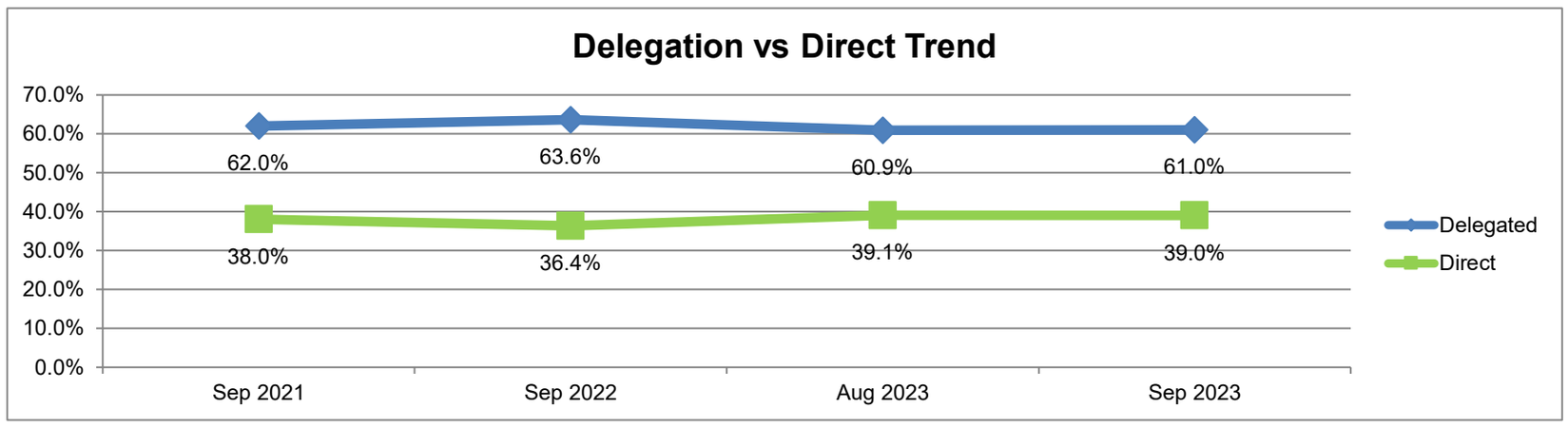
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021 to Sep 2022	Sep 2022 to Sep 2023	Aug 2023 to Sep 2023
Adults	41,924	48,711	52,176	51,499	14.3%	15.2%	14.7%	14.7%	16.2%	5.7%	-1.3%
Child	97,460	101,276	101,555	100,038	33.3%	31.5%	28.6%	28.5%	3.9%	-1.2%	-1.5%
SPD	26,330	28,200	30,864	30,592	9.0%	8.8%	8.7%	8.7%	7.1%	8.5%	-0.9%
ACA OE	100,469	115,018	121,928	120,016	34.3%	35.8%	34.3%	34.2%	14.5%	4.3%	-1.6%
Duals	20,535	22,319	41,722	41,629	7.0%	6.9%	11.8%	11.9%	8.7%	86.5%	-0.2%
LTC	-	-	138	139	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%
LTC-Dual	-	-	1,020	1,004	0.0%	0.0%	0.3%	0.3%	0.0%	0.0%	-1.6%
Medi-Cal Total	286,718	315,524	349,403	344,917	98.0%	98.2%	98.4%	98.4%	10.0%	9.3%	-1.3%
Group Care	5,914	5,809	5,645	5,631	2.0%	1.8%	1.6%	1.6%	-1.8%	-3.1%	-0.2%
Total	**292,632**	**321,333**	**355,048**	**350,548**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.8%**	**9.1%**	**-1.3%**



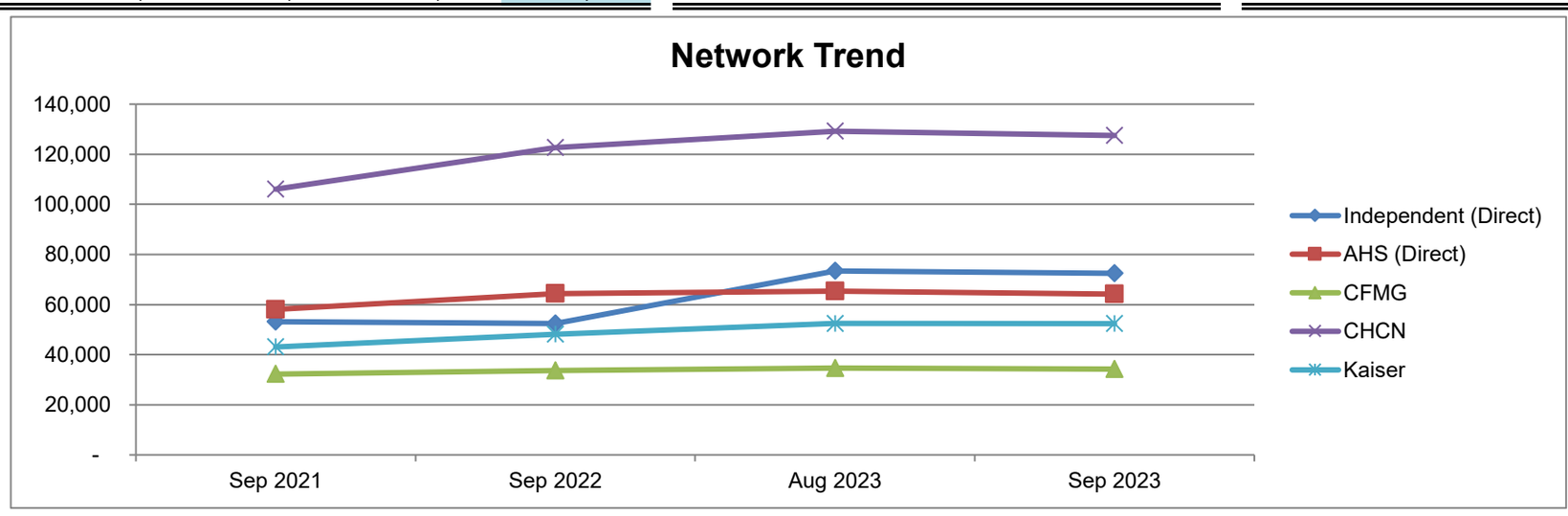
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021 to Sep 2022	Sep 2022 to Sep 2023	Aug 2023 to Sep 2023
Delegated	181,326	204,491	216,300	213,911	62.0%	63.6%	60.9%	61.0%	12.8%	4.6%	-1.1%
Direct	111,306	116,842	138,748	136,637	38.0%	36.4%	39.1%	39.0%	5.0%	16.9%	-1.5%
Total	**292,632**	**321,333**	**355,048**	**350,548**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.8%**	**9.1%**	**-1.3%**



Network Trend

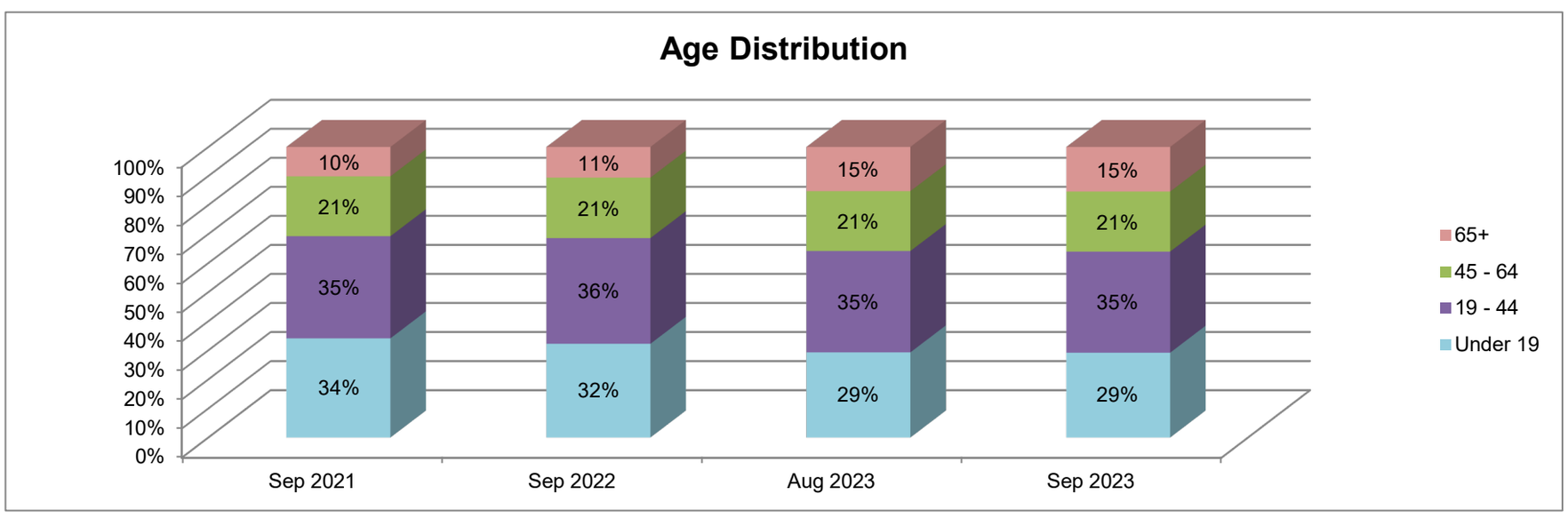
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021 to Sep 2022	Sep 2022 to Sep 2023	Aug 2023 to Sep 2023
Independent (Direct)	53,246	52,418	73,404	72,504	18.2%	16.3%	20.7%	20.7%	-1.6%	38.3%	-1.2%
AHS (Direct)	58,060	64,424	65,344	64,133	19.8%	20.0%	18.4%	18.3%	11.0%	-0.5%	-1.9%
CFMG	32,217	33,577	34,649	34,144	11.0%	10.4%	9.8%	9.7%	4.2%	1.7%	-1.5%
CHCN	106,050	122,696	129,183	127,430	36.2%	38.2%	36.4%	36.4%	15.7%	3.9%	-1.4%
Kaiser	43,059	48,218	52,468	52,337	14.7%	15.0%	14.8%	14.9%	12.0%	8.5%	-0.2%
Total	**292,632**	**321,333**	**355,048**	**350,548**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.8%**	**9.1%**	**-1.3%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

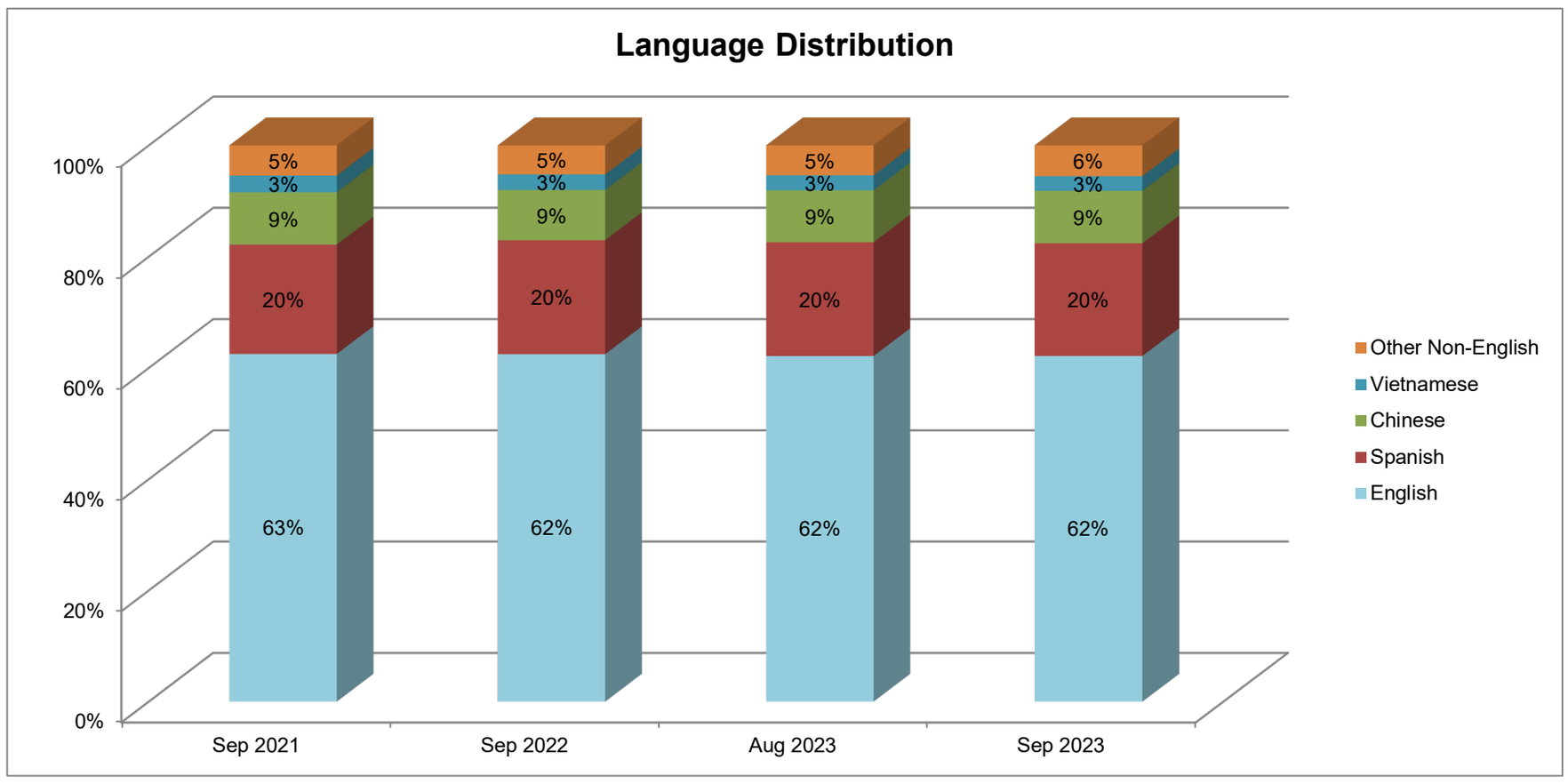
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021 to Sep 2022	Sep 2022 to Sep 2023	Aug 2023 to Sep 2023
Under 19	99,751	103,516	103,911	102,104	34%	32%	29%	29%	4%	-1%	-2%
19 - 44	102,887	116,874	123,789	121,849	35%	36%	35%	35%	14%	4%	-2%
45 - 64	60,370	66,989	73,289	72,443	21%	21%	21%	21%	11%	8%	-1%
65+	29,624	33,954	54,059	53,863	10%	11%	15%	15%	15%	59%	0%
Total	**292,632**	**321,333**	**355,048**	**350,259**	**100%**	**100%**	**100%**	**100%**	**10%**	**9%**	**-1%**



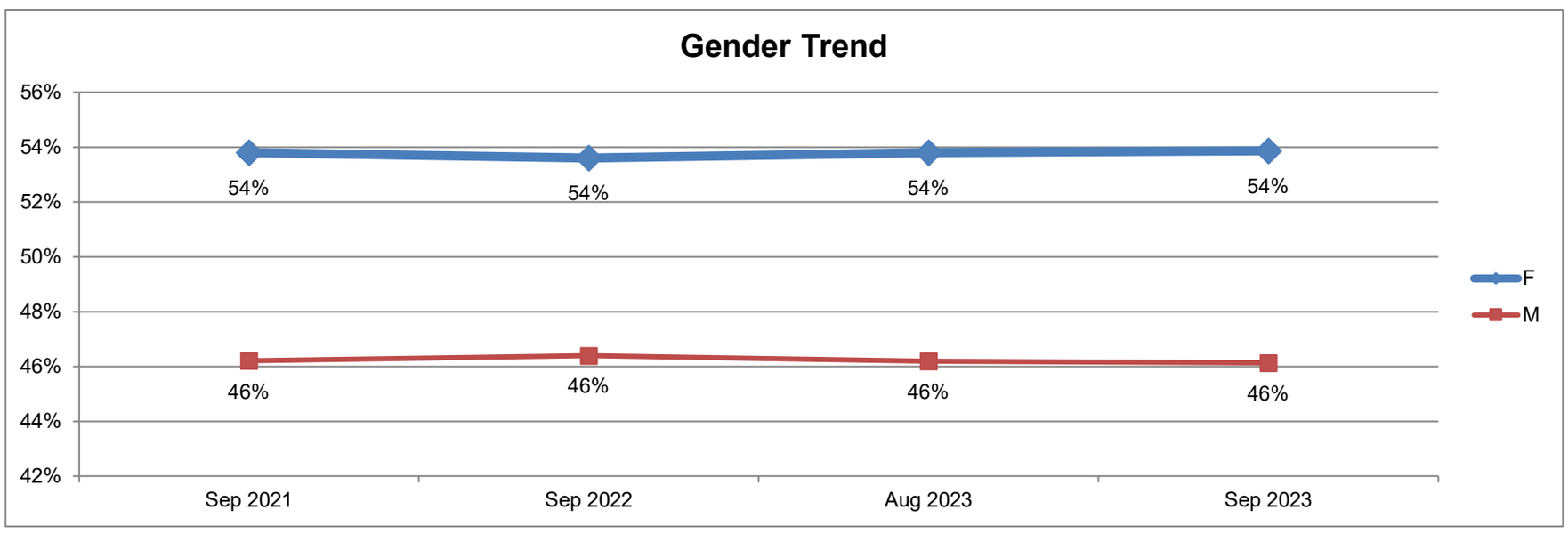
Language Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021 to Sep 2022	Sep 2022 to Sep 2023	Aug 2023 to Sep 2023
English	182,896	200,696	220,565	217,655	63%	62%	62%	62%	10%	8%	-1%
Spanish	57,525	65,837	72,596	70,947	20%	20%	20%	20%	14%	8%	-2%
Chinese	27,513	29,053	33,152	33,023	9%	9%	9%	9%	6%	14%	0%
Vietnamese	8,789	8,928	9,609	9,233	3%	3%	3%	3%	2%	3%	-4%
Other Non-English	15,909	16,819	19,126	19,401	5%	5%	5%	6%	6%	15%	1%
Total	**292,632**	**321,333**	**355,048**	**350,259**	**100%**	**100%**	**100%**	**100%**	**10%**	**9%**	**-1%**

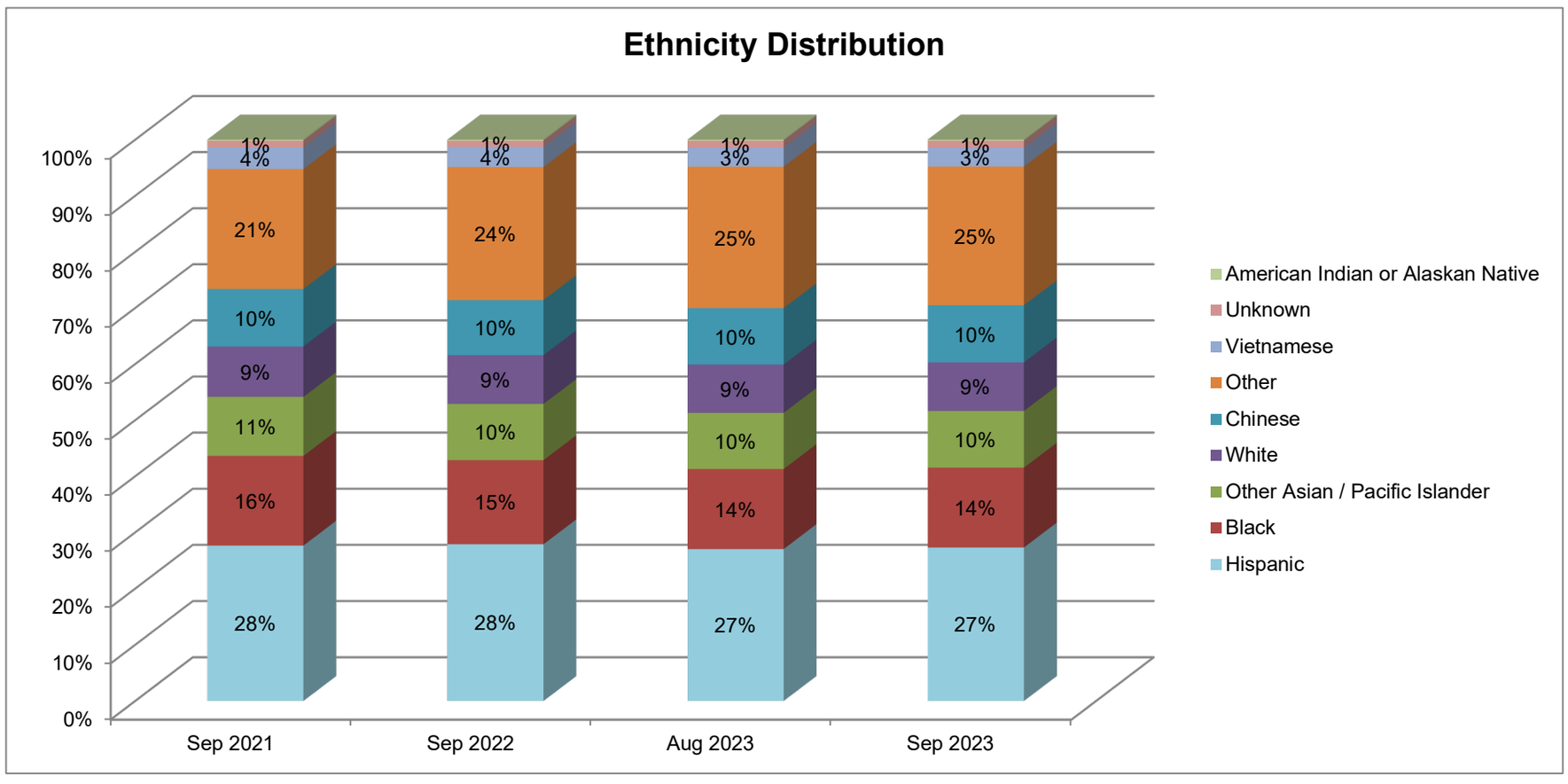


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Gender Trend	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021 to Sep 2022	Sep 2022 to Sep 2023	Aug 2023 to Sep 2023
F	157,426	172,247	191,038	188,677	54%	54%	54%	54%	9%	10%	-1%
M	135,206	149,086	164,010	161,582	46%	46%	46%	46%	10%	8%	-1%
Total	**292,632**	**321,333**	**355,048**	**350,259**	**100%**	**100%**	**100%**	**100%**	**10%**	**9%**	**-1%**



Ethnicity Trend	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021	Sep 2022	Aug 2023	Sep 2023	Sep 2021 to Sep 2022	Sep 2022 to Sep 2023	Aug 2023 to Sep 2023
Hispanic	80,857	89,573	95,902	95,595	28%	28%	27%	27%	11%	7%	0%
Black	46,756	48,141	50,614	49,809	16%	15%	14%	14%	3%	3%	-2%
Other Asian / Pacific Islander	30,769	32,208	35,566	35,405	11%	10%	10%	10%	5%	10%	0%
White	26,326	27,911	30,577	30,362	9%	9%	9%	9%	6%	9%	-1%
Chinese	29,994	31,599	35,715	35,649	10%	10%	10%	10%	5%	13%	0%
Other	62,583	76,226	89,524	86,602	21%	24%	25%	25%	22%	14%	-3%
Vietnamese	11,278	11,448	12,104	11,738	4%	4%	3%	3%	2%	3%	-3%
Unknown	3,446	3,533	4,327	4,380	1%	1%	1%	1%	3%	24%	1%
American Indian or Alaskan Native	623	694	719	719	0%	0%	0%	0%	11%	4%	0%
Total	**292,632**	**321,333**	**355,048**	**350,259**	**100%**	**100%**	**100%**	**100%**	**10%**	**9%**	**-1%**



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

Medi-Cal By City

City	Sep 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	132,779	38%	18,910	29,673	13,963	55,529	14,704
Hayward	54,299	16%	10,509	11,492	5,883	17,011	9,404
Fremont	32,506	9%	12,692	4,753	1,287	8,525	5,249
San Leandro	31,224	9%	6,366	4,265	3,433	11,287	5,873
Union City	14,560	4%	5,122	2,148	617	3,906	2,767
Alameda	13,366	4%	2,914	1,994	1,694	4,547	2,217
Berkeley	12,873	4%	2,604	1,624	1,316	5,356	1,973
Livermore	10,552	3%	1,557	580	1,834	4,663	1,918
Newark	8,203	2%	2,468	2,499	296	1,485	1,455
Castro Valley	8,811	3%	1,860	1,298	1,114	2,623	1,916
San Lorenzo	7,258	2%	1,259	1,218	699	2,591	1,491
Pleasanton	6,036	2%	1,377	354	543	2,673	1,089
Dublin	6,450	2%	1,469	396	652	2,755	1,178
Emeryville	2,416	1%	517	436	312	735	416
Albany	1,996	1%	320	199	342	712	423
Piedmont	437	0%	83	119	29	89	117
Sunol	71	0%	17	9	6	23	16
Antioch	40	0%	12	7	7	11	3
Other	1,040	0%	257	196	117	342	128
Total	**344,917**	**100%**	**70,313**	**63,260**	**34,144**	**124,863**	**52,337**

Group Care By City

City	Sep 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,786	32%	391	340	-	1,055	-
Hayward	624	11%	299	137	-	188	-
Fremont	613	11%	426	60	-	127	-
San Leandro	583	10%	230	84	-	269	-
Union City	298	5%	193	39	-	66	-
Alameda	281	5%	98	21	-	162	-
Berkeley	166	3%	48	11	-	107	-
Livermore	98	2%	33	2	-	63	-
Newark	137	2%	92	27	-	18	-
Castro Valley	192	3%	78	30	-	84	-
San Lorenzo	129	2%	46	16	-	67	-
Pleasanton	61	1%	22	3	-	36	-
Dublin	101	2%	34	6	-	61	-
Emeryville	35	1%	14	6	-	15	-
Albany	21	0%	9	1	-	11	-
Piedmont	11	0%	2	-	-	9	-
Sunol	-	0%	-	-	-	-	-
Antioch	25	0%	6	8	-	11	-
Other	470	8%	170	82	-	218	-
Total	**5,631**	**100%**	**2,191**	**873**	**-**	**2,567**	**-**

Total By City

City	Sep 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	134,565	38%	19,301	30,013	13,963	56,584	14,704
Hayward	54,923	16%	10,808	11,629	5,883	17,199	9,404
Fremont	33,119	9%	13,118	4,813	1,287	8,652	5,249
San Leandro	31,807	9%	6,596	4,349	3,433	11,556	5,873
Union City	14,858	4%	5,315	2,187	617	3,972	2,767
Alameda	13,647	4%	3,012	2,015	1,694	4,709	2,217
Berkeley	13,039	4%	2,652	1,635	1,316	5,463	1,973
Livermore	10,650	3%	1,590	582	1,834	4,726	1,918
Newark	8,340	2%	2,560	2,526	296	1,503	1,455
Castro Valley	9,003	3%	1,938	1,328	1,114	2,707	1,916
San Lorenzo	7,387	2%	1,305	1,234	699	2,658	1,491
Pleasanton	6,097	2%	1,399	357	543	2,709	1,089
Dublin	6,551	2%	1,503	402	652	2,816	1,178
Emeryville	2,451	1%	531	442	312	750	416
Albany	2,017	1%	329	200	342	723	423
Piedmont	448	0%	85	119	29	98	117
Sunol	71	0%	17	9	6	23	16
Antioch	65	0%	18	15	7	22	3
Other	1,510	0%	427	278	117	560	128
Total	**350,548**	**100%**	**72,504**	**64,133**	**34,144**	**127,430**	**52,337**

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

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

Date: **March 8th, 2024**

Subject: **Finance Report – December 2023**

Executive Summary

- For the month ended December 31st, 2023, the Alliance had enrollment of 351,980 members, a Net Income of $10.6 million and 724% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$135,075	$823,047
Medical Expense	122,174	759,412
Admin. Expense	7,007	44,709
Other Inc. / (Exp.)	4,670	16,460
Net Income	**$10,564**	**$35,386**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	$10,249	$33,987
Group Care	315	1,399
	$10,564	**$35,386**

*Includes consulting cost for Medicare implementation.

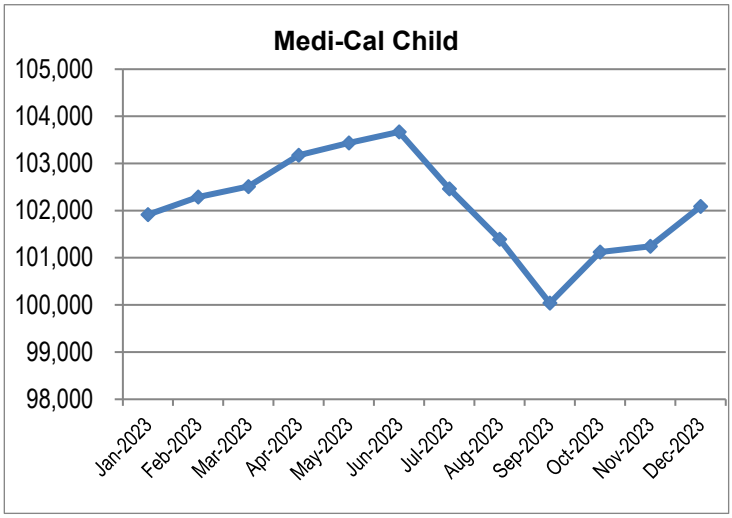
Enrollment

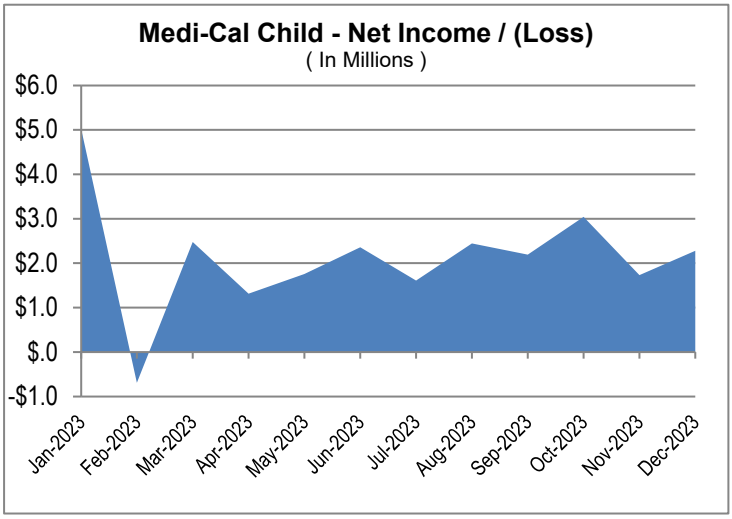
- Total enrollment decreased by 546 members since November 2023.
- Total enrollment decreased by 9,705 members since June 2023.

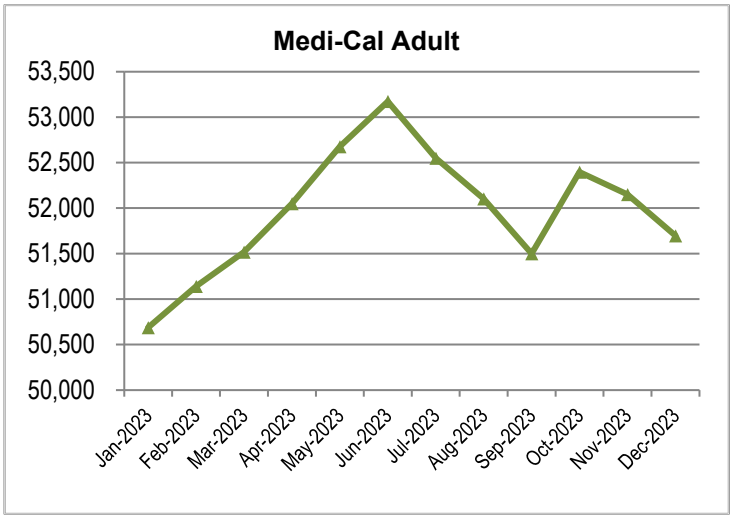
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

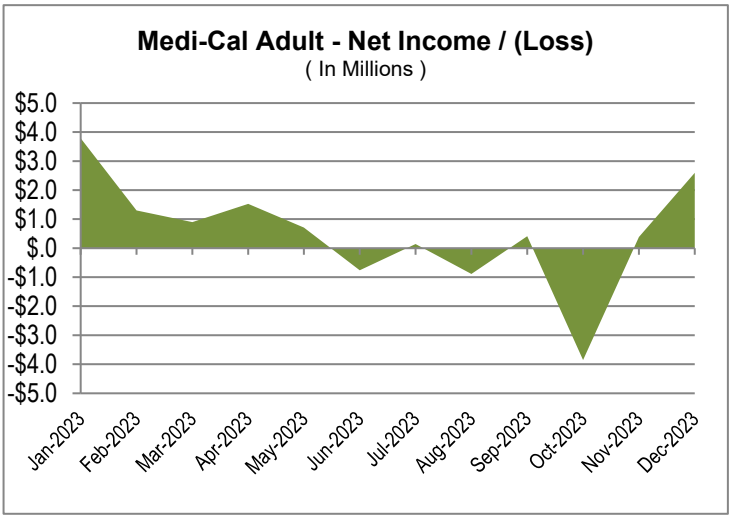
Enrollment					Member Months			
December 2023					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
51,696	51,301	395	0.8%	Adult	312,394	311,720	674	0.2%
102,088	99,008	3,080	3.1%	Child	608,345	604,131	4,214	0.7%
30,846	30,488	358	1.2%	SPD	185,086	184,597	489	0.3%
40,974	41,325	(351)	-0.8%	Duals	248,499	249,263	(764)	-0.3%
119,668	119,605	63	0.1%	ACA OE	727,213	727,757	(544)	-0.1%
135	137	(2)	-1.5%	LTC	825	826	(1)	-0.1%
951	971	(20)	-2.1%	LTC Duals	5,979	6,009	(30)	-0.5%
346,358	**342,835**	**3,523**	**1.0%**	**Medi-Cal Total**	**2,088,341**	**2,084,303**	**4,038**	**0.2%**
5,622	5,577	45	0.8%	Group Care	33,757	33,718	39	0.1%
351,980	**348,412**	**3,568**	**1.0%**	**Total**	**2,122,098**	**2,118,021**	**4,077**	**0.2%**

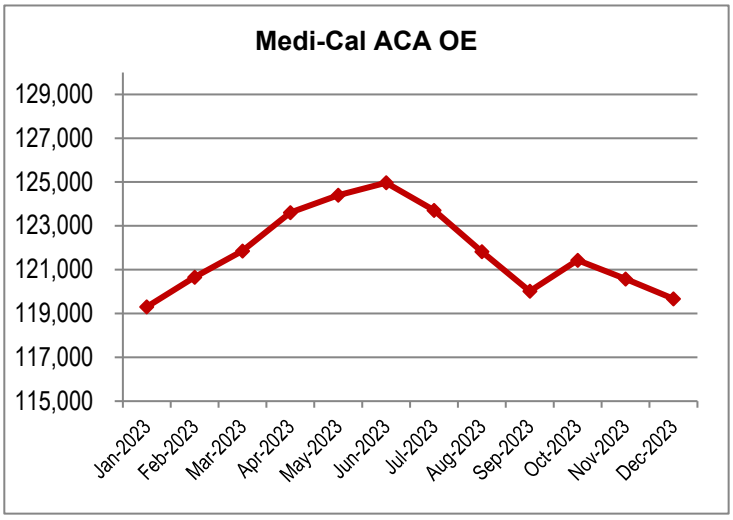
Enrollment and Profitability by Program and Category of Aid

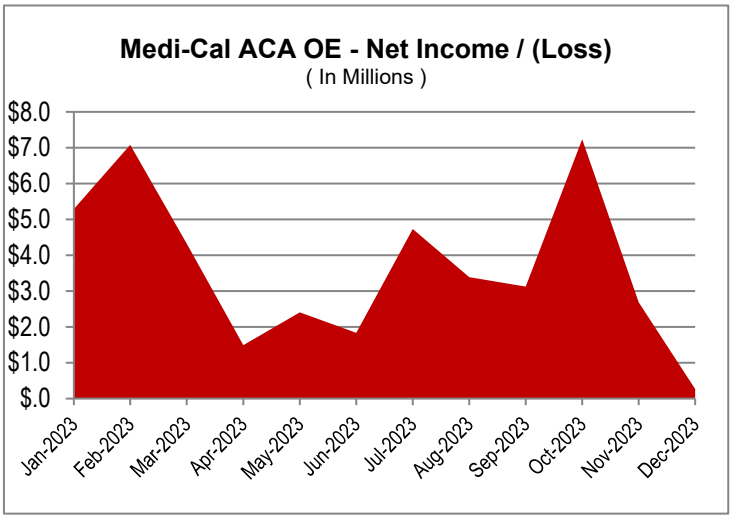




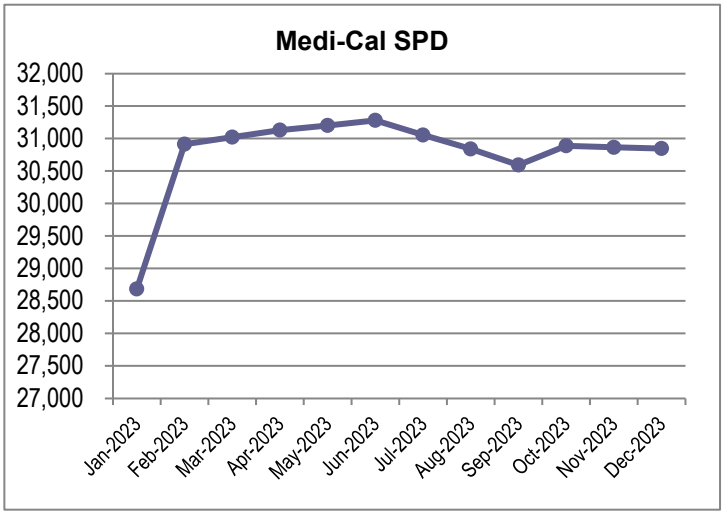


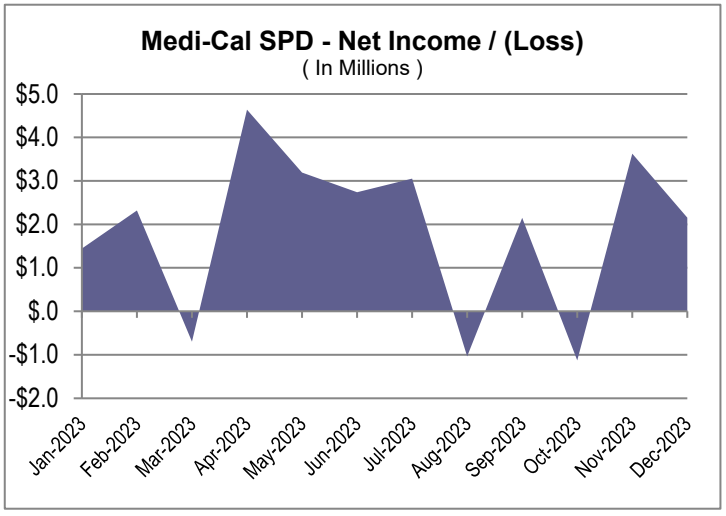


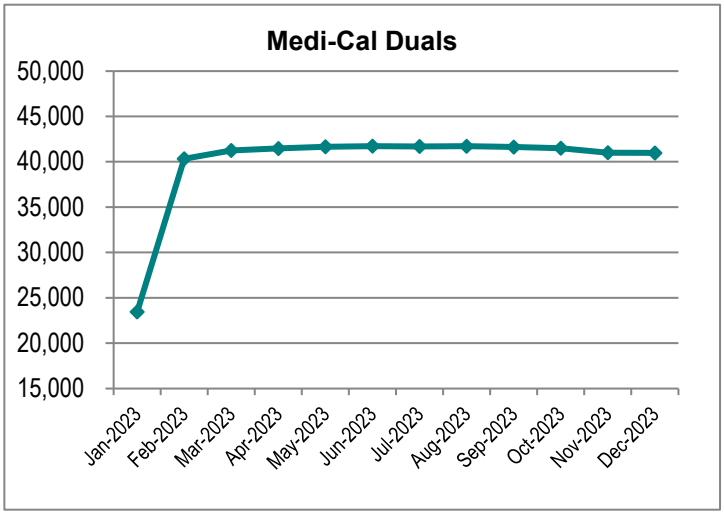


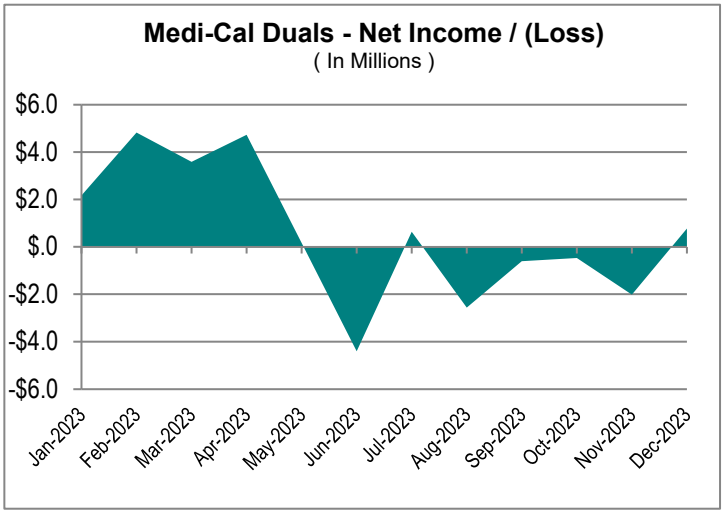


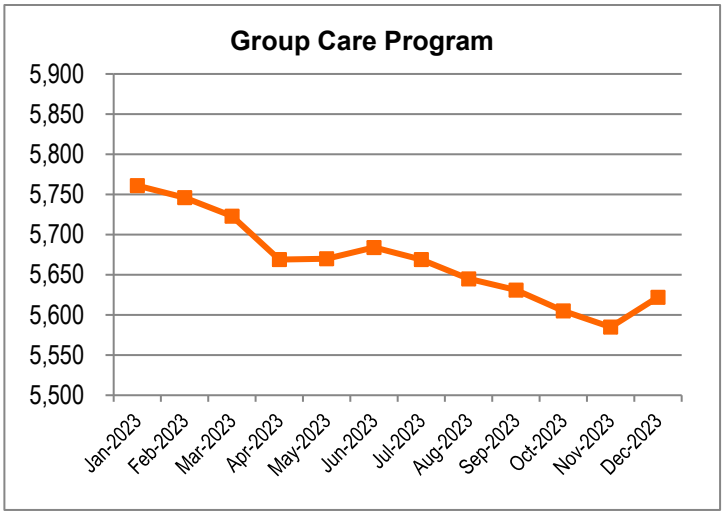
Enrollment and Profitability by Program and Category of Aid

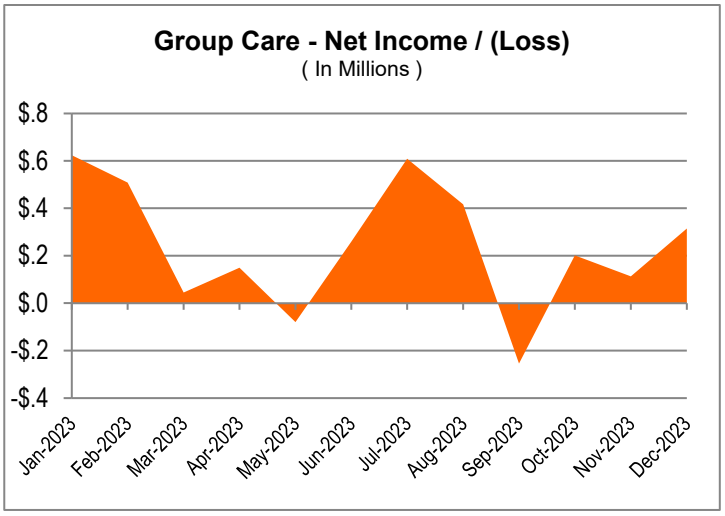




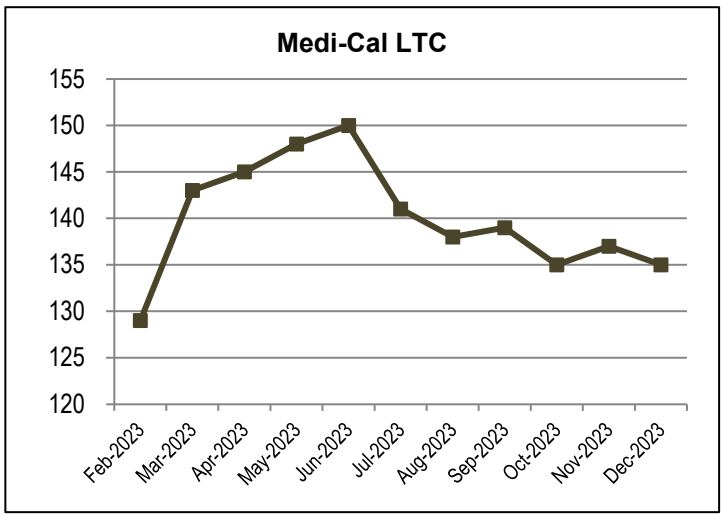


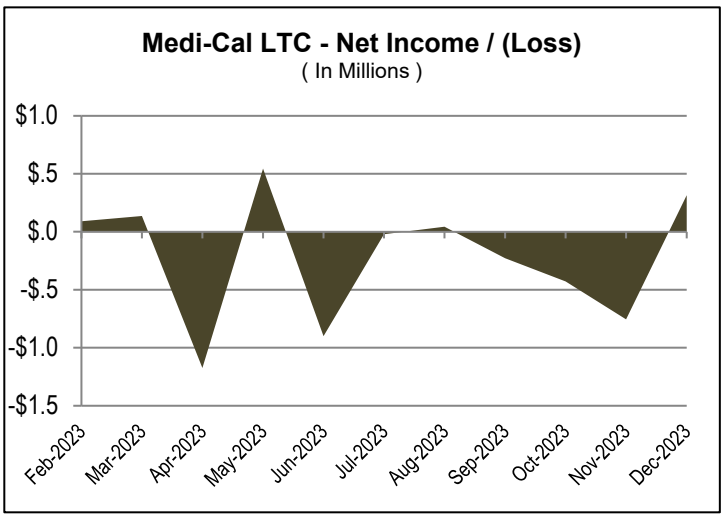


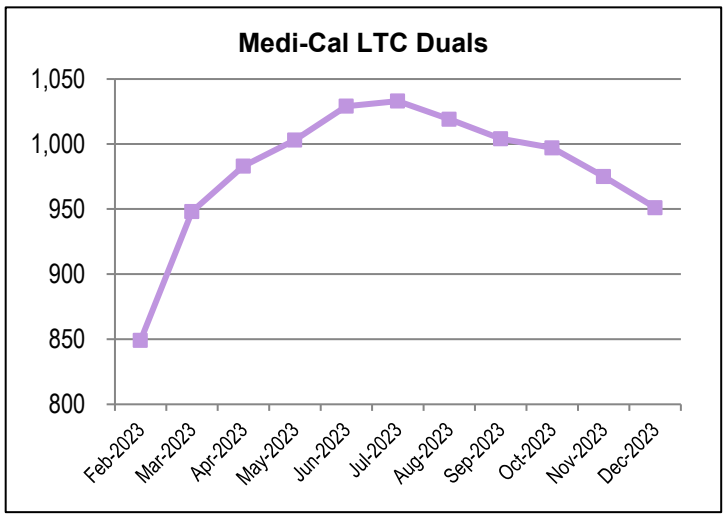


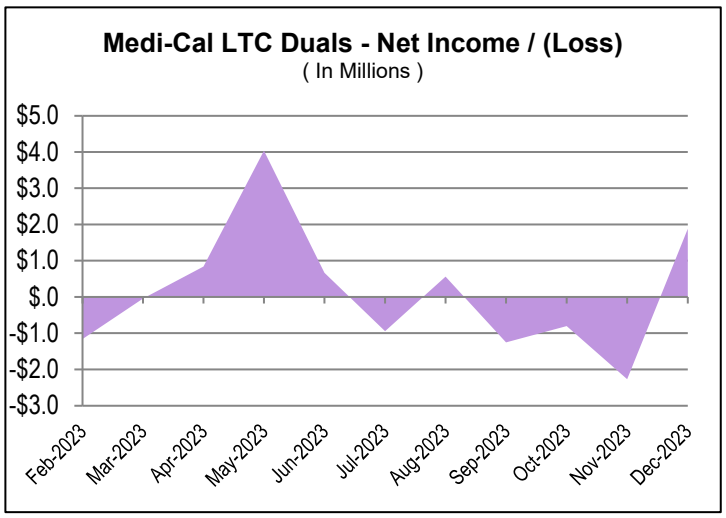


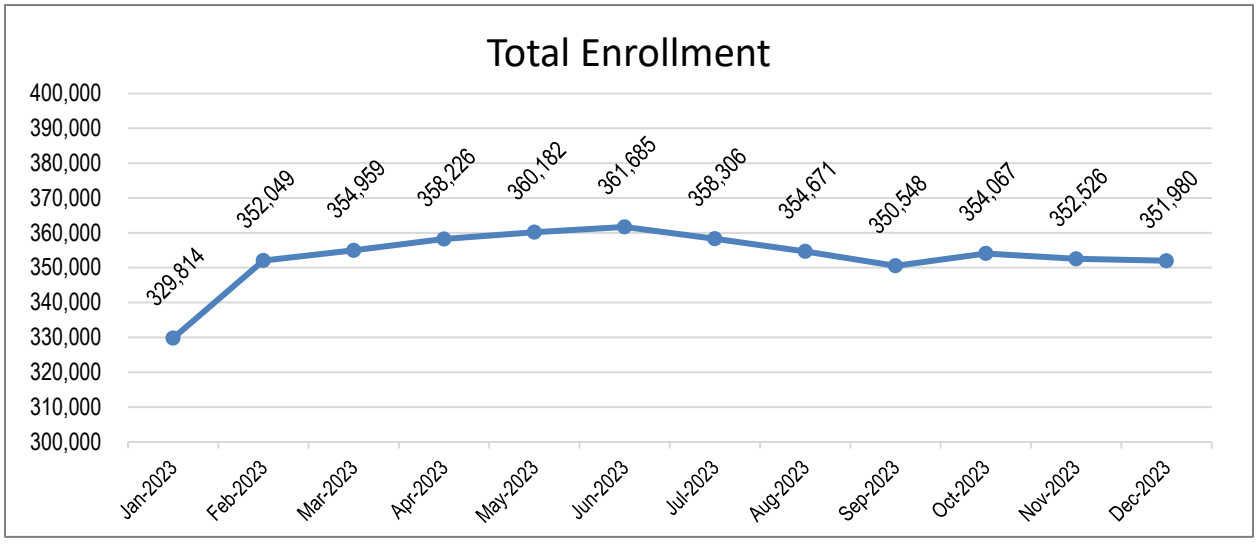
Enrollment and Profitability by Program and Category of Aid

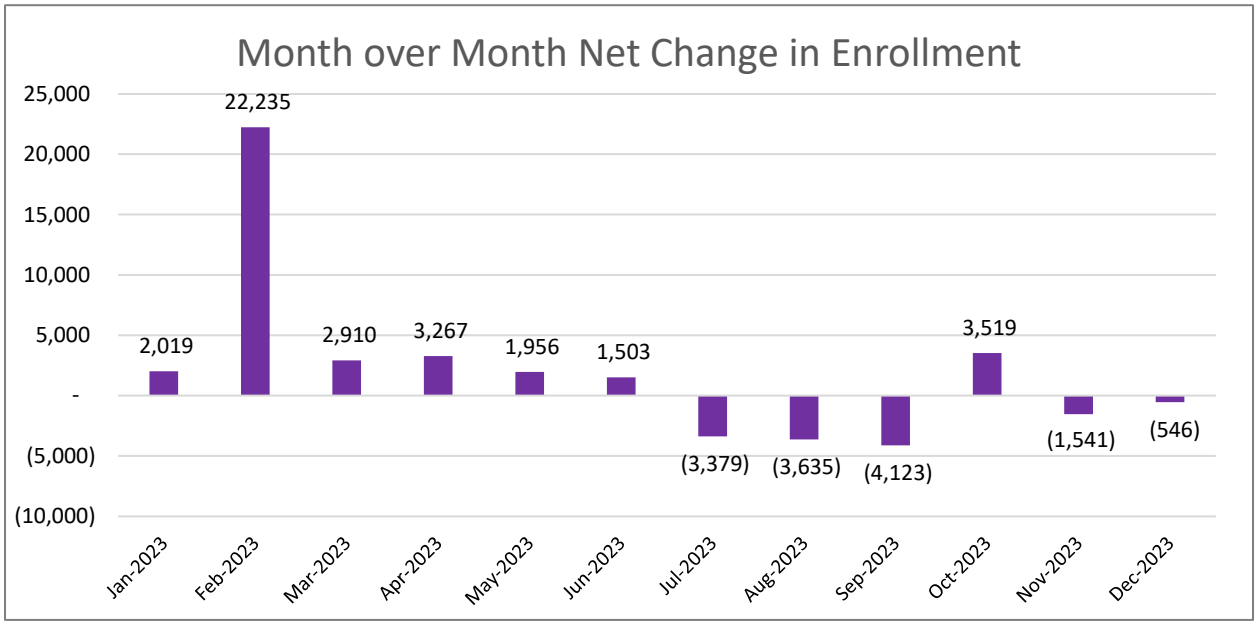










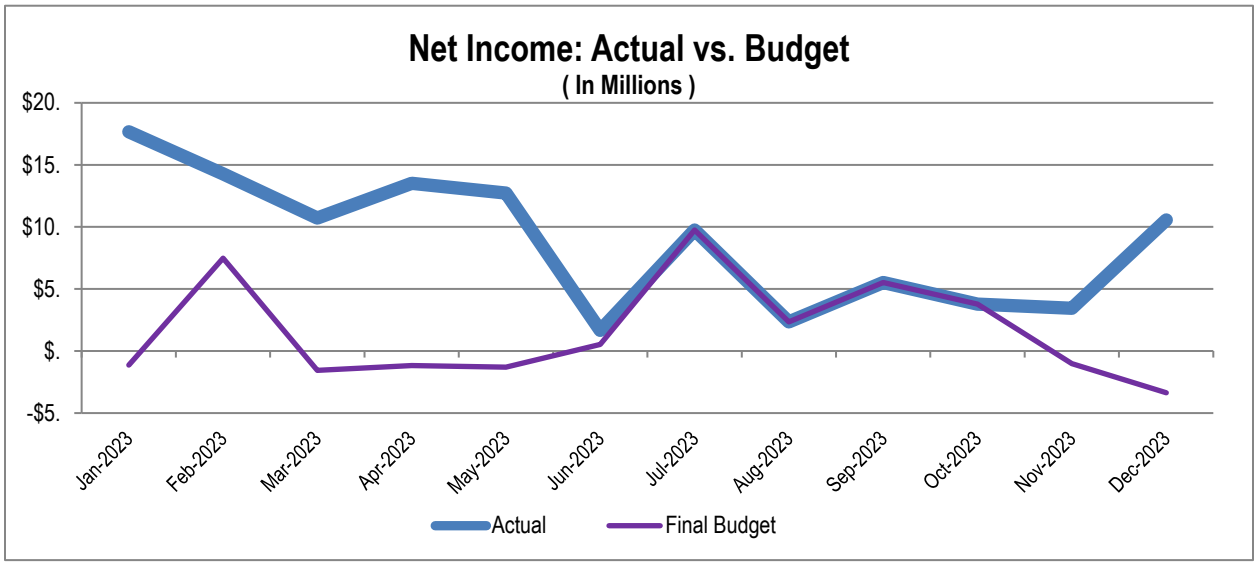


- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started in July 2023. In preparation for the Single Plan Model, DHCS is no longer assigning members to Anthem. New members are now all assigned to the Alliance.

Net Income

- For the month ended December 31st, 2023
  - Actual Net Income $10.6 million.
  - Budgeted Net Loss $3.4 million.

- For the fiscal YTD ended December 31st, 2023
  - Actual Net Income $35.4 million.
  - Budgeted Net Income $17.0 million.

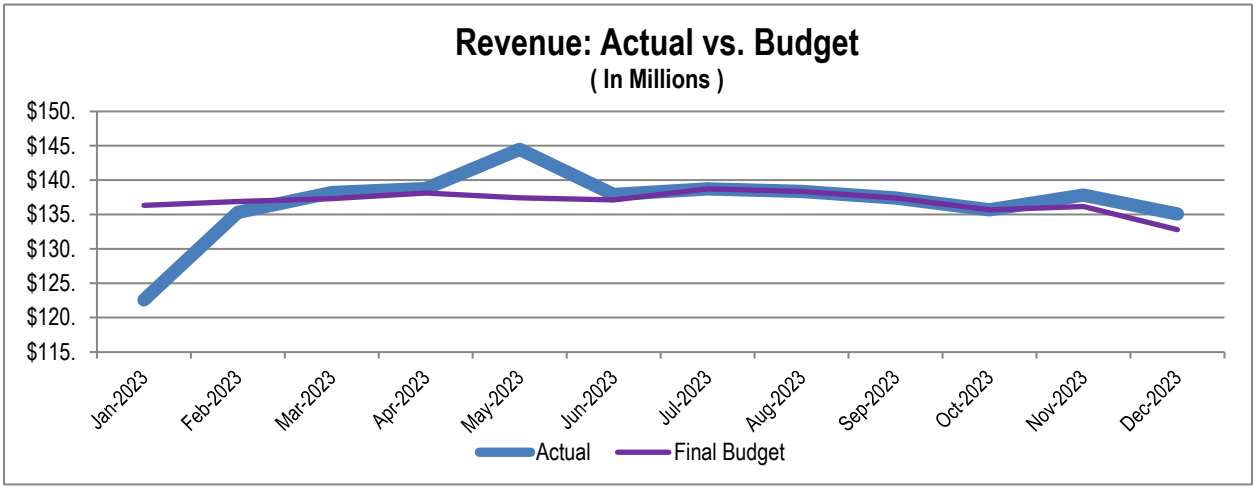


- The favorable variance of $13.9 million in the current month is primarily due to:
  - Favorable $6.4 million lower than anticipated Medical Expense.
  - Favorable $3.0 million lower than anticipated Administrative Expense.
  - Favorable $2.3 million higher than anticipated Revenue.
  - Favorable $2.2 million higher than anticipated Other Income/Expense.

Revenue

- For the month ended December 31st, 2023
  - Actual Revenue: $135.1 million.
  - Budgeted Revenue: $132.8 million.

- For the fiscal YTD ended December 31st, 2023
  - Actual Revenue: $823.0 million.
  - Budgeted Revenue: $819.1 million.

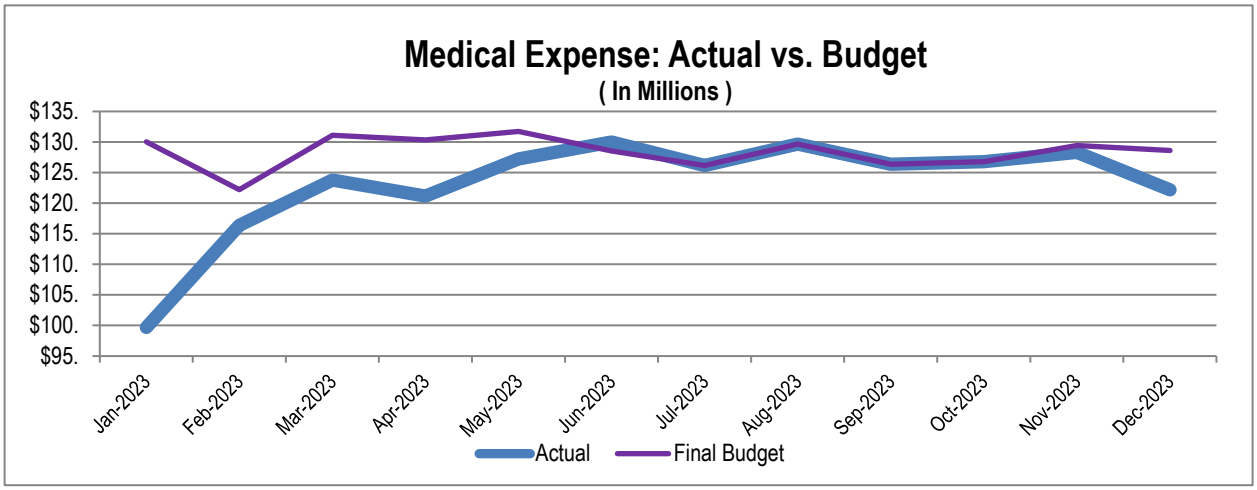


- For the month ended December 31st, 2023, the favorable revenue variance of $2.3 million is primarily due to timing of revenue recognition:
  - Favorable Capitation Rate variance. Higher rates were received primarily due to differences in Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) membership distribution.
  - Favorable November Estimate to Actual true-up and large retroactive payments.
  - Favorable enrollment volume variance for December 2023.
  - Unfavorable accrual for Medical Loss Ratio payback for Fiscal Year 2014-2015 for the ACA OE population.
  - Unfavorable MCO Tax reconciliation by DHCS for Fiscal Year 2019 and prior periods.

Medical Expense

- For the month ended December 31st, 2023
  - Actual Medical Expense: $122.2 million.
  - Budgeted Medical Expense: $128.6 million.

- For the fiscal YTD ended December 31st, 2023
  - Actual Medical Expense: $759.4 million.
  - Budgeted Medical Expense: $767.0 million.



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

- For December, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $2.0 million. Year to date, the estimate for prior years increased by $4.2 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)
Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$153,950,048	$0	$153,950,048	$155,185,871	$1,235,822	0.8%
Primary Care FFS	$33,519,621	$5,892	$33,525,513	$33,356,922	($162,698)	-0.5%
Specialty Care FFS	$29,886,426	$60,824	$29,947,250	$31,049,358	$1,162,932	3.7%
Outpatient FFS	$47,068,588	$66,325	$47,134,913	$48,143,859	$1,075,272	2.2%
Ancillary FFS	$64,524,883	$654,073	$65,178,955	$65,039,828	$514,945	0.8%
Pharmacy FFS	$49,227,087	$43,910	$49,270,998	$51,572,865	$2,345,777	4.5%
ER Services FFS	$33,984,220	$1,017	$33,985,237	$34,241,988	$257,768	0.8%
Inpatient Hospital & SNF FFS	$193,459,008	$1,125,624	$194,584,632	$198,700,397	$5,241,389	2.6%
Long Term Care FFS	$118,715,410	$2,280,115	$120,995,525	$115,298,322	($3,417,088)	-3.0%
Other Benefits & Services	$27,387,911	$0	$27,387,911	$30,511,986	$3,124,075	10.2%
Net Reinsurance	$451,052	$0	$451,052	$869,388	$418,336	48.1%
Provider Incentive	$3,000,000	$0	$3,000,000	$3,000,000	$0	0.0%
	$755,174,253	**$4,237,782**	**$759,412,034**	**$766,970,784**	**$11,796,531**	**1.5%**

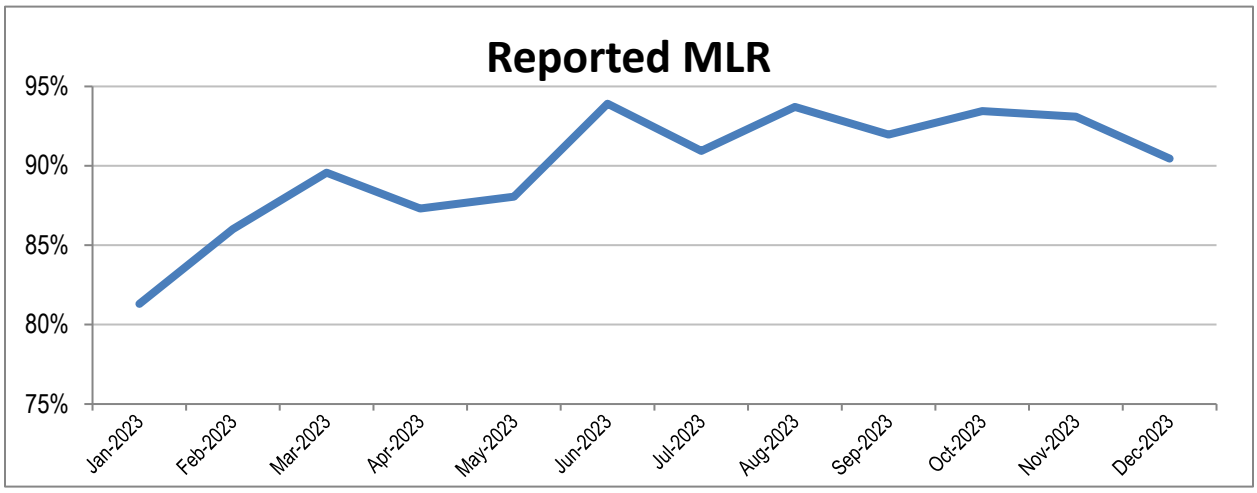
Medical Expense - Actual vs. Budget (Per Member Per Month) Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$72.55	$0.00	$72.55	$73.27	$0.72	1.0%
Primary Care FFS	$15.80	$0.00	$15.80	$15.75	($0.05)	-0.3%
Specialty Care FFS	$14.08	$0.03	$14.11	$14.66	$0.58	3.9%
Outpatient FFS	$22.18	$0.03	$22.21	$22.73	$0.55	2.4%
Ancillary FFS	$30.41	$0.31	$30.71	$30.71	$0.30	1.0%
Pharmacy FFS	$23.20	$0.02	$23.22	$24.35	$1.15	4.7%
ER Services FFS	$16.01	$0.00	$16.01	$16.17	$0.15	0.9%
Inpatient Hospital & SNF FFS	$91.16	$0.53	$91.69	$93.81	$2.65	2.8%
Long Term Care FFS	$55.94	$1.07	$57.02	$54.44	($1.51)	-2.8%
Other Benefits & Services	$12.91	$0.00	$12.91	$14.41	$1.50	10.4%
Net Reinsurance	$0.21	$0.00	$0.21	$0.41	$0.20	48.2%
Provider Incentive	$1.41	$0.00	$1.41	$1.42	$0.00	0.2%
	$355.86	**$2.00**	**$357.86**	**$362.12**	**$6.25**	**1.7%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $11.8 million favorable to budget. On a PMPM basis, medical expense is 1.7% favorable to budget. For per-member-per-month expense:
    - Capitated Expense is slightly under budget, largely driven by favorable Supplemental Maternity, FQHC, and Global Subcontract expenses.
    - Primary Care Expense is slightly above budget driven mostly by the higher ACA OE and SPD utilization.
    - Specialty Care Expense is below budget, driven mostly by lower SPD and Duals utilization.
    - Outpatient Expense is under budget due to lower facility other and dialysis utilization.
    - Ancillary Expense is under budget mostly due to lower unit cost in the Child, SPD and Dual member groups.
    - Pharmacy Expense is under budget mostly due to lower Non-PBM expense driven by lower utilization by SPDs and ACA OEs.
    - Emergency Room Expense is under budget driven mostly by lower utilization in SPDs.
    - Inpatient Expense is under budget mostly driven by lower utilization and unit cost by SPD and Adult categories of aid.
    - Long Term Care Expense is over budget mostly due to higher utilization and unit cost in the SPD, ACA OE and Duals populations.
    - Other Benefits & Services is under budget, due to favorable Cal AIM Incentive, community relations, other purchased services and employee expense.

- Net Reinsurance year-to-date is under budget because more recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 90.4% for the month and 92.3% for the fiscal year-to-date.



Administrative Expense

- For the month ended December 31, 2023
  - Actual Administrative Expense: $7.0 million.
  - Budgeted Administrative Expense: $10.0 million.

- For the fiscal YTD ended December 31, 2023
  - Actual Administrative Expense: $44.7 million.
  - Budgeted Administrative Expense: $50.0 million.

Summary of Administrative Expense (In Dollars)
For the Month and Fiscal Year-to-Date
Favorable/(Unfavorable)

Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$4,586,613	$6,596,917	$2,010,304	30.5%	Employee Expense	$28,690,864	$31,403,711	$2,712,846	8.6%
65,983	60,325	(5,658)	-9.4%	Medical Benefits Admin Expense	1,177,706	1,175,972	(1,734)	-0.1%
517,860	1,075,146	557,286	51.8%	Purchased & Professional Services	5,982,298	7,147,136	1,164,838	16.3%
1,836,226	2,285,225	448,998	19.6%	Other Admin Expense	8,858,166	10,304,200	1,446,033	14.0%
$7,006,682	$10,017,613	$3,010,931	30.1%	Total Administrative Expense	$44,709,035	$50,031,018	$5,321,984	10.6%

The year-to-date variances include:

- Favorable impact of delayed timing of start dates for Consulting for new projects and Computer Support Services.
- Favorable FTE and Temporary Services variances and delayed Training, Travel, Recruitment, and other employee-related expenses.

The Administrative Loss Ratio (ALR) is 5.2% of net revenue for the month and 5.4% of net revenue year-to-date.

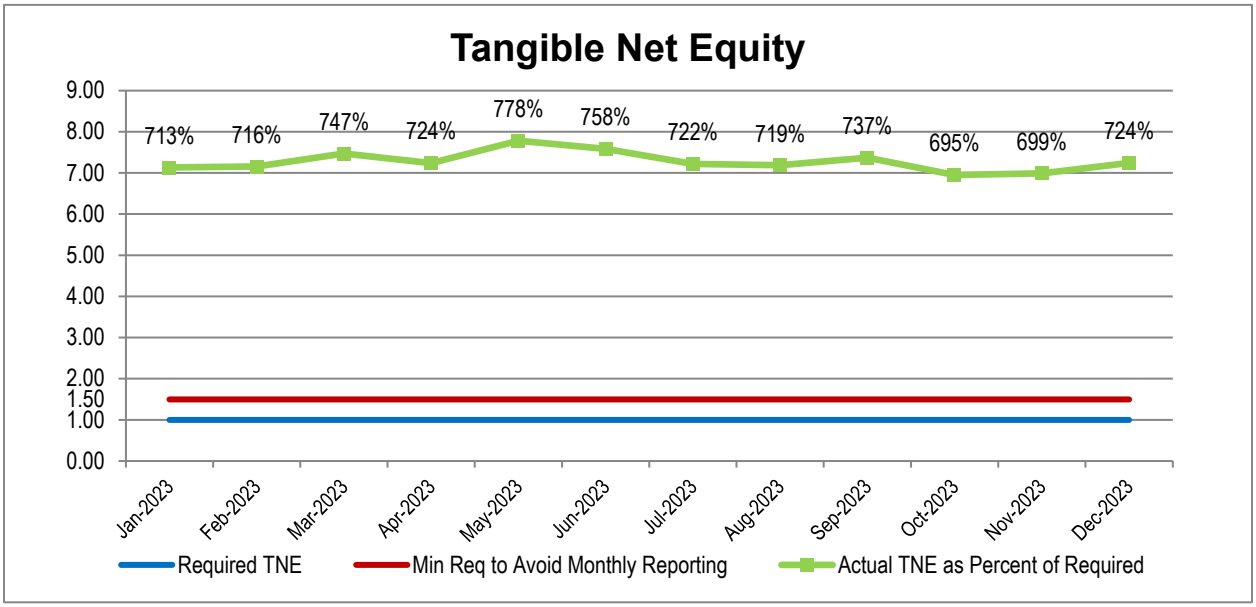
Other Income / (Expense)

Other Income & Expense is comprised of investment income and claims interest.

- Fiscal year-to-date net investments show a gain of $16.8 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $294,000.

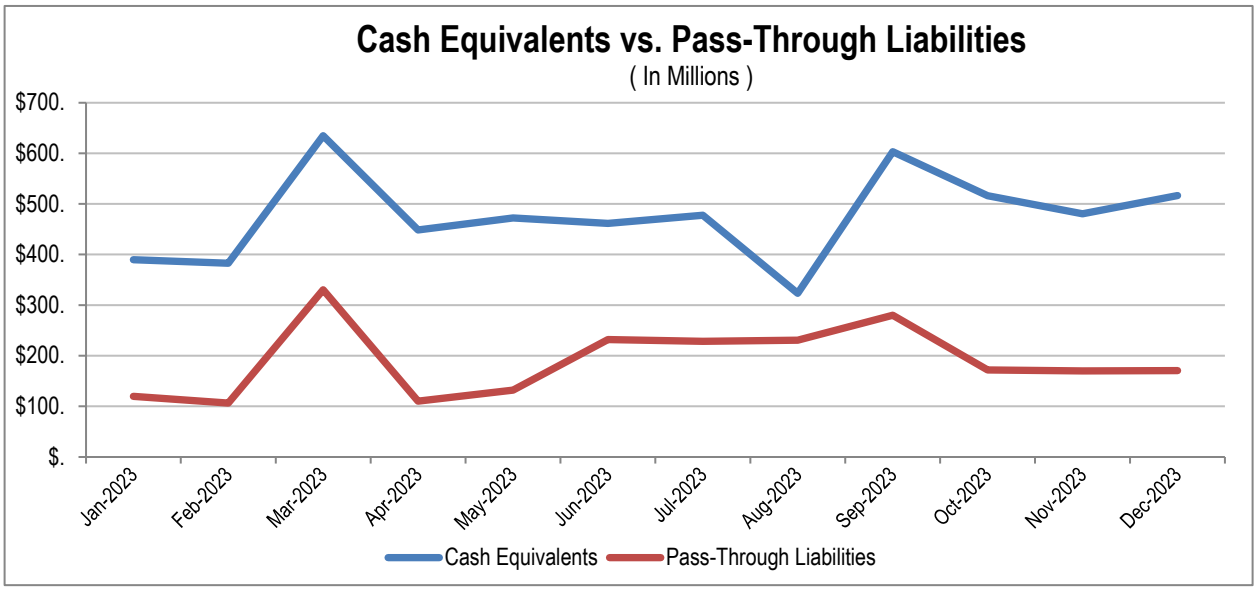
Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
    - Required TNE $49.6 million
    - Actual TNE $359.3 million
    - Excess TNE $309.7 million
    - TNE % of Required TNE 724%



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

- Key Metrics
  - Cash & Cash Equivalents $516.0 million
  - Pass-Through Liabilities $170.7 million
  - Uncommitted Cash $345.3 million
  - Working Capital $344.1 million
  - Current Ratio 1.82 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $1.1 million.
- Annual capital budget: $1.6 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.

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED DECEMBER 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
346,358	342,835	3,523	1.0%	1- Medi-Cal	2,088,341	2,084,303	4,038	0.2%
5,622	5,577	45	0.8%	2- GroupCare	33,757	33,718	39	0.1%
351,980	**348,412**	**3,568**	**1.0%**	**3- TOTAL MEMBER MONTHS**	**2,122,098**	**2,118,021**	**4,077**	**0.2%**
				REVENUE				
$135,075,053	**$132,807,117**	**$2,267,937**	**1.7%**	**4- TOTAL REVENUE**	**$823,047,115**	**$819,115,281**	**$3,931,834**	**0.5%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$25,392,210	$25,962,568	$570,359	2.2%	5- Capitated Medical Expense	$153,950,048	$155,185,871	$1,235,822	0.8%
				Fee for Service Medical Expenses:				
$31,780,422	$33,945,587	$2,165,165	6.4%	6- Inpatient Hospital Expense	$194,584,632	$198,700,397	$4,115,765	2.1%
$5,534,573	$5,393,238	($141,336)	(2.6%)	7- Primary Care Physician Expense	$33,525,513	$33,356,922	($168,590)	(0.5%)
$4,965,019	$5,528,507	$563,488	10.2%	8- Specialty Care Physician Expense	$29,947,250	$31,049,358	$1,102,109	3.5%
$11,813,926	$11,031,605	($782,321)	(7.1%)	9- Ancillary Medical Expense	$65,178,955	$65,039,828	($139,128)	(0.2%)
$7,586,067	$8,112,653	$526,586	6.5%	10- Outpatient Medical Expense	$47,134,913	$48,143,859	$1,008,946	2.1%
$5,555,420	$5,776,148	$220,728	3.8%	11- Emergency Expense	$33,985,237	$34,241,988	$256,751	0.7%
$7,242,527	$8,976,673	$1,734,146	19.3%	12- Pharmacy Expense	$49,270,998	$51,572,865	$2,301,867	4.5%
$17,894,464	$17,284,719	($609,745)	(3.5%)	13- Long Term Care Expense	$120,995,525	$115,298,322	($5,697,204)	(4.9%)
$92,372,417	$96,049,129	$3,676,712	3.8%	14- Total Fee for Service Expense	$574,623,024	$577,403,539	$2,780,516	0.5%
$4,693,272	$6,348,009	$1,654,737	26.1%	15- Other Benefits & Services	$27,387,911	$30,511,986	$3,124,076	10.2%
($283,702)	$255,435	$539,137	211.1%	16- Reinsurance Expense	$451,052	$869,388	$418,336	48.1%
$0	$0	$0	0.0%	17- Risk Pool Distribution	$3,000,000	$3,000,000	$0	(0.0%)
$122,174,197	**$128,615,141**	**$6,440,944**	**5.0%**	**18- TOTAL MEDICAL EXPENSES**	**$759,412,034**	**$766,970,784**	**$7,558,750**	**1.0%**
$12,900,857	**$4,191,976**	**$8,708,881**	**207.8%**	**19- GROSS MARGIN**	**$63,635,081**	**$52,144,496**	**$11,490,584**	**22.0%**
				ADMINISTRATIVE EXPENSES				
$4,586,613	$6,596,917	$2,010,304	30.5%	20- Personnel Expense	$28,690,864	$31,403,711	$2,712,847	8.6%
$65,983	$60,325	($5,658)	(9.4%)	21- Benefits Administration Expense	$1,177,706	$1,175,972	($1,734)	(0.1%)
$517,860	$1,075,146	$557,286	51.8%	22- Purchased & Professional Services	$5,982,298	$7,147,136	$1,164,838	16.3%
$1,836,226	$2,285,225	$448,998	19.6%	23- Other Administrative Expense	$8,858,166	$10,304,200	$1,446,033	14.0%
$7,006,682	**$10,017,613**	**$3,010,931**	**30.1%**	**24- TOTAL ADMINISTRATIVE EXPENSES**	**$44,709,035**	**$50,031,019**	**$5,321,985**	**10.6%**
$5,894,175	**($5,825,638)**	**$11,719,812**	**201.2%**	**25- NET OPERATING INCOME / (LOSS)**	**$18,926,046**	**$2,113,477**	**$16,812,569**	**795.5%**
				OTHER INCOME / EXPENSES				
$4,669,592	**$2,460,000**	**$2,209,592**	**89.8%**	**26- TOTAL OTHER INCOME / (EXPENSES)**	**$16,459,858**	**$14,878,587**	**$1,581,270**	**10.6%**
$10,563,766	**($3,365,638)**	**$13,929,404**	**413.9%**	**27- NET INCOME / (LOSS)**	**$35,385,904**	**$16,992,065**	**$18,393,839**	**108.2%**
90.4%	96.8%	6.4%	6.6%	28- Medical Loss Ratio	92.3%	93.6%	1.3%	1.4%
9.6%	3.2%	6.4%	200.0%	29- Gross Margin Ratio	7.7%	6.4%	1.3%	20.3%
5.2%	7.5%	2.3%	30.7%	30- Administrative Expense Ratio	5.4%	6.1%	0.7%	11.5%
7.8%	-2.5%	10.3%	412.0%	31- Net Income / (Loss) Ratio	4.3%	2.1%	2.2%	104.8%

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED DECEMBER 31, 2023

	12/31/2023	11/30/2023	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	($104,562,280)	$24,020,681	($128,582,961)	-535.30%
Short-Term Investments	620,592,043	456,476,983	164,115,061	35.95%
Interest Receivable	3,986,756	941,384	3,045,372	323.50%
Premium Receivables	227,060,158	246,298,660	(19,238,502)	-7.81%
Reinsurance Receivables	4,267,742	3,649,520	618,222	16.94%
Other Receivables	679,492	289,506	389,986	134.71%
Prepaid Expenses	3,736,069	4,104,927	(368,858)	-8.99%
CalPERS Net Pension Assets	(5,286,448)	(5,286,448)	0	0.00%
Deferred Outflow	14,099,056	14,099,056	0	0.00%
TOTAL CURRENT ASSETS	**$764,572,587**	**$744,594,269**	**$19,978,319**	**2.68%**
OTHER ASSETS:				
Long-Term Investments	4,738,227	7,098,007	(2,359,780)	-33.25%
Restricted Assets	350,000	350,000	0	0.00%
GASB 87-Lease Assets (Net)	1,202,404	1,268,317	(65,913)	-5.20%
GASB 96-SBITA Assets (Net)	4,613,515	4,850,009	(236,494)	-4.88%
TOTAL OTHER ASSETS	**$10,904,146**	**$13,566,333**	**($2,662,187)**	**-19.62%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,149,359	10,149,359	0	0.00%
Furniture And Equipment	12,958,278	12,969,465	(11,187)	-0.09%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	$38,834,086	$38,845,273	($11,187)	-0.03%
Less: Accumulated Depreciation	($32,836,353)	($32,766,263)	($70,090)	0.21%
NET PROPERTY AND EQUIPMENT	**$5,997,733**	**$6,079,009**	**($81,276)**	**-1.34%**
TOTAL ASSETS	**$781,474,466**	**$764,239,612**	**$17,234,855**	**2.26%**
CURRENT LIABILITIES:				
Accounts Payable	5,522,051	2,278,704	3,243,347	142.33%
Other Accrued Liabilities	24,634,929	23,668,841	966,088	4.08%
GASB 87 ST Lease Liabilities	901,070	778,049	123,021	15.81%
GASB 96 ST SBITA Liabilities	2,160,890	2,132,894	27,996	1.31%
Claims Payable	30,091,843	30,584,248	(492,405)	-1.61%
IBNP Reserves	168,142,497	163,472,423	4,670,074	2.86%
Pass-Through Liabilities	170,713,987	169,810,295	903,692	0.53%
Risk Sharing - Providers	6,629,337	6,629,337	0	0.00%
Payroll Liabilities	6,711,455	8,555,738	(1,844,283)	-21.56%
Deferred Inflow	5,004,985	5,004,985	0	0.00%
TOTAL CURRENT LIABILITIES	**$420,513,043**	**$412,915,513**	**$7,597,530**	**1.84%**
LONG TERM LIABILITIES:				
GASB 87 LT Lease Liabilities	472,201	552,032	(79,831)	-14.46%
GASB 96 LT SBITA Liabilities	1,146,277	1,992,888	(846,611)	-42.48%
TOTAL LONG TERM LIABILITIES	**$1,618,478**	**$2,544,920**	**($926,442)**	**-36.40%**
TOTAL LIABILITIES	**$422,131,521**	**$415,460,433**	**$6,671,088**	**1.61%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	323,116,808	323,116,808	0	0.00%
Year-to Date Net Income / (Loss)	35,385,904	24,822,137	10,563,766	42.56%
TOTAL NET WORTH	**$359,342,945**	**$348,779,179**	**$10,563,766**	**3.03%**
TOTAL LIABILITIES AND NET WORTH	**$781,474,466**	**$764,239,612**	**$17,234,855**	**2.26%**
Cash Equivalents	$516,029,763	$480,497,664	$35,532,100	7.39%
Pass-Through	$170,713,987	$169,810,295	$903,692	0.53%
Uncommitted Cash	$345,315,777	$310,687,369	$34,628,408	11.15%
Working Capital	$344,059,545	$331,678,756	$12,380,788	3.73%
Current Ratio	181.8%	180.3%	1.5%	0.8%

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 12/31/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,572,834	$7,688,322	$15,434,713	$15,434,713
Total	2,572,834	7,688,322	15,434,713	15,434,713
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	132,502,117	400,870,273	807,611,997	807,611,997
Premium Receivable	19,238,503	(15,889,372)	69,302,263	69,302,263
Total	151,740,620	384,980,901	876,914,260	876,914,260
Investment & Other Income Cash Flows				
Other Revenue (Grants)	101,252	222,648	513,318	513,318
Investment Income	4,695,315	9,955,301	16,361,742	16,361,742
Interest Receivable	(3,045,372)	(3,536,618)	(3,272,180)	(3,272,180)
Total	1,751,195	6,641,331	13,602,880	13,602,880
Medical & Hospital Cash Flows				
Total Medical Expenses	(122,174,195)	(377,244,084)	(759,412,034)	(759,412,034)
Other Receivable	(1,008,207)	(2,272,218)	(1,088,170)	(1,088,170)
Claims Payable	(492,404)	(930,628)	(8,608,081)	(8,608,081)
IBNP Payable	4,670,074	11,247,271	3,638,094	3,638,094
Risk Share Payable	0	2,000,000	1,022,154	1,022,154
Health Program	0	11,640	0	0
Other Liabilities	0	1	1	1
Total	(119,004,732)	(367,188,018)	(764,448,036)	(764,448,036)
Administrative Cash Flows				
Total Administrative Expenses	(7,133,553)	(23,711,286)	(45,123,832)	(45,123,832)
Prepaid Expenses	368,859	1,823,970	1,164,650	1,164,650
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	(790,565)	1,440,447	2,215,033	2,215,033
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	(1,844,283)	(369,334)	781,568	781,568
Net Lease Assets/Liabilities (Short term & Long term)	(473,017)	(896,468)	(630,545)	(630,545)
Depreciation Expense	70,091	190,931	359,228	359,228
Total	(9,802,468)	(21,521,740)	(41,233,898)	(41,233,898)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**27,257,449**	**10,600,796**	**100,269,919**	**100,269,919**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 12/31/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	2,359,780	2,289,337	6,822,310	6,822,310
	2,359,780	2,289,337	6,822,310	6,822,310
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	5,903,692	(99,430,962)	(51,308,890)	(51,308,890)
Restricted Cash	0	0	0	0
	5,903,692	(99,430,962)	(51,308,890)	(51,308,890)
Fixed Asset Cash Flows				
Depreciation expense	70,091	190,931	359,228	359,228
Fixed Asset Acquisitions	11,187	(580,042)	(1,138,990)	(1,138,990)
Change in A/D	(70,091)	(190,931)	(359,228)	(359,228)
	11,187	(580,042)	(1,138,990)	(1,138,990)
Total Cash Flows from Investing Activities	**8,274,659**	**(97,721,667)**	**(45,625,570)**	**(45,625,570)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**35,532,108**	**(87,120,871)**	**54,644,349**	**54,644,349**
Rounding	(9)	0	(1)	(1)
Cash @ Beginning of Period	480,497,664	603,150,634	461,385,415	461,385,415
Cash @ End of Period	**$516,029,763**	**$516,029,763**	**$516,029,763**	**$516,029,763**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 12/31/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$10,563,762	$17,781,175	$35,385,904	$35,385,904
Add back: Depreciation	70,091	190,931	359,228	359,228
Receivables				
Premiums Receivable	19,238,503	(15,889,372)	69,302,263	69,302,263
Interest Receivable	(3,045,372)	(3,536,618)	(3,272,180)	(3,272,180)
Other Receivable	(1,008,207)	(2,272,218)	(1,088,170)	(1,088,170)
Total	15,184,924	(21,698,208)	64,941,913	64,941,913
Prepaid Expenses	368,859	1,823,970	1,164,650	1,164,650
Trade Payables	(790,565)	1,440,447	2,215,033	2,215,033
Claims Payable, IBNR & Risk Share				
IBNP	4,670,074	11,247,271	3,638,094	3,638,094
Claims Payable	(492,404)	(930,628)	(8,608,081)	(8,608,081)
Risk Share Payable	0	2,000,000	1,022,154	1,022,154
Other Liabilities	0	1	1	1
Total	4,177,670	12,316,644	(3,947,832)	(3,947,832)
Unearned Revenue				
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	(1,844,283)	(369,334)	781,568	781,568
Net Lease Assets/Liabilities (Short term & Long term)	(473,017)	(896,468)	(630,545)	(630,545)
Health Program	0	11,640	0	0
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	(2,317,300)	(1,254,162)	151,023	151,023
Cash Flows from Operating Activities	**$27,257,441**	**$10,600,797**	**$100,269,919**	**$100,269,919**
Difference (rounding)	(8)	1	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 12/31/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$151,740,620	$384,980,901	$876,914,260	$876,914,260
Commercial Premium Revenue	2,572,834	7,688,322	15,434,713	15,434,713
Other Income	101,252	222,648	513,318	513,318
Investment Income	1,649,943	6,418,683	13,089,562	13,089,562
Cash Paid To:				
Medical Expenses	(119,004,732)	(367,188,018)	(764,448,036)	(764,448,036)
Vendor & Employee Expenses	(9,802,468)	(21,521,740)	(41,233,898)	(41,233,898)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	27,257,449	10,600,796	100,269,919	100,269,919
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	11,187	(580,042)	(1,138,990)	(1,138,990)
Net Cash Provided By (Used In) Financing Activities	11,187	(580,042)	(1,138,990)	(1,138,990)
Cash Flows from Investing Activities:				
Changes in Investments	2,359,780	2,289,337	6,822,310	6,822,310
Restricted Cash	5,903,692	(99,430,962)	(51,308,890)	(51,308,890)
Net Cash Provided By (Used In) Investing Activities	8,263,472	(97,141,625)	(44,486,580)	(44,486,580)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**35,532,108**	**(87,120,871)**	**54,644,349**	**54,644,349**
Cash @ Beginning of Period	480,497,664	603,150,634	461,385,415	461,385,415
Subtotal	$516,029,772	$516,029,763	$516,029,764	$516,029,764
Rounding	(9)	0	(1)	(1)
Cash @ End of Period	**$516,029,763**	**$516,029,763**	**$516,029,763**	**$516,029,763**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$10,563,762	$17,781,175	$35,385,904	$35,385,904
Depreciation	70,091	190,931	359,228	359,228
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	15,184,924	(21,698,208)	64,941,913	64,941,913
Prepaid Expenses	368,859	1,823,970	1,164,650	1,164,650
Trade Payables	(790,565)	1,440,447	2,215,033	2,215,033
Claims payable & IBNP	4,177,670	12,316,644	(3,947,832)	(3,947,832)
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	(2,317,300)	(1,254,162)	151,023	151,023
Subtotal	27,257,441	10,600,797	100,269,919	100,269,919
Rounding	8	(1)	0	0
Cash Flows from Operating Activities	**$27,257,449**	**$10,600,796**	**$100,269,919**	**$100,269,919**
Rounding Difference	8	(1)	0	0

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF DECEMBER 2023

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments	102,088	51,696	30,846	119,668	40,974	135	951	346,358	5,622	-	351,980
Net Revenue	$13,589,814	$16,911,597	$35,039,365	$44,613,737	$11,944,713	$1,718,250	$8,684,744	$132,502,220	$2,572,833	$0	$135,075,053
Medical Expense	$11,150,941	$14,071,994	$32,167,246	$43,624,000	$10,935,603	$1,372,517	$6,657,234	$119,979,534	$2,194,662	$0	$122,174,197
Gross Margin	$2,438,873	$2,839,603	$2,872,119	$989,737	$1,009,110	$345,733	$2,027,510	$12,522,686	$378,171	$0	$12,900,857
Administrative Expense	$433,268	$731,688	$2,244,297	$2,198,997	$679,303	$97,490	$463,816	$6,848,858	$145,471	$12,353	$7,006,682
Operating Income / (Expense)	$2,005,605	$2,107,915	$627,823	($1,209,260)	$329,807	$248,243	$1,563,694	$5,673,827	$232,700	($12,353)	$5,894,175
Other Income / (Expense)	$272,113	$487,927	$1,526,122	$1,477,067	$442,467	$66,177	$315,868	$4,587,740	$81,852	$0	$4,669,592
Net Income / (Loss)	$2,277,718	$2,595,842	$2,153,945	$267,806	$772,274	$314,420	$1,879,562	$10,261,568	$314,551	($12,353)	$10,563,766
PMPM Metrics:											
Revenue PMPM	$133.12	$327.14	$1,135.95	$372.81	$291.52	$12,727.78	$9,132.22	$382.56	$457.64	$0.00	$383.76
Medical Expense PMPM	$109.23	$272.21	$1,042.83	$364.54	$266.89	$10,166.79	$7,000.25	$346.40	$390.37	$0.00	$347.11
Gross Margin PMPM	$23.89	$54.93	$93.11	$8.27	$24.63	$2,560.99	$2,131.98	$36.16	$67.27	$0.00	$36.65
Administrative Expense PMPM	$4.24	$14.15	$72.76	$18.38	$16.58	$722.15	$487.71	$19.77	$25.88	$0.00	$19.91
Operating Income / (Expense) PMPM	$19.65	$40.78	$20.35	($10.11)	$8.05	$1,838.84	$1,644.26	$16.38	$41.39	$0.00	$16.75
Other Income / (Expense) PMPM	$2.67	$9.44	$49.48	$12.34	$10.80	$490.20	$332.14	$13.25	$14.56	$0.00	$13.27
Net Income / (Loss) PMPM	$22.31	$50.21	$69.83	$2.24	$18.85	$2,329.04	$1,976.41	$29.63	$55.95	$0.00	$30.01
Ratio:											
Medical Loss Ratio	82.1%	83.2%	91.8%	97.8%	91.6%	79.9%	76.7%	90.5%	85.3%	0.0%	90.4%
Gross Margin Ratio	17.9%	16.8%	8.2%	2.2%	8.4%	20.1%	23.3%	9.5%	14.7%	0.0%	9.6%
Administrative Expense Ratio	3.2%	4.3%	6.4%	4.9%	5.7%	5.7%	5.3%	5.2%	5.7%	0.0%	5.2%
Net Income Ratio	16.8%	15.3%	6.1%	0.6%	6.5%	18.3%	21.6%	7.7%	12.2%	0.0%	7.8%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE DECEMBER 2023

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	608,345	312,394	185,086	727,213	248,499	825	5,979	2,088,341	33,757	-	2,122,098
Net Revenue	$81,227,770	$98,746,962	$213,037,913	$283,961,798	$72,224,102	$8,533,166	$49,880,692	$807,612,402	$15,434,713	$0	$823,047,115
Medical Expense	$65,976,942	$96,984,328	$195,447,814	$253,713,437	$73,719,237	$9,238,301	$50,942,614	$746,022,673	$13,389,362	$0	$759,412,034
Gross Margin	$15,250,828	$1,762,634	$17,590,099	$30,248,361	($1,495,135)	($705,135)	($1,061,922)	$61,589,729	$2,045,352	$0	$63,635,081
Administrative Expense	$2,917,825	$4,678,334	$14,126,954	$14,009,809	$4,339,436	$609,186	$2,898,262	$43,579,805	$936,139	$193,090	$44,709,035
Operating Income / (Expense)	$12,333,003	($2,915,700)	$3,463,145	$16,238,552	($5,834,571)	($1,314,321)	($3,960,184)	$18,009,924	$1,109,212	($193,090)	$18,926,046
Other Income / (Expense)	$959,806	$1,712,827	$5,349,017	$5,194,274	$1,589,297	$237,217	$1,127,798	$16,170,236	$289,622	$0	$16,459,858
Net Income / (Loss)	$13,292,808	($1,202,873)	$8,812,162	$21,432,827	($4,245,274)	($1,077,104)	($2,832,386)	$34,180,160	$1,398,834	($193,090)	$35,385,904
PMPM Metrics:											
Revenue PMPM	$133.52	$316.10	$1,151.02	$390.48	$290.64	$10,343.23	$8,342.65	$386.72	$457.23	$0.00	$387.85
Medical Expense PMPM	$108.45	$310.46	$1,055.98	$348.88	$296.66	$11,197.94	$8,520.26	$357.23	$396.64	$0.00	$357.86
Gross Margin PMPM	$25.07	$5.64	$95.04	$41.59	($6.02)	($854.71)	($177.61)	$29.49	$60.59	$0.00	$29.99
Administrative Expense PMPM	$4.80	$14.98	$76.33	$19.27	$17.46	$738.41	$484.74	$20.87	$27.73	$0.00	$21.07
Operating Income / (Expense) PMPM	$20.27	($9.33)	$18.71	$22.33	($23.48)	($1,593.12)	($662.35)	$8.62	$32.86	$0.00	$8.92
Other Income / (Expense) PMPM	$1.58	$5.48	$28.90	$7.14	$6.40	$287.54	$188.63	$7.74	$8.58	$0.00	$7.76
Net Income / (Loss) PMPM	$21.85	($3.85)	$47.61	$29.47	($17.08)	($1,305.58)	($473.72)	$16.37	$41.44	$0.00	$16.67
Ratio:											
Medical Loss Ratio	81.2%	98.2%	91.7%	89.3%	102.1%	108.3%	102.1%	92.4%	86.7%	0.0%	92.3%
Gross Margin Ratio	18.8%	1.8%	8.3%	10.7%	-2.1%	-8.3%	-2.1%	7.6%	13.3%	0.0%	7.7%
Administrative Expense Ratio	3.6%	4.7%	6.6%	4.9%	6.0%	7.1%	5.8%	5.4%	6.1%	0.0%	5.4%
Net Income Ratio	16.4%	-1.2%	4.1%	7.5%	-5.9%	-12.6%	-5.7%	4.2%	9.1%	0.0%	4.3%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED December 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$4,586,613	$6,596,917	$2,010,304	30.5%	Personnel Expenses	$28,690,864	$31,403,711	$2,712,847	8.6%
65,983	60,325	(5,658)	(9.4%)	Benefits Administration Expense	1,177,706	1,175,972	(1,734)	(0.1%)
517,860	1,075,146	557,286	51.8%	Purchased & Professional Services	5,982,298	7,147,136	1,164,838	16.3%
372,592	522,013	149,421	28.6%	Occupancy	2,823,017	2,998,362	175,345	5.8%
460,270	742,753	282,483	38.0%	Printing Postage & Promotion	2,521,400	2,945,403	424,003	14.4%
983,988	993,097	9,109	0.9%	Licenses Insurance & Fees	3,376,829	4,192,873	816,044	19.5%
19,376	27,362	7,986	29.2%	Supplies & Other Expenses	136,921	167,562	30,641	18.3%
$2,420,069	$3,420,696	$1,000,627	29.3%	Total Other Administrative Expense	$16,018,170	$18,627,308	$2,609,138	14.0%
$7,006,682	$10,017,613	$3,010,931	30.1%	Total Administrative Expenses	$44,709,035	$50,031,019	$5,321,985	10.6%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED December 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
3,179,885	4,383,823	1,203,937	27.5%	Salaries & Wages	18,672,645	19,465,852	793,207	4.1%
241,873	466,357	224,484	48.1%	Paid Time Off	1,802,364	2,064,182	261,818	12.7%
2,425	5,860	3,435	58.6%	Incentives	12,963	1,919,347	1,906,384	99.3%
0	0	0	0.0%	Severance Pay	6,160	0	(6,160)	0.0%
69,565	75,675	6,109	8.1%	Payroll Taxes	317,833	322,651	4,818	1.5%
14,376	18,767	4,391	23.4%	Overtime	180,484	164,828	(15,656)	(9.5%)
232,756	370,137	137,380	37.1%	CalPERS ER Match	1,543,833	1,661,508	117,675	7.1%
759,953	827,403	67,450	8.2%	Employee Benefits	4,202,979	4,269,022	66,043	1.5%
5,451	0	(5,451)	0.0%	Personal Floating Holiday	5,457	2,644	(2,813)	(106.4%)
13,146	24,750	11,604	46.9%	Premium Bi/Multilingual Pay	63,840	46,500	(17,340)	(37.3%)
(72)	0	72	0.0%	Prizes	51	0	(51)	0.0%
0	0	0	0.0%	Holiday Bonus	1,135,012	0	(1,135,012)	0.0%
21,689	36,925	15,236	41.3%	Employee Relations	57,651	137,293	79,642	58.0%
16,730	20,875	4,145	19.9%	Work from Home Stipend	95,880	102,695	6,815	6.6%
1,826	4,518	2,692	59.6%	Transportation Reimbursement	4,198	11,759	7,561	64.3%
11,985	23,027	11,042	48.0%	Travel & Lodging	68,610	125,594	56,984	45.4%
(4,728)	222,221	226,949	102.1%	Temporary Help Services	350,120	715,826	365,706	51.1%
17,967	65,550	47,582	72.6%	Staff Development/Training	99,034	273,143	174,109	63.7%
1,785	51,031	49,247	96.5%	Staff Recruitment/Advertising	71,751	120,867	49,116	40.6%
$4,586,613	**$6,596,917**	**$2,010,304**	**30.5%**	**Total Employee Expenses**	**$28,690,864**	**$31,403,711**	**$2,712,847**	**8.6%**
				Benefit Administration Expense				
26,840	21,615	(5,225)	(24.2%)	RX Administration Expense	125,706	124,438	(1,268)	(1.0%)
0	0	0	0.0%	Behavioral Hlth Administration Fees	817,710	817,710	0	0.0%
39,143	38,710	(432)	(1.1%)	Telemedicine Admin Fees	234,290	233,824	(466)	(0.2%)
$65,983	**$60,325**	**($5,658)**	**(9.4%)**	**Total Benefit Administration Expenses**	**$1,177,706**	**$1,175,972**	**($1,734)**	**(0.1%)**
				Purchased & Professional Services				
(102,489)	305,446	407,935	133.6%	Consultant Fees - Non Medical	1,503,363	2,296,301	792,938	34.5%
588,552	541,779	(46,773)	(8.6%)	Computer Support Services	2,327,929	2,338,406	10,477	0.4%
11,875	12,500	625	5.0%	Audit Fees	71,250	72,500	1,250	1.7%
0	33	33	100.0%	Consultant Fees - Medical	0	67	67	100.0%
113,806	2,314	(111,492)	(4,818.2%)	Other Purchased Services	964,159	752,628	(211,531)	(28.1%)
4,734	1,574	(3,160)	(200.8%)	Maint.& Repair-Office Equipment	10,176	5,804	(4,372)	(75.3%)
0	0	0	0.0%	Maint.&Repair-Computer Hardware	1,180	1,180	0	0.0%
(211,873)	98,698	310,571	314.7%	Medical Refund Recovery Fees	358,362	646,810	288,447	44.6%
10,990	0	(10,990)	0.0%	Software - IT Licenses & Subsc	10,990	0	(10,990)	0.0%
70,000	18,750	(51,250)	(273.3%)	Hardware (Non-Capital)	412,200	599,646	187,446	31.3%
29,758	41,702	11,943	28.6%	Provider Relations-Credentialing	181,449	196,229	14,781	7.5%
2,507	52,350	49,843	95.2%	Legal Fees	141,240	237,566	96,326	40.5%
$517,860	**$1,075,146**	**$557,286**	**51.8%**	**Total Purchased & Professional Services**	**$5,982,298**	**$7,147,136**	**$1,164,838**	**16.3%**
				Occupancy				
70,090	55,894	(14,196)	(25.4%)	Depreciation	359,228	338,345	(20,883)	(6.2%)
62,638	62,639	1	0.0%	Building Lease	373,671	373,672	1	0.0%
(19,325)	5,870	25,195	429.2%	Leased and Rented Office Equipment	28,750	44,159	15,408	34.9%
30,050	18,932	(11,118)	(58.7%)	Utilities	128,594	121,302	(7,291)	(6.0%)
103,469	86,510	(16,959)	(19.6%)	Telephone	508,931	485,441	(23,490)	(4.8%)

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED December 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
52,953	43,032	(9,921)	(23.1%)	Building Maintenance	181,376	196,907	15,531	7.9%
72,716	249,136	176,419	70.8%	SBITA Amortization Expense-GASB 96	1,242,467	1,438,535	196,069	13.6%
$372,592	**$522,013**	**$149,421**	**28.6%**	**Total Occupancy**	**$2,823,017**	**$2,998,362**	**$175,345**	**5.8%**
				Printing Postage & Promotion				
(15,714)	212,584	228,298	107.4%	Postage	173,449	499,621	326,173	65.3%
4,504	5,300	796	15.0%	Design & Layout	26,759	27,516	757	2.8%
(87,164)	304,202	391,366	128.7%	Printing Services	341,726	784,898	443,172	56.5%
(3,476)	6,910	10,386	150.3%	Mailing Services	54,665	64,041	9,376	14.6%
9,576	9,462	(114)	(1.2%)	Courier/Delivery Service	57,969	56,889	(1,080)	(1.9%)
888	0	(888)	0.0%	Pre-Printed Materials and Publications	888	0	(888)	0.0%
0	16,250	16,250	100.0%	Promotional Products	5,659	22,871	17,213	75.3%
197	150	(47)	(31.1%)	Promotional Services	1,647	4,750	3,103	65.3%
505,835	169,562	(336,273)	(198.3%)	Community Relations	1,712,764	1,380,161	(332,602)	(24.1%)
45,625	18,333	(27,291)	(148.9%)	Translation - Non-Clinical	145,876	104,655	(41,221)	(39.4%)
$460,270	**$742,753**	**$282,483**	**38.0%**	**Total Printing Postage & Promotion**	**$2,521,400**	**$2,945,403**	**$424,003**	**14.4%**
				Licenses Insurance & Fees				
0	250,000	250,000	100.0%	Regulatory Penalties	80,000	250,000	170,000	68.0%
62,787	28,000	(34,787)	(124.2%)	Bank Fees	200,545	163,587	(36,959)	(22.6%)
83,393	80,112	(3,281)	(4.1%)	Insurance Premium	482,087	489,022	6,936	1.4%
632,902	423,057	(209,845)	(49.6%)	Licenses, Permits and Fees	1,666,316	2,197,708	531,392	24.2%
204,906	211,928	7,021	3.3%	Subscriptions and Dues - NonIT	947,880	1,092,555	144,675	13.2%
$983,988	**$993,097**	**$9,109**	**0.9%**	**Total Licenses Insurance & Postage**	**$3,376,829**	**$4,192,873**	**$816,044**	**19.5%**
				Supplies & Other Expenses				
13,876	5,909	(7,967)	(134.8%)	Office and Other Supplies	59,088	48,338	(10,750)	(22.2%)
0	2,500	2,500	100.0%	Furniture and Equipment	12,364	19,153	6,789	35.4%
1,539	1,200	(339)	(28.2%)	Ergonomic Supplies	18,117	16,025	(2,092)	(13.1%)
3,961	12,186	8,225	67.5%	Commissary-Food & Beverage	20,501	45,215	24,714	54.7%
0	0	0	0.0%	Miscellaneous Expense	22,000	27,948	5,948	21.3%
0	4,850	4,850	100.0%	Member Incentive Expense	4,850	9,700	4,850	50.0%
0	100	100	100.0%	Covid-19 IT Expenses	0	200	200	100.0%
0	617	617	100.0%	Covid-19 Non IT Expenses	0	983	983	100.0%
$19,376	**$27,362**	**$7,986**	**29.2%**	**Total Supplies & Other Expense**	**$136,921**	**$167,562**	**$30,641**	**18.3%**
$7,006,682	**$10,017,613**	**$3,010,931**	**30.1%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$44,709,035**	**$50,031,019**	**$5,321,985**	**10.6%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED JUNE 30, 2024

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Catalyst 9300 - Catalyst Switches	IT-FY24-01	$ -	$ -	**$ -**	$ 50,000	$ 50,000
	Cisco Catalyst 8500 - Routers	IT-FY24-02	$ -	$ -	**$ -**	$ 60,000	$ 60,000
	Cisco AP-9166 - Access Point	IT-FY24-03	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 426,471	$ -	**$ 426,471**	$ 426,371	$ (100)
	PURE Storage array	IT-FY24-05	$ -	$ -	**$ -**	$ 300,000	$ 300,000
	PKI management	IT-FY24-06	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	IBM Power Hardware Upgrade	IT-FY24-07	$ 560,652	$ -	**$ 560,652**	$ 288,629	$ (272,023)
	Misc Hardware	IT-FY24-08	$ 7,119	$ -	**$ 7,119**	$ 15,000	$ 7,881
	Network / AV Cabling	IT-FY24-09	$ 107,600	$ -	**$ 107,600**	$ 30,000	$ (77,600)
	Training Room Projector	IT-FY24-10	$ 12,546	$ (11,187)	**$ 1,359**	$ 13,000	$ 11,641
	Conference room upgrades	IT-FY24-11	$ -		**$ -**	$ 107,701	$ 107,701
Hardware Subtotal			**$ 1,114,388**	**$ (11,187)**	**$ 1,103,201**	**$ 1,320,701**	**$ 217,500**
2. Software:							
	Zerto renewal and Tier 2 add	AC-FY24-01	$ -	$ -	**$ -**	$ 126,000	$ 126,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 126,000**	**$ 126,000**
3. Building Improvement:							
	Appliances over 1k new/replacement (all buildings/suites)	FA-FY24-01	**$ -**	$ -	**$ -**	$ -	$ -
	ACME Security: Readers, HID boxes, Cameras, Doors (planned/unplanned	FA-FY24-02	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	HVAC: Replace VAV boxes, duct work, replace old equipment	FA-FY24-03	$ 18,295	$ -	**$ 18,295**	$ 20,000	$ 1,705
	Electrical work for projects, workstations requirement	FA-FY24-04	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	1240 Interior blinds replacement	FA-FY24-05	**$ -**	$ -	**$ -**	$ 25,000	$ 25,000
	EV Charging stations, if not completed in FY23 and carried over to FY24	FA-FY24-06	**$ 17,494**	$ -	**$ 17,494**	$ 50,000	$ 32,506
Building Improvement Subtotal			**$ 35,789**	**$ -**	**$ 35,789**	**$ 125,000**	**$ 89,211**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)	FA-FY24-17	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	Replace, reconfigure, re-design workstations	FA-FY24-18	$ -	$ -	**$ -**	$ 20,000.00	$ 20,000
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ 30,000**	**$ 30,000**
GRAND TOTAL			**$ 1,150,177**	**$ (11,187)**	**$ 1,138,990**	**$ 1,601,701**	**$ 462,711**

5. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 12/31/23	**$ 38,834,086**
Fixed Assets @ Cost - 6/30/23	**$ 37,695,096**
Fixed Assets Acquired YTD	**$ 1,138,990**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2024

TANGIBLE NET EQUITY (TNE)	Jul-23	Aug-23	QTR. END Sep-23	Oct-23	Nov-23	QTR. END Dec-23
Current Month Net Income / (Loss)	$9,746,933	$2,343,460	$5,514,335	$3,776,499	$3,440,910	$10,563,766
YTD Net Income / (Loss)	$9,746,933	$12,090,393	$17,604,728	$21,381,227	$24,822,137	$35,385,903
Actual TNE						
Net Assets	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178	$359,342,945
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$333,703,974**	**$336,047,435**	**$341,561,770**	**$345,338,268**	**$348,779,178**	**$359,342,945**
Increase/(Decrease) in Actual TNE	$9,746,933	$2,343,460	$5,514,335	$3,776,499	$3,440,910	$10,563,766
Required TNE[(1)]	**$46,228,233**	**$46,744,204**	**$46,352,062**	**$49,676,617**	**$49,894,371**	**$49,622,261**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$69,342,350	$70,116,307	$69,528,093	$74,514,926	$74,841,557	$74,433,391
TNE Excess / (Deficiency)	$287,475,741	$289,303,231	$295,209,708	$295,661,651	$298,884,807	$309,720,684
Actual TNE as a Multiple of Required	**7.22**	**7.19**	**7.37**	**6.95**	**6.99**	**7.24**

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

LIQUID TANGIBLE NET EQUITY						
Net Assets	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178	$359,342,945
Fixed Assets at Net Book Value	(5,169,098)	(5,539,264)	(5,608,622)	(5,653,388)	(6,079,010)	(5,997,733)
Net Lease Assets/Liabilities/Interest	(711,429)	(475,037)	(1,115,074)	(727,353)	(662,463)	(1,135,481)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$328,184,876**	**$330,158,171**	**$335,603,148**	**$339,334,880**	**$342,350,168**	**$352,995,212**
Liquid TNE as Multiple of Required	**7.10**	**7.06**	**7.24**	**6.83**	**6.86**	**7.11**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2024

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

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	102,463	101,393	100,038	101,120	101,243	102,088							608,345
Adult	52,550	52,102	51,499	52,396	52,151	51,696							312,394
SPD	31,055	30,840	30,592	30,888	30,865	30,846							185,086
ACA OE	123,707	121,819	120,016	121,430	120,573	119,668							727,213
Duals	41,688	41,715	41,629	41,496	40,997	40,974							248,499
MCAL LTC	141	138	139	135	137	135							825
MCAL LTC Duals	1,033	1,019	1,004	997	975	951							5,979
Medi-Cal Program	352,637	349,026	344,917	348,462	346,941	346,358							2,088,341
Group Care Program	5,669	5,645	5,631	5,605	5,585	5,622							33,757
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**							**2,122,098**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)	1,082	123	845							(1,582)
Adult	(624)	(448)	(603)	897	(245)	(455)							(1,478)
SPD	(225)	(215)	(248)	296	(23)	(19)							(434)
ACA OE	(1,260)	(1,888)	(1,803)	1,414	(857)	(905)							(5,299)
Duals	(43)	27	(86)	(133)	(499)	(23)							(757)
MCAL LTC	(9)	(3)	1	(4)	2	(2)							(15)
MCAL LTC Duals	4	(14)	(15)	(7)	(22)	(24)							(78)
Medi-Cal Program	(3,364)	(3,611)	(4,109)	3,545	(1,521)	(583)							(9,643)
Group Care Program	(15)	(24)	(14)	(26)	(20)	37							(62)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**							**(9,705)**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	29.1%	29.1%	29.0%	29.0%	29.2%	29.5%							29.1%
Adult % of Medi-Cal	14.9%	14.9%	14.9%	15.0%	15.0%	14.9%							15.0%
SPD % of Medi-Cal	8.8%	8.8%	8.9%	8.9%	8.9%	8.9%							8.9%
ACA OE % of Medi-Cal	35.1%	34.9%	34.8%	34.8%	34.8%	34.6%							34.8%
Duals % of Medi-Cal	11.8%	12.0%	12.1%	11.9%	11.8%	11.8%							11.9%
Medi-Cal Program % of Total	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%							98.4%
Group Care Program % of Total	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%							1.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**							**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2024

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

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027	72,504	78,530	75,141	76,228							449,977
Alameda Health System	66,089	65,344	64,133	63,271	63,903	63,545							386,285
	140,636	138,371	136,637	141,801	139,044	139,773							836,262
Delegated:													
CFMG	34,810	34,649	34,144	34,035	35,105	35,399							208,142
CHCN	130,230	129,183	127,430	126,705	127,641	128,331							769,520
Kaiser	52,630	52,468	52,337	51,526	50,736	48,477							308,174
Delegated Subtotal	217,670	216,300	213,911	212,266	213,482	212,207							1,285,836
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**							**2,122,098**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(939)	(2,265)	(1,734)	5,164	(2,757)	729							(1,802)
Delegated:													
CFMG	(441)	(161)	(505)	(109)	1,070	294							148
CHCN	(1,721)	(1,047)	(1,753)	(725)	936	690							(3,620)
Kaiser	(278)	(162)	(131)	(811)	(790)	(2,259)							(4,431)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	1,216	(1,275)							(7,903)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**							**(9,705)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	39.3%	39.0%	39.0%	40.0%	39.4%	39.7%							39.4%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	10.0%	10.1%							9.8%
CHCN	36.3%	36.4%	36.4%	35.8%	36.2%	36.5%							36.3%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.4%	13.8%							14.5%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	60.6%	60.3%							60.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**							**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2024	FINAL BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program by Category of Aid:													
Child	102,463	101,393	100,038	101,120	100,109	99,008	102,159	100,933	99,823	98,725	97,639	96,565	1,199,975
Adult	52,550	52,102	51,499	52,396	51,872	51,301	57,478	56,788	56,107	55,434	54,769	54,112	646,408
SPD	31,055	30,840	30,592	30,888	30,734	30,488	42,473	42,133	41,796	41,462	41,130	40,801	434,392
ACA OE	123,707	121,819	120,016	121,430	121,180	119,605	149,197	147,556	145,933	144,328	142,740	141,170	1,598,681
Duals	41,688	41,715	41,629	41,496	41,410	41,325	45,787	45,694	45,600	45,506	45,412	45,318	522,580
MCAL LTC	141	138	139	135	136	137	172	173	174	175	176	177	1,873
MCAL LTC Duals	1,033	1,019	1,004	997	985	971	1,194	1,176	1,159	1,142	1,125	1,108	12,913
Medi-Cal Program	352,637	349,026	344,917	348,462	346,426	342,835	398,460	394,453	390,592	386,772	382,991	379,251	4,416,822
Group Care Program	5,669	5,645	5,631	5,605	5,591	5,577	5,563	5,549	5,535	5,521	5,507	5,493	66,886
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,017**	**348,412**	**404,023**	**400,002**	**396,127**	**392,293**	**388,498**	**384,744**	**4,483,708**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)	1,082	(1,011)	(1,101)	3,151	(1,226)	(1,110)	(1,098)	(1,086)	(1,074)	(7,105)
Adult	(624)	(448)	(603)	897	(524)	(571)	6,177	(690)	(681)	(673)	(665)	(657)	938
SPD	(225)	(215)	(248)	296	(154)	(246)	11,985	(340)	(337)	(334)	(332)	(329)	9,521
ACA OE	(1,260)	(1,888)	(1,803)	1,414	(250)	(1,575)	29,592	(1,641)	(1,623)	(1,605)	(1,588)	(1,570)	16,203
Duals	(43)	27	(86)	(133)	(86)	(85)	4,462	(93)	(94)	(94)	(94)	(94)	3,587
MCAL LTC	(9)	(3)	1	(4)	1	1	35	1	1	1	1	1	27
MCAL LTC Duals	4	(14)	(15)	(7)	(12)	(14)	223	(18)	(17)	(17)	(17)	(17)	79
Medi-Cal Program	(3,364)	(3,611)	(4,109)	3,545	(2,036)	(3,591)	55,625	(4,007)	(3,861)	(3,820)	(3,781)	(3,740)	23,250
Group Care Program	(15)	(24)	(14)	(26)	(14)	(14)	(14)	(14)	(14)	(14)	(14)	(14)	(191)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(2,050)**	**(3,605)**	**55,611**	**(4,021)**	**(3,875)**	**(3,834)**	**(3,795)**	**(3,754)**	**23,059**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	29.1%	29.1%	29.0%	29.0%	28.9%	28.9%	25.6%	25.6%	25.6%	25.5%	25.5%	25.5%	27.2%
Adult % (Medi-Cal)	14.9%	14.9%	14.9%	15.0%	15.0%	15.0%	14.4%	14.4%	14.4%	14.3%	14.3%	14.3%	14.6%
SPD % (Medi-Cal)	8.8%	8.8%	8.9%	8.9%	8.9%	8.9%	10.7%	10.7%	10.7%	10.7%	10.7%	10.8%	9.8%
ACA OE % (Medi-Cal)	35.1%	34.9%	34.8%	34.8%	35.0%	34.9%	37.4%	37.4%	37.4%	37.3%	37.3%	37.2%	36.2%
Duals % (Medi-Cal)	11.8%	12.0%	12.1%	11.9%	12.0%	12.1%	11.5%	11.6%	11.7%	11.8%	11.9%	11.9%	11.8%
MCAL LTC % (Medi-Cal)	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%
MCAL LTC Duals % (Medi-Cal)	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Medi-Cal Program % of Total	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.5%
Group Care Program % of Total	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2024	FINAL BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027	72,504	78,530	78,174	77,543	103,987	103,154	102,341	101,536	100,739	99,949	1,066,031
Alameda Health System	66,089	65,344	64,133	63,271	62,977	62,254	86,850	85,925	85,022	84,129	83,245	82,371	891,610
	140,636	138,371	136,637	141,801	141,151	139,797	190,837	189,079	187,363	185,665	183,984	182,320	1,957,641
Delegated:													
CFMG	34,810	34,649	34,144	34,035	33,709	33,339	43,104	42,595	42,131	41,671	41,217	40,767	456,171
CHCN	130,230	129,183	127,430	126,705	125,969	124,637	170,082	168,328	166,633	164,957	163,297	161,657	1,759,108
Kaiser	52,630	52,468	52,337	51,526	51,188	50,639	0	0	0	0	0	0	310,788
Delegated Subtotal	217,670	216,300	213,911	212,266	210,866	208,615	213,186	210,923	208,764	206,628	204,514	202,424	2,526,067
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,017**	**348,412**	**404,023**	**400,002**	**396,127**	**392,293**	**388,498**	**384,744**	**4,483,708**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	305	(1,520)	(523)	6,026	(356)	(631)	26,444	(833)	(813)	(805)	(797)	(790)	25,707
Alameda Health System	(1,244)	(745)	(1,211)	(862)	(294)	(723)	24,596	(925)	(903)	(893)	(884)	(874)	15,038
	(939)	(2,265)	(1,734)	5,164	(650)	(1,354)	51,040	(1,758)	(1,716)	(1,698)	(1,681)	(1,664)	40,745
Delegated:													
CFMG	(441)	(161)	(505)	(109)	(326)	(370)	9,765	(509)	(464)	(460)	(454)	(450)	5,516
CHCN	(1,721)	(1,047)	(1,753)	(725)	(736)	(1,332)	45,445	(1,754)	(1,695)	(1,676)	(1,660)	(1,640)	29,706
Kaiser	(278)	(162)	(131)	(811)	(338)	(549)	0	0	0	0	0	0	(2,269)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	(1,400)	(2,251)	55,210	(2,263)	(2,159)	(2,136)	(2,114)	(2,090)	32,953
Total	**(3,379)**	**(1,370)**	**(2,389)**	**(1,645)**	**(1,400)**	**(2,251)**	**55,210**	**(2,263)**	**(2,159)**	**(2,136)**	**(2,114)**	**(2,090)**	**32,014**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	20.8%	20.6%	20.7%	22.2%	22.2%	22.3%	25.7%	25.8%	25.8%	25.9%	25.9%	26.0%	23.8%
Alameda Health System	18.4%	18.4%	18.3%	17.9%	17.9%	17.9%	21.5%	21.5%	21.5%	21.4%	21.4%	21.4%	19.9%
	39.3%	39.0%	39.0%	40.0%	40.1%	40.1%	47.2%	47.3%	47.3%	47.3%	47.4%	47.4%	43.7%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	9.6%	9.6%	10.7%	10.6%	10.6%	10.6%	10.6%	10.6%	10.2%
CHCN	36.3%	36.4%	36.4%	35.8%	35.8%	35.8%	42.1%	42.1%	42.1%	42.0%	42.0%	42.0%	39.2%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.5%	14.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	59.9%	59.9%	52.8%	52.7%	52.7%	52.7%	52.6%	52.6%	56.3%
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 2024

	Variance Jul-23	Variance Aug-23	Variance Sep-23	Variance Oct-23	Variance Nov-23	Variance Dec-23	Variance Jan-24	Variance Feb-24	Variance Mar-24	Variance Apr-24	Variance May-24	Variance Jun-24	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	1,134	3,080							4,214
Adult	0	0	0	0	279	395							674
SPD	0	0	0	0	131	358							489
ACA OE	0	0	0	0	(607)	63							(544)
Duals	0	0	0	0	(413)	(351)							(764)
MCAL LTC	0	0	0	0	1	(2)							(1)
MCAL LTC Duals	0	0	0	0	(10)	(20)							(30)
Medi-Cal Program	0	0	0	0	515	3,523							4,038
Group Care Program	0	0	0	0	(6)	45							39
Total	**0**	**0**	**0**	**0**	**509**	**3,568**							**4,077**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													0
Directly Contracted (DCP)	0	0	0	0	(3,033)	(1,315)							(4,348)
Alameda Health System	0	0	0	0	926	1,291							2,217
	0	0	0	0	(2,107)	(24)							(2,131)
Delegated:													
CFMG	0	0	0	0	1,396	2,060							3,456
CHCN	0	0	0	0	1,672	3,694							5,366
Kaiser	0	0	0	0	(452)	(2,162)							(2,614)
Delegated Subtotal	0	0	0	0	2,616	3,592							6,208
Total	**0**	**0**	**0**	**0**	**509**	**3,568**							**4,077**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED DECEMBER 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,200,054	$1,121,783	($78,271)	(7.0%)	PCP Capitation	$7,027,129	$6,890,688	($136,441)	(2.0%)
4,389,758	4,486,426	96,668	2.2%	PCP Capitation FQHC	26,218,033	26,481,896	263,863	1.0%
309,957	289,580	(20,377)	(7.0%)	Specialty-Capitation	1,810,164	1,775,457	(34,707)	(2.0%)
3,821,425	3,929,810	108,385	2.8%	Specialty-Capitation FQHC	22,829,101	23,111,317	282,216	1.2%
539,443	539,093	(350)	(0.1%)	Laboratory Capitation	3,012,362	3,058,833	46,471	1.5%
254,677	249,193	(5,484)	(2.2%)	Vision Cap	1,521,903	1,513,728	(8,175)	(0.5%)
90,089	84,337	(5,752)	(6.8%)	CFMG Capitation	526,588	516,828	(9,759)	(1.9%)
189,360	194,521	5,161	2.7%	Anc IPA Admin Capitation FQHC	1,131,373	1,144,841	13,468	1.2%
13,559,396	13,711,975	152,579	1.1%	Kaiser Capitation	83,756,737	84,015,590	258,852	0.3%
4,672	0	(4,672)	0.0%	BHT Supplemental Expense	4,672	0	(4,672)	0.0%
318,004	607,007	289,003	47.6%	Maternity Supplemental Expense	1,818,139	2,311,103	492,963	21.3%
715,374	748,843	33,469	4.5%	DME Cap	4,293,848	4,365,591	71,743	1.6%
$25,392,210	**$25,962,568**	**$570,359**	**2.2%**	**5 - TOTAL CAPITATED EXPENSES**	**$153,950,048**	**$155,185,871**	**$1,235,822**	**0.8%**
				FEE FOR SERVICE MEDICAL EXPENSES:				
3,448,971	0	(3,448,971)	0.0%	IBNR Inpatient Services	(258,377)	(2,306,298)	(2,047,921)	88.8%
103,469	0	(103,469)	0.0%	IBNR Settlement (IP)	(7,750)	(69,188)	(61,438)	88.8%
275,919	0	(275,919)	0.0%	IBNR Claims Fluctuation (IP)	(20,669)	(184,504)	(163,835)	88.8%
25,359,745	33,945,587	8,585,842	25.3%	Inpatient Hospitalization FFS	175,518,769	188,190,629	12,671,860	6.7%
1,611,684	0	(1,611,684)	0.0%	IP OB - Mom & NB	11,641,299	7,462,632	(4,178,666)	(56.0%)
90,591	0	(90,591)	0.0%	IP Behavioral Health	1,080,963	895,483	(185,480)	(20.7%)
890,044	0	(890,044)	0.0%	IP Facility Rehab FFS	6,630,397	4,711,642	(1,918,755)	(40.7%)
$31,780,422	**$33,945,587**	**$2,165,165**	**6.4%**	**6 - Inpatient Hospital & SNF Expense**	**$194,584,632**	**$198,700,397**	**$4,115,765**	**2.1%**
259,347	0	(259,347)	0.0%	IBNR PCP	(159,291)	46,983	206,274	439.0%
7,781	0	(7,781)	0.0%	IBNR Settlement (PCP)	(4,779)	1,409	6,188	439.2%
20,748	0	(20,748)	0.0%	IBNR Claims Fluctuation (PCP)	(12,742)	3,759	16,501	439.0%
1,719,909	1,987,769	267,860	13.5%	Primary Care Non-Contracted FF	11,553,395	11,515,900	(37,495)	(0.3%)
299,971	233,830	(66,142)	(28.3%)	PCP FQHC FFS	2,809,771	2,526,560	(283,211)	(11.2%)
0	0	0	0.0%	Phys Extended Hours Incentive	3,000	6,000	3,000	50.0%
2,308,724	3,171,639	862,915	27.2%	Prop 56 Physician Exp	13,826,858	15,584,223	1,757,364	11.3%
14,717	0	(14,717)	0.0%	Prop 56 Hyde Exp	87,728	58,257	(29,470)	(50.6%)
79,903	0	(79,903)	0.0%	Prop 56 Trauma Exp	476,549	316,945	(159,604)	(50.4%)
96,628	0	(96,628)	0.0%	Prop 56 Develop. Screening Exp	576,570	383,782	(192,788)	(50.2%)
726,846	0	(726,846)	0.0%	Prop 56 Family Planning Exp	4,361,025	2,905,675	(1,455,350)	(50.1%)
0	0	0	0.0%	Prop 56 VBP Exp	7,428	7,428	0	0.0%
$5,534,573	**$5,393,238**	**($141,336)**	**(2.6%)**	**7 - Primary Care Physician Expense**	**$33,525,513**	**$33,356,922**	**($168,590)**	**(0.5%)**
342,126	0	(342,126)	0.0%	IBNR Specialist	(1,513,176)	(704,271)	808,905	(114.9%)
256,506	0	(256,506)	0.0%	Psychiatrist FFS	1,513,753	927,497	(586,256)	(63.2%)
2,071,398	5,454,841	3,383,443	62.0%	Specialty Care FFS	14,011,460	20,032,520	6,021,059	30.1%
141,895	0	(141,895)	0.0%	Specialty Anesthesiology	1,022,007	733,088	(288,919)	(39.4%)
1,012,140	0	(1,012,140)	0.0%	Specialty Imaging FFS	6,676,028	4,332,553	(2,343,474)	(54.1%)
12,451	0	(12,451)	0.0%	Obstetrics FFS	103,715	71,825	(31,890)	(44.4%)
118,011	0	(118,011)	0.0%	Specialty IP Surgery FFS	1,613,291	1,146,377	(466,914)	(40.7%)
531,280	0	(531,280)	0.0%	Specialty OP Surgery FFS	3,609,879	2,380,160	(1,229,719)	(51.7%)
374,515	0	(374,515)	0.0%	Spec IP Physician	2,663,632	1,804,945	(858,687)	(47.6%)
67,064	73,666	6,602	9.0%	SCP FQHC FFS	413,110	402,134	(10,976)	(2.7%)
10,263	0	(10,263)	0.0%	IBNR Settlement (SCP)	(45,394)	(21,127)	24,267	(114.9%)
27,369	0	(27,369)	0.0%	IBNR Claims Fluctuation (SCP)	(121,056)	(56,342)	64,714	(114.9%)
$4,965,019	**$5,528,507**	**$563,488**	**10.2%**	**8 - Specialty Care Physician Expense**	**$29,947,250**	**$31,049,358**	**$1,102,109**	**3.5%**
1,050,319	0	(1,050,319)	0.0%	IBNR Ancillary	2,020,711	2,122,555	101,844	4.8%
31,510	0	(31,510)	0.0%	IBNR Settlement (ANC)	60,621	63,677	3,056	4.8%
84,026	0	(84,026)	0.0%	IBNR Claims Fluctuation (ANC)	161,658	169,805	8,147	4.8%
(1,566,386)	0	1,566,386	0.0%	IBNR Transportation FFS	(1,449,696)	45,720	1,495,415	3,270.8%
1,122,376	0	(1,122,376)	0.0%	Behavioral Health Therapy FFS	7,511,937	4,951,126	(2,560,811)	(51.7%)
1,000,585	0	(1,000,585)	0.0%	Psychologist & Other MH Prof.	6,428,870	4,215,464	(2,213,406)	(52.5%)
211,686	0	(211,686)	0.0%	Acupuncture/Biofeedback	1,569,757	1,075,338	(494,418)	(46.0%)
75,589	0	(75,589)	0.0%	Hearing Devices	525,712	381,525	(144,187)	(37.8%)
13,465	0	(13,465)	0.0%	Imaging/MRI/CT Global	200,622	141,544	(59,077)	(41.7%)
62,704	0	(62,704)	0.0%	Vision FFS	279,181	164,593	(114,587)	(69.6%)
10	0	(10)	0.0%	Family Planning	50	30	(20)	(66.7%)
479,986	0	(479,986)	0.0%	Laboratory-FFS	2,953,018	1,917,612	(1,035,406)	(54.0%)
43,349	0	(43,349)	0.0%	ANC Therapist	544,571	395,200	(149,372)	(37.8%)
1,121,625	0	(1,121,625)	0.0%	Transportation (Ambulance)-FFS	6,079,211	3,746,485	(2,332,725)	(62.3%)
2,706,428	0	(2,706,428)	0.0%	Transportation (Other)-FFS	10,304,846	5,929,067	(4,375,779)	(73.8%)
1,402,143	0	(1,402,143)	0.0%	Hospice	8,747,299	5,779,983	(2,967,316)	(51.3%)

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED DECEMBER 31, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,046,895	0	(1,046,895)	0.0%	Home Health Services	7,444,287	4,994,036	(2,450,251)	(49.1%)
0	9,154,248	9,154,248	100.0%	Other Medical-FFS	3,993	18,334,293	18,330,301	100.0%
(119,475)	0	119,475	0.0%	Medical Refunds through HMS	(526,544)	(309,963)	216,581	(69.9%)
858,782	0	(858,782)	0.0%	Medical Refunds	(31,491)	(565,083)	(533,592)	94.4%
10,677	0	(10,677)	0.0%	DME & Medical Supplies	159,375	116,689	(42,686)	(36.6%)
0	0	0	0.0%	GEMT FFS	(373,988)	(373,988)	0	0.0%
1,434,790	1,430,045	(4,744)	(0.3%)	ECM Base/Outreach FFS Anc.	8,003,560	8,004,044	484	0.0%
17,362	24,486	7,123	29.1%	CS Housing Deposits FFS Ancillary	121,059	135,985	14,925	11.0%
180,477	207,352	26,875	13.0%	CS Housing Tenancy FFS Ancillary	1,136,119	1,183,089	46,971	4.0%
48,044	42,851	(5,193)	(12.1%)	CS Housing Navigation Services FFS Ancillary	266,991	257,647	(9,344)	(3.6%)
76,116	55,836	(20,280)	(36.3%)	CS Medical Respite FFS Ancillary	414,422	377,892	(36,530)	(9.7%)
28,167	14,715	(13,453)	(91.4%)	CS Medically Tailored Meals FFS Ancillary	154,071	128,446	(25,625)	(20.0%)
3,840	49	(3,791)	(7,781.7%)	CS Asthma Remediation FFS Ancillary	19,067	11,648	(7,419)	(63.7%)
0	10,000	10,000	100.0%	MOT Wrap Around (Non Medical MOT Cost)	0	20,000	20,000	100.0%
380,423	0	(380,423)	0.0%	Community Based Adult Services (CBAS)	2,422,144	1,425,263	(996,881)	(69.9%)
0	7,646	7,646	100.0%	CS Pilot LTC Diversion Expense	0	15,291	15,291	100.0%
8,410	3,823	(4,587)	(120.0%)	CS Pilot LTC Transition Expense	27,524	23,701	(3,823)	(16.1%)
0	80,556	80,556	100.0%	Justice Involved Pilot	0	161,111	161,111	100.0%
$11,813,926	**$11,031,605**	**($782,321)**	**(7.1%)**	**9 - Ancillary Medical Expense**	**$65,178,955**	**$65,039,828**	**($139,128)**	**(0.2%)**
815,666	0	(815,666)	0.0%	IBNR Outpatient	159,744	422,626	262,882	62.2%
24,470	0	(24,470)	0.0%	IBNR Settlement (OP)	4,790	12,677	7,887	62.2%
65,253	0	(65,253)	0.0%	IBNR Claims Fluctuation (OP)	12,780	33,811	21,031	62.2%
1,281,971	8,112,653	6,830,682	84.2%	Out Patient FFS	9,639,775	22,749,006	13,109,232	57.6%
1,278,462	0	(1,278,462)	0.0%	OP Ambul Surgery FFS	10,076,197	6,937,396	(3,138,801)	(45.2%)
1,399,663	0	(1,399,663)	0.0%	OP Fac Imaging Services FFS	9,671,601	6,670,623	(3,000,978)	(45.0%)
14,474	0	(14,474)	0.0%	Behav Health FFS	28,676	(21,966)	(50,642)	230.5%
444,260	0	(444,260)	0.0%	OP Facility Lab FFS	3,131,671	2,081,864	(1,049,808)	(50.4%)
120,858	0	(120,858)	0.0%	OP Facility Cardio FFS	892,294	608,098	(284,196)	(46.7%)
89,626	0	(89,626)	0.0%	OP Facility PT/OT/ST FFS	902,702	270,230	(632,472)	(234.0%)
2,051,364	0	(2,051,364)	0.0%	OP Facility Dialysis FFS	12,614,684	8,379,495	(4,235,189)	(50.5%)
$7,586,067	**$8,112,653**	**$526,586**	**6.5%**	**10 - Outpatient Medical Expense Medical Expense**	**$47,134,913**	**$48,143,859**	**$1,008,946**	**2.1%**
293,826	0	(293,826)	0.0%	IBNR Emergency	(427,433)	30,260	457,693	1,512.5%
8,814	0	(8,814)	0.0%	IBNR Settlement (ER)	(12,821)	910	13,731	1,508.9%
23,508	0	(23,508)	0.0%	IBNR Claims Fluctuation (ER)	(34,190)	2,423	36,613	1,511.1%
764,997	0	(764,997)	0.0%	Special ER Physician FFS	4,727,389	3,056,795	(1,670,594)	(54.7%)
4,464,275	5,776,148	1,311,874	22.7%	ER Facility	29,732,293	31,151,600	1,419,307	4.6%
$5,555,420	**$5,776,148**	**$220,728**	**3.8%**	**11 - Emergency Expense**	**$33,985,237**	**$34,241,988**	**$256,751**	**0.7%**
404,001	0	(404,001)	0.0%	IBNR Pharmacy OP	(40,317)	(204,308)	(163,991)	80.3%
12,121	0	(12,121)	0.0%	IBNR Settlement (RX) OP	(1,212)	(6,133)	(4,921)	80.2%
32,320	0	(32,320)	0.0%	IBNR Claims Fluctuation (RX) OP	(3,225)	(16,345)	(13,120)	80.3%
446,235	370,539	(75,696)	(20.4%)	Pharmacy FFS	2,858,365	2,681,207	(177,158)	(6.6%)
114,927	8,574,299	8,459,372	98.7%	Pharmacy Non-PBM FFS-Other Anc	787,916	17,746,902	16,958,987	95.6%
4,329,408	0	(4,329,408)	0.0%	Pharmacy Non-PBM FFS-OP FAC	31,913,203	21,975,503	(9,937,700)	(45.2%)
259,978	0	(259,978)	0.0%	Pharmacy Non-PBM FFS-PCP	1,127,908	615,362	(512,547)	(83.3%)
1,663,733	0	(1,663,733)	0.0%	Pharmacy Non-PBM FFS-SCP	12,762,547	8,807,902	(3,954,645)	(44.9%)
10,475	0	(10,475)	0.0%	Pharmacy Non-PBM FFS-FQHC	56,933	41,158	(15,775)	(38.3%)
4,327	0	(4,327)	0.0%	Pharmacy Non-PBM FFS-HH	38,942	27,987	(10,955)	(39.1%)
0	0	0	0.0%	RX Refunds HMS	(63)	(63)	0	0.0%
(35,000)	31,834	66,834	209.9%	Pharmacy Rebate	(230,000)	(96,308)	133,692	(138.8%)
$7,242,527	**$8,976,673**	**$1,734,146**	**19.3%**	**12 - Pharmacy Expense**	**$49,270,998**	**$51,572,865**	**$2,301,867**	**4.5%**
(2,406,984)	0	2,406,984	0.0%	IBNR LTC	3,495,695	4,802,539	1,306,844	27.2%
(72,209)	0	72,209	0.0%	IBNR Settlement (LTC)	104,873	144,077	39,204	27.2%
(192,560)	0	192,560	0.0%	IBNR Claims Fluctuation (LTC)	279,654	384,202	104,548	27.2%
17,662,305	0	(17,662,305)	0.0%	LTC Custodial Care	98,835,252	63,392,176	(35,443,075)	(55.9%)
2,903,912	17,284,719	14,380,808	83.2%	LTC SNF	18,280,052	46,575,327	28,295,276	60.8%
$17,894,464	**$17,284,719**	**($609,745)**	**(3.5%)**	**13 - Long Term Care Expense**	**$120,995,525**	**$115,298,322**	**($5,697,204)**	**(4.9%)**
$92,372,417	**$96,049,129**	**$3,676,712**	**3.8%**	**14 - TOTAL FFS MEDICAL EXPENSES**	**$574,623,024**	**$577,403,539**	**$2,780,516**	**0.5%**
0	(411,997)	(411,997)	100.0%	Clinical Vacancy	0	(402,647)	(402,647)	100.0%
50,636	122,724	72,089	58.7%	Quality Analytics	485,393	942,155	456,761	48.5%
874,838	1,390,211	515,374	37.1%	Health Plan Services Department Total	4,703,191	5,172,945	469,754	9.1%
599,830	882,064	282,235	32.0%	Case & Disease Management Department Total	3,415,533	3,586,942	171,409	4.8%
2,092,610	1,665,374	(427,236)	(25.7%)	Medical Services Department Total	11,757,552	11,884,552	126,999	1.1%
656,974	2,001,553	1,344,580	67.2%	Quality Management Department Total	4,346,700	6,398,655	2,051,955	32.1%

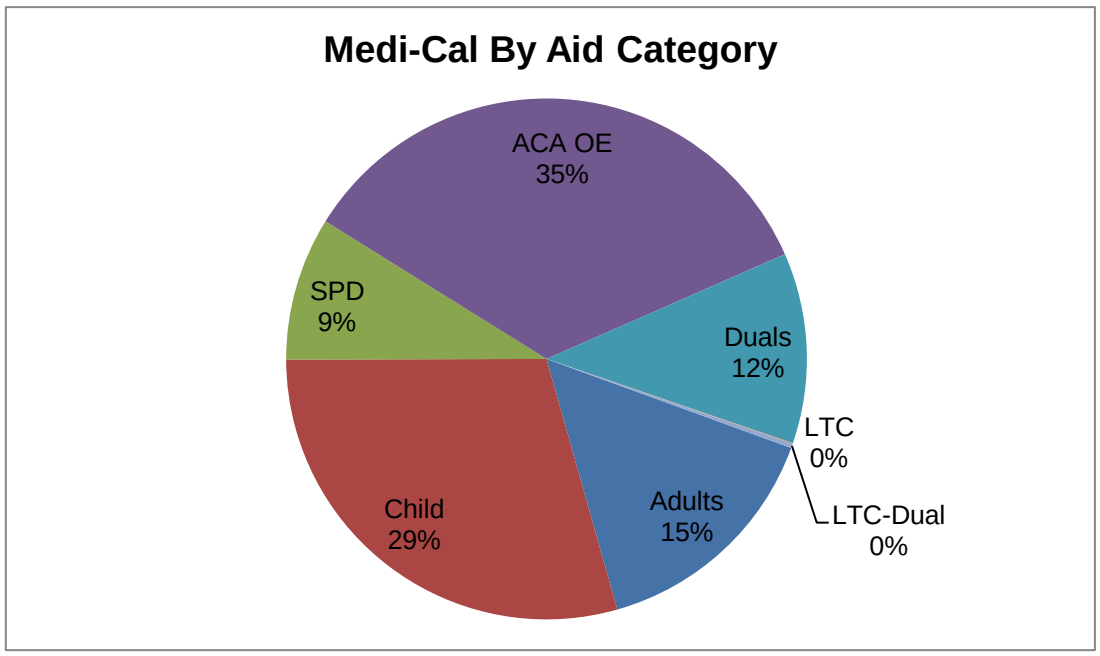
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED DECEMBER 31, 2023

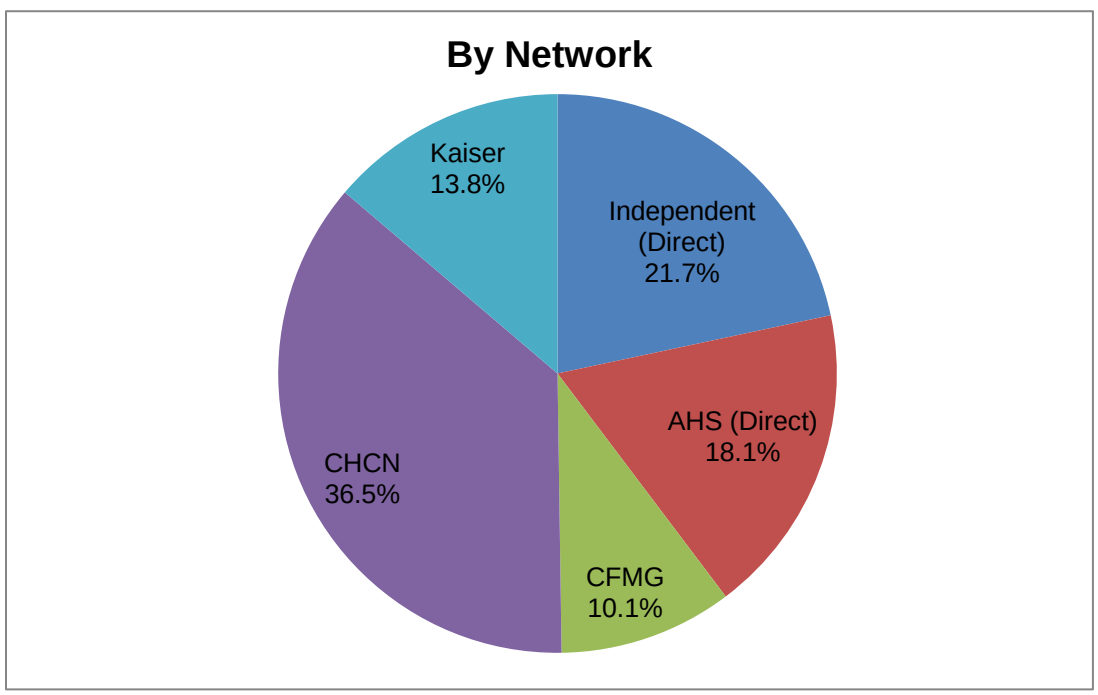
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
233,952	408,236	174,284	42.7%	HCS Behavioral Health Department Total	1,475,571	1,647,193	171,622	10.4%
128,580	206,213	77,633	37.6%	Pharmacy Services Department Total	828,657	876,593	47,936	5.5%
55,854	83,630	27,776	33.2%	Regulatory Readiness Total	375,313	405,599	30,286	7.5%
$4,693,272	**$6,348,009**	**$1,654,737**	**26.1%**	**15 - Other Benefits & Services**	**$27,387,911**	**$30,511,986**	**$3,124,076**	**10.2%**
(1,347,925)	(766,304)	581,621	(75.9%)	Reinsurance Recoveries	(5,922,925)	(5,265,498)	657,427	(12.5%)
1,064,223	1,021,739	(42,484)	(4.2%)	Reinsurance Premium	6,373,977	6,134,886	(239,091)	(3.9%)
($283,702)	**$255,435**	**$539,137**	**211.1%**	**16- Reinsurance Expense**	**$451,052**	**$869,388**	**$418,336**	**48.1%**
0	0	0	0.0%	P4P Risk Pool Provider Incenti	3,000,000	3,000,000	0	0.0%
$0	**$0**	**$0**	**0.0%**	**17 - Risk Pool Distribution**	**$3,000,000**	**$3,000,000**	**$0**	**0.0%**
$122,174,197	**$128,615,141**	**$6,440,944**	**5.0%**	**18 - TOTAL MEDICAL EXPENSES**	**$759,412,034**	**$766,970,784**	**$7,558,750**	**1.0%**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Dec 2023	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	52,174	15%	10,629	9,872	790	22,025	8,858
Child	101,634	29%	8,380	9,382	32,231	33,788	17,853
SPD	30,848	9%	10,020	4,407	1,148	13,052	2,221
ACA OE	119,669	35%	19,524	36,581	1,231	47,077	15,256
Duals	40,976	12%	24,440	2,463	1	9,784	4,288
LTC	135	0%	134	1	-	-	-
LTC-Dual	951	0%	950	-	-	-	1
Medi-Cal	346,387		74,077	62,706	35,401	125,726	48,477
Group Care	5,622		2,164	842	-	2,616	-
Total	**352,009**	**100%**	**76,241**	**63,548**	**35,401**	**128,342**	**48,477**
Medi-Cal %	98.4%		97.2%	98.7%	100.0%	98.0%	100.0%
Group Care %	1.6%		2.8%	1.3%	0.0%	2.0%	0.0%
	Network Distribution		*21.7%*	*18.1%*	*10.1%*	*36.5%*	*13.8%*
			% Direct:	**40%**		**% Delegated:**	**60%**

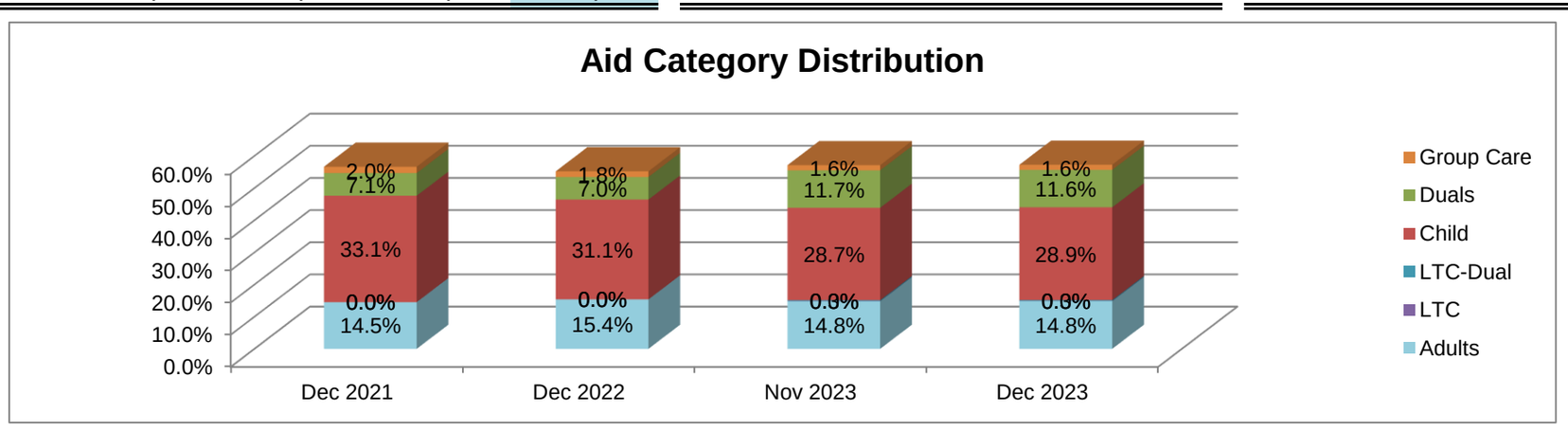




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

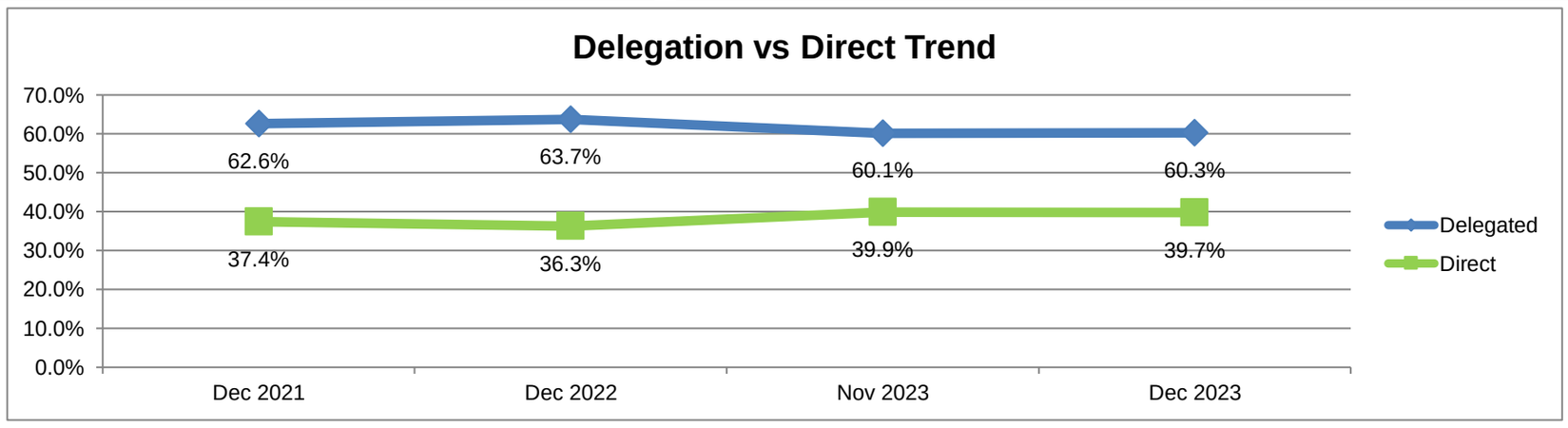
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Dec 2021	Dec 2022	Nov 2023	Dec 2023	Dec 2021	Dec 2022	Nov 2023	Dec 2023	Dec 2021 to Dec 2022	Dec 2022 to Dec 2023	Nov 2023 to Dec 2023
Adults	43,077	50,351	52,222	52,174	14.5%	15.4%	14.8%	14.8%	16.9%	3.6%	-0.1%
Child	98,150	101,791	101,557	101,634	33.1%	31.1%	28.7%	28.9%	3.7%	-0.2%	0.1%
SPD	26,450	28,452	30,887	30,848	8.9%	8.7%	8.7%	8.8%	7.6%	8.4%	-0.1%
ACA OE	102,264	118,397	120,666	119,669	34.5%	36.1%	34.2%	34.0%	15.8%	1.1%	-0.8%
Duals	20,964	23,028	41,217	40,976	7.1%	7.0%	11.7%	11.6%	9.8%	77.9%	-0.6%
LTC	-	-	139	135	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-2.9%
LTC-Dual	-	-	980	951	0.0%	0.0%	0.3%	0.3%	0.0%	0.0%	-3.0%
Medi-Cal Total	290,905	322,019	347,668	346,387	98.0%	98.2%	98.4%	98.4%	10.7%	7.6%	-0.4%
Group Care	5,823	5,776	5,586	5,622	2.0%	1.8%	1.6%	1.6%	-0.8%	-2.7%	0.6%
Total	**296,728**	**327,795**	**353,254**	**352,009**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.5%**	**7.4%**	**-0.4%**



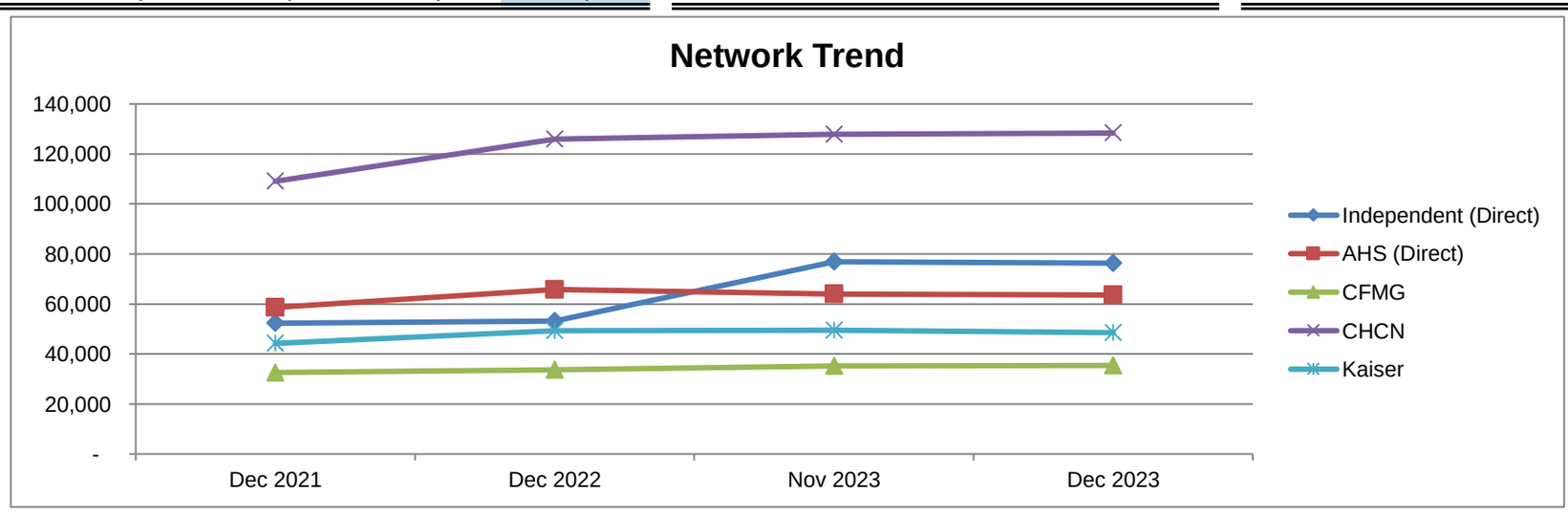
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Dec 2021	Dec 2022	Nov 2023	Dec 2023	Dec 2021	Dec 2022	Nov 2023	Dec 2023	Dec 2021 to Dec 2022	Dec 2022 to Dec 2023	Nov 2023 to Dec 2023
Delegated	185,850	208,881	212,412	212,220	62.6%	63.7%	60.1%	60.3%	12.4%	1.6%	-0.1%
Direct	110,878	118,914	140,842	139,789	37.4%	36.3%	39.9%	39.7%	7.2%	17.6%	-0.7%
Total	**296,728**	**327,795**	**353,254**	**352,009**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.5%**	**7.4%**	**-0.4%**



Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Dec 2021	Dec 2022	Nov 2023	Dec 2023	Dec 2021	Dec 2022	Nov 2023	Dec 2023	Dec 2021 to Dec 2022	Dec 2022 to Dec 2023	Nov 2023 to Dec 2023
Independent (Direct)	52,288	53,143	76,872	76,241	17.6%	16.2%	21.8%	21.7%	1.6%	43.5%	-0.8%
AHS (Direct)	58,590	65,771	63,970	63,548	19.7%	20.1%	18.1%	18.1%	12.3%	-3.4%	-0.7%
CFMG	32,573	33,648	35,124	35,401	11.0%	10.3%	9.9%	10.1%	3.3%	5.2%	0.8%
CHCN	109,059	126,009	127,787	128,342	36.8%	38.4%	36.2%	36.5%	15.5%	1.9%	0.4%
Kaiser	44,218	49,224	49,501	48,477	14.9%	15.0%	14.0%	13.8%	11.3%	-1.5%	-2.1%
Total	**296,728**	**327,795**	**353,254**	**352,009**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.5%**	**7.4%**	**-0.4%**



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

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

Date: **March 8th, 2024**

Subject: **Finance Report – January 2024**

Executive Summary

- For the month ended January 31st, 2024, the Alliance had enrollment of 400,518 members, a Net Loss of $8.0 million and 612% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$166,714	$989,761
Medical Expense	168,642	928,054
Admin. Expense	8,322	53,031
Other Inc. / (Exp.)	2,241	18,701
Net Income	**($8,009)**	**$27,377**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	($7,361)	$26,626
Group Care	(648)	751
	($8,009)	**$27,377**

*Includes consulting cost for Medicare implementation.

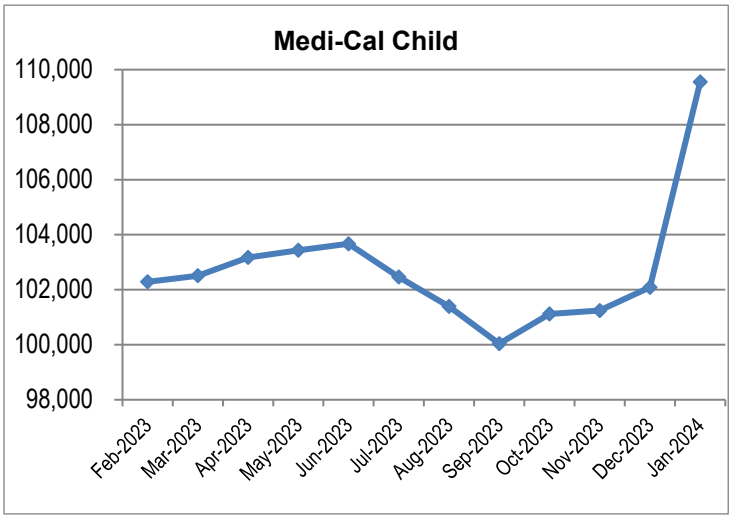
Enrollment

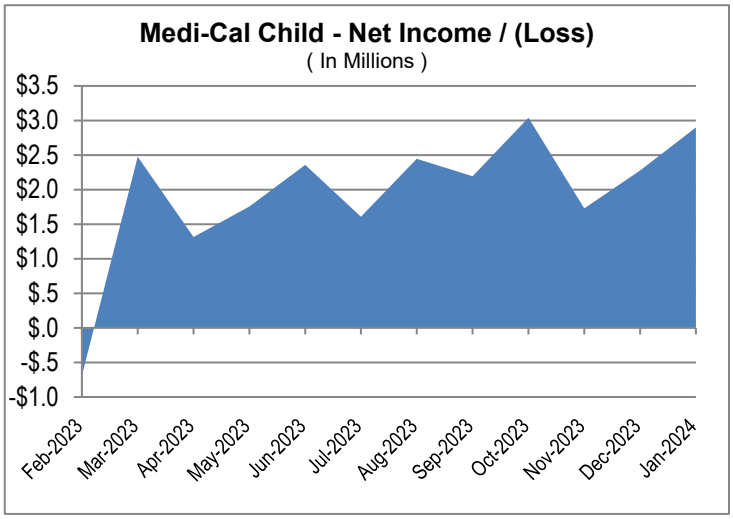
- Total enrollment increased by 48,538 members since December 2023.
- Total enrollment increased by 38,833 members since June 2023.

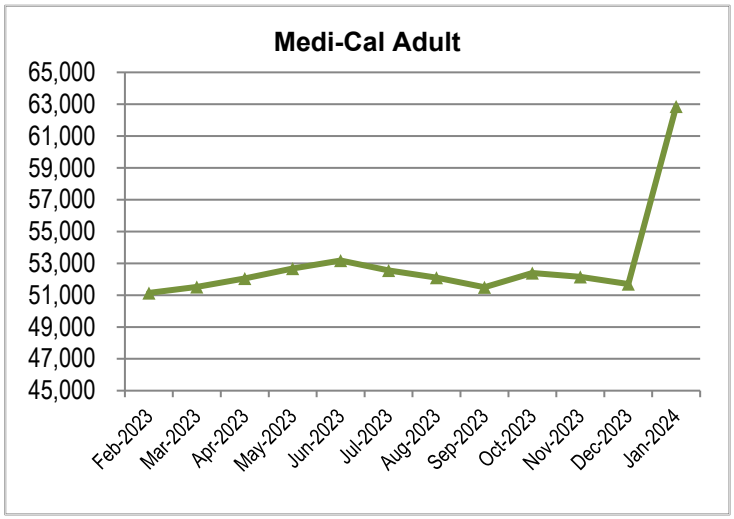
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

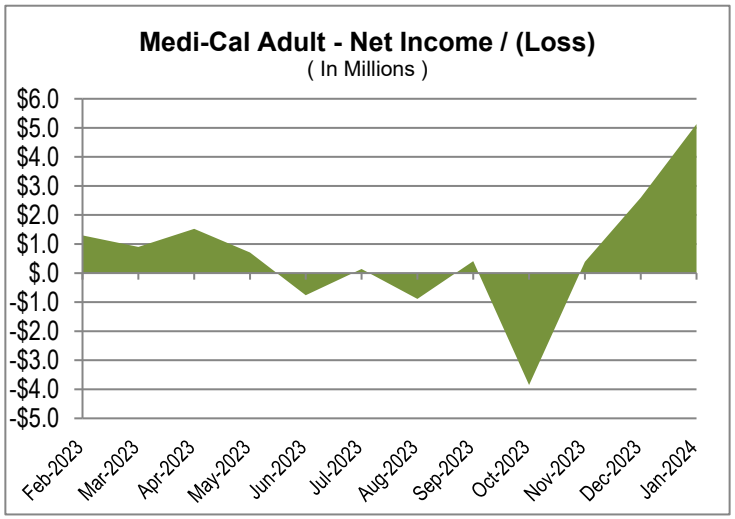
Enrollment					Member Months			
Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
62,860	57,478	5,382	9.4%	Adult	375,254	369,198	6,056	1.6%
109,553	102,159	7,394	7.2%	Child	717,898	706,290	11,608	1.6%
35,013	42,473	(7,460)	-17.6%	SPD	220,099	227,070	(6,971)	-3.1%
40,117	45,787	(5,670)	-12.4%	Duals	288,616	295,050	(6,434)	-2.2%
145,842	149,197	(3,355)	-2.2%	ACA OE	873,055	876,954	(3,899)	-0.4%
219	172	47	27.3%	LTC	1,044	998	46	4.6%
1,311	1,194	117	9.8%	LTC Duals	7,290	7,203	87	1.2%
394,915	**398,460**	**(3,545)**	**-0.9%**	**Medi-Cal Total**	**2,483,256**	**2,482,763**	**493**	**0.0%**
5,603	5,563	40	0.7%	Group Care	39,360	39,281	79	0.2%
400,518	**404,023**	**(3,505)**	**-0.9%**	**Total**	**2,522,616**	**2,522,044**	**572**	**0.0%**

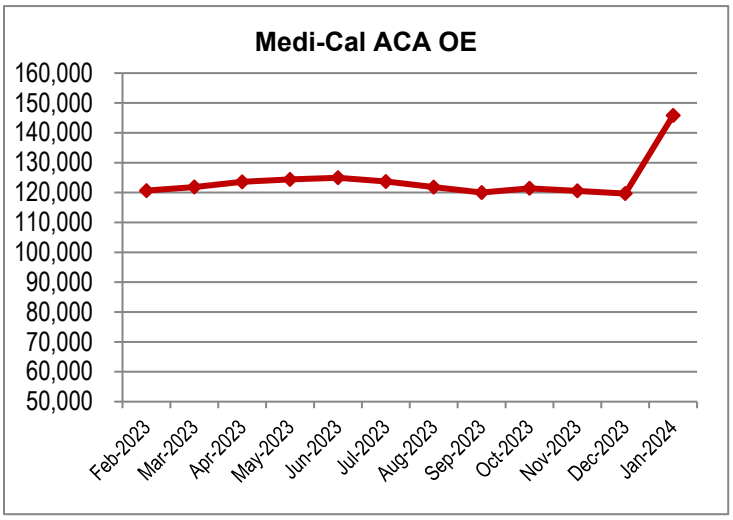
Enrollment and Profitability by Program and Category of Aid

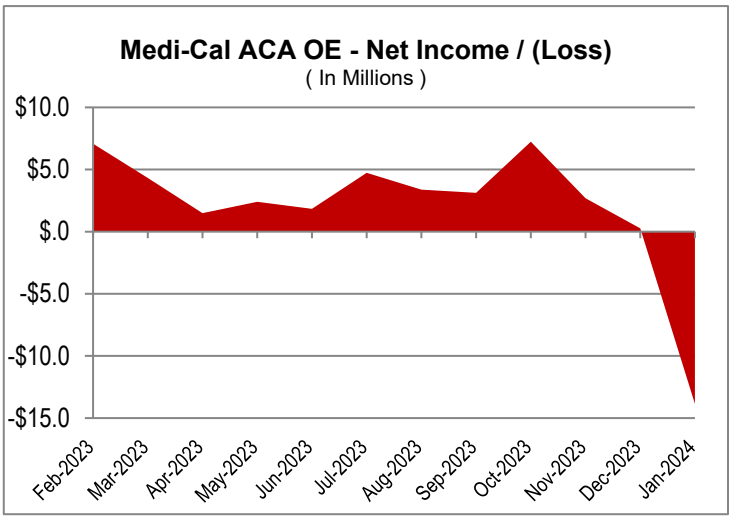




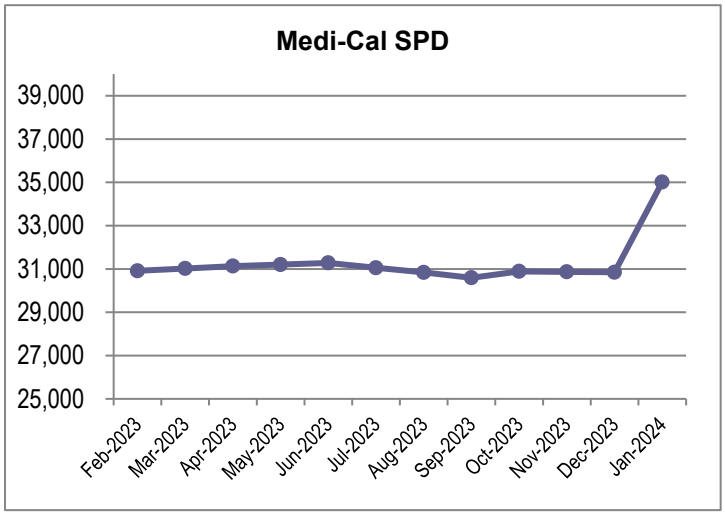


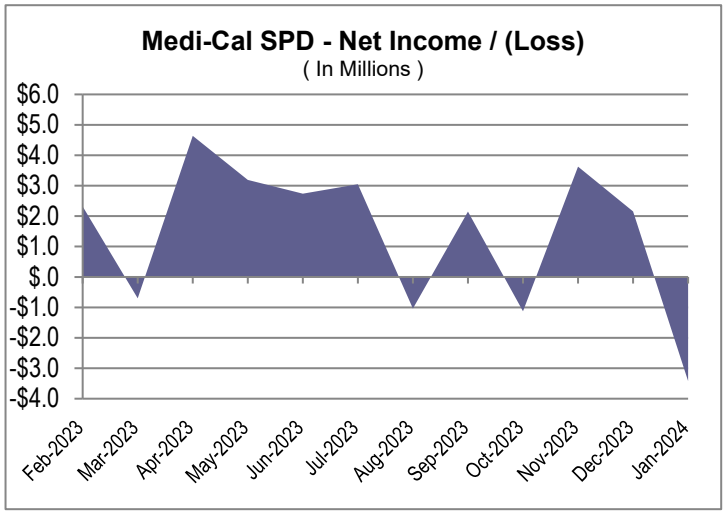


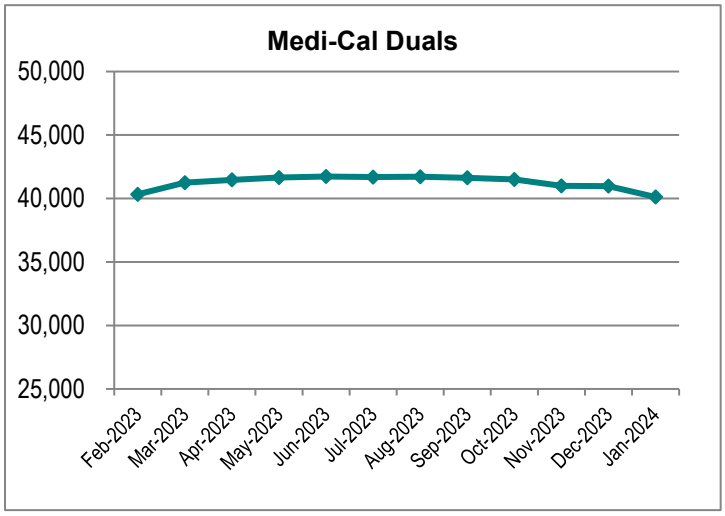


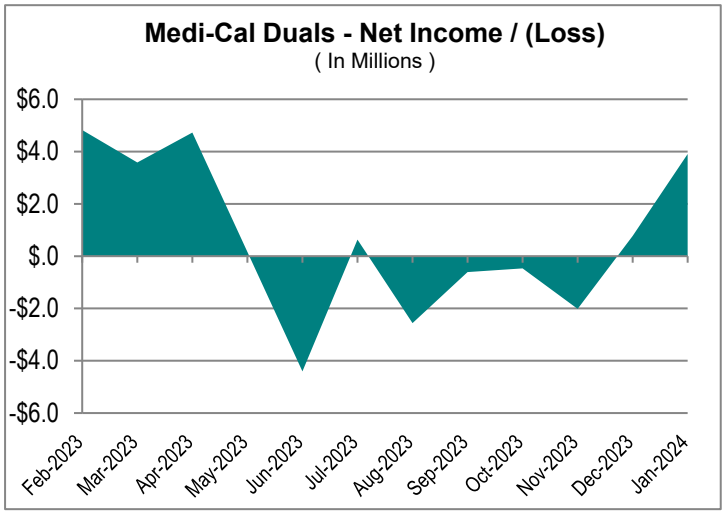


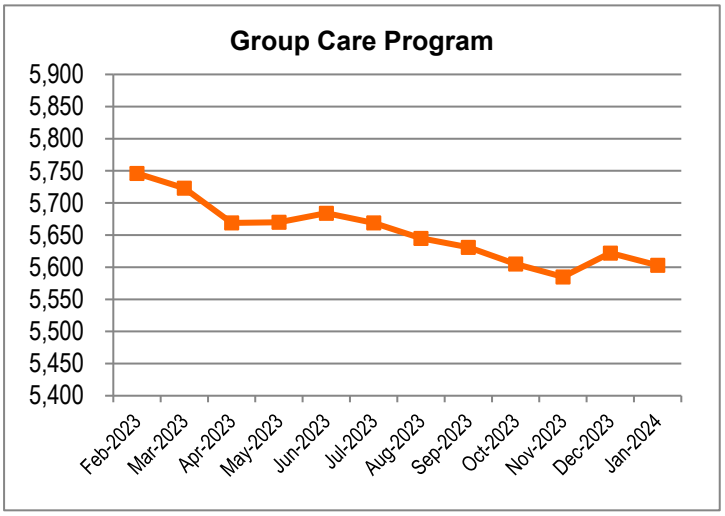
Enrollment and Profitability by Program and Category of Aid

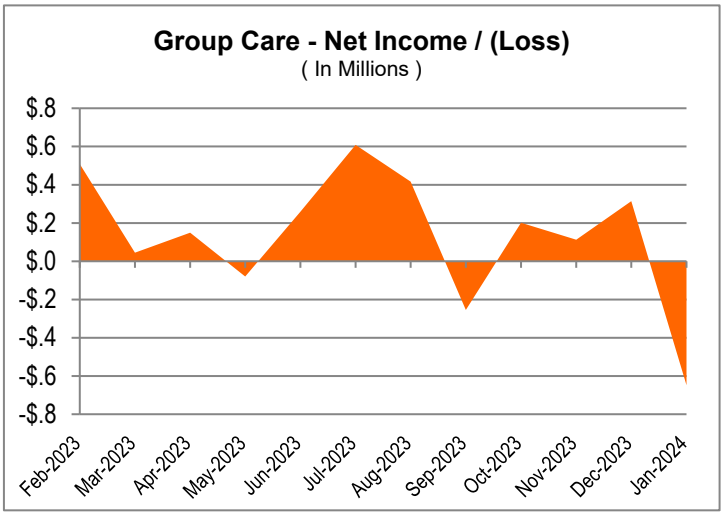




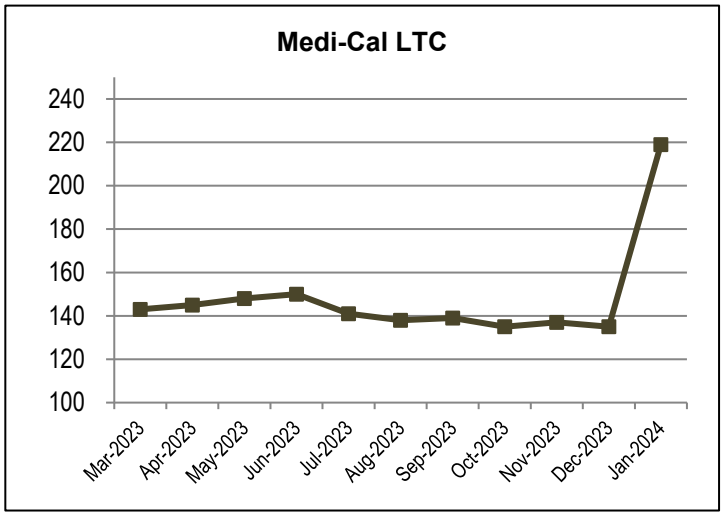


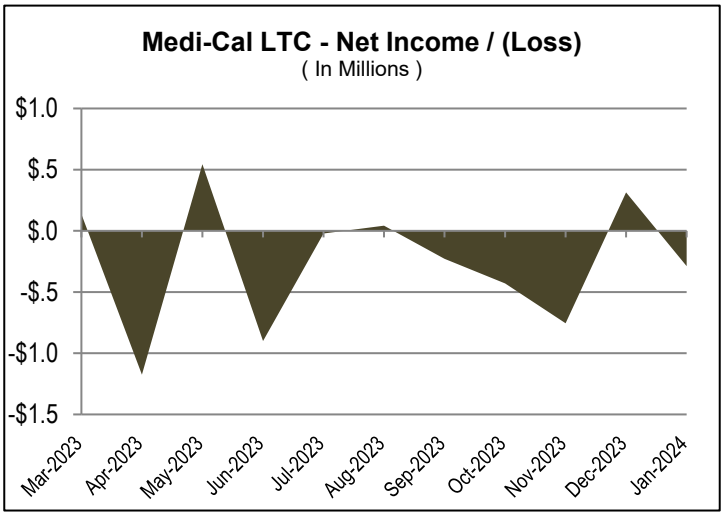


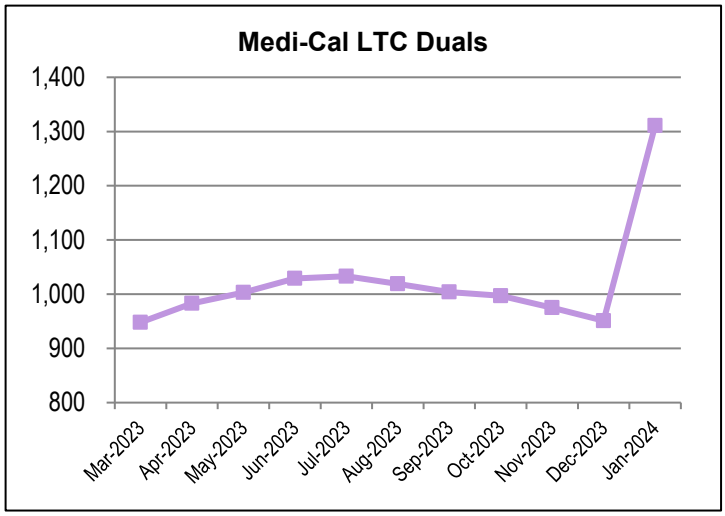


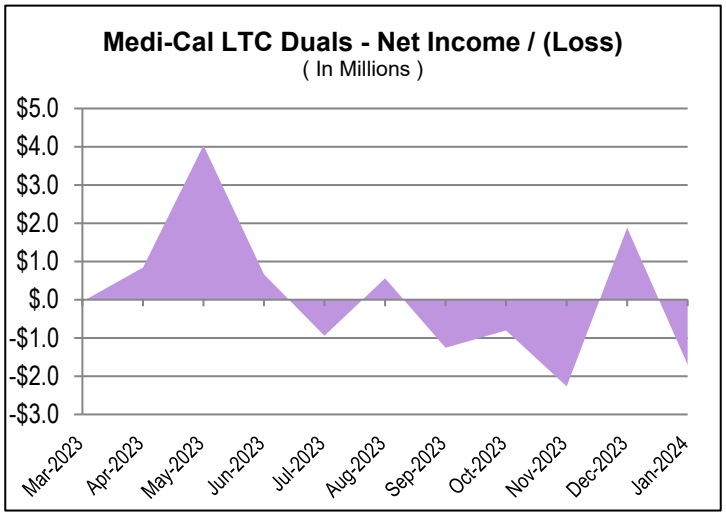


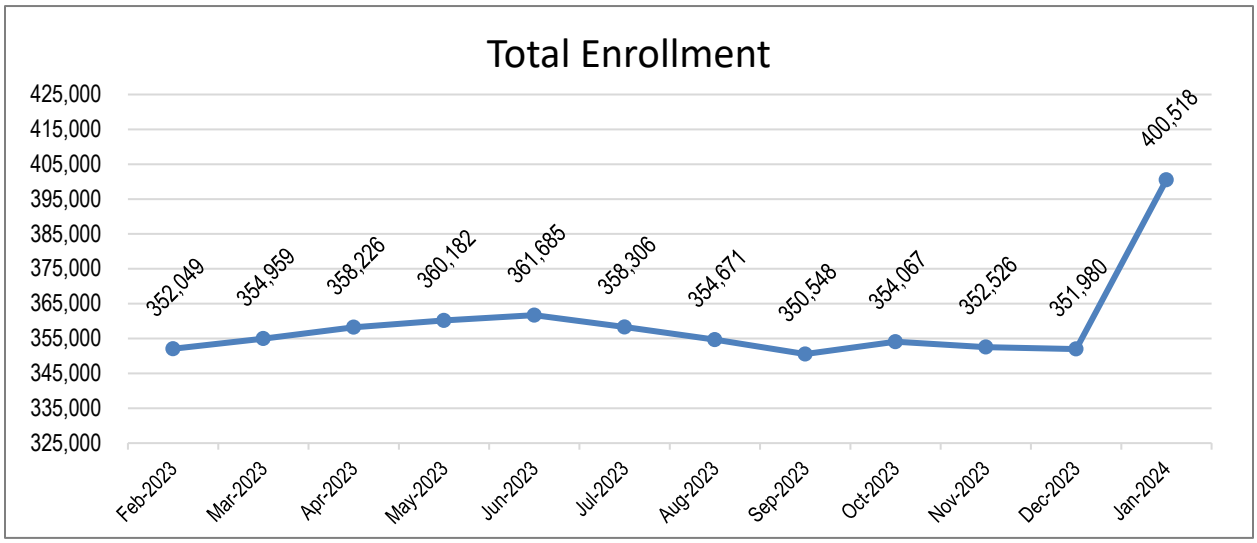
Enrollment and Profitability by Program and Category of Aid

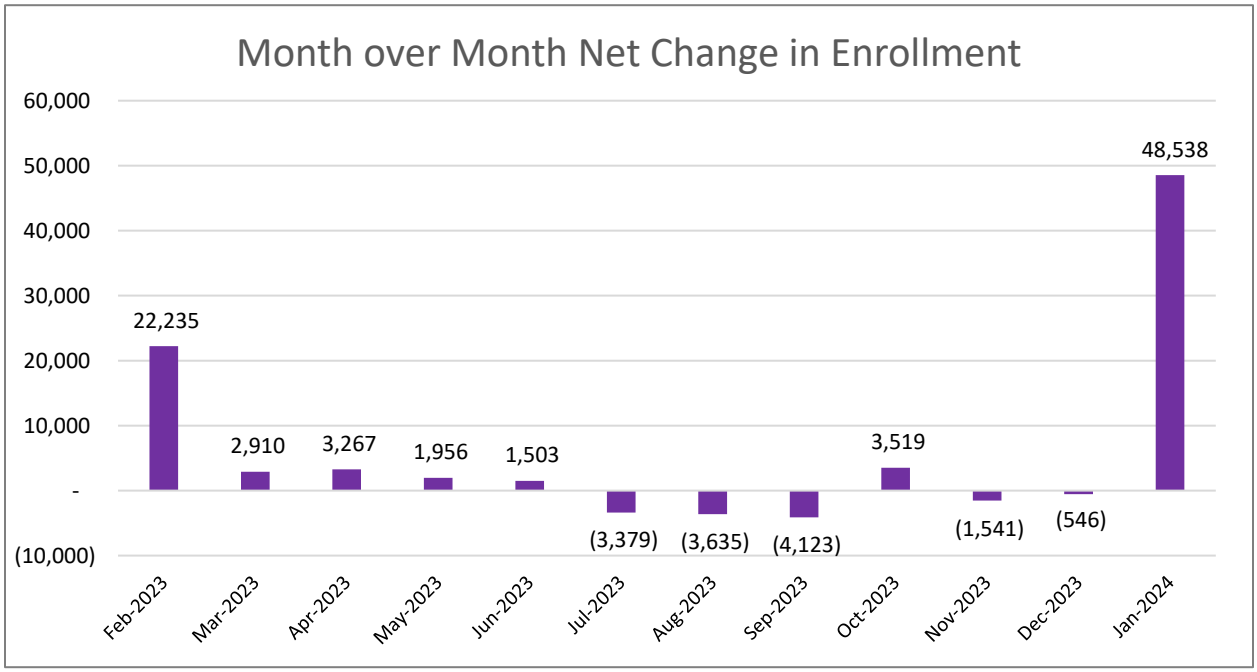










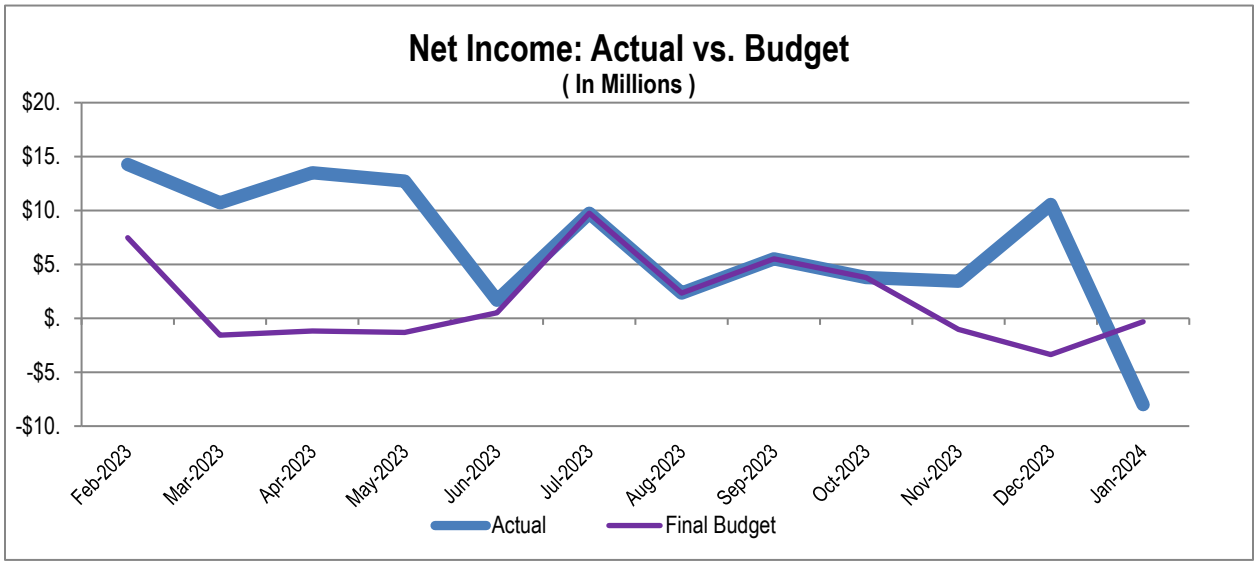


- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and will continue through May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the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

Net Income

- For the month ended January 31st, 2024
  - Actual Net Loss $8.0 million.
  - Budgeted Net Loss $316,000.

- For the fiscal YTD ended January 31st, 2024
  - Actual Net Income $27.4 million.
  - Budgeted Net Income $16.7 million.

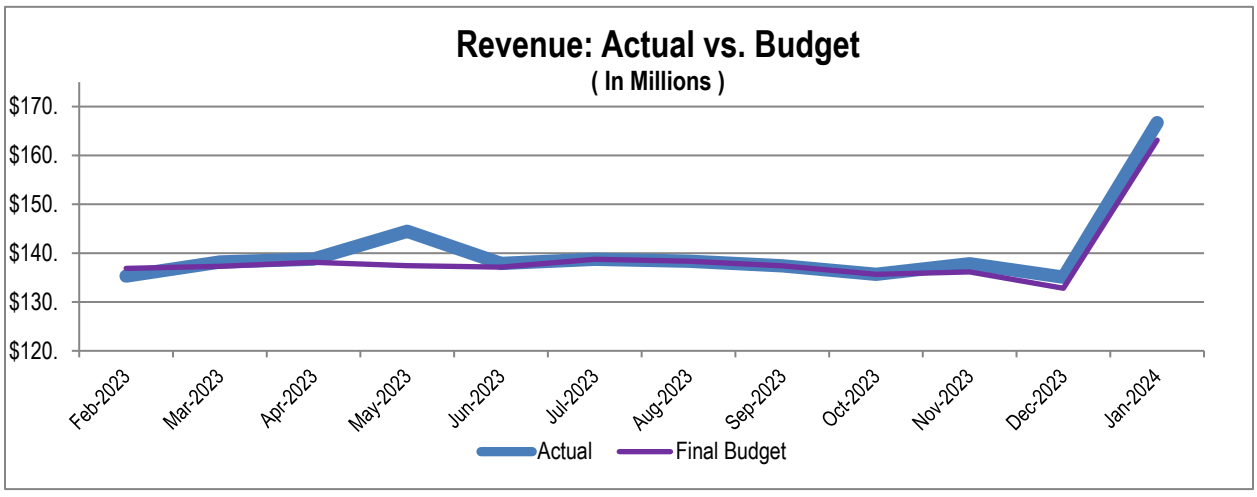


- The unfavorable variance of $7.7 million in the current month is primarily due to:
  - Favorable $3.6 million higher than anticipated Revenue.
  - Unfavorable $11.5 million higher than anticipated Medical Expense.

Revenue

- For the month ended January 31st, 2024
  - Actual Revenue: $166.7 million.
  - Budgeted Revenue: $163.1 million.

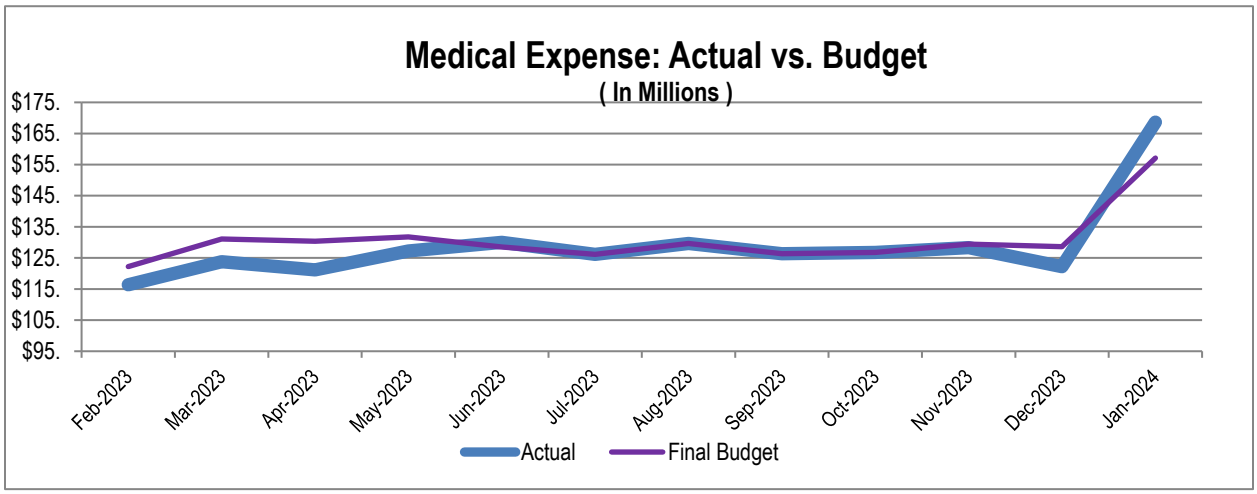
- For the fiscal YTD ended January 31st, 2024
  - Actual Revenue: $989.8 million.
  - Budgeted Revenue: $982.2 million.



- For the month ended January 31st, 2024, the favorable revenue variance of $3.6 million is primarily due to the following:
    - Favorable Capitation Rate variance. Rates were not available at time of budget and the magnitude of new Targeted Rate Increase (TRI) revenue and expense was unknown and therefore not budgeted.
    - The 2022 Acuity Adjustment reserve was released.
    - Unfavorable Medi-Cal enrollment volume variance for January 2024.
    - Unfavorable Prop 56 variance, which was budgeted as a partial placeholder for Targeted Rate Increase (TRI).
    - Unfavorable reserve for Medical Loss Ratio payback to DHCS for the period FY15 for the ACA OE population.

Medical Expense

- For the month ended January 31st, 2024
    - Actual Medical Expense: $168.6 million.
    - Budgeted Medical Expense: $157.1 million.
- For the fiscal YTD ended January 31st, 2024
    - Actual Medical Expense: $928.1 million.
    - Budgeted Medical Expense: $924.1 million.



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

- For January, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $10.6 million. Year to date, the estimate for prior years increased by $6.7 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)

Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$172,917,710	$0	$172,917,710	$171,571,715	($1,345,994)	-0.8%
Primary Care FFS	$40,003,775	($7,326)	$39,996,449	$40,167,608	$163,832	0.4%
Specialty Care FFS	$37,931,020	$142	$37,931,161	$38,848,666	$917,647	2.4%
Outpatient FFS	$58,933,632	$251,306	$59,184,938	$60,705,330	$1,771,698	2.9%
Ancillary FFS	$77,744,912	$614,616	$78,359,529	$79,475,917	$1,731,005	2.2%
Pharmacy FFS	$61,400,488	$221,196	$61,621,685	$64,163,999	$2,763,511	4.3%
ER Services FFS	$42,744,044	($9,561)	$42,734,484	$42,056,214	($687,830)	-1.6%
Inpatient Hospital & SNF FFS	$244,985,367	$3,785,676	$248,771,043	$248,138,126	$3,152,759	1.3%
Long Term Care FFS	$150,589,625	$1,838,859	$152,428,485	$139,429,897	($11,159,728)	-8.0%
Other Benefits & Services	$31,773,246	$0	$31,773,246	$35,279,470	$3,506,224	9.9%
Net Reinsurance	($664,974)	$0	($664,974)	$1,237,571	$1,902,546	153.7%
Provider Incentive	$3,000,000	$0	$3,000,000	$3,000,000	$0	0.0%
	$921,358,846	**$6,694,909**	**$928,053,755**	**$924,074,515**	**$2,715,670**	**0.3%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

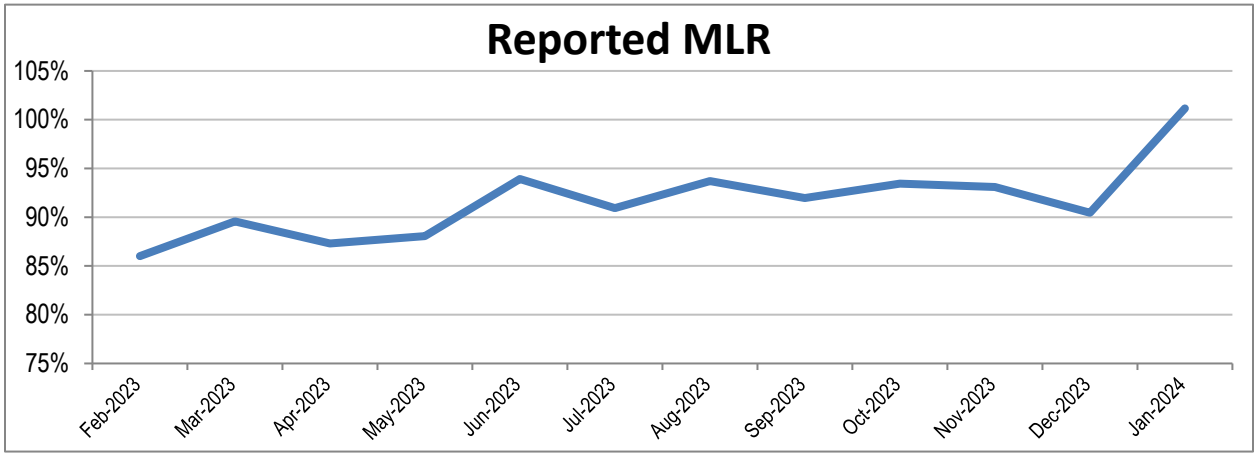
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$68.55	$0.00	$68.55	$68.03	($0.52)	-0.8%
Primary Care FFS	$15.86	($0.00)	$15.86	$15.93	$0.07	0.4%
Specialty Care FFS	$15.04	$0.00	$15.04	$15.40	$0.37	2.4%
Outpatient FFS	$23.36	$0.10	$23.46	$24.07	$0.71	2.9%
Ancillary FFS	$30.82	$0.24	$31.06	$31.51	$0.69	2.2%
Pharmacy FFS	$24.34	$0.09	$24.43	$25.44	$1.10	4.3%
ER Services FFS	$16.94	($0.00)	$16.94	$16.68	($0.27)	-1.6%
Inpatient Hospital & SNF FFS	$97.12	$1.50	$98.62	$98.39	$1.27	1.3%
Long Term Care FFS	$59.70	$0.73	$60.42	$55.28	($4.41)	-8.0%
Other Benefits & Services	$12.60	$0.00	$12.60	$13.99	$1.39	10.0%
Net Reinsurance	($0.26)	$0.00	($0.26)	$0.49	$0.75	153.7%
Provider Incentive	$1.19	$0.00	$1.19	$1.19	$0.00	0.0%
	$365.24	**$2.65**	**$367.89**	**$366.40**	**$1.16**	**0.3%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $2.7 million favorable to budget. On a PMPM basis, medical expense is 0.3% favorable to budget. For per-member-per-month expense:
    - Capitated Expense is slightly over budget, largely driven by unfavorable accruals for PCP Capitation expense due to inception of Provider Targeted Rate Increases (TRI), partially offset by favorable FQHC expense.

- Primary Care Expense is slightly under budget driven mostly by the lower ACA OE and Child utilization.
- Specialty Care Expense is below budget, driven mostly by lower SPD and Duals utilization.
- Outpatient Expense is under budget due to lower facility other and dialysis utilization across most populations.
- Ancillary Expense is under budget mostly due to lower utilization in the Child Category of Aid.
- Pharmacy Expense is under budget mostly due to lower Non-PBM expense driven by lower utilization in the SPD and ACA OE populations.
- Emergency Room Expense is under budget driven mostly by lower utilization in SPDs.
- Inpatient Expense is under budget driven mostly by lower utilization in the ACA OE Category of Aid.
- Long Term Care Expense is over budget mostly due to higher utilization and unit cost in the SPD, ACA OE and Duals populations.
- Other Benefits & Services is under budget, due to favorable community relations, other purchased services and employee expense.
- Net Reinsurance year-to-date is under budget because more recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 101.2% for the month and 93.8% for the fiscal year-to-date.



Administrative Expense

- For the month ended January 31st, 2024
  - Actual Administrative Expense: $8.3 million.
  - Budgeted Administrative Expense: $8.8 million.

- For the fiscal YTD ended January 31st, 2024
  - Actual Administrative Expense: $53.0 million.
  - Budgeted Administrative Expense: $58.8 million.

Summary of Administrative Expense (In Dollars) For the Month and Fiscal Year-to-Date Favorable/(Unfavorable)								
Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$5,530,207	$6,002,551	$472,344	7.9%	Employee Expense	$34,221,072	$37,406,261	$3,185,189	8.5%
76,021	74,108	(1,913)	-2.6%	Medical Benefits Admin Expense	1,253,727	1,250,081	(3,646)	-0.3%
1,025,715	895,740	(129,975)	-14.5%	Purchased & Professional Services	7,008,013	8,042,876	1,034,863	12.9%
1,689,844	1,829,306	139,462	7.6%	Other Admin Expense	10,548,011	12,133,506	1,585,496	13.1%
$8,321,788	$8,801,706	$479,918	5.5%	Total Administrative Expense	$53,030,822	$58,832,724	$5,801,901	9.9%

The year-to-date variances include:

- Favorable impact of delayed timing of start dates for Consulting for new projects and Computer Support Services.
- Favorable Employee and Temporary Services variances and delayed Training, Travel, Recruitment, and other employee-related expenses.

The Administrative Loss Ratio (ALR) is 5.0% of net revenue for the month and 5.4% of net revenue year-to-date.

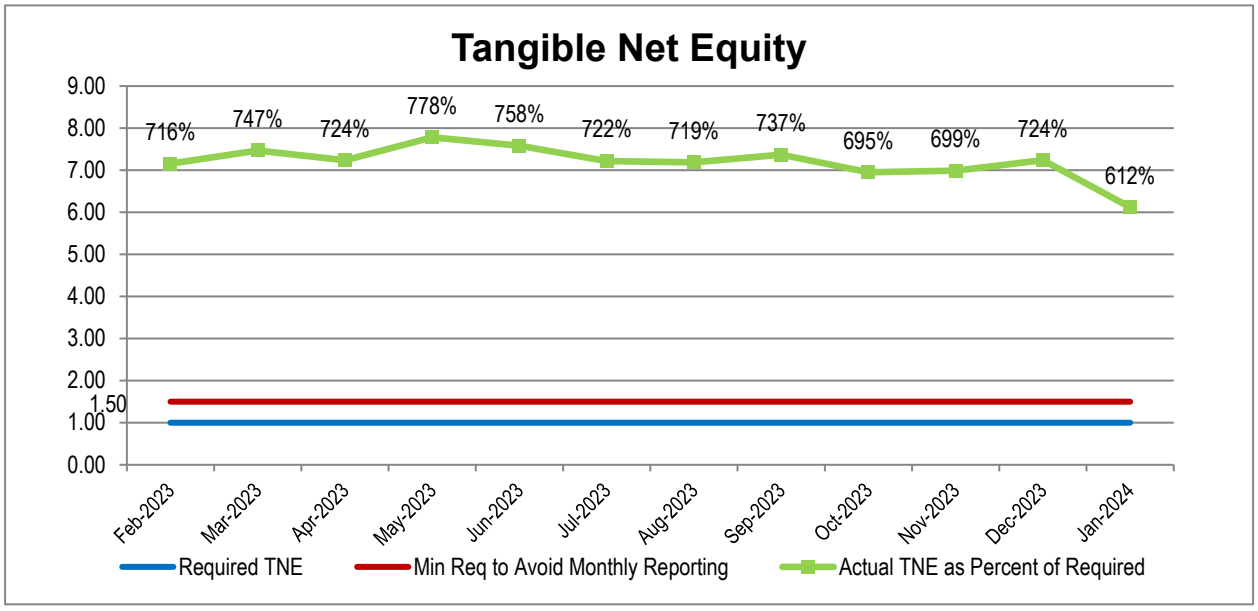
Other Income / (Expense)

Other Income & Expense is comprised of investment income and claims interest.

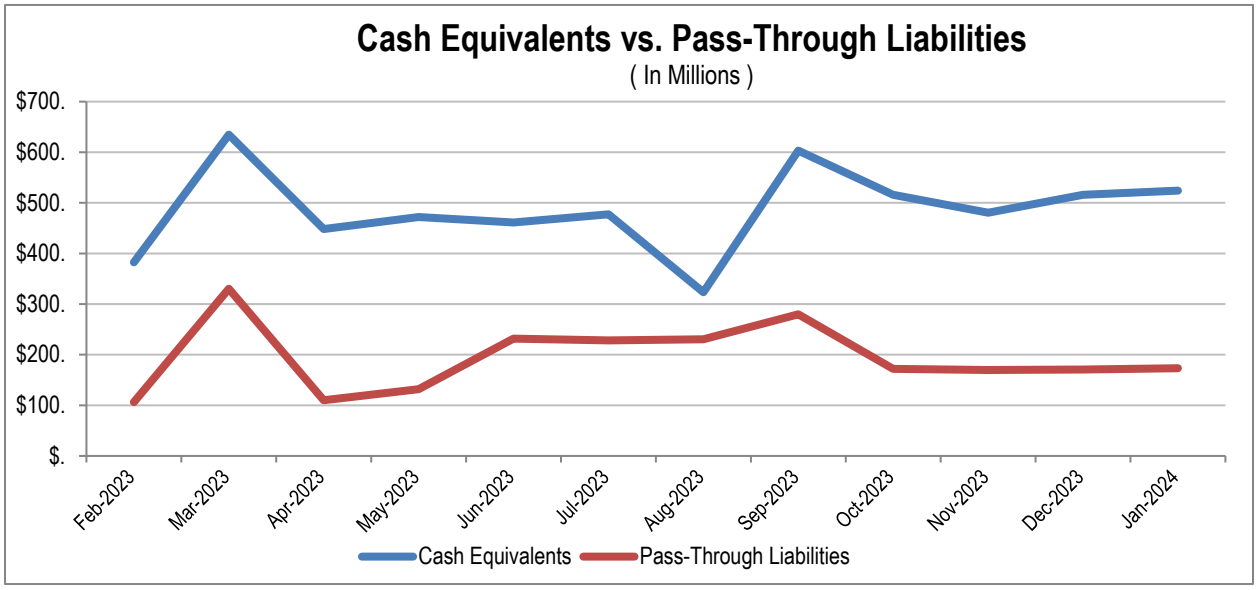
- Fiscal year-to-date net investments show a gain of $19.1 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $379,000.

Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
    - Required TNE $57.4 million
    - Actual TNE $351.3 million
    - Excess TNE $293.9 million
    - TNE % of Required TNE 612%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
  - Cash & Cash Equivalents $524.1 million
  - Pass-Through Liabilities $173.3 million
  - Uncommitted Cash $350.8 million
  - Working Capital $336.0 million
  - Current Ratio 1.71 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $1.2 million.
- Annual capital budget: $1.6 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.

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED JANUARY 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
394,915	398,460	(3,545)	(0.9%)	1 - Medi-Cal	2,483,256	2,482,763	493	0.0%
5,603	5,563	40	0.7%	2 - GroupCare	39,360	39,281	79	0.2%
400,518	**404,023**	**(3,505)**	**(0.9%)**	**3 - TOTAL MEMBER MONTHS**	**2,522,616**	**2,522,044**	**572**	**0.0%**
				REVENUE				
$166,713,747	**$163,129,934**	**$3,583,812**	**2.2%**	**4 - TOTAL REVENUE**	**$989,760,862**	**$982,245,215**	**$7,515,647**	**0.8%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$18,967,661	$16,385,845	($2,581,817)	(15.8%)	5 - Capitated Medical Expense	$172,917,710	$171,571,715	($1,345,994)	(0.8%)
				Fee for Service Medical Expenses:				
$54,186,411	$49,437,729	($4,748,682)	(9.6%)	6 - Inpatient Hospital Expense	$248,771,043	$248,138,126	($632,917)	(0.3%)
$6,470,937	$6,810,685	$339,749	5.0%	7 - Primary Care Physician Expense	$39,996,449	$40,167,608	$171,158	0.4%
$7,983,912	$7,799,308	($184,604)	(2.4%)	8 - Specialty Care Physician Expense	$37,931,161	$38,848,666	$917,505	2.4%
$13,180,573	$14,436,090	$1,255,517	8.7%	9 - Ancillary Medical Expense	$78,359,529	$79,475,917	$1,116,389	1.4%
$12,050,025	$12,561,471	$511,446	4.1%	10 - Outpatient Medical Expense	$59,184,938	$60,705,330	$1,520,392	2.5%
$8,749,246	$7,814,226	($935,020)	(12.0%)	11 - Emergency Expense	$42,734,484	$42,056,214	($678,270)	(1.6%)
$12,350,687	$12,591,135	$240,448	1.9%	12 - Pharmacy Expense	$61,621,685	$64,163,999	$2,542,315	4.0%
$31,432,959	$24,131,576	($7,301,384)	(30.3%)	13 - Long Term Care Expense	$152,428,485	$139,429,897	($12,998,587)	(9.3%)
$146,404,750	$135,582,219	($10,822,530)	(8.0%)	14 - Total Fee for Service Expense	$721,027,773	$712,985,759	($8,042,015)	(1.1%)
$4,385,335	$4,767,484	$382,149	8.0%	15 - Other Benefits & Services	$31,773,246	$35,279,471	$3,506,225	9.9%
($1,116,026)	$368,183	$1,484,209	403.1%	16 - Reinsurance Expense	($664,974)	$1,237,571	$1,902,546	153.7%
$0	$0	$0	0.0%	17 - Risk Pool Distribution	$3,000,000	$3,000,000	$0	(0.0%)
$168,641,720	**$157,103,732**	**($11,537,989)**	**(7.3%)**	**18 - TOTAL MEDICAL EXPENSES**	**$928,053,755**	**$924,074,516**	**($3,979,239)**	**(0.4%)**
($1,927,973)	**$6,026,203**	**($7,954,176)**	**(132.0%)**	**19 - GROSS MARGIN**	**$61,707,107**	**$58,170,699**	**$3,536,408**	**6.1%**
				ADMINISTRATIVE EXPENSES				
$5,530,207	$6,002,551	$472,344	7.9%	20 - Personnel Expense	$34,221,072	$37,406,263	$3,185,191	8.5%
$76,021	$74,108	($1,913)	(2.6%)	21 - Benefits Administration Expense	$1,253,727	$1,250,081	($3,646)	(0.3%)
$1,025,715	$895,740	($129,975)	(14.5%)	22 - Purchased & Professional Services	$7,008,013	$8,042,876	$1,034,863	12.9%
$1,689,844	$1,829,306	$139,462	7.6%	23 - Other Administrative Expense	$10,548,011	$12,133,506	$1,585,496	13.1%
$8,321,788	**$8,801,706**	**$479,919**	**5.5%**	**24 - TOTAL ADMINISTRATIVE EXPENSES**	**$53,030,822**	**$58,832,725**	**$5,801,903**	**9.9%**
($10,249,761)	**($2,775,503)**	**($7,474,258)**	**269.3%**	**25 - NET OPERATING INCOME / (LOSS)**	**$8,676,285**	**($662,026)**	**$9,338,311**	**(1,410.6%)**
				OTHER INCOME / EXPENSES				
$2,240,703	**$2,460,000**	**($219,297)**	**(8.9%)**	**26 - TOTAL OTHER INCOME / (EXPENSES)**	**$18,700,561**	**$17,338,587**	**$1,361,974**	**7.9%**
($8,009,058)	**($315,503)**	**($7,693,554)**	**(2,438.5%)**	**27 - NET INCOME / (LOSS)**	**$27,376,846**	**$16,676,561**	**$10,700,285**	**64.2%**
101.2%	96.3%	-4.9%	-5.1%	28 - Medical Loss Ratio	93.8%	94.1%	0.3%	0.3%
-1.2%	3.7%	-4.9%	-132.4%	29 - Gross Margin Ratio	6.2%	5.9%	0.3%	5.1%
5.0%	5.4%	0.4%	7.4%	30 - Administrative Expense Ratio	5.4%	6.0%	0.6%	10.0%
-4.8%	-0.2%	-4.6%	-2,300.0%	31 - Net Income / (Loss) Ratio	2.8%	1.7%	1.1%	64.7%

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH

	1/31/2024	12/31/2023	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$71,248,415	($104,562,280)	$175,810,695	-168.14%
Short-Term Investments	452,825,898	620,592,043	(167,766,146)	-27.03%
Interest Receivable	3,372,472	3,986,756	(614,284)	-15.41%
Premium Receivables	264,648,167	227,060,158	37,588,009	16.55%
Reinsurance Receivables	5,192,459	4,267,742	924,717	21.67%
Other Receivables	699,148	679,492	19,656	2.89%
Prepaid Expenses	2,505,779	3,736,069	(1,230,289)	-32.93%
CalPERS Net Pension Assets	(5,286,448)	(5,286,448)	0	0.00%
Deferred Outflow	14,099,056	14,099,056	0	0.00%
TOTAL CURRENT ASSETS	**$809,304,945**	**$764,572,587**	**$44,732,358**	**5.85%**
OTHER ASSETS:				
Long-Term Investments	4,748,952	4,738,227	10,725	0.23%
Restricted Assets	350,000	350,000	0	0.00%
GASB 87-Lease Assets (Net)	1,136,490	1,202,404	(65,913)	-5.48%
GASB 96-SBITA Assets (Net)	4,412,698	4,613,515	(200,817)	-4.35%
TOTAL OTHER ASSETS	**$10,648,141**	**$10,904,146**	**($256,005)**	**-2.35%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,167,264	10,149,359	17,905	0.18%
Furniture And Equipment	12,962,138	12,958,278	3,860	0.03%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	$38,855,851	$38,834,086	$21,765	0.06%
Less: Accumulated Depreciation	($32,906,443)	($32,836,353)	($70,090)	0.21%
NET PROPERTY AND EQUIPMENT	**$5,949,408**	**$5,997,733**	**($48,325)**	**-0.81%**
TOTAL ASSETS	**$825,902,494**	**$781,474,466**	**$44,428,027**	**5.69%**
CURRENT LIABILITIES:				
Accounts Payable	4,105,836	5,522,051	(1,416,215)	-25.65%
Other Accrued Liabilities	17,577,983	24,634,929	(7,056,946)	-28.65%
GASB 87 ST Lease Liabilities	831,119	901,070	(69,951)	-7.76%
GASB 96 ST SBITA Liabilities	2,226,765	2,160,890	65,875	3.05%
Claims Payable	54,961,645	30,091,843	24,869,802	82.65%
IBNP Reserves	200,914,934	168,142,497	32,772,437	19.49%
Pass-Through Liabilities	173,306,815	170,713,987	2,592,828	1.52%
Risk Sharing - Providers	6,629,337	6,629,337	0	0.00%
Payroll Liabilities	7,711,460	6,711,455	1,000,005	14.90%
Deferred Inflow	5,004,985	5,004,985	0	0.00%
TOTAL CURRENT LIABILITIES	**$473,270,877**	**$420,513,043**	**$52,757,835**	**12.55%**
LONG TERM LIABILITIES:				
GASB 87 LT Lease Liabilities	396,771	472,201	(75,430)	-15.97%
GASB 96 LT SBITA Liabilities	900,958	1,146,277	(245,319)	-21.40%
TOTAL LONG TERM LIABILITIES	**$1,297,729**	**$1,618,478**	**($320,749)**	**-19.82%**
TOTAL LIABILITIES	**$474,568,606**	**$422,131,521**	**$52,437,085**	**12.42%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	323,116,808	323,116,808	0	0.00%
Year-to Date Net Income / (Loss)	27,376,846	35,385,904	(8,009,058)	-22.63%
TOTAL NET WORTH	**$351,333,888**	**$359,342,945**	**($8,009,058)**	**-2.23%**
TOTAL LIABILITIES AND NET WORTH	**$825,902,494**	**$781,474,466**	**$44,428,027**	**5.69%**
Cash Equivalents	$524,074,312	$516,029,763	$8,044,549	1.56%
Pass-Through	$173,306,815	$170,713,987	$2,592,828	1.52%
Uncommitted Cash	$350,767,498	$345,315,777	$5,451,721	1.58%
Working Capital	$336,034,068	$344,059,545	($8,025,477)	-2.33%
Current Ratio	171.0%	181.8%	-10.8%	-5.9%

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 1/31/2024

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,562,317	$7,684,207	$15,404,993	$17,997,030
Total	2,562,317	7,684,207	15,404,993	17,997,030
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	164,151,371	431,922,949	835,623,663	971,763,367
Premium Receivable	(37,588,009)	(30,926,764)	27,621,056	31,714,254
Total	126,563,362	400,996,185	863,244,719	1,003,477,621
Investment & Other Income Cash Flows				
Other Revenue (Grants)	192,092	1,890,082	2,324,068	2,481,537
Investment Income	2,148,006	7,130,119	13,957,938	16,733,622
Interest Receivable	614,284	(2,405,961)	(2,891,549)	(2,657,896)
Total	2,954,382	6,614,240	13,390,457	16,557,263
Medical & Hospital Cash Flows				
Total Medical Expenses	(168,641,720)	(419,111,290)	(801,898,165)	(928,053,757)
Other Receivable	(949,905)	(2,194,562)	(2,086,732)	(2,014,253)
Claims Payable	0	0	0	0
IBNP Payable	32,772,437	31,737,334	26,292,651	36,410,531
Risk Share Payable	0	0	0	0
Health Program	0	0	0	0
Other Liabilities	0	(1)	0	0
Total	(136,819,188)	(389,568,519)	(777,692,246)	(893,657,479)
Administrative Cash Flows				
Total Administrative Expenses	(8,421,121)	(23,520,448)	(47,782,584)	(53,544,955)
Prepaid Expenses	1,235,819	1,783,589	2,300,660	2,376,649
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	(1,463,212)	(21,565,217)	61,800	751,822
Other Accrued Liabilities	(12,028,080)	(10,846,221)	(11,623,452)	(11,623,452)
Payroll Liabilities	1,000,007	(91,861)	1,440,253	1,781,573
Net Lease Assets/Liabilities (Short term & Long term)	(58,095)	(466,224)	(482,146)	(688,640)
Depreciation Expense	136,003	400,651	775,925	890,712
Total	(19,598,679)	(54,305,731)	(55,309,544)	(60,056,291)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**(24,337,806)**	**(28,579,618)**	**59,038,379**	**84,318,144**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 1/31/2024

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(10,725)	2,301,354	6,831,391	6,811,585
	(10,725)	2,301,354	6,831,391	6,811,585
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	32,480,760	34,974,206	(17,693,932)	(26,818,685)
Restricted Cash	0	0	0	0
	32,480,760	34,974,206	(17,693,932)	(26,818,685)
Fixed Asset Cash Flows				
Depreciation expense	136,003	400,651	775,925	890,712
Fixed Asset Acquisitions	(87,677)	(696,670)	(1,556,235)	(1,622,149)
Change in A/D	(136,003)	(400,651)	(775,925)	(890,712)
	(87,677)	(696,670)	(1,556,235)	(1,622,149)
Total Cash Flows from Investing Activities	**32,382,358**	**36,578,890**	**(12,418,776)**	**(21,629,249)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**8,044,552**	**7,999,272**	**46,619,603**	**62,688,895**
Rounding	(3)	1	(1)	3
Cash @ Beginning of Period	516,029,764	516,075,040	477,454,711	461,385,415
Cash @ End of Period	**$524,074,313**	**$524,074,313**	**$524,074,313**	**$524,074,313**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 1/31/2024

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($8,009,058)	$5,995,617	$17,629,912	$27,376,846
Add back: Depreciation	136,003	400,651	775,925	890,712
Receivables				
Premiums Receivable	(37,588,009)	(30,926,764)	27,621,056	31,714,254
Interest Receivable	614,284	(2,405,961)	(2,891,549)	(2,657,896)
Other Receivable	(949,905)	(2,194,562)	(2,086,732)	(2,014,253)
Total	(37,923,630)	(35,527,287)	22,642,775	27,042,105
Prepaid Expenses	1,235,819	1,783,589	2,300,660	2,376,649
Trade Payables	(1,463,212)	(21,565,217)	61,800	751,822
Claims Payable, IBNR & Risk Share				
IBNP	32,772,437	31,737,334	26,292,651	36,410,531
Claims Payable	0	0	0	0
Risk Share Payable	0	0	0	0
Other Liabilities	0	(1)	0	0
Total	32,772,437	31,737,333	26,292,651	36,410,531
Unearned Revenue				
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	(12,028,080)	(10,846,221)	(11,623,452)	(11,623,452)
Payroll Liabilities	1,000,007	(91,861)	1,440,253	1,781,573
Net Lease Assets/Liabilities (Short term & Long term)	(58,095)	(466,224)	(482,146)	(688,640)
Health Program	0	0	0	0
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	(11,086,168)	(11,404,306)	(10,665,345)	(10,530,519)
Cash Flows from Operating Activities	**($24,337,809)**	**($28,579,620)**	**$59,038,378**	**$84,318,146**
Difference (rounding)	(3)	(2)	(1)	2

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 1/31/2024

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$126,563,362	$400,996,185	$863,244,719	$1,003,477,621
Commercial Premium Revenue	2,562,317	7,684,207	15,404,993	17,997,030
Other Income	192,092	1,890,082	2,324,068	2,481,537
Investment Income	2,762,290	4,724,158	11,066,389	14,075,726
Cash Paid To:				
Medical Expenses	(136,819,188)	(389,568,519)	(777,692,246)	(893,657,479)
Vendor & Employee Expenses	(19,598,679)	(54,305,731)	(55,309,544)	(60,056,291)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	(24,337,806)	(28,579,618)	59,038,379	84,318,144
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	(87,677)	(696,670)	(1,556,235)	(1,622,149)
Net Cash Provided By (Used In) Financing Activities	(87,677)	(696,670)	(1,556,235)	(1,622,149)
Cash Flows from Investing Activities:				
Changes in Investments	(10,725)	2,301,354	6,831,391	6,811,585
Restricted Cash	32,480,760	34,974,206	(17,693,932)	(26,818,685)
Net Cash Provided By (Used In) Investing Activities	32,470,035	37,275,560	(10,862,541)	(20,007,100)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**8,044,552**	**7,999,272**	**46,619,603**	**62,688,895**
Cash @ Beginning of Period	516,029,764	516,075,040	477,454,711	461,385,415
Subtotal	$524,074,316	$524,074,312	$524,074,314	$524,074,310
Rounding	(3)	1	(1)	3
Cash @ End of Period	**$524,074,313**	**$524,074,313**	**$524,074,313**	**$524,074,313**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($8,009,058)	$5,995,617	$17,629,912	$27,376,846
Depreciation	136,003	400,651	775,925	890,712
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	(37,923,630)	(35,527,287)	22,642,775	27,042,105
Prepaid Expenses	1,235,819	1,783,589	2,300,660	2,376,649
Trade Payables	(1,463,212)	(21,565,217)	61,800	751,822
Claims payable & IBNP	32,772,437	31,737,333	26,292,651	36,410,531
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	(11,086,168)	(11,404,306)	(10,665,345)	(10,530,519)
Subtotal	(24,337,809)	(28,579,620)	59,038,378	84,318,146
Rounding	3	2	1	(2)
Cash Flows from Operating Activities	**($24,337,806)**	**($28,579,618)**	**$59,038,379**	**$84,318,144**
Rounding Difference	3	2	1	(2)

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE JANUARY 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	717,898	375,254	220,099	873,055	288,616	1,044	7,290	2,483,256	39,360	-	2,522,616
Revenue	$95,894,738	$124,547,145	$253,400,071	$333,906,761	$92,336,701	$10,969,700	$60,708,716	$971,763,832	$17,997,030	$0	$989,760,862
Medical Expense	77,437,350	116,959,764	237,306,238	315,540,549	89,416,702	11,873,239	63,040,489	911,574,331	16,479,424	-	$928,053,755
Gross Margin	$18,457,387	$7,587,381	$16,093,833	$18,366,212	$2,919,999	($903,538)	($2,331,773)	$60,189,501	$1,517,606	$0	$61,707,107
Administrative Expense	$3,337,672	$5,625,590	$16,778,182	$16,718,028	$5,036,034	$733,183	$3,489,447	$51,718,135	$1,090,637	$222,050	$53,030,822
Operating Income / (Expense)	$15,119,716	$1,961,791	($684,349)	$1,648,184	($2,116,035)	($1,636,721)	($5,821,220)	$8,471,366	$426,969	($222,050)	$8,676,285
Other Income / (Expense)	$1,073,338	$1,963,671	$6,075,168	$5,926,444	$1,776,559	$271,743	$1,289,946	$18,376,869	$323,692	$0	$18,700,561
Net Income / (Loss)	$16,193,054	$3,925,461	$5,390,819	$7,574,629	($339,476)	($1,364,978)	($4,531,274)	$26,848,235	$750,661	($222,050)	$27,376,846
PMPM Metrics:											
Revenue PMPM	$133.58	$331.90	$1,151.30	$382.46	$319.93	$10,507.38	$8,327.67	$391.33	$457.24	$0.00	$392.35
Medical Expense PMPM	$107.87	$311.68	$1,078.18	$361.42	$309.81	$11,372.83	$8,647.53	$367.09	$418.68	$0.00	$367.89
Gross Margin PMPM	$25.71	$20.22	$73.12	$21.04	$10.12	($865.46)	($319.86)	$24.24	$38.56	$0.00	$24.46
Administrative Expense PMPM	$4.65	$14.99	$76.23	$19.15	$17.45	$702.28	$478.66	$20.83	$27.71	$0.00	$21.02
Operating Income / (Expense) PMPM	$21.06	$5.23	($3.11)	$1.89	($7.33)	($1,567.74)	($798.52)	$3.41	$10.85	$0.00	$3.44
Other Income / (Expense) PMPM	$1.50	$5.23	$27.60	$6.79	$6.16	$260.29	$176.95	$7.40	$8.22	$0.00	$7.41
Net Income / (Loss) PMPM	$22.56	$10.46	$24.49	$8.68	($1.18)	($1,307.45)	($621.57)	$10.81	$19.07	$0.00	$10.85
Ratio:											
Medical Loss Ratio	80.8%	93.9%	93.6%	94.5%	96.8%	108.2%	103.8%	93.8%	91.6%	0.0%	93.8%
Gross Margin Ratio	19.2%	6.1%	6.4%	5.5%	3.2%	-8.2%	-3.8%	6.2%	8.4%	0.0%	6.2%
Administrative Expense Ratio	3.5%	4.5%	6.6%	5.0%	5.5%	6.7%	5.7%	5.3%	6.1%	0.0%	5.4%
Net Income Ratio	16.9%	3.2%	2.1%	2.3%	-0.4%	-12.4%	-7.5%	2.8%	4.2%	0.0%	2.8%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF JANUARY 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	109,553	62,860	35,013	145,842	40,117	219	1,311	394,915	5,603	-	400,518
Revenue	$14,666,968	$25,800,183	$40,362,159	$49,944,963	$20,112,599	$2,436,534	$10,828,024	$164,151,430	$2,562,317	$0	$166,713,747
Medical Expense	11,460,408	19,975,436	41,858,425	61,827,112	15,697,465	2,634,938	12,097,875	165,551,658	3,090,062	-	$168,641,720
Gross Margin	$3,206,560	$5,824,747	($1,496,266)	($11,882,149)	$4,415,134	($198,403)	($1,269,851)	($1,400,228)	($527,745)	$0	($1,927,973)
Administrative Expense	$419,847	$947,256	$2,651,228	$2,708,219	$696,598	$123,997	$591,185	$8,138,330	$154,498	$28,960	$8,321,788
Operating Income / (Expense)	$2,786,713	$4,877,491	($4,147,494)	($14,590,368)	$3,718,536	($322,400)	($1,861,036)	($9,538,558)	($682,243)	($28,960)	($10,249,761)
Other Income / (Expense)	$113,533	$250,843	$726,151	$732,170	$187,262	$34,527	$162,148	$2,206,633	$34,070	$0	$2,240,703
Net Income / (Loss)	$2,900,246	$5,128,334	($3,421,343)	($13,858,198)	$3,905,798	($287,874)	($1,698,887)	($7,331,925)	($648,173)	($28,960)	($8,009,058)
PMPM Metrics:											
Revenue PMPM	$133.88	$410.44	$1,152.78	$342.46	$501.35	$11,125.73	$8,259.36	$415.66	$457.31	$0.00	$416.25
Medical Expense PMPM	$104.61	$317.78	$1,195.51	$423.93	$391.29	$12,031.68	$9,227.98	$419.21	$551.50	$0.00	$421.06
Gross Margin PMPM	$29.27	$92.66	($42.73)	($81.47)	$110.06	($905.95)	($968.61)	($3.55)	($94.19)	$0.00	($4.81)
Administrative Expense PMPM	$3.83	$15.07	$75.72	$18.57	$17.36	$566.20	$450.94	$20.61	$27.57	$0.00	$20.78
Operating Income / (Expense) PMPM	$25.44	$77.59	($118.46)	($100.04)	$92.69	($1,472.15)	($1,419.55)	($24.15)	($121.76)	$0.00	($25.59)
Other Income / (Expense) PMPM	$1.04	$3.99	$20.74	$5.02	$4.67	$157.66	$123.68	$5.59	$6.08	$0.00	$5.59
Net Income / (Loss) PMPM	$26.47	$81.58	($97.72)	($95.02)	$97.36	($1,314.49)	($1,295.87)	($18.57)	($115.68)	$0.00	($20.00)
Ratio:											
Medical Loss Ratio	78.1%	77.4%	103.7%	123.8%	78.0%	108.1%	111.7%	100.9%	120.6%	0.0%	101.2%
Gross Margin Ratio	21.9%	22.6%	-3.7%	-23.8%	22.0%	-8.1%	-11.7%	-0.9%	-20.6%	0.0%	-1.2%
Administrative Expense Ratio	2.9%	3.7%	6.6%	5.4%	3.5%	5.1%	5.5%	5.0%	6.0%	0.0%	5.0%
Net Income Ratio	19.8%	19.9%	-8.5%	-27.7%	19.4%	-11.8%	-15.7%	-4.5%	-25.3%	0.0%	-4.8%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED January 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$5,530,207	$6,002,551	$472,344	7.9%	Personnel Expenses	$34,221,072	$37,406,263	$3,185,191	8.5%
76,021	74,108	(1,913)	(2.6%)	Benefits Administration Expense	1,253,727	1,250,081	(3,646)	(0.3%)
1,025,715	895,740	(129,975)	(14.5%)	Purchased & Professional Services	7,008,013	8,042,876	1,034,863	12.9%
403,590	506,851	103,261	20.4%	Occupancy	3,226,607	3,505,214	278,606	7.9%
905,653	343,520	(562,133)	(163.6%)	Printing Postage & Promotion	3,427,053	3,288,923	(138,130)	(4.2%)
343,412	960,438	617,026	64.2%	Licenses Insurance & Fees	3,720,241	5,153,311	1,433,070	27.8%
37,189	18,497	(18,692)	(101.1%)	Supplies & Other Expenses	174,109	186,058	11,949	6.4%
$2,791,580	$2,799,155	$7,575	0.3%	Total Other Administrative Expense	$18,809,751	$21,426,463	$2,616,712	12.2%
$8,321,788	$8,801,706	$479,919	5.5%	Total Administrative Expenses	$53,030,822	$58,832,725	$5,801,903	9.9%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED January 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
3,475,838	3,014,643	(461,195)	(15.3%)	Salaries & Wages	22,148,483	22,480,495	332,012	1.5%
472,251	326,361	(145,889)	(44.7%)	Paid Time Off	2,274,615	2,390,543	115,929	4.8%
1,050	5,850	4,800	82.1%	Compensated Incentives	14,013	1,925,197	1,911,184	99.3%
0	642,000	642,000	100.0%	Severance Pay	6,160	642,000	635,840	99.0%
147,286	136,777	(10,508)	(7.7%)	Payroll Taxes	465,119	459,428	(5,690)	(1.2%)
9,955	23,517	13,561	57.7%	Overtime	190,439	188,344	(2,095)	(1.1%)
338,528	254,990	(83,538)	(32.8%)	CalPERS ER Match	1,882,361	1,916,498	34,137	1.8%
814,125	938,303	124,178	13.2%	Employee Benefits	5,017,104	5,207,325	190,222	3.7%
165,419	167,057	1,638	1.0%	Personal Floating Holiday	170,876	169,701	(1,175)	(0.7%)
15,228	19,000	3,772	19.9%	Premium Bi/Multilingual Pay	79,068	65,500	(13,568)	(20.7%)
0	0	0	0.0%	Prizes	51	0	(51)	0.0%
3,780	0	(3,780)	0.0%	Med Ins Opted Out Stipend	3,780	0	(3,780)	0.0%
6,949	0	(6,949)	0.0%	Holiday Bonus	1,141,961	0	(1,141,961)	0.0%
2,411	0	(2,411)	0.0%	Sick Leave	2,411	0	(2,411)	0.0%
(4,648)	62,150	66,798	107.5%	Compensated Employee Relations	53,003	199,444	146,440	73.4%
17,230	22,150	4,920	22.2%	Work from Home Stipend	113,110	124,845	11,735	9.4%
1,325	4,737	3,412	72.0%	Mileage, Parking & LocalTravel	5,522	16,496	10,973	66.5%
9,717	19,242	9,525	49.5%	Travel & Lodging	78,327	144,835	66,508	45.9%
14,941	270,930	255,989	94.5%	Temporary Help Services	365,060	986,756	621,695	63.0%
35,827	28,813	(7,014)	(24.3%)	Staff Development/Training	134,861	301,956	167,095	55.3%
2,996	66,031	63,035	95.5%	Staff Recruitment/Advertising	74,748	186,899	112,151	60.0%
$5,530,207	**$6,002,551**	**$472,344**	**7.9%**	**Total Employee Expenses**	**$34,221,072**	**$37,406,263**	**$3,185,191**	**8.5%**
				Benefit Administration Expense				
24,234	21,585	(2,649)	(12.3%)	RX Administration Expense	149,940	146,024	(3,916)	(2.7%)
0	0	0	0.0%	Behavioral Hlth Administration Fees	817,710	817,710	0	0.0%
51,787	52,523	736	1.4%	Telemedicine Admin Fees	286,077	286,347	270	0.1%
$76,021	**$74,108**	**($1,913)**	**(2.6%)**	**Total Benefit Administration Expenses**	**$1,253,727**	**$1,250,081**	**($3,646)**	**(0.3%)**
				Purchased & Professional Services				
228,890	344,987	116,097	33.7%	Consultant Fees - Non Medical	1,732,253	2,641,288	909,036	34.4%
217,996	242,196	24,200	10.0%	Computer Support Services	2,545,925	2,580,602	34,677	1.3%
11,875	12,500	625	5.0%	Audit Fees	83,125	85,000	1,875	2.2%
0	33	33	100.0%	Consultant Fees - Medical	0	100	100	100.0%
115,279	(16,669)	(131,948)	791.6%	Other Purchased Services	1,079,438	735,959	(343,479)	(46.7%)
0	1,574	1,574	100.0%	Maint.& Repair-Office Equipment	10,176	7,378	(2,798)	(37.9%)
0	0	0	0.0%	Maint.&Repair-Computer Hardware	1,180	1,180	0	0.0%
238,167	120,336	(117,831)	(97.9%)	Medical Refund Recovery Fees	596,529	767,145	170,616	22.2%
126,227	0	(126,227)	0.0%	Software - IT Licenses & Subsc	137,217	0	(137,217)	0.0%
53,306	86,468	33,162	38.4%	Hardware (Non-Capital)	465,506	686,114	220,608	32.2%
28,262	51,965	23,703	45.6%	Provider Relations-Credentialing	209,711	248,194	38,483	15.5%
5,713	52,350	46,637	89.1%	Legal Fees	146,953	289,916	142,963	49.3%
$1,025,715	**$895,740**	**($129,975)**	**(14.5%)**	**Total Purchased & Professional Services**	**$7,008,013**	**$8,042,876**	**$1,034,863**	**12.9%**
				Occupancy				
70,090	54,493	(15,597)	(28.6%)	Depreciation	429,318	392,838	(36,480)	(9.3%)
64,798	62,639	(2,159)	(3.4%)	Building Lease	438,470	436,311	(2,158)	(0.5%)
(5,825)	5,870	11,695	199.2%	Leased and Rented Office Equipment	22,925	50,029	27,103	54.2%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED January 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
16,000	18,432	2,432	13.2%	Utilities	144,594	139,734	(4,859)	(3.5%)
41,785	86,510	44,725	51.7%	Telephone	550,715	571,951	21,236	3.7%
15,927	29,772	13,845	46.5%	Building Maintenance	197,303	226,679	29,376	13.0%
200,816	249,136	48,320	19.4%	SBITA Amortization Expense-GASB 96	1,443,283	1,687,671	244,388	14.5%
$403,590	**$506,851**	**$103,261**	**20.4%**	**Total Occupancy**	**$3,226,607**	**$3,505,214**	**$278,606**	**7.9%**
				Printing Postage & Promotion				
124,684	37,191	(87,493)	(235.3%)	Postage	298,133	536,812	238,679	44.5%
0	5,300	5,300	100.0%	Design & Layout	26,759	32,816	6,057	18.5%
347,683	42,407	(305,277)	(719.9%)	Printing Services	689,409	827,304	137,895	16.7%
17,142	6,910	(10,232)	(148.1%)	Mailing Services	71,807	70,951	(856)	(1.2%)
10,479	9,247	(1,232)	(13.3%)	Courier/Delivery Service	68,448	66,136	(2,312)	(3.5%)
150	500	350	70.1%	Pre-Printed Materials and Publications	1,038	500	(538)	(107.6%)
287	0	(287)	0.0%	Promotional Products	5,946	22,871	16,926	74.0%
0	150	150	100.0%	Promotional Services	1,647	4,900	3,253	66.4%
378,490	158,478	(220,012)	(138.8%)	Community Relations	2,091,254	1,538,639	(552,614)	(35.9%)
26,737	83,337	56,601	67.9%	Translation - Non-Clinical	172,613	187,993	15,380	8.2%
$905,653	**$343,520**	**($562,133)**	**(163.6%)**	**Total Printing Postage & Promotion**	**$3,427,053**	**$3,288,923**	**($138,130)**	**(4.2%)**
				Licenses Insurance & Fees				
0	250,000	250,000	100.0%	Regulatory Penalties	80,000	500,000	420,000	84.0%
30,861	29,000	(1,861)	(6.4%)	Bank Fees	231,407	192,587	(38,820)	(20.2%)
83,393	89,100	5,707	6.4%	Insurance Premium	565,480	578,122	12,642	2.2%
172,143	392,987	220,844	56.2%	Licenses, Permits and Fees	1,838,459	2,590,695	752,236	29.0%
57,015	199,352	142,337	71.4%	Subscriptions and Dues - NonIT	1,004,895	1,291,907	287,012	22.2%
$343,412	**$960,438**	**$617,026**	**64.2%**	**Total Licenses Insurance & Postage**	**$3,720,241**	**$5,153,311**	**$1,433,070**	**27.8%**
				Supplies & Other Expenses				
4,248	5,829	1,581	27.1%	Office and Other Supplies	63,336	54,167	(9,169)	(16.9%)
0	5,000	5,000	100.0%	Furniture and Equipment	12,364	24,153	11,789	48.8%
18,936	1,300	(17,636)	(1,356.6%)	Ergonomic Supplies	37,053	17,325	(19,728)	(113.9%)
13,506	5,901	(7,605)	(128.9%)	Meals and Entertainment	34,007	51,116	17,109	33.5%
499	0	(499)	0.0%	Miscellaneous Expense	22,499	27,948	5,448	19.5%
0	0	0	0.0%	Member Incentive Expense	4,850	9,700	4,850	50.0%
0	100	100	100.0%	Covid-19 IT Expenses	0	300	300	100.0%
0	367	367	100.0%	Covid-19 Non IT Expenses	0	1,350	1,350	100.0%
$37,189	**$18,497**	**($18,692)**	**(101.1%)**	**Total Supplies & Other Expense**	**$174,109**	**$186,058**	**$11,949**	**6.4%**
$8,321,788	**$8,801,706**	**$479,919**	**5.5%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$53,030,822**	**$58,832,725**	**$5,801,903**	**9.9%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED JUNE 30, 2024

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Catalyst 9300 - Catalyst Switches	IT-FY24-01	$ -	$ -	**$ -**	$ 50,000	$ 50,000
	Cisco Catalyst 8500 - Routers	IT-FY24-02	$ -	$ -	**$ -**	$ 60,000	$ 60,000
	Cisco AP-9166 - Access Point	IT-FY24-03	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 426,471	$ -	**$ 426,471**	$ 426,371	$ (100)
	PURE Storage array	IT-FY24-05	$ -	$ -	**$ -**	$ 300,000	$ 300,000
	PKI management	IT-FY24-06	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	IBM Power Hardware Upgrade	IT-FY24-07	$ 560,652	$ -	**$ 560,652**	$ 288,629	$ (272,023)
	Misc Hardware	IT-FY24-08	$ 7,119	$ -	**$ 7,119**	$ 15,000	$ 7,881
	Network / AV Cabling	IT-FY24-09	$ 107,600	$ -	**$ 107,600**	$ 30,000	$ (77,600)
	Training Room Projector	IT-FY24-10	$ 1,359	$ -	**$ 1,359**	$ 13,000	$ 11,641
	Conference room upgrades	IT-FY24-11	$ -	$ -	**$ -**	$ 107,701	$ 107,701
Hardware Subtotal			**$ 1,103,201**	**$ -**	**$ 1,103,201**	**$ 1,320,701**	**$ 217,500**
2. Software:							
	Zerto renewal and Tier 2 add	AC-FY24-01	$ -	$ -	**$ -**	$ 126,000	$ 126,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 126,000**	**$ 126,000**
3. Building Improvement:							
	Appliances over 1k new/replacement (all buildings/suites)	FA-FY24-01	**$ -**	$ -	**$ -**	$ -	$ -
	ACME Security: Readers, HID boxes, Cameras, Doors (planned/unplanned	FA-FY24-02	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	HVAC: Replace VAV boxes, duct work, replace old equipment	FA-FY24-03	$ 18,295	$ -	**$ 18,295**	$ 20,000	$ 1,705
	Electrical work for projects, workstations requirement	FA-FY24-04	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	1240 Interior blinds replacement	FA-FY24-05	**$ -**	$ -	**$ -**	$ 25,000	$ 25,000
	EV Charging stations, if not completed in FY23 and carried over to FY24	FA-FY24-06	**$ 17,494**	$ 17,905	**$ 35,399**	$ 50,000	$ 14,601
Building Improvement Subtotal			**$ 35,789**	**$ 17,905**	**$ 53,694**	**$ 125,000**	**$ 71,306**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)	FA-FY24-17	$ -	$ 3,860	**$ 3,860**	$ 10,000	$ 6,140
	Replace, reconfigure, re-design workstations	FA-FY24-18	$ -	$ -	**$ -**	$ 20,000.00	$ 20,000
Furniture & Equipment Subtotal			**$ -**	**$ 3,860**	**$ 3,860**	**$ 30,000**	**$ 26,140**
GRAND TOTAL			**$ 1,138,990**	**$ 21,765**	**$ 1,160,755**	**$ 1,601,701**	**$ 440,946**

5. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 1/31/24	**$ 38,855,851**
Fixed Assets @ Cost - 6/30/23	**$ 37,695,096**
Fixed Assets Acquired YTD	**$ 1,160,755**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2024

TANGIBLE NET EQUITY (TNE)

	Jul-23	Aug-23	QTR. END Sep-23	Oct-23	Nov-23	QTR. END Dec-23	Jan-24
Current Month Net Income / (Loss)	$9,746,933	$2,343,460	$5,514,335	$3,776,499	$3,440,910	$10,563,766	($8,009,058)
YTD Net Income / (Loss)	$9,746,933	$12,090,393	$17,604,728	$21,381,227	$24,822,137	$35,385,903	$27,376,845
Actual TNE							
Net Assets	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178	$359,342,945	$351,333,888
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$333,703,974**	**$336,047,435**	**$341,561,770**	**$345,338,268**	**$348,779,178**	**$359,342,945**	**$351,333,888**
Increase/(Decrease) in Actual TNE	$9,746,933	$2,343,460	$5,514,335	$3,776,499	$3,440,910	$10,563,766	($8,009,058)
Required TNE[(1)]	**$46,228,233**	**$46,744,204**	**$46,352,062**	**$49,676,617**	**$49,894,371**	**$49,622,261**	**$57,429,796**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$69,342,350	$70,116,307	$69,528,093	$74,514,926	$74,841,557	$74,433,391	$86,144,695
TNE Excess / (Deficiency)	$287,475,741	$289,303,231	$295,209,708	$295,661,651	$298,884,807	$309,720,684	$293,904,092
Actual TNE as a Multiple of Required	**7.22**	**7.19**	**7.37**	**6.95**	**6.99**	**7.24**	**6.12**

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

LIQUID TANGIBLE NET EQUITY

Net Assets	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178	$359,342,945	$351,333,888
Fixed Assets at Net Book Value	(5,169,098)	(5,539,264)	(5,608,622)	(5,653,388)	(6,079,010)	(5,997,733)	(7,085,899)
Net Lease Assets/Liabilities/Interest	(711,429)	(475,037)	(1,115,074)	(727,353)	(662,463)	(1,135,481)	(1,193,576)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$328,184,876**	**$330,158,171**	**$335,603,148**	**$339,334,880**	**$342,350,168**	**$352,995,212**	**$343,897,989**
Liquid TNE as Multiple of Required	**7.10**	**7.06**	**7.24**	**6.83**	**6.86**	**7.11**	**5.99**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2024

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	102,463	101,393	100,038	101,120	101,243	102,088	109,553						717,898
Adult	52,550	52,102	51,499	52,396	52,151	51,696	62,860						375,254
SPD	31,055	30,840	30,592	30,888	30,865	30,846	35,013						220,099
ACA OE	123,707	121,819	120,016	121,430	120,573	119,668	145,842						873,055
Duals	41,688	41,715	41,629	41,496	40,997	40,974	40,117						288,616
MCAL LTC	141	138	139	135	137	135	219						1,044
MCAL LTC Duals	1,033	1,019	1,004	997	975	951	1,311						7,290
Medi-Cal Program	352,637	349,026	344,917	348,462	346,941	346,358	394,915						2,483,256
Group Care Program	5,669	5,645	5,631	5,605	5,585	5,622	5,603						39,360
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**	**400,518**						**2,522,616**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)	1,082	123	845	7,465						5,883
Adult	(624)	(448)	(603)	897	(245)	(455)	11,164						9,686
SPD	(225)	(215)	(248)	296	(23)	(19)	4,167						3,733
ACA OE	(1,260)	(1,888)	(1,803)	1,414	(857)	(905)	26,174						20,875
Duals	(43)	27	(86)	(133)	(499)	(23)	(857)						(1,614)
MCAL LTC	(9)	(3)	1	(4)	2	(2)	84						69
MCAL LTC Duals	4	(14)	(15)	(7)	(22)	(24)	360						282
Medi-Cal Program	(3,364)	(3,611)	(4,109)	3,545	(1,521)	(583)	48,557						38,914
Group Care Program	(15)	(24)	(14)	(26)	(20)	37	(19)						(81)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**	**48,538**						**38,833**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	29.1%	29.1%	29.0%	29.0%	29.2%	29.5%	27.7%						28.9%
Adult % of Medi-Cal	14.9%	14.9%	14.9%	15.0%	15.0%	14.9%	15.9%						15.1%
SPD % of Medi-Cal	8.8%	8.8%	8.9%	8.9%	8.9%	8.9%	8.9%						8.9%
ACA OE % of Medi-Cal	35.1%	34.9%	34.8%	34.8%	34.8%	34.6%	36.9%						35.2%
Duals % of Medi-Cal	11.8%	12.0%	12.1%	11.9%	11.8%	11.8%	10.2%						11.6%
Medi-Cal Program % of Total	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%	98.6%						98.4%
Group Care Program % of Total	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.4%						1.6%
Total	**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 2024

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

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027	72,504	78,530	75,141	76,228	104,906						554,883
Alameda Health System	66,089	65,344	64,133	63,271	63,903	63,545	83,981						470,266
	140,636	138,371	136,637	141,801	139,044	139,773	188,887						1,025,149
Delegated:													
CFMG	34,810	34,649	34,144	34,035	35,105	35,399	42,148						250,290
CHCN	130,230	129,183	127,430	126,705	127,641	128,331	169,483						939,003
Kaiser	52,630	52,468	52,337	51,526	50,736	48,477	0						308,174
Delegated Subtotal	217,670	216,300	213,911	212,266	213,482	212,207	211,631						1,497,467
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**	**400,518**						**2,522,616**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(939)	(2,265)	(1,734)	5,164	(2,757)	729	49,114						47,312
Delegated:													0
CFMG	(441)	(161)	(505)	(109)	1,070	294	6,749						6,897
CHCN	(1,721)	(1,047)	(1,753)	(725)	936	690	41,152						37,532
Kaiser	(278)	(162)	(131)	(811)	(790)	(2,259)	(48,477)						(52,908)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	1,216	(1,275)	(576)						(8,479)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**	**48,538**						**38,833**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	39.3%	39.0%	39.0%	40.0%	39.4%	39.7%	47.2%						40.6%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	10.0%	10.1%	10.5%						9.9%
CHCN	36.3%	36.4%	36.4%	35.8%	36.2%	36.5%	42.3%						37.2%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.4%	13.8%	0.0%						12.2%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	60.6%	60.3%	52.8%						59.4%
Total	**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 2024	FINAL BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program by Category of Aid:													
Child	102,463	101,393	100,038	101,120	100,109	99,008	102,159	100,933	99,823	98,725	97,639	96,565	1,199,975
Adult	52,550	52,102	51,499	52,396	51,872	51,301	57,478	56,788	56,107	55,434	54,769	54,112	646,408
SPD	31,055	30,840	30,592	30,888	30,734	30,488	42,473	42,133	41,796	41,462	41,130	40,801	434,392
ACA OE	123,707	121,819	120,016	121,430	121,180	119,605	149,197	147,556	145,933	144,328	142,740	141,170	1,598,681
Duals	41,688	41,715	41,629	41,496	41,410	41,325	45,787	45,694	45,600	45,506	45,412	45,318	522,580
MCAL LTC	141	138	139	135	136	137	172	173	174	175	176	177	1,873
MCAL LTC Duals	1,033	1,019	1,004	997	985	971	1,194	1,176	1,159	1,142	1,125	1,108	12,913
Medi-Cal Program	352,637	349,026	344,917	348,462	346,426	342,835	398,460	394,453	390,592	386,772	382,991	379,251	4,416,822
Group Care Program	5,669	5,645	5,631	5,605	5,591	5,577	5,563	5,549	5,535	5,521	5,507	5,493	66,886
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,017**	**348,412**	**404,023**	**400,002**	**396,127**	**392,293**	**388,498**	**384,744**	**4,483,708**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)	1,082	(1,011)	(1,101)	3,151	(1,226)	(1,110)	(1,098)	(1,086)	(1,074)	(7,105)
Adult	(624)	(448)	(603)	897	(524)	(571)	6,177	(690)	(681)	(673)	(665)	(657)	938
SPD	(225)	(215)	(248)	296	(154)	(246)	11,985	(340)	(337)	(334)	(332)	(329)	9,521
ACA OE	(1,260)	(1,888)	(1,803)	1,414	(250)	(1,575)	29,592	(1,641)	(1,623)	(1,605)	(1,588)	(1,570)	16,203
Duals	(43)	27	(86)	(133)	(86)	(85)	4,462	(93)	(94)	(94)	(94)	(94)	3,587
MCAL LTC	(9)	(3)	1	(4)	1	1	35	1	1	1	1	1	27
MCAL LTC Duals	4	(14)	(15)	(7)	(12)	(14)	223	(18)	(17)	(17)	(17)	(17)	79
Medi-Cal Program	(3,364)	(3,611)	(4,109)	3,545	(2,036)	(3,591)	55,625	(4,007)	(3,861)	(3,820)	(3,781)	(3,740)	23,250
Group Care Program	(15)	(24)	(14)	(26)	(14)	(14)	(14)	(14)	(14)	(14)	(14)	(14)	(191)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(2,050)**	**(3,605)**	**55,611**	**(4,021)**	**(3,875)**	**(3,834)**	**(3,795)**	**(3,754)**	**23,059**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	29.1%	29.1%	29.0%	29.0%	28.9%	28.9%	25.6%	25.6%	25.6%	25.5%	25.5%	25.5%	27.2%
Adult % (Medi-Cal)	14.9%	14.9%	14.9%	15.0%	15.0%	15.0%	14.4%	14.4%	14.4%	14.3%	14.3%	14.3%	14.6%
SPD % (Medi-Cal)	8.8%	8.8%	8.9%	8.9%	8.9%	8.9%	10.7%	10.7%	10.7%	10.7%	10.7%	10.8%	9.8%
ACA OE % (Medi-Cal)	35.1%	34.9%	34.8%	34.8%	35.0%	34.9%	37.4%	37.4%	37.4%	37.3%	37.3%	37.2%	36.2%
Duals % (Medi-Cal)	11.8%	12.0%	12.1%	11.9%	12.0%	12.1%	11.5%	11.6%	11.7%	11.8%	11.9%	11.9%	11.8%
MCAL LTC % (Medi-Cal)	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%
MCAL LTC Duals % (Medi-Cal)	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Medi-Cal Program % of Total	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.5%
Group Care Program % of Total	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2024	FINAL BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027	72,504	78,530	78,174	77,543	103,987	103,154	102,341	101,536	100,739	99,949	1,066,031
Alameda Health System	66,089	65,344	64,133	63,271	62,977	62,254	86,850	85,925	85,022	84,129	83,245	82,371	891,610
	140,636	138,371	136,637	141,801	141,151	139,797	190,837	189,079	187,363	185,665	183,984	182,320	1,957,641
Delegated:													
CFMG	34,810	34,649	34,144	34,035	33,709	33,339	43,104	42,595	42,131	41,671	41,217	40,767	456,171
CHCN	130,230	129,183	127,430	126,705	125,969	124,637	170,082	168,328	166,633	164,957	163,297	161,657	1,759,108
Kaiser	52,630	52,468	52,337	51,526	51,188	50,639	0	0	0	0	0	0	310,788
Delegated Subtotal	217,670	216,300	213,911	212,266	210,866	208,615	213,186	210,923	208,764	206,628	204,514	202,424	2,526,067
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,017**	**348,412**	**404,023**	**400,002**	**396,127**	**392,293**	**388,498**	**384,744**	**4,483,708**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	305	(1,520)	(523)	6,026	(356)	(631)	26,444	(833)	(813)	(805)	(797)	(790)	25,707
Alameda Health System	(1,244)	(745)	(1,211)	(862)	(294)	(723)	24,596	(925)	(903)	(893)	(884)	(874)	15,038
	(939)	(2,265)	(1,734)	5,164	(650)	(1,354)	51,040	(1,758)	(1,716)	(1,698)	(1,681)	(1,664)	40,745
Delegated:													
CFMG	(441)	(161)	(505)	(109)	(326)	(370)	9,765	(509)	(464)	(460)	(454)	(450)	5,516
CHCN	(1,721)	(1,047)	(1,753)	(725)	(736)	(1,332)	45,445	(1,754)	(1,695)	(1,676)	(1,660)	(1,640)	29,706
Kaiser	(278)	(162)	(131)	(811)	(338)	(549)	(50,639)	0	0	0	0	0	(52,908)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	(1,400)	(2,251)	4,571	(2,263)	(2,159)	(2,136)	(2,114)	(2,090)	(17,686)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(2,050)**	**(3,605)**	**55,611**	**(4,021)**	**(3,875)**	**(3,834)**	**(3,795)**	**(3,754)**	**23,059**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	20.8%	20.6%	20.7%	22.2%	22.2%	22.3%	25.7%	25.8%	25.8%	25.9%	25.9%	26.0%	23.8%
Alameda Health System	18.4%	18.4%	18.3%	17.9%	17.9%	17.9%	21.5%	21.5%	21.5%	21.4%	21.4%	21.4%	19.9%
	39.3%	39.0%	39.0%	40.0%	40.1%	40.1%	47.2%	47.3%	47.3%	47.3%	47.4%	47.4%	43.7%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	9.6%	9.6%	10.7%	10.6%	10.6%	10.6%	10.6%	10.6%	10.2%
CHCN	36.3%	36.4%	36.4%	35.8%	35.8%	35.8%	42.1%	42.1%	42.1%	42.0%	42.0%	42.0%	39.2%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.5%	14.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	59.9%	59.9%	52.8%	52.7%	52.7%	52.7%	52.6%	52.6%	56.3%
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 2024

	Variance Jul-23	Variance Aug-23	Variance Sep-23	Variance Oct-23	Variance Nov-23	Variance Dec-23	Variance Jan-24	Variance Feb-24	Variance Mar-24	Variance Apr-24	Variance May-24	Variance Jun-24	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	1,134	3,080	7,394						11,608
Adult	0	0	0	0	279	395	5,382						6,056
SPD	0	0	0	0	131	358	(7,460)						(6,971)
ACA OE	0	0	0	0	(607)	63	(3,355)						(3,899)
Duals	0	0	0	0	(413)	(351)	(5,670)						(6,434)
MCAL LTC	0	0	0	0	1	(2)	47						46
MCAL LTC Duals	0	0	0	0	(10)	(20)	117						87
Medi-Cal Program	0	0	0	0	515	3,523	(3,545)						493
Group Care Program	0	0	0	0	(6)	45	40						79
Total	**0**	**0**	**0**	**0**	**509**	**3,568**	**(3,505)**						**572**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	(3,033)	(1,315)	919						(3,429)
Alameda Health System	0	0	0	0	926	1,291	(2,869)						(652)
	0	0	0	0	(2,107)	(24)	(1,950)						(4,081)
Delegated:													
CFMG	0	0	0	0	1,396	2,060	(956)						2,500
CHCN	0	0	0	0	1,672	3,694	(599)						4,767
Kaiser	0	0	0	0	(452)	(2,162)	0						(2,614)
Delegated Subtotal	0	0	0	0	2,616	3,592	(1,555)						4,653
Total	**0**	**0**	**0**	**0**	**509**	**3,568**	**(3,505)**						**572**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED JANUARY 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$5,060,857	$1,440,491	($3,620,366)	(251.3%)	PCP Capitation	$12,087,986	$8,331,179	($3,756,807)	(45.1%)
5,787,744	6,359,973	572,228	9.0%	PCP Capitation FQHC	32,005,777	32,841,869	836,092	2.5%
363,283	374,266	10,982	2.9%	Specialty-Capitation	2,173,447	2,149,722	(23,725)	(1.1%)
5,031,580	5,709,885	678,305	11.9%	Specialty-Capitation FQHC	27,860,681	28,821,202	960,521	3.3%
714,034	726,046	12,011	1.7%	Laboratory Capitation	3,726,397	3,784,879	58,482	1.5%
335,601	336,701	1,100	0.3%	Vision Cap	1,857,504	1,850,428	(7,075)	(0.4%)
105,687	109,008	3,321	3.0%	CFMG Capitation	632,275	625,837	(6,439)	(1.0%)
249,435	279,028	29,593	10.6%	Anc IPA Admin Capitation FQHC	1,380,807	1,423,869	43,061	3.0%
16,456	0	(16,456)	0.0%	Kaiser Capitation	83,773,193	84,015,590	242,397	0.3%
0	0	0	0.0%	BHT Supplemental Expense	4,672	0	(4,672)	0.0%
428,610	0	(428,610)	0.0%	Maternity Supplemental Expense	2,246,749	2,311,103	64,353	2.8%
874,374	1,050,448	176,074	16.8%	DME Cap	5,168,221	5,416,039	247,818	4.6%
$18,967,661	**$16,385,845**	**($2,581,817)**	**(15.8%)**	**5 - TOTAL CAPITATED EXPENSES**	**$172,917,710**	**$171,571,715**	**($1,345,994)**	**(0.8%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
5,961,256	0	(5,961,256)	0.0%	IBNR Inpatient Services	5,702,879	(2,306,298)	(8,009,177)	347.3%
178,837	0	(178,837)	0.0%	IBNR Settlement (IP)	171,087	(69,188)	(240,275)	347.3%
476,900	0	(476,900)	0.0%	IBNR Claims Fluctuation (IP)	456,231	(184,504)	(640,735)	347.3%
44,065,400	49,437,729	5,372,330	10.9%	Inpatient Hospitalization FFS	219,584,168	237,628,358	18,044,189	7.6%
2,371,378	0	(2,371,378)	0.0%	IP OB - Mom & NB	14,012,677	7,462,632	(6,550,045)	(87.8%)
82,216	0	(82,216)	0.0%	IP Behavioral Health	1,163,180	895,483	(267,696)	(29.9%)
1,050,424	0	(1,050,424)	0.0%	IP Facility Rehab FFS	7,680,821	4,711,642	(2,969,179)	(63.0%)
$54,186,411	**$49,437,729**	**($4,748,682)**	**(9.6%)**	**6 - Inpatient Hospital & SNF Expense**	**$248,771,043**	**$248,138,126**	**($632,917)**	**(0.3%)**
748,999	0	(748,999)	0.0%	IBNR PCP	589,708	46,983	(542,725)	(1,155.2%)
22,471	0	(22,471)	0.0%	IBNR Settlement (PCP)	17,692	1,409	(16,283)	(1,155.6%)
59,921	0	(59,921)	0.0%	IBNR Claims Fluctuation (PCP)	47,179	3,759	(43,420)	(1,155.1%)
4,226,330	2,732,729	(1,493,601)	(54.7%)	Primary Care Non-Contracted FF	15,779,725	14,248,629	(1,531,096)	(10.7%)
376,495	324,655	(51,840)	(16.0%)	PCP FQHC FFS	3,186,266	2,851,215	(335,051)	(11.8%)
500	0	(500)	0.0%	Phys Extended Hours Incentive	3,500	6,000	2,500	41.7%
44,170	3,753,302	3,709,132	98.8%	Prop 56 Physician	13,871,028	19,337,524	5,466,496	28.3%
105,017	0	(105,017)	0.0%	Prop 56 Hyde	192,744	58,257	(134,487)	(230.8%)
74,811	0	(74,811)	0.0%	Prop 56 Trauma Screening	551,360	316,945	(234,415)	(74.0%)
66,421	0	(66,421)	0.0%	Prop 56 Develop. Screening	642,991	383,782	(259,209)	(67.5%)
752,658	0	(752,658)	0.0%	Prop 56 Family Planning	5,113,683	2,905,675	(2,208,008)	(76.0%)
(6,856)	0	6,856	0.0%	Prop 56 VBP	573	7,428	6,856	92.3%
$6,470,937	**$6,810,685**	**$339,749**	**5.0%**	**7 - Primary Care Physician Expense**	**$39,996,449**	**$40,167,608**	**$171,158**	**0.4%**
1,792,489	0	(1,792,489)	0.0%	IBNR Specialist	279,313	(704,271)	(983,584)	139.7%
315,072	0	(315,072)	0.0%	Psychiatrist FFS	1,828,826	927,497	(901,328)	(97.2%)
2,573,800	7,694,464	5,120,664	66.5%	Specialty Care FFS	16,585,261	27,726,984	11,141,723	40.2%
190,451	0	(190,451)	0.0%	Specialty Anesthesiology	1,212,458	733,088	(479,370)	(65.4%)
1,073,306	0	(1,073,306)	0.0%	Specialty Imaging FFS	7,749,334	4,332,553	(3,416,780)	(78.9%)
22,393	0	(22,393)	0.0%	Obstetrics FFS	126,108	71,825	(54,283)	(75.6%)
404,954	0	(404,954)	0.0%	Specialty IP Surgery FFS	2,018,245	1,146,377	(871,868)	(76.1%)
717,819	0	(717,819)	0.0%	Specialty OP Surgery FFS	4,327,698	2,380,160	(1,947,538)	(81.8%)
591,908	0	(591,908)	0.0%	Spec IP Physician	3,255,540	1,804,945	(1,450,595)	(80.4%)
104,545	104,844	299	0.3%	SCP FQHC FFS	517,655	506,978	(10,678)	(2.1%)
53,775	0	(53,775)	0.0%	IBNR Settlement (SCP)	8,381	(21,127)	(29,508)	139.7%
143,399	0	(143,399)	0.0%	IBNR Claims Fluctuation (SCP)	22,343	(56,342)	(78,685)	139.7%
$7,983,912	**$7,799,308**	**($184,604)**	**(2.4%)**	**8 - Specialty Care Physician Expense**	**$37,931,161**	**$38,848,666**	**$917,505**	**2.4%**
1,184,745	0	(1,184,745)	0.0%	IBNR Ancillary	3,205,456	2,122,555	(1,082,901)	(51.0%)
35,544	0	(35,544)	0.0%	IBNR Settlement (ANC)	96,165	63,677	(32,488)	(51.0%)
94,780	0	(94,780)	0.0%	IBNR Claims Fluctuation (ANC)	256,438	169,805	(86,633)	(51.0%)
1,459,601	0	(1,459,601)	0.0%	IBNR Transportation FFS	9,905	45,720	35,815	78.3%
1,248,150	0	(1,248,150)	0.0%	Behavioral Health Therapy FFS	8,760,087	4,951,126	(3,808,961)	(76.9%)
1,117,321	0	(1,117,321)	0.0%	Psychologist & Other MH Prof.	7,546,191	4,215,464	(3,330,727)	(79.0%)
351,639	0	(351,639)	0.0%	Acupuncture/Biofeedback	1,921,396	1,075,338	(846,058)	(78.7%)
206,120	0	(206,120)	0.0%	Hearing Devices	731,833	381,525	(350,308)	(91.8%)
17,775	0	(17,775)	0.0%	Imaging/MRI/CT Global	218,397	141,544	(76,853)	(54.3%)
48,045	0	(48,045)	0.0%	Vision FFS	327,226	164,593	(162,632)	(98.8%)
10	0	(10)	0.0%	Family Planning	59	30	(30)	(100.0%)
586,634	0	(586,634)	0.0%	Laboratory-FFS	3,539,652	1,917,612	(1,622,040)	(84.6%)
77,057	0	(77,057)	0.0%	ANC Therapist	621,628	395,200	(226,428)	(57.3%)
1,099,759	0	(1,099,759)	0.0%	Transportation (Ambulance)-FFS	7,178,970	3,746,485	(3,432,485)	(91.6%)
3,061	0	(3,061)	0.0%	Transportation (Other)-FFS	10,307,907	5,929,067	(4,378,840)	(73.9%)
1,327,893	0	(1,327,893)	0.0%	Hospice	10,075,192	5,779,983	(4,295,209)	(74.3%)

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED JANUARY 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,207,140	0	(1,207,140)	0.0%	Home Health Services	8,651,427	4,994,036	(3,657,391)	(73.2%)
6,878	12,545,299	12,538,421	99.9%	Other Medical-FFS	10,871	30,879,593	30,868,722	100.0%
(64,700)	0	64,700	0.0%	Medical Refunds through HMS	(591,245)	(309,963)	281,282	(90.7%)
(550,130)	0	550,130	0.0%	Medical Refunds	(581,621)	(565,083)	16,538	(2.9%)
18,580	0	(18,580)	0.0%	DME & Medical Supplies	177,956	116,689	(61,266)	(52.5%)
0	0	0	0.0%	GEMT FFS	(373,988)	(373,988)	0	0.0%
2,365,899	1,880,791	(485,108)	(25.8%)	ECM Base/Outreach FFS Anc.	10,369,459	9,884,835	(484,624)	(4.9%)
40,382	0	(40,382)	0.0%	CS Housing Deposits FFS Ancillary	161,441	135,985	(25,456)	(18.7%)
450,813	0	(450,813)	0.0%	CS Housing Tenancy FFS Ancillary	1,586,931	1,183,089	(403,842)	(34.1%)
117,428	0	(117,428)	0.0%	CS Housing Navigation Services FFS Ancillary	384,419	257,647	(126,772)	(49.2%)
171,460	0	(171,460)	0.0%	CS Medical Respite FFS Ancillary	585,882	377,892	(207,990)	(55.0%)
70,934	0	(70,934)	0.0%	CS Medically Tailored Meals FFS Ancillary	225,005	128,446	(96,559)	(75.2%)
3,910	0	(3,910)	0.0%	CS Asthma Remediation FFS Ancillary	22,977	11,648	(11,329)	(97.3%)
0	10,000	10,000	100.0%	MOT Wrap Around (Non Medical MOT Cost)	0	30,000	30,000	100.0%
479,258	0	(479,258)	0.0%	Community Based Adult Services (CBAS)	2,901,401	1,425,263	(1,476,139)	(103.6%)
0	0	0	0.0%	CS Pilot LTC Diversion Expense	0	15,291	15,291	100.0%
4,587	0	(4,587)	0.0%	CS Pilot LTC Transition Expense	32,112	23,701	(8,410)	(35.5%)
0	0	0	0.0%	Justice Involved Pilot	0	161,111	161,111	100.0%
$13,180,573	**$14,436,090**	**$1,255,517**	**8.7%**	**9 - Ancillary Medical Expense**	**$78,359,529**	**$79,475,917**	**$1,116,389**	**1.4%**
2,848,415	0	(2,848,415)	0.0%	IBNR Outpatient	3,008,159	422,626	(2,585,533)	(611.8%)
85,452	0	(85,452)	0.0%	IBNR Settlement (OP)	90,242	12,677	(77,565)	(611.9%)
227,873	0	(227,873)	0.0%	IBNR Claims Fluctuation (OP)	240,653	33,811	(206,842)	(611.8%)
1,722,085	12,561,471	10,839,386	86.3%	Out Patient FFS	11,361,860	35,310,477	23,948,617	67.8%
1,836,203	0	(1,836,203)	0.0%	OP Ambul Surgery FFS	11,912,400	6,937,396	(4,975,004)	(71.7%)
1,996,524	0	(1,996,524)	0.0%	OP Fac Imaging Services FFS	11,668,125	6,670,623	(4,997,502)	(74.9%)
26,407	0	(26,407)	0.0%	Behav Health FFS	55,082	(21,966)	(77,049)	350.8%
624,798	0	(624,798)	0.0%	OP Facility Lab FFS	3,756,469	2,081,864	(1,674,606)	(80.4%)
140,292	0	(140,292)	0.0%	OP Facility Cardio FFS	1,032,585	608,098	(424,487)	(69.8%)
102,582	0	(102,582)	0.0%	OP Facility PT/OT/ST FFS	1,005,284	270,230	(735,053)	(272.0%)
2,439,395	0	(2,439,395)	0.0%	OP Facility Dialysis FFS	15,054,079	8,379,495	(6,674,584)	(79.7%)
$12,050,025	**$12,561,471**	**$511,446**	**4.1%**	**10 - Outpatient Medical Expense Medical Expense**	**$59,184,938**	**$60,705,330**	**$1,520,392**	**2.5%**
948,622	0	(948,622)	0.0%	IBNR Emergency	521,189	30,260	(490,929)	(1,622.4%)
28,458	0	(28,458)	0.0%	IBNR Settlement (ER)	15,637	910	(14,727)	(1,618.4%)
75,890	0	(75,890)	0.0%	IBNR Claims Fluctuation (ER)	41,700	2,423	(39,277)	(1,621.0%)
1,004,484	0	(1,004,484)	0.0%	Special ER Physician FFS	5,731,873	3,056,795	(2,675,078)	(87.5%)
6,691,792	7,814,226	1,122,434	14.4%	ER Facility	36,424,085	38,965,826	2,541,741	6.5%
$8,749,246	**$7,814,226**	**($935,020)**	**(12.0%)**	**11 - Emergency Expense**	**$42,734,484**	**$42,056,214**	**($678,270)**	**(1.6%)**
3,347,324	0	(3,347,324)	0.0%	IBNR Pharmacy OP	3,307,007	(204,308)	(3,511,315)	1,718.6%
100,419	0	(100,419)	0.0%	IBNR Settlement (RX) OP	99,207	(6,133)	(105,340)	1,717.6%
267,786	0	(267,786)	0.0%	IBNR Claims Fluctuation (RX) OP	264,561	(16,345)	(280,906)	1,718.6%
582,528	374,336	(208,192)	(55.6%)	Pharmacy FFS	3,440,893	3,055,543	(385,350)	(12.6%)
111,040	12,184,621	12,073,581	99.1%	Pharmacy Non-PBM FFS-Other Anc	898,956	29,931,523	29,032,568	97.0%
5,349,848	0	(5,349,848)	0.0%	Pharmacy Non-PBM FFS-OP FAC	37,263,051	21,975,503	(15,287,548)	(69.6%)
319,223	0	(319,223)	0.0%	Pharmacy Non-PBM FFS-PCP	1,447,131	615,362	(831,769)	(135.2%)
2,286,983	0	(2,286,983)	0.0%	Pharmacy Non-PBM FFS-SCP	15,049,530	8,807,902	(6,241,628)	(70.9%)
13,069	0	(13,069)	0.0%	Pharmacy Non-PBM FFS-FQHC	70,003	41,158	(28,844)	(70.1%)
7,467	0	(7,467)	0.0%	Pharmacy Non-PBM FFS-HH	46,410	27,987	(18,423)	(65.8%)
0	0	0	0.0%	RX Refunds HMS	(63)	(63)	0	0.0%
(35,000)	32,178	67,178	208.8%	Pharmacy Rebate	(265,000)	(64,130)	200,870	(313.2%)
$12,350,687	**$12,591,135**	**$240,448**	**1.9%**	**12 - Pharmacy Expense**	**$61,621,685**	**$64,163,999**	**$2,542,315**	**4.0%**
7,621,338	0	(7,621,338)	0.0%	IBNR LTC	11,117,033	4,802,539	(6,314,494)	(131.5%)
228,641	0	(228,641)	0.0%	IBNR Settlement (LTC)	333,514	144,077	(189,437)	(131.5%)
609,708	0	(609,708)	0.0%	IBNR Claims Fluctuation (LTC)	889,362	384,202	(505,160)	(131.5%)
19,330	0	(19,330)	0.0%	LTC - ICF/DD	19,330	0	(19,330)	0.0%
19,967,077	0	(19,967,077)	0.0%	LTC Custodial Care	118,802,329	63,392,176	(55,410,153)	(87.4%)
2,986,866	24,131,576	21,144,710	87.6%	LTC SNF	21,266,917	70,706,903	49,439,986	69.9%
$31,432,959	**$24,131,576**	**($7,301,384)**	**(30.3%)**	**13 - Long Term Care Expense**	**$152,428,485**	**$139,429,897**	**($12,998,587)**	**(9.3%)**
$146,404,750	**$135,582,219**	**($10,822,530)**	**(8.0%)**	**14 - TOTAL FFS MEDICAL EXPENSES**	**$721,027,773**	**$712,985,759**	**($8,042,015)**	**(1.1%)**
0	(421,566)	(421,566)	100.0%	Clinical Vacancy	0	(824,213)	(824,213)	100.0%
111,701	133,237	21,536	16.2%	Quality Analytics	597,095	1,075,392	478,297	44.5%
1,008,340	1,176,084	167,744	14.3%	Health Plan Services Department Total	5,711,531	6,349,029	637,498	10.0%
721,770	688,258	(33,512)	(4.9%)	Case & Disease Management Department Total	4,137,303	4,275,200	137,896	3.2%
1,107,881	1,549,813	441,932	28.5%	Medical Services Department Total	12,865,434	13,434,365	568,932	4.2%

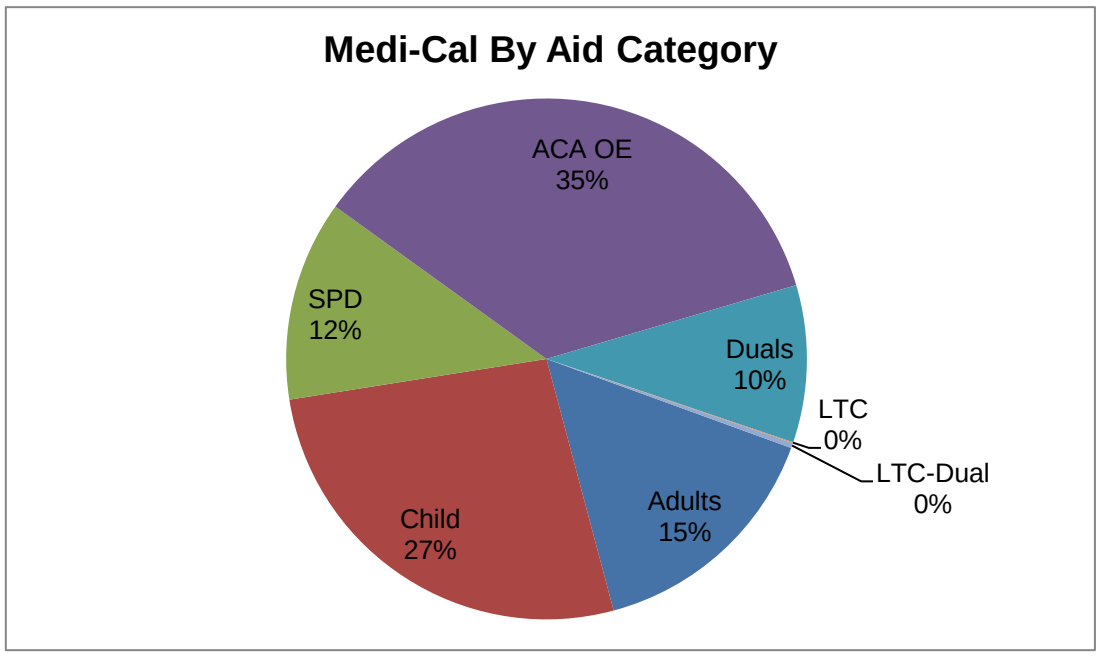
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED JANUARY 31, 2024

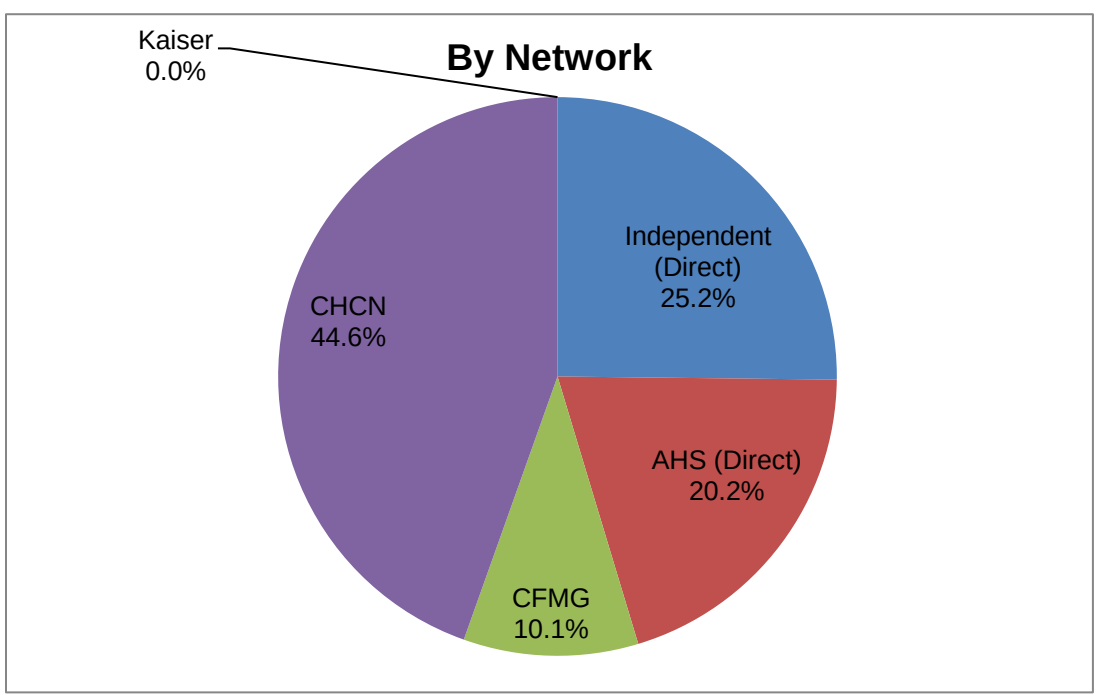
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
911,778	1,085,850	174,072	16.0%	Quality Management Department Total	5,258,478	7,484,504	2,226,026	29.7%
296,848	340,703	43,855	12.9%	HCS Behavioral Health Department Total	1,772,419	1,987,896	215,477	10.8%
162,625	150,169	(12,456)	(8.3%)	Pharmacy Services Department Total	991,282	1,026,762	35,480	3.5%
64,391	64,937	546	0.8%	Regulatory Readiness Total	439,704	470,536	30,832	6.6%
$4,385,335	**$4,767,484**	**$382,149**	**8.0%**	**15 - Other Benefits & Services**	**$31,773,246**	**$35,279,471**	**$3,506,225**	**9.9%**
(2,502,630)	(1,104,550)	1,398,080	(126.6%)	Reinsurance Recoveries	(8,425,555)	(6,370,049)	2,055,507	(32.3%)
1,386,604	1,472,734	86,130	5.8%	Reinsurance Premium	7,760,581	7,607,620	(152,961)	(2.0%)
($1,116,026)	**$368,183**	**$1,484,209**	**403.1%**	**16- Reinsurance Expense**	**($664,974)**	**$1,237,571**	**$1,902,546**	**153.7%**
0	0	0	0.0%	P4P Risk Pool Provider Incenti	3,000,000	3,000,000	0	0.0%
$0	**$0**	**$0**	**0.0%**	**17 - Risk Pool Distribution**	**$3,000,000**	**$3,000,000**	**$0**	**0.0%**
$168,641,720	**$157,103,732**	**($11,537,989)**	**(7.3%)**	**18 - TOTAL MEDICAL EXPENSES**	**$928,053,755**	**$924,074,516**	**($3,979,239)**	**(0.4%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Jan 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	62,870	15%	20,321	12,823	31	29,695	-
Child	109,562	27%	10,345	13,290	39,072	46,855	-
SPD	51,185	12%	12,066	5,359	1,416	32,344	-
ACA OE	145,842	35%	29,644	49,468	1,629	65,101	-
Duals	40,118	10%	28,908	2,169	1	9,040	-
LTC	219	0%	195	9	-	15	-
LTC-Dual	1,311	0%	1,310	-	-	1	-
Medi-Cal	411,107		102,789	83,118	42,149	183,051	-
Group Care	5,603		2,134	864	-	2,605	-
Total	**416,710**	**100%**	**104,923**	**83,982**	**42,149**	**185,656**	**-**
Medi-Cal %	98.7%		98.0%	99.0%	100.0%	98.6%	0%
Group Care %	1.3%		2.0%	1.0%	0.0%	1.4%	0.0%
	Network Distribution		*25.2%*	*20.2%*	*10.1%*	*44.6%*	*0.0%*
			% Direct:	**45%**		**% Delegated:**	**55%**

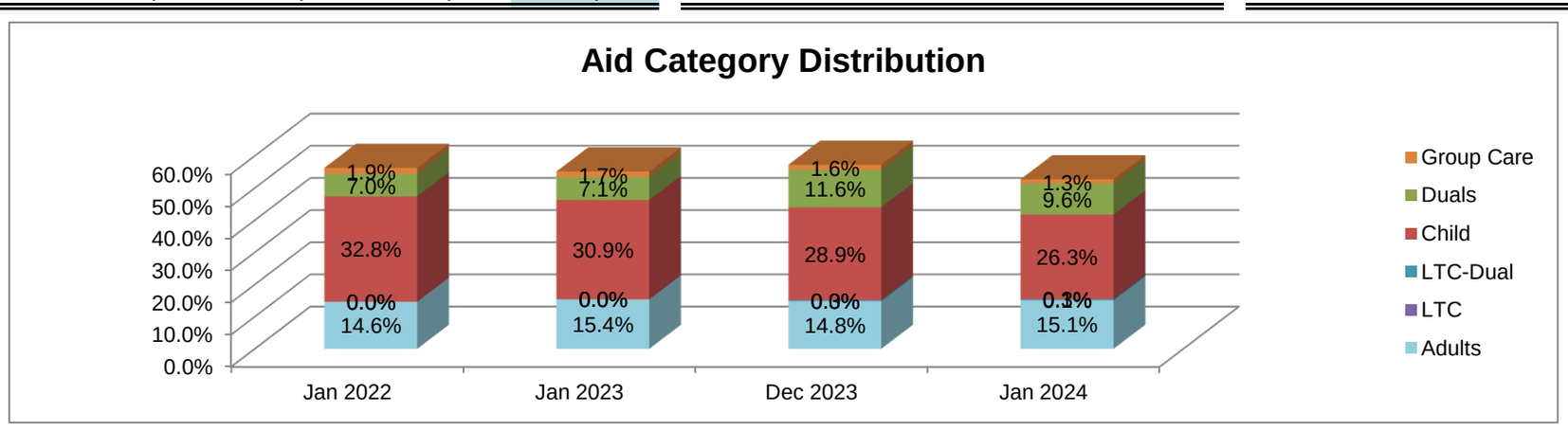




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

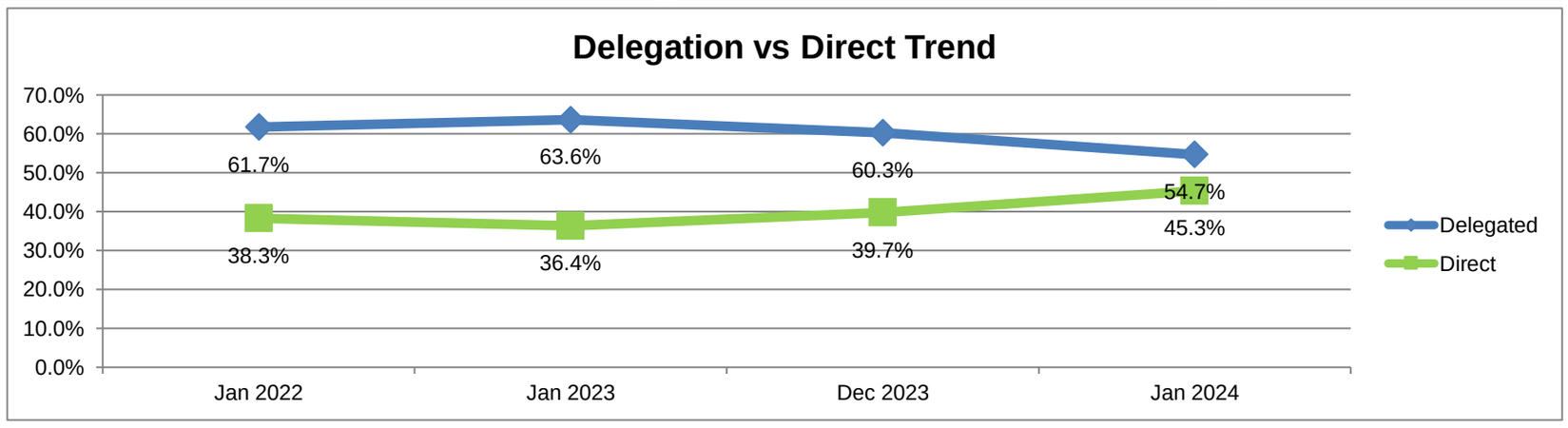
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022 to Jan 2023	Jan 2023 to Jan 2024	Dec 2023 to Jan 2024
Adults	44,340	50,687	52,174	62,870	14.6%	15.4%	14.8%	15.1%	14.3%	24.0%	20.5%
Child	99,337	101,914	101,634	109,562	32.8%	30.9%	28.9%	26.3%	2.6%	7.5%	7.8%
SPD	26,633	28,685	30,848	51,185	8.8%	8.7%	8.8%	12.3%	7.7%	78.4%	65.9%
ACA OE	105,897	119,302	119,669	145,842	34.9%	36.2%	34.0%	35.0%	12.7%	22.2%	21.9%
Duals	21,135	23,444	40,976	40,118	7.0%	7.1%	11.6%	9.6%	10.9%	71.1%	-2.1%
LTC	-	6	135	219	0.0%	0.0%	0.0%	0.1%	0.0%	3550.0%	62.2%
LTC-Dual	-	15	951	1,311	0.0%	0.0%	0.3%	0.3%	0.0%	8640.0%	37.9%
Medi-Cal Total	297,342	324,053	346,387	411,107	98.1%	98.3%	98.4%	98.7%	9.0%	26.9%	18.7%
Group Care	5,831	5,761	5,622	5,603	1.9%	1.7%	1.6%	1.3%	-1.2%	-2.7%	-0.3%
Total	**303,173**	**329,814**	**352,009**	**416,710**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.8%**	**26.3%**	**18.4%**



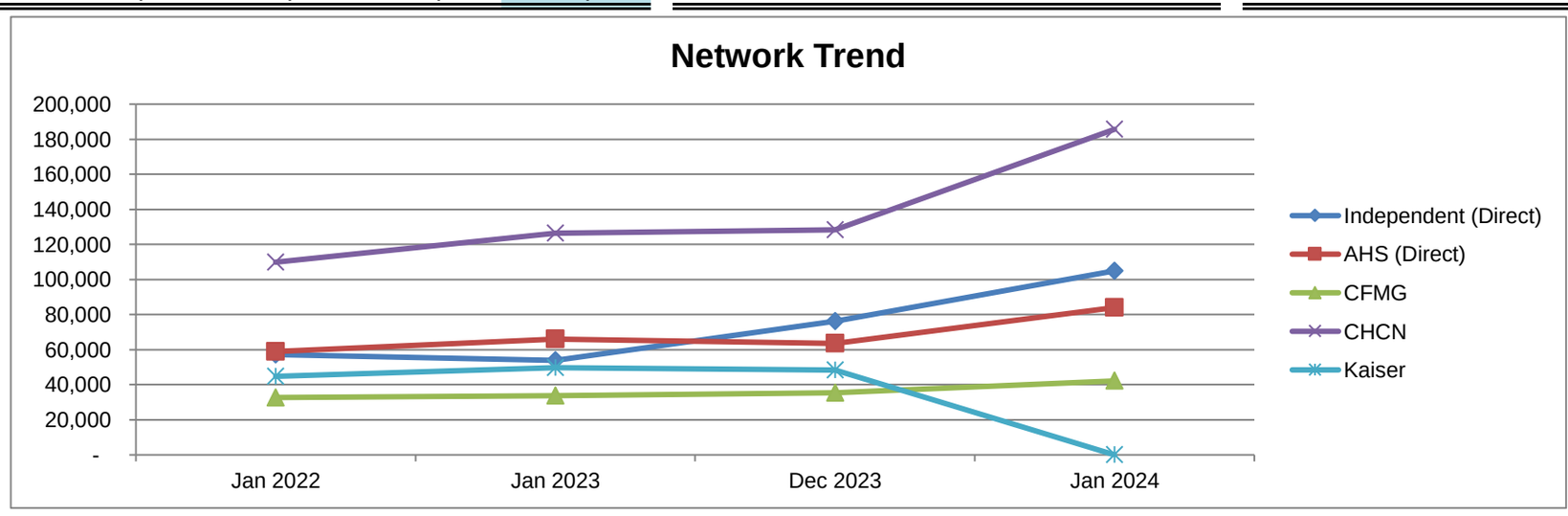
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022 to Jan 2023	Jan 2023 to Jan 2024	Dec 2023 to Jan 2024
Delegated	187,200	209,892	212,220	227,805	61.7%	63.6%	60.3%	54.7%	12.1%	8.5%	7.3%
Direct	115,973	119,922	139,789	188,905	38.3%	36.4%	39.7%	45.3%	3.4%	57.5%	35.1%
Total	**303,173**	**329,814**	**352,009**	**416,710**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.8%**	**26.3%**	**18.4%**



Network Trend

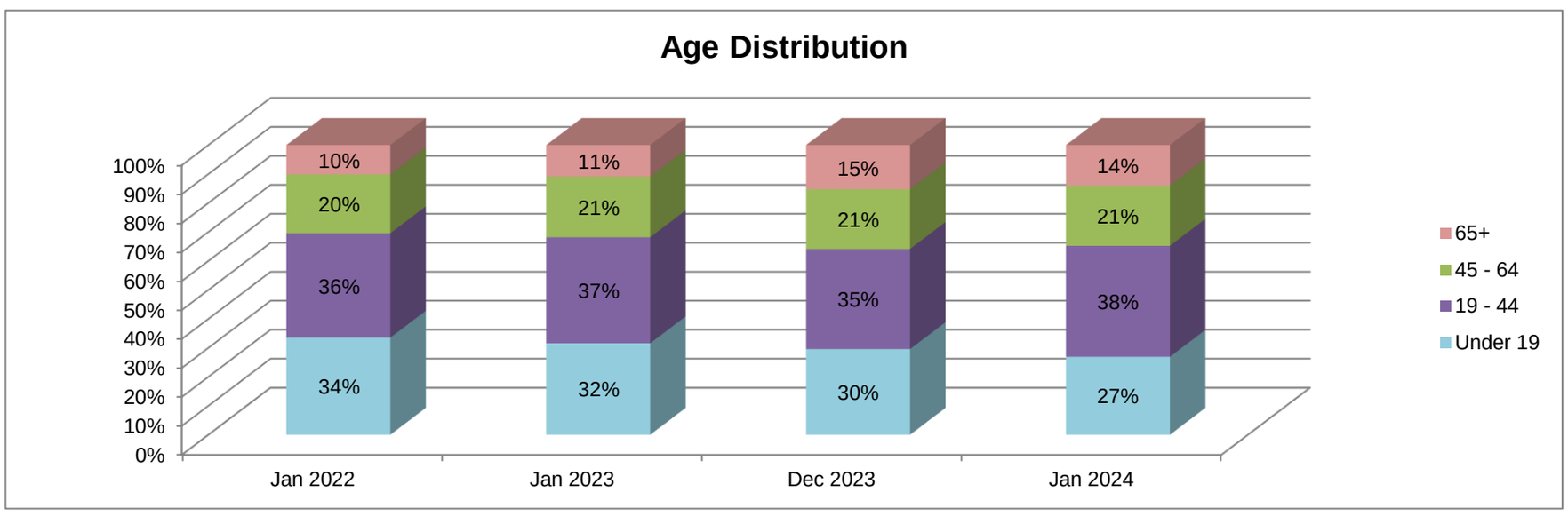
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022 to Jan 2023	Jan 2023 to Jan 2024	Dec 2023 to Jan 2024
Independent (Direct)	57,046	53,870	76,241	104,923	18.8%	16.3%	21.7%	25.2%	-5.6%	94.8%	37.6%
AHS (Direct)	58,927	66,052	63,548	83,982	19.4%	20.0%	18.1%	20.2%	12.1%	27.1%	32.2%
CFMG	32,689	33,741	35,401	42,149	10.8%	10.2%	10.1%	10.1%	3.2%	24.9%	19.1%
CHCN	109,878	126,433	128,342	185,656	36.2%	38.3%	36.5%	44.6%	15.1%	46.8%	44.7%
Kaiser	44,633	49,718	48,477	-	14.7%	15.1%	13.8%	0.0%	11.4%	-100.0%	-100.0%
Total	**303,173**	**329,814**	**352,009**	**416,710**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.8%**	**26.3%**	**18.4%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

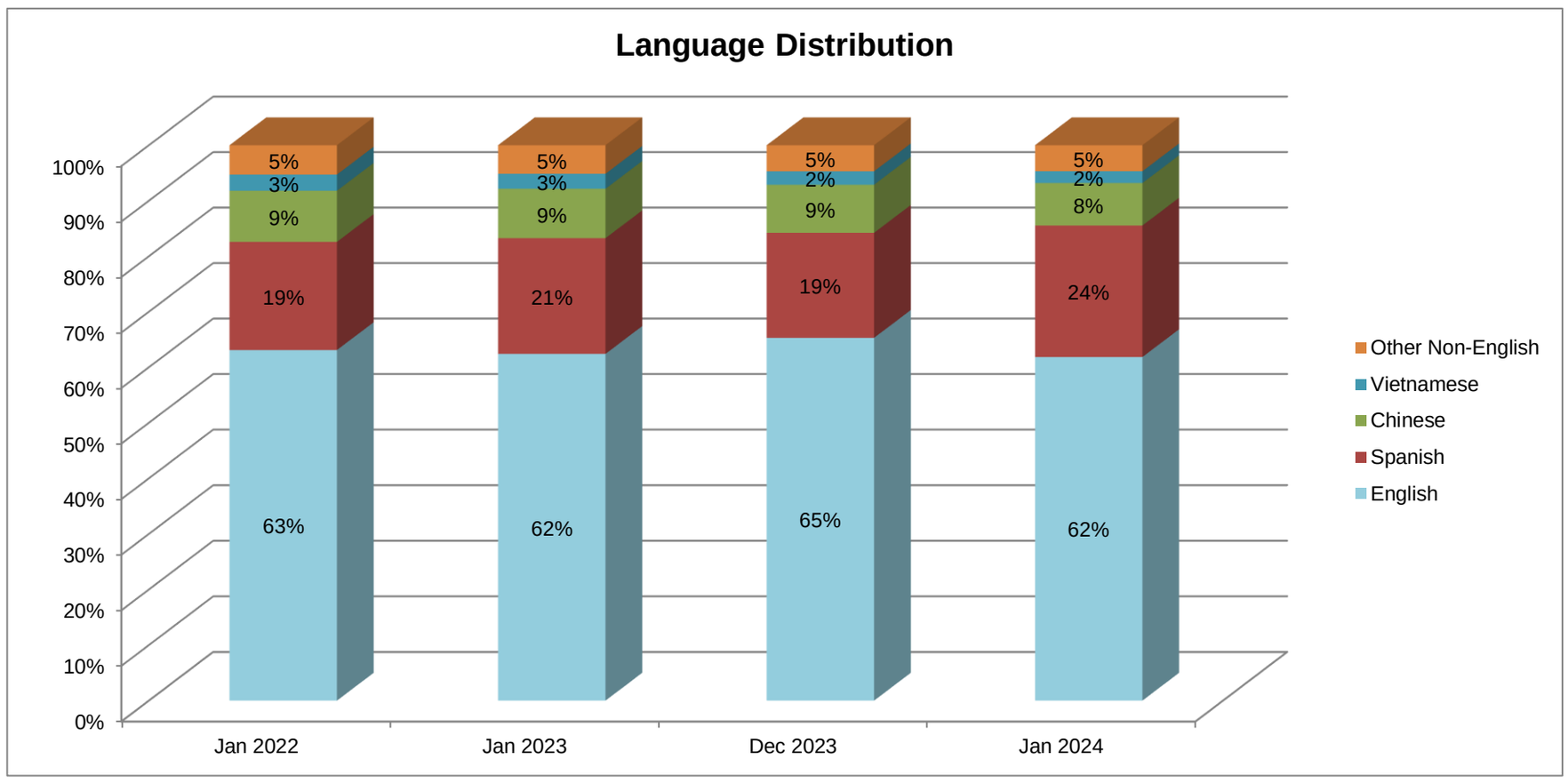
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022 to Jan 2023	Jan 2023 to Jan 2024	Dec 2023 to Jan 2024
Under 19	101,615	104,152	104,062	107,826	34%	32%	30%	27%	2%	4%	4%
19 - 44	109,198	120,648	121,694	153,381	36%	37%	35%	38%	10%	27%	26%
45 - 64	61,651	69,127	72,612	83,432	20%	21%	21%	21%	12%	21%	15%
65+	30,709	35,887	53,641	55,899	10%	11%	15%	14%	17%	56%	4%
Total	**303,173**	**329,814**	**352,009**	**400,538**	**100%**	**100%**	**100%**	**100%**	**9%**	**21%**	**14%**



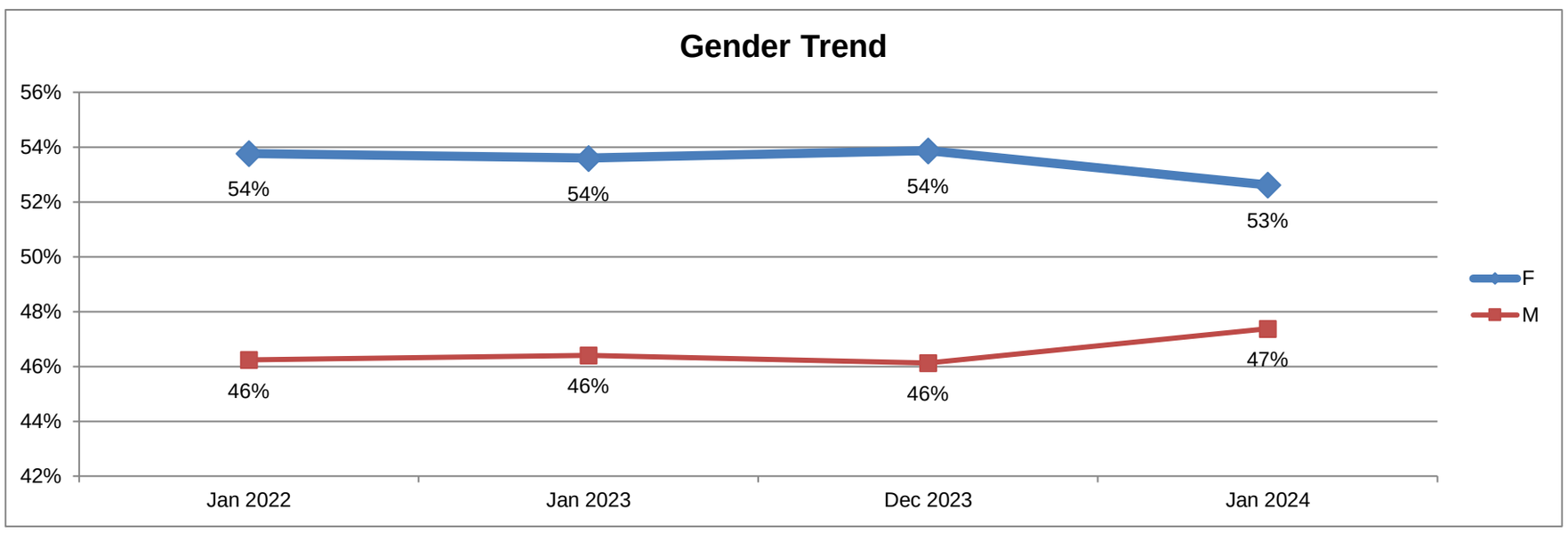
Language Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022 to Jan 2023	Jan 2023 to Jan 2024	Dec 2023 to Jan 2024
English	191,279	205,802	229,835	247,662	63%	62%	65%	62%	8%	20%	8%
Spanish	59,086	68,746	66,602	94,894	19%	21%	19%	24%	16%	38%	42%
Chinese	27,931	29,364	30,505	30,650	9%	9%	9%	8%	5%	4%	0%
Vietnamese	8,831	8,924	8,507	8,528	3%	3%	2%	2%	1%	-4%	0%
Other Non-English	16,046	16,978	16,560	18,804	5%	5%	5%	5%	6%	11%	14%
Total	**303,173**	**329,814**	**352,009**	**400,538**	**100%**	**100%**	**100%**	**100%**	**9%**	**21%**	**14%**

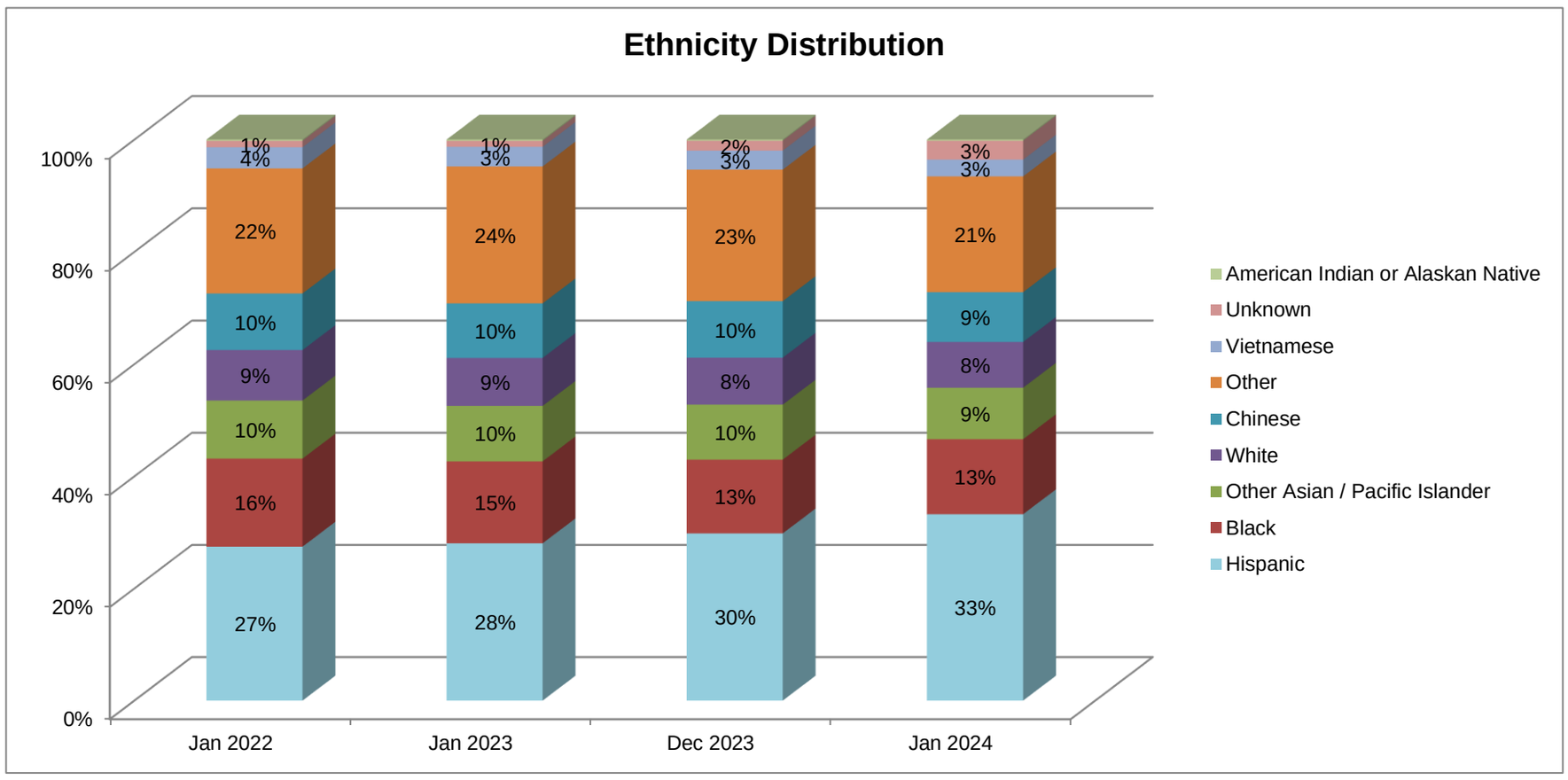


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Gender Trend	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022 to Jan 2023	Jan 2023 to Jan 2024	Dec 2023 to Jan 2024
F	162,997	176,768	189,639	210,770	54%	54%	54%	53%	8%	19%	11%
M	140,176	153,046	162,370	189,768	46%	46%	46%	47%	9%	24%	17%
Total	**303,173**	**329,814**	**352,009**	**400,538**	**100%**	**100%**	**100%**	**100%**	**9%**	**21%**	**14%**



Ethnicity Trend	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022 to Jan 2023	Jan 2023 to Jan 2024	Dec 2023 to Jan 2024
Hispanic	83,229	92,528	104,945	133,127	27%	28%	30%	33%	11%	44%	27%
Black	47,604	48,188	46,303	53,587	16%	15%	13%	13%	1%	11%	16%
Other Asian / Pacific Islander	31,403	32,634	34,537	36,752	10%	10%	10%	9%	4%	13%	6%
White	27,265	28,155	29,449	32,654	9%	9%	8%	8%	3%	16%	11%
Chinese	30,557	32,069	35,470	35,545	10%	10%	10%	9%	5%	11%	0%
Other	67,560	80,433	82,447	82,586	22%	24%	23%	21%	19%	3%	0%
Vietnamese	11,406	11,535	11,943	12,000	4%	3%	3%	3%	1%	4%	0%
Unknown	3,506	3,582	6,228	13,480	1%	1%	2%	3%	2%	276%	116%
American Indian or Alaskan Native	643	690	687	807	0%	0%	0%	0%	7%	17%	17%
Total	**303,173**	**329,814**	**352,009**	**400,538**	**100%**	**100%**	**100%**	**100%**	**9%**	**21%**	**14%**



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

Medi-Cal By City

City	Jan 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	160,312	41%	32,432	39,120	17,129	71,631	-
Hayward	62,132	16%	15,539	15,312	7,127	24,154	-
Fremont	35,604	9%	15,307	6,451	1,767	12,079	-
San Leandro	32,865	8%	8,950	5,425	4,180	14,310	-
Union City	14,516	4%	5,837	2,529	790	5,360	-
Alameda	13,941	4%	3,839	2,420	2,031	5,651	-
Berkeley	15,464	4%	4,371	2,084	1,697	7,312	-
Livermore	12,444	3%	2,572	733	2,121	7,018	-
Newark	9,059	2%	3,128	3,566	433	1,932	-
Castro Valley	9,229	2%	2,510	1,623	1,336	3,760	-
San Lorenzo	7,196	2%	1,710	1,479	799	3,208	-
Pleasanton	7,118	2%	2,147	479	719	3,773	-
Dublin	7,246	2%	2,223	504	826	3,693	-
Emeryville	2,715	1%	661	558	420	1,076	-
Albany	2,542	1%	697	264	521	1,060	-
Piedmont	473	0%	127	173	48	125	-
Sunol	77	0%	22	12	7	36	-
Antioch	60	0%	18	16	7	19	-
Other	1,942	0%	699	370	191	682	-
Total	**394,935**	**100%**	**102,789**	**83,118**	**42,149**	**166,879**	**-**

Group Care By City

City	Jan 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,782	32%	363	340	-	1,079	-
Hayward	632	11%	294	142	-	196	-
Fremont	596	11%	417	52	-	127	-
San Leandro	586	10%	236	81	-	269	-
Union City	303	5%	194	41	-	68	-
Alameda	285	5%	98	21	-	166	-
Berkeley	165	3%	49	15	-	101	-
Livermore	99	2%	34	2	-	63	-
Newark	133	2%	80	31	-	22	-
Castro Valley	192	3%	82	29	-	81	-
San Lorenzo	135	2%	45	21	-	69	-
Pleasanton	59	1%	18	3	-	38	-
Dublin	108	2%	34	7	-	67	-
Emeryville	34	1%	12	6	-	16	-
Albany	19	0%	10	1	-	8	-
Piedmont	11	0%	3	-	-	8	-
Sunol	1	0%	1	-	-	-	-
Antioch	22	0%	6	5	-	11	-
Other	441	8%	158	67	-	216	-
Total	**5,603**	**100%**	**2,134**	**864**	**-**	**2,605**	**-**

Total By City

City	Jan 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	162,094	40%	32,795	39,460	17,129	72,710	-
Hayward	62,764	16%	15,833	15,454	7,127	24,350	-
Fremont	36,200	9%	15,724	6,503	1,767	12,206	-
San Leandro	33,451	8%	9,186	5,506	4,180	14,579	-
Union City	14,819	4%	6,031	2,570	790	5,428	-
Alameda	14,226	4%	3,937	2,441	2,031	5,817	-
Berkeley	15,629	4%	4,420	2,099	1,697	7,413	-
Livermore	12,543	3%	2,606	735	2,121	7,081	-
Newark	9,192	2%	3,208	3,597	433	1,954	-
Castro Valley	9,421	2%	2,592	1,652	1,336	3,841	-
San Lorenzo	7,331	2%	1,755	1,500	799	3,277	-
Pleasanton	7,177	2%	2,165	482	719	3,811	-
Dublin	7,354	2%	2,257	511	826	3,760	-
Emeryville	2,749	1%	673	564	420	1,092	-
Albany	2,561	1%	707	265	521	1,068	-
Piedmont	484	0%	130	173	48	133	-
Sunol	78	0%	23	12	7	36	-
Antioch	82	0%	24	21	7	30	-
Other	2,383	1%	857	437	191	898	-
Total	**400,538**	**100%**	**104,923**	**83,982**	**42,149**	**169,484**	**-**

ALAMEDA Alliance FOR HEALTH

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

Operations

Ruth Watson

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

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

Date: **March 8th, 2024**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:
    - The Member Services Department received twenty-five percent (25%) increase in calls in February 2024, totaling 23,899 compared to 17,147 in February 2023. Increased call volumes are related to the MCP Transition and Adult Expansion of 110K new members on January 1, 2024.
    - The abandonment rate for February 2024 was nine percent (9%), compared to twenty-four percent (24%) in February 2023.
    - The Department's service level was seventy-nine percent (79%) in February 2024, compared to forty-one percent (41%) in February 2023. The average speed to answer (ASA) was fifty-eight seconds (00:58) compared to six minutes and seven seconds (06:07) in 2023. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
    - The average talk time (ATT) was six minutes and forty-nine seconds (06:49) for February 2024 compared to seven minutes and nine seconds (07:09) for February 2023.
    - Ninety-eight percent (98%) of calls were answered within 10 minutes for February 2024 compared to sixty-five (65%) in February 2023.
    - Outbound calls totaled eighty-four hundred and four (8404) in February 2024 compared to sixty-four hundred and two (6402) in February 2023.
    - The top five call reasons for February 2024 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Benefits, 4). ID Card Requests, 5). Provider Network. The top five call reasons for February 2023 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Benefits, 4). Kaiser, 5). ID Card Requests.
    - February utilization for the member automated eligibility IVR system totaled nineteen hundred-sixty eighty-two (1960) in February 2024 compared to one thousand thirty-four (1034) in February 2023.
    - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests and in-person) while honoring the organization's policies. The Department responded to seventeen hundred eighty-four (1784) web-based requests in February 2024 compared to nine hundred sixty-four (964) in February 2023. The top three web reason requests for February 2024 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information. Sixty-three (63) members were assisted in-person in February 2024.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health Unit received a total of sixteen hundred twenty-four (1624) calls in February 2024.
    - The abandonment rate was seventeen percent (17%).
    - The service level was seventy-one percent (71%).
    - The average speed to answer (ASA) was one minute forty seconds. (1:40).
    - Calls answered in 10 minutes were ninety-six percent (96%).
    - The Average Talk Time (ATT) was nine minutes and eighteen seconds (09:18). ATT are impacted by the DHCS requirements to complete a screening for all members initiating MH services for the first time.
    - Fourteen hundred sixty-three (1463) outbound calls were completed in February 2024.
    - Two hundred forty-seven (247) outreach campaigns were completed in February 2024. This includes fifty-three (53) BH/ABA screenings.
    - One hundred ninety-two (192) screenings were completed in February 2024.
    - Sixty-four (64) referrals were made to the County (ACCESS) in February 2024.
    - Sixteen (16) members were referred to Center Point for SUD services in February 2024.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 266,339 claims in February 2024 compared to 167,475 in February 2023.
    - The Auto Adjudication was 81.0% in February 2024 compared to 80.9% in February 2023.
    - Claims compliance for the 30-day turn-around time was 91.4% in February 2024 compared to 99.4% in February 2023. The 45-day turn-around time was 99.9% in February 2024 compared to 99.9% in February 2023.

- Monthly Analysis:

    - In the month of February, we received a total of 266,339 claims in the HEALTHsuite system. This represents a decrease of 10.76% from January and is higher, by 98,864 claims, than the number of claims received in February 2023; the higher volume of received claims remains attributed to an increased membership.
    - We received 88.53% of claims via EDI and 11.47% of claims via paper.
    - During the month of February, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 81.0% for the month of February.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services department's call volume in February 2024 was 9,359 calls compared to 5,936 calls in February 2023.
    - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
    - The Provider Services department completed 231 calls/visits during February 2024.
    - The Provider Services department answered 5,034 calls for February 2024 and made 2,551 outbound calls.

Credentialing

- 12-Month Trend Summary:

    - At the Peer Review and Credentialing (PRCC) meeting held on February 20, 2024, there were one hundred and forty-eight (148) initial network providers approved; nine (9) primary care providers, six (6) specialists, six (6) ancillary providers, fifteen (15) midlevel providers, and one hundred and twelve (112) behavioral health providers. Additionally, thirty-nine (39) providers were re-credentialed at this meeting; fifteen (15) primary care providers, fifteen (15) specialists, four (4) ancillary provider, and five (5) midlevel providers.

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

Provider Dispute Resolution

- 12-Month Trend Summary:

    - In February 2024, the Provider Dispute Resolution (PDR) team received 2,064 PDRs versus 996 in February 2023.
    - The PDR team resolved 1,007 cases in February 2024 compared to 889 cases in February 2023.
    - In February 2024, the PDR team upheld 66% of cases versus 72% in February 2023.
    - The PDR team resolved 100% of cases within the compliance standard of 95% within 45 working days in February 2024 compared to 100% in February 2023.

- Monthly Analysis:

    - AAH received 2,064 PDRs in February 2024.
    - In the month of February 1,007 PDRs were resolved. Out of the 1,007 PDRs, 666 were upheld and 341 were overturned.
    - The overturn rate for PDRs was 34%, which did not meet our goal of 25% or less.
    - Below is a breakdown of the various causes for the 666 overturned PDRs. Please note that there was one primary area that caused the Department to miss their goal of 25% or less. There were two larger than normal categories of overturn cases. The first was due to the Member OHC corrections, with 63 cases that had been denied incorrectly. The second was due to PTPN claims denied incorrectly for no authorization, with 34 cases. The combined volume of the two primary reasons for the overturned PDRs this month stopped us from achieving the goal of 25% or less.

        - System Related Issues 23% (75 cases):
            - 41 cases: General configuration issues, i.e., Not Covered, Modifier, Eligibility (13%)
            - 19 cases: Palliative Care Financial Responsibility (6%)
            - 5 cases: LTC SOC Recoupment (1%)
            - 10 cases: CES (3%)

        - OHC Related Issues 18% (63 cases)
            - 63 cases: OHC Member TPL data, incorrect primary EOB not matching, incorrect manual entry (18%)

        - Authorization Related Issues 30% (102 cases):
            - 49 cases: Processor errors when auth on file (14%)
            - 15 cases: System (4%)
            - 34 cases: PTPN (11%)
            - 4 cases: Um review (1%)

        - Additional Documentation Provided 5% (18 cases):
            - 15 cases: Duplicate claim documentation that allows for claims to be adjusted (4%)
            - 3 cases: Timely Filing (1%)

        - Incorrect Rates 8% (28 cases)
            - 22 cases: System (6%)
            - 6 cases: LOA (2%)

        - Claim Processing Errors 16% (55 cases)
            - 31 cases: Duplicate (9%)
            - 24 cases: Various Processor errors (7%)

- 1,007 out of 1,007 cases were resolved within 45 working days resulting in a 100% compliance rate.
- The average turnaround time for resolving PDRs in February was 41 days.
- There were 3,442 PDRs pending resolution as of 02/29/2024, with no cases older than 45 working days.

Community Relations and Outreach

- 12-Month Trend Summary:
  - In February 2024, the Alliance completed 668 member orientation outreach calls and 142 member orientations by phone.
  - The C&O Department reached 1,037 people (57% identified as Alliance members) during outreach activities, compared to 115 individuals (98% self-identified as Alliance members) in February 2023.
  - The C&O Department spent a total of $312.10 in donations, fees, and/or sponsorships, compared to $250 in February 2023.
  - The C&O Department reached members in 13 cities/unincorporated areas throughout Alameda County, the Bay Area, and the U.S., compared to 12 cities in February 2023.

- Monthly Analysis:
  - In February 2024, the C&O Department completed 668 member orientation outreach calls and 142 member orientations by phone, 2 community events, 2 member education events, and 84 Alliance website inquiries.
  - Among the 1037 people reached, 57% identified as Alliance members.
  - In February 2024, the C&O Department reached members in 13 locations throughout Alameda County, the Bay Area, and the U.S.
  - Please see attached **Addendum A**.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	February 2024
Incoming Calls (R/V)	23,899
Abandoned Rate (R/V)	9%
Answered Calls (R/V)	21,684
Average Speed to Answer (ASA)	00:58
Calls Answered in 30 Seconds (R/V)	79%
Average Talk Time (ATT)	06:49
Calls Answered in 10 minutes	98%
Outbound Calls	7,351

Top 5 Call Reasons (Medi-Cal and Group Care) February 2024
Change of PCP
Eligibility/Enrollment
Benefits
ID Card Requests
Provider Network Info

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

MSBH	February 2024
Incoming Calls (R/V)	1624
Abandoned Rate (R/V)	17%
Answered Calls (R/V)	1353
Average Speed to Answer (ASA)	01:40
Calls Answered in 30 Seconds (R/V)	71%
Average Talk Time (ATT)	09:18
Calls Answered in 10 minutes	96%
Outbound Calls	1463
Screenings Completed	162
ACBH Referrals	64
SUD referrals to Center Point	16

Claims Department
January 2024 Final and February 2024 Final

METRICS

Claims Compliance	Jan-24	Feb-24
90% of clean claims processed within 30 calendar days	88.0%	91.4%
95% of all claims processed within 45 working days	99.9%	99.9%
Claims Volume (Received)	**Jan-24**	**Feb-24**
Paper claims	27,273	30,550
EDI claims	271,192	235,789
Claim Volume Total	**298,465**	**266,339**
Percentage of Claims Volume by Submission Method	**Jan-24**	**Feb-24**
% Paper	9.14%	11.47%
% EDI	90.86%	88.53%
Claims Processed	**Jan-24**	**Feb-24**
HEALTHsuite Paid (original claims)	198,846	200,503
HEALTHsuite Denied (original claims)	77,836	68,775
HEALTHsuite Original Claims Sub-Total	**276,682**	**269,278**
HEALTHsuite Adjustments	11,009	7,599
HEALTHsuite Total	**287,691**	**276,877**
Claims Expense	**Jan-24**	**Feb-24**
Medical Claims Paid	$112,276,627	$113,271,742
Interest Paid	$84,602	$115,387
Auto Adjudication	**Jan-24**	**Feb-24**
Claims Auto Adjudicated	276,682	269,278
% Auto Adjudicated	81.7%	81.0%
Average Days from Receipt to Payment	**Jan-24**	**Feb-24**
HEALTHsuite	15	15
Pended Claim Age	**Jan-24**	**Feb-24**
0-29 calendar days	32,848	30,078
HEALTHsuite		
30-59 calendar days	7,036	208
HEALTHsuite		
Over 60 calendar days	4	27
HEALTHsuite		

Claims Department
January 2024 Final and February 2024 Final

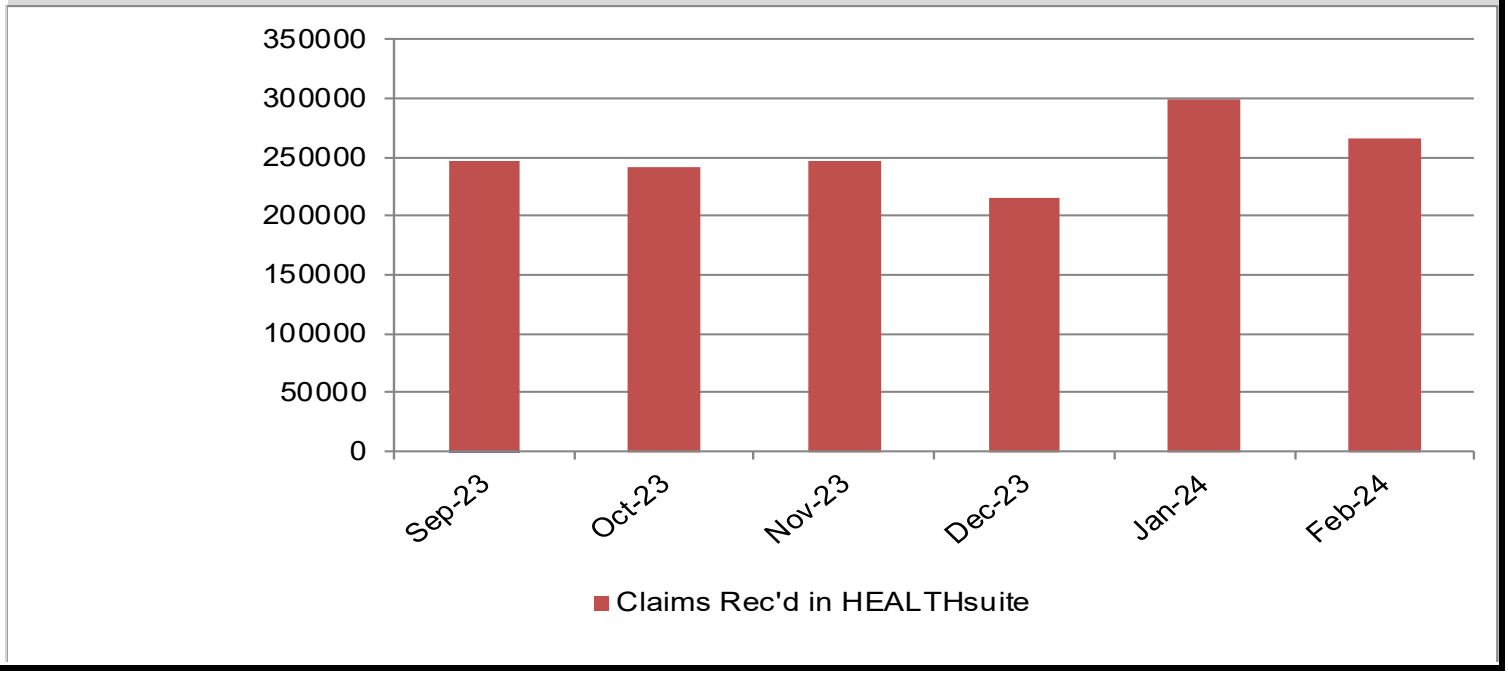
Overall Denial Rate	Jan-24	Feb-24
Claims denied in HEALTHsuite	77,836	68,775
% Denied	27.1%	24.8%

Feb-24

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	24%
No Benefits Found For Dates of Service	13%
Duplicate Claims	10%
Non-Covered Benefit For This Plan	10%
Must Submit Paper Claim With Copy of Primary Payor EOB	7%
% Total of all denials	**64%**

Claims Received By Month

Run Date	10/1/2023	11/1/2023	12/1/2023	1/1/2024	2/1/2024	3/1/2024
Claims Received Through	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**
Claims Rec'd in HEALTHsuite	247,423	241,298	247,537	215,246	298,465	266,339



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing February 2024 to February 2023 as follows: 30 Days - 91.4% (2024) vs 99.4% (2023) 45 Days - 99.9% (2024) vs 99.9% (2023) 90 Days - 99.9% (2024) vs 99.9% (2023)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 266,339 claims in February 2024 vs 167,475 in February 2023.	N/A	N/A
EDI - the volume of EDI submissions remains consistent from month to month at ~77% - 87%.	N/A	N/A
Original Claims Processed - AAH processed 269,278 in February 2024 (21 working days) vs 153,555 in February 2023 (20 working days).	N/A	N/A
Medical Claims Expense - the amount of paid claims in February 2024 was $113,271,742 (4 check runs) vs $61,837,573 in February 2023 (4 check runs).	N/A	N/A
Interest Expense - the amount of interest paid in February 2024 was $115,387 vs $25,121 in February 2023.	N/A	< $496,000 per fiscal year or $30,000 per month
Auto Adjudication - the AAH rate in February 2024 was 81.0% vs 80.9% in February 2023.	N/A	70% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in February 2024 was 15 days vs 18 days in February 2023.	N/A	<= 25 days

Claims Year Over Year Summary

Pended Claim Age - comparing February 2024 to February 2023 as follows: 0-30 calendar days - 30,078 (2024) vs 8,418 (2023) 30-59 calendar days - 208 (2024) vs 44 (2023) Over 60 calendar days - 27 (2024) vs 0 (2023)	N/A	N/A
Top 5 Denial Reasons - the claim denial reasons remain consistent from month to month so there is no significant changes to report from February 2024 to February 2023.	N/A	N/A

Provider Relations Dashboard February 2024

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10695	9359										
Abandoned Calls	4806	4325										
Answered Calls (PR)	5889	5034										
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	413	2551										
Abandoned Calls (R/V)												
Answered Calls (R/V)	413	2551										
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	1140	1358										
N/A												
Outbound Calls	1140	1358										
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	11835	13268										
Abandoned Calls	4806	4325										
Total Answered Incoming, R/V, Outbound Calls	7442	8993										

Provider Relations Dashboard February 2024

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.5%	5.6%										
Benefits	4.3%	3.6%										
Claims Inquiry	38.5%	41.7%										
Change of PCP	3.3%	3.9%										
Check Tracer	1.1%	1.1%										
Complaint/Grievance (includes PDR's)	4.4%	4.3%										
Contracts/Credentialing	1.1%	1.0%										
Demographic Change	0.0%	0.0%										
Eligibility - Call from Provider	23.0%	20.5%										
Exempt Grievance/ G&A	0.6%	0.1%										
General Inquiry/Non member	0.0%	0.0%										
Health Education	0.0%	0.0%										
Intrepreter Services Request	0.5%	0.6%										
Provider Portal Assistance	3.7%	3.8%										
Pharmacy	0.1%	0.1%										
Prop 56	0.2%	0.4%										
Provider Network Info	0.0%	0.0%										
Transportation Services	0.2%	0.2%										
Transferred Call	0.0%	0.0%										
All Other Calls	13.4%	13.1%										
TOTAL	100.0%	100.0%										

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	13	56										
Contracting/Credentialing	9	21										
Drop-ins	27	49										
JOM's	3	2										
New Provider Orientation	104	103										
Quarterly Visits	0	0										
UM Issues	0	0										
Total Field Visits	156	231	0	0	0	0	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS						
Practitioners		BH/ABA 1,606	AHP 532	PCP 375	SPEC 700	PCP/SPEC 13
AAH/AHS/CHCN Breakdown			AAH 2,022	AHS 271	CHCN 572	COMBINATION OF GROUPS 361
Facilities	**416**					

VENDOR SUMMARY					
Credentialing Verification Organization, Symply CVO					
	Number	**Average Calendar Days in Process**	**Goal - Business Days**	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	122	21	25	Y	Y
Recred Files in Process	14	69	25	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**136**				

CAQH Applications Processed in January 2024	
Standard Providers and Allied Health	**Invoice not received**

February 2024 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	9
SPEC	6
ANCILLARY	6
MIDLEVEL/AHP	15
BH/ABA	112
	148
Recredentialing	
PCP	15
SPEC	15
ANCILLARY	4
MIDLEVEL/AHP	5
	39
TOTAL	**187**

February 2024 Facility Approvals	
Initial Credentialing	**5**
Recredentialing	**20**
	25
Facility Files in Process	**40**

February 2024 Employee Metrics	5			
File Processing	Timely processing within 3 days of receipt		Y	
Credentialing Accuracy	<3% error rate		Y	
DHCS, DMHC, CMS, NCQA Compliant	98%		Y	
MBC Monitoring	Timely processing within 3 days of receipt		Y	

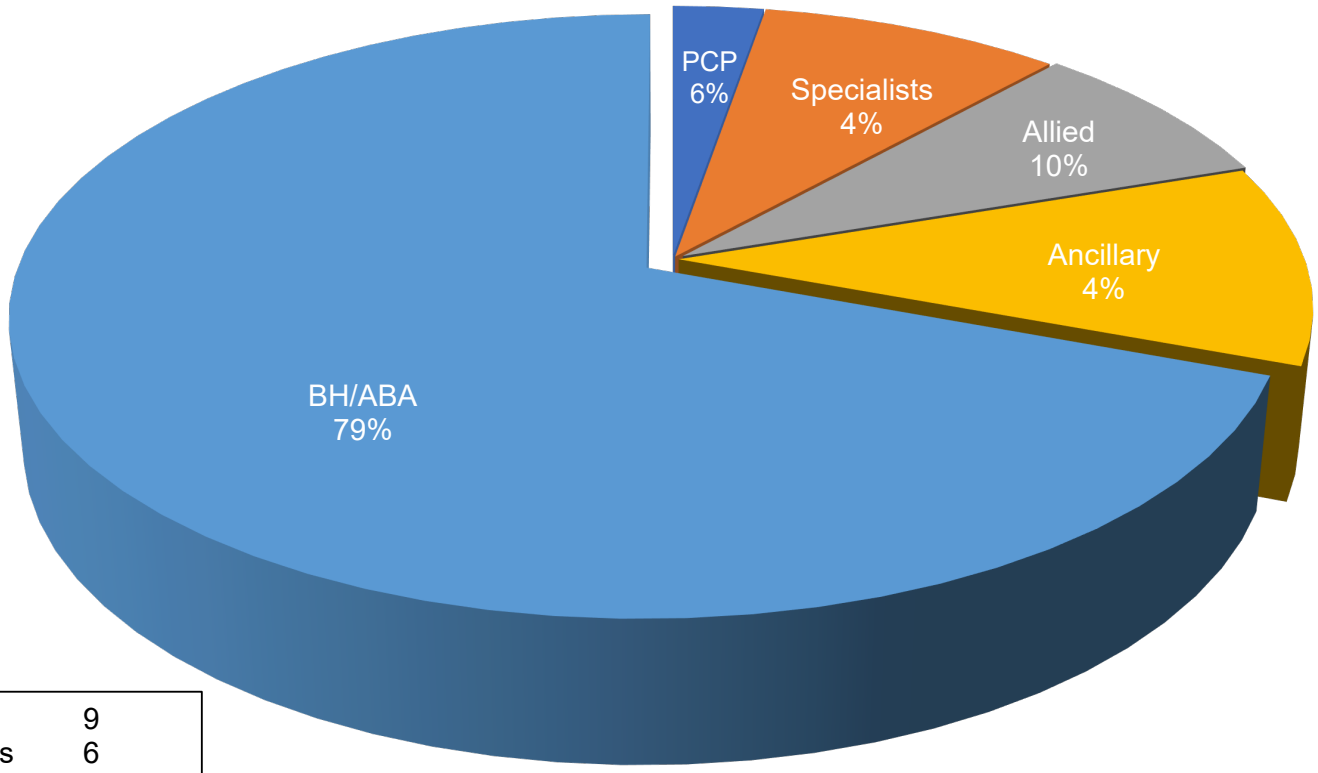
LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Ajayi	Ijeoma	BH-Telehealth	INITIAL	2/20/2024
Akhtar Sim	Nadia	BH	INITIAL	2/20/2024
Alden	Steven	BH-Telehealth	INITIAL	2/20/2024
Alvarado	Emilio	BH	INITIAL	2/20/2024
Amayun	Ira	Allied Health	INITIAL	2/20/2024
Amin	Marwa	ABA-Telehealth	INITIAL	2/20/2024
Austin	Gerald	Specialist	INITIAL	2/20/2024
Aziz	Shararah	BH-Telehealth	INITIAL	2/20/2024
Babajide	Lukman-Afis	BH-Telehealth	INITIAL	2/20/2024
Balayan	Shaina-Jill	Allied Health	INITIAL	2/20/2024
Barden	Lawrence	Allied Health	INITIAL	2/20/2024
Barker	Julie Ann	Allied Health	INITIAL	2/20/2024
Bhat	Anita	Specialist	INITIAL	2/20/2024
Brandt	Clara	BH	INITIAL	2/20/2024
Buxton	Lisa	ABA-Telehealth	INITIAL	2/20/2024
Cahambing	Janice	BH	INITIAL	2/20/2024
Carter	KizzyAnn	BH-Telehealth	INITIAL	2/20/2024
Chang	Semi	ABA-Telehealth	INITIAL	2/20/2024
Chauhan	Anu	ABA	INITIAL	2/20/2024
Cheek	Maya	BH	INITIAL	2/20/2024
Chia	Moon Yuen	ABA	INITIAL	2/20/2024
Cole	Deanna	ABA-Telehealth	INITIAL	2/20/2024
Cooper	Katherine	BH	INITIAL	2/20/2024
Cope	Ashley	ABA-Telehealth	INITIAL	2/20/2024
Crespin	Ashley	ABA	INITIAL	2/20/2024
Curry	Laura	BH-Telehealth	INITIAL	2/20/2024
Dennis	Emily	ABA-Telehealth	INITIAL	2/20/2024
Diaz	Ivette	ABA-Telehealth	INITIAL	2/20/2024
Dockter-Reynolds	Veronica	ABA-Telehealth	INITIAL	2/20/2024
Ericksen	Tara	Allied Health	INITIAL	2/20/2024
Escobedo	Angeline	BH	INITIAL	2/20/2024
Evans	Elisabeth	ABA-Telehealth	INITIAL	2/20/2024
Fabric	Mollie	ABA	INITIAL	2/20/2024
Fair	Naomi	BH	INITIAL	2/20/2024
Fuentes	Ashlee	ABA-Telehealth	INITIAL	2/20/2024
Geller	Ryan	ABA-Telehealth	INITIAL	2/20/2024
Gray	Carolynn	BH	INITIAL	2/20/2024
Gucho	Florentina	ABA	INITIAL	2/20/2024
Hakopyan	Armine	BH-Telehealth	INITIAL	2/20/2024
Hannigan	Valerie	Ancillary	INITIAL	2/20/2024
Harris	Ari	BH-Telehealth	INITIAL	2/20/2024
Henriquez	Arnold	ABA	INITIAL	2/20/2024
Hilsinger	Marion	BH	INITIAL	2/20/2024
Isaacsohn	Maya	Primary Care Physician	INITIAL	2/20/2024
Jackson	Paul	BH	INITIAL	2/20/2024
Jewert	Jennifer	BH-Telehealth	INITIAL	2/20/2024
Jimenez	Aaron-Ross	Specialist	INITIAL	2/20/2024
Johnson	Yasin	ABA	INITIAL	2/20/2024
Johnson White	Jhaurel	BH-Telehealth	INITIAL	2/20/2024
Juvvadi	Anita	Primary Care Physician	INITIAL	2/20/2024
Kakkar	Ayoosh	BH-Telehealth	INITIAL	2/20/2024
Kalra	Amit	Primary Care Physician	INITIAL	2/20/2024
Kaur	Harinder	BH-Telehealth	INITIAL	2/20/2024
Keough	Kenneth	BH	INITIAL	2/20/2024
Koenig	Christine	ABA-Telehealth	INITIAL	2/20/2024
Kooturu	Sri Vardan Reddy	Primary Care Physician	INITIAL	2/20/2024
La Croix	Diandra	BH	INITIAL	2/20/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Laberinto	Noreen	ABA-Telehealth	INITIAL	2/20/2024
Last	Benedicte	BH-Telehealth	INITIAL	2/20/2024
Le	Christine	Allied Health	INITIAL	2/20/2024
Lee	Chuan Tung	Ancillary	INITIAL	2/20/2024
Loebner	Jaime	BH-Telehealth	INITIAL	2/20/2024
Lucas	Natalie	Allied Health	INITIAL	2/20/2024
Mabazza	Claro Mark	BH-Telehealth	INITIAL	2/20/2024
Manikowski	Wendy	ABA-Telehealth	INITIAL	2/20/2024
Mathur	Preeti	BH-Telehealth	INITIAL	2/20/2024
Mbure	Judy	BH-Telehealth	INITIAL	2/20/2024
McCubbin	Kelsey	ABA-Telehealth	INITIAL	2/20/2024
McDonald	Shante	Doula	INITIAL	2/20/2024
McQueen	Azalea	Doula	INITIAL	2/20/2024
Mecca	Mary	Allied Health	INITIAL	2/20/2024
Megeath	Vanessa	ABA-Telehealth	INITIAL	2/20/2024
Mehta	Alison	BH	INITIAL	2/20/2024
Meyer	Matthew	ABA-Telehealth	INITIAL	2/20/2024
Michael	Eric	BH-Telehealth	INITIAL	2/20/2024
Muldoon	Timothy	Primary Care Physician	INITIAL	2/20/2024
Murillo	Nicole	ABA-Telehealth	INITIAL	2/20/2024
Navarro	Mariana	BH-Telehealth	INITIAL	2/20/2024
Nerio	Consuelo	BH	INITIAL	2/20/2024
Norman	Timothy	BH	INITIAL	2/20/2024
Olson	Justin	BH-Telehealth	INITIAL	2/20/2024
Onuoha	Chinyere	BH	INITIAL	2/20/2024
Pace	Kayla	ABA-Telehealth	INITIAL	2/20/2024
Pajouhi	Pegah	BH-Telehealth	INITIAL	2/20/2024
Park	Ryan	ABA	INITIAL	2/20/2024
Percival	Karina	ABA-Telehealth	INITIAL	2/20/2024
Porter	Alada	ABA-Telehealth	INITIAL	2/20/2024
Price	Adam	ABA-Telehealth	INITIAL	2/20/2024
Price	Lauren	ABA-Telehealth	INITIAL	2/20/2024
Puri	Isabel	BH-Telehealth	INITIAL	2/20/2024
Quintanilla Mejia	Belkiz	Allied Health	INITIAL	2/20/2024
Ramirez-Moya	Lorerky	BH-Telehealth	INITIAL	2/20/2024
Rawal	Amit	ABA-Telehealth	INITIAL	2/20/2024
Rehfield	Patricia	BH	INITIAL	2/20/2024
Rehimtoola	Nermeen	Allied Health	INITIAL	2/20/2024
Reid	Caitlin	Ancillary	INITIAL	2/20/2024
Remily	Amberlie	ABA-Telehealth	INITIAL	2/20/2024
Rheins	Samantha	ABA-Telehealth	INITIAL	2/20/2024
Rijhwani	Marvi	BH-Telehealth	INITIAL	2/20/2024
Rivera	Elizabeth	ABA	INITIAL	2/20/2024
Rivera Gonzalez	Ana	BH	INITIAL	2/20/2024
Rodriguez	Claire	ABA	INITIAL	2/20/2024
Rosenberg	Marina	Allied Health	INITIAL	2/20/2024
Rush	Amelia	ABA-Telehealth	INITIAL	2/20/2024
Saleekongprayoon	Jessica	ABA	INITIAL	2/20/2024
Sanchez	Alexa	ABA-Telehealth	INITIAL	2/20/2024
Sanchula-Tadepu	Gagana	ABA-Telehealth	INITIAL	2/20/2024
Santiago	Daniel	ABA	INITIAL	2/20/2024
Sarantos	Andrew	ABA	INITIAL	2/20/2024
Sayers	Jamie	BH	INITIAL	2/20/2024
Sellers	LaCandia	BH	INITIAL	2/20/2024
Sevcik	Kimberley	BH	INITIAL	2/20/2024
Shaghaghi	Bita	BH-Telehealth	INITIAL	2/20/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Shah	Swetang	Primary Care Physician	INITIAL	2/20/2024
Shaikh	Zahid	Primary Care Physician	INITIAL	2/20/2024
Sherred	Leanne	Ancillary	INITIAL	2/20/2024
Shrestha	Lydia	Primary Care Physician	INITIAL	2/20/2024
Shurn	Najuma	BH	INITIAL	2/20/2024
Sim Le	Gloria	BH-Telehealth	INITIAL	2/20/2024
Simonian	Michael	ABA-Telehealth	INITIAL	2/20/2024
Singh	Rishika	Primary Care Physician	INITIAL	2/20/2024
Smith	Aysia	ABA-Telehealth	INITIAL	2/20/2024
Stablein	Gary	BH-Telehealth	INITIAL	2/20/2024
Steele	Andrea	BH-Telehealth	INITIAL	2/20/2024
Stovall	Shannon	BH	INITIAL	2/20/2024
Sung	Janet	Specialist	INITIAL	2/20/2024
Thomas	Keyauna	BH-Telehealth	INITIAL	2/20/2024
Thompson	Brianna	BH-Telehealth	INITIAL	2/20/2024
Thompson-Tucker	Alyssa	Allied Health	INITIAL	2/20/2024
Torres	Trina	ABA-Telehealth	INITIAL	2/20/2024
Tran	Lucy	ABA	INITIAL	2/20/2024
Travis	Adam	BH	INITIAL	2/20/2024
Tse	Courteney	ABA-Telehealth	INITIAL	2/20/2024
Vahid	Bobbak	Specialist	INITIAL	2/20/2024
Vallejos	Jennifer	ABA	INITIAL	2/20/2024
Vega	Amber	ABA-Telehealth	INITIAL	2/20/2024
Vergara	Yadira	ABA-Telehealth	INITIAL	2/20/2024
Vijayasarathi	Krishna	BH-Telehealth	INITIAL	2/20/2024
Waclawski	Meghan	ABA-Telehealth	INITIAL	2/20/2024
Waldron-Anzalone	Angela	BH-Telehealth	INITIAL	2/20/2024
Williamson	Christine	BH	INITIAL	2/20/2024
Williams-Salis	Whitney	Allied Health	INITIAL	2/20/2024
Wolfe-Roubatis	Emily	Allied Health	INITIAL	2/20/2024
Wu	Brian	BH	INITIAL	2/20/2024
Yu	Katherine	Specialist	INITIAL	2/20/2024
Zea	Milagros	ABA-Telehealth	INITIAL	2/20/2024
Zhou	Suyang	Allied Health	INITIAL	2/20/2024
Zombres	Tara	ABA	INITIAL	2/20/2024
Allen	Daniel	Specialist	RE-CRED	2/27/2024
Al-Mufti	Haseeb	Specialist	RE-CRED	2/27/2024
Banks	Norman	Primary Care Physician	RE-CRED	2/20/2024
Batra	Vineet	Specialist	RE-CRED	2/27/2024
Butler	Ashli	Allied Health	RE-CRED	2/20/2024
Chen	Benjamin	Primary Care Physician	RE-CRED	2/20/2024
Chen	Ji	Primary Care Physician	RE-CRED	2/20/2024
Chen	Kwan Sian	Specialist	RE-CRED	2/20/2024
Chen	Michael	Ancillary	RE-CRED	2/20/2024
Chin	Catherine	Primary Care Physician	RE-CRED	2/20/2024
Clemons	Charles	Primary Care Physician	RE-CRED	2/20/2024
Fisher	Pascale	Allied Health	RE-CRED	2/20/2024
Grubbs	Vanessa	Primary Care Physician	RE-CRED	2/20/2024
Hundal	Sarbjit	Specialist	RE-CRED	2/27/2024
Jannapureddy	Deepika	Primary Care Physician	RE-CRED	2/27/2024
Khyne	Aye	Specialist	RE-CRED	2/20/2024
Klosterman	Tristan	Specialist	RE-CRED	2/27/2024
Leung	Jessica	Primary Care Physician	RE-CRED	2/27/2024
Li-Bland	Esther	Primary Care Physician	RE-CRED	2/20/2024
Lin	James	Specialist	RE-CRED	2/20/2024
Liu	Aiming	Ancillary	RE-CRED	2/27/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Loo	Amelia	Ancillary	RE-CRED	2/20/2024
Ma	Fajie	Specialist	RE-CRED	2/20/2024
Macdonald	Michael	Specialist	RE-CRED	2/27/2024
Manthiram	Vanni	Specialist	RE-CRED	2/20/2024
Maurer	Toby	Specialist	RE-CRED	2/20/2024
Nguyen	Suzanne	Primary Care Physician	RE-CRED	2/20/2024
Nguyen	Tuyet Van	Allied Health	RE-CRED	2/20/2024
Ortiz Soto	Xaviera	Primary Care Physician	RE-CRED	2/20/2024
Pontell	Sarah	Allied Health	RE-CRED	2/20/2024
Reen	Ranjit	Primary Care Physician	RE-CRED	2/20/2024
Riordan	Margaret	Specialist	RE-CRED	2/20/2024
Rosenthal	Monique	Allied Health	RE-CRED	2/27/2024
Rubenstein	Ronald	Specialist	RE-CRED	2/27/2024
Ruiz	Anabel	Primary Care Physician	RE-CRED	2/20/2024
Schlegel	Amy	Ancillary	RE-CRED	2/27/2024
Sood	Veronica	Primary Care Physician	RE-CRED	2/27/2024
Srivastava	Rupa	Primary Care Physician	RE-CRED	2/20/2024
Villagomez	Silvia	Specialist	RE-CRED	2/27/2024

FEBRUARY PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	9
Specialists	6
Allied Health	15
Ancillary	6
BH/ABA	112
Total	148

Provider Dispute Resolution
January 2024 and February 2024

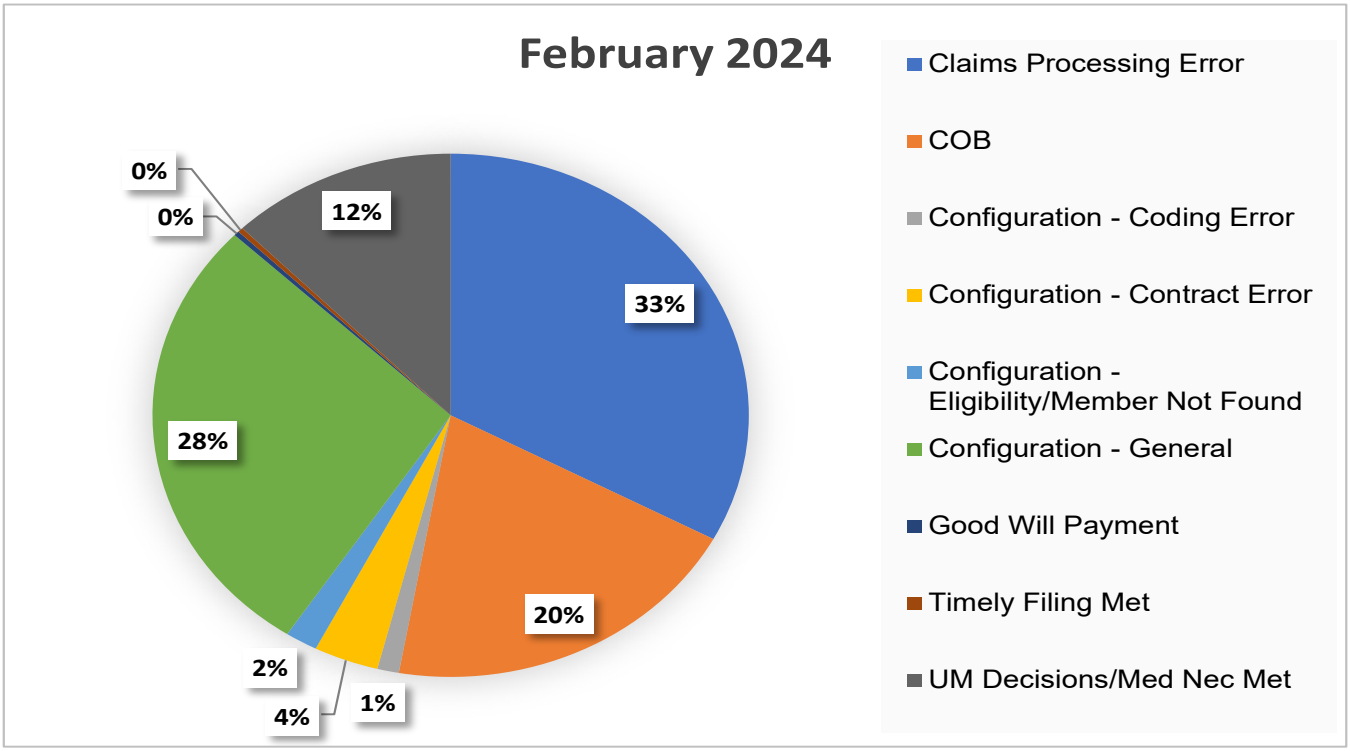
METRICS

PDR Compliance	Jan-24	Feb-24
# of PDRs Resolved	1,461	1,007
# Resolved Within 45 Working Days	1,455	1,007
% of PDRs Resolved Within 45 Working Days	99.5%	100.0%
PDRs Received	**Jan-24**	**Feb-24**
# of PDRs Received	2,172	2,064
PDR Volume Total	**2,172**	**2,064**
PDRs Resolved	**Jan-24**	**Feb-24**
# of PDRs Upheld	912	666
% of PDRs Upheld	62%	66%
# of PDRs Overturned	549	341
% of PDRs Overturned	38%	34%
Total # of PDRs Resolved	**1,461**	**1,007**
Average Turnaround Time	**Jan-24**	**Feb-24**
Average # of Days to Resolve PDRs	42	41
Oldest Resolved PDR in Days	77	44
Unresolved PDR Age	**Jan-24**	**Feb-24**
0-45 Working Days	2,695	3,442
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**2,695**	**3,442**

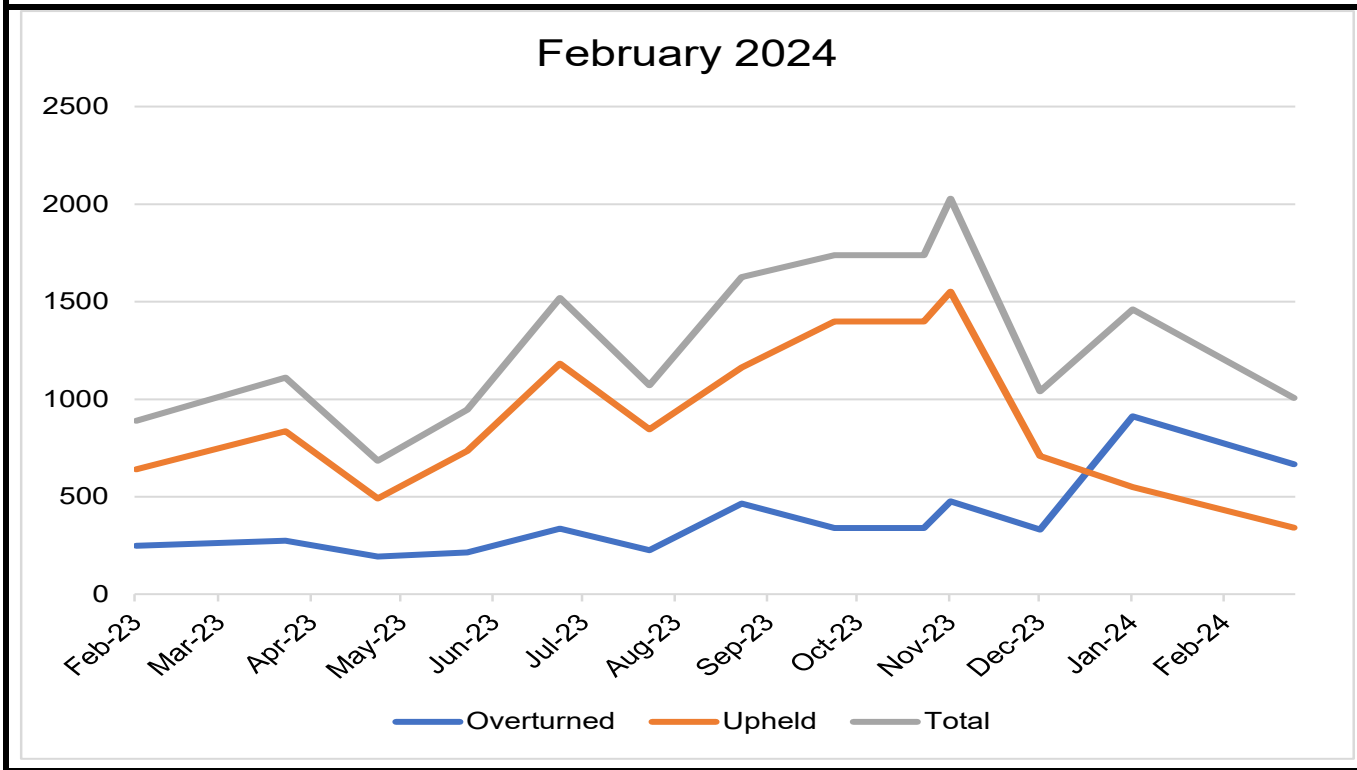
Provider Dispute Resolution
January 2024 and February 2024

Feb-24

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Provider Dispute Resolution Year Over Year Summary		
Monthly Results	**Regulatory Requirements**	**AAH Goal**
# of PDRs Resolved - 1,007 in February 2024 vs 889 in February 2023	N/A	N/A
# of PDRs Received - 2,064 in February 2024 vs 996 in February 2023	N/A	N/A
# of PDRs Resolved within 45 working days - 1,007 in February 2024 vs 889 in February 2023	N/A	N/A
% of PDRs Resolved within 45 working days - 100% in February 2024 vs 100% in February 2023	95%	95%
Average # of Days to Resolve PDRs - 41 days in February 2024 vs 30 days in February 2023	N/A	30
Oldest Resolved PDR in Days - 44 days in February 2024 vs 44 days February 2023	N/A	N/A
# of PDRs Upheld - 666 in February 2024 vs 641 in February 2023	N/A	N/A
% of PDRs Upheld - 66% in February 2024 vs 72% in February 2023	N/A	> 75%
# of PDRs Overturned - 341 in February 2024 vs 248 in February 2023	N/A	N/A
% of PDRs Overturned - 34% in February 2024 vs 28% in February 2023	N/A	< 25%

Provider Dispute Resolution Year Over Year Summary		
PDR Overturn Reasons: Claims processing errors - 33% (2024) vs 50% (2023) Configuration errors - 34% (2024) vs 23% (2023) COB - 20% (2024) vs 21% (2023) Clinical Review/UM Decisions/Medical Necessity Met - 12% (2024) vs 5% (2023)	N/A	N/A

During February 2024, the Alliance completed **668** member orientation outreach calls among net new members and non-utilizers and conducted **142** member orientations (**21%** member participation rate). In addition, in February 2024, the Outreach team completed **84** Alliance website inquiries, **3** service requests, **1** social media inquiry, **2** community events, and **2** member education events. The Alliance reached a total of **895** people at the Black Joy Parade 2024, the Harmony of Heritage: Lunar New Year and Black History Month celebration, the Ohlone College Flea Market, and the Tzu Chi Lunar New Year Celebration community outreach activities.*

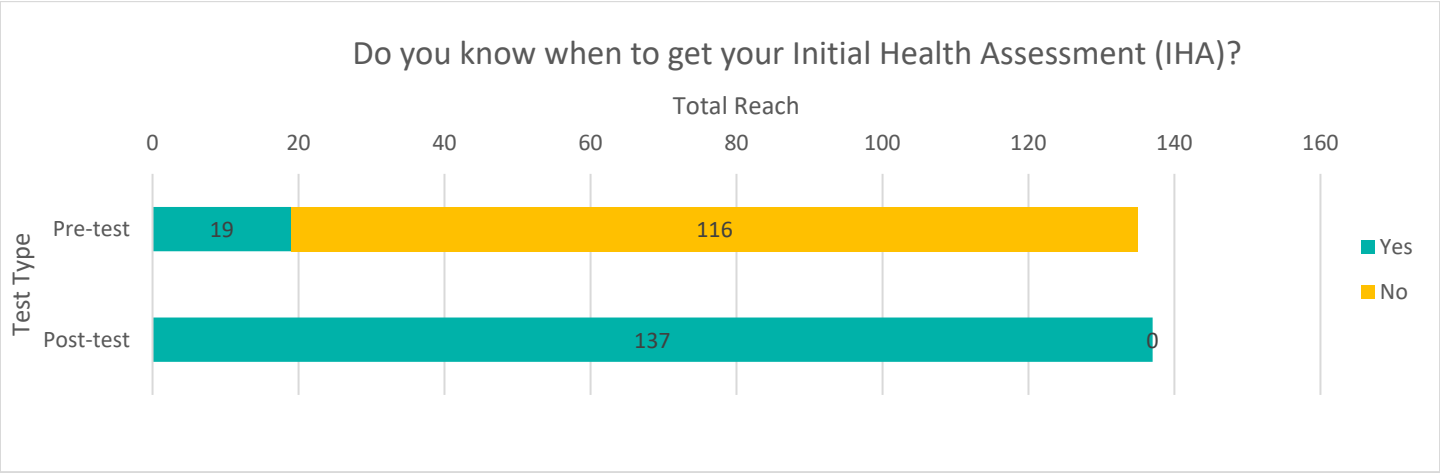
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **31,485** self-identified Alliance members have been reached during outreach activities.

On Monday, March 16, 2020, the Alliance began helping members by telephone only, following the statewide Shelter-in-Place (SIP) guidance to protect the general public from Coronavirus Disease (COVID-19). Subsequently, the Alliance proactively postponed all face-to-face member orientations until further notice.

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of February 29, 2024, the Outreach Team completed **33,586** member orientation outreach calls and conducted **8,071** member orientations (**24%** member participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment (IHA) by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between February 1, through February 29, 2024 (20 working days) – **142** members completed an MO by phone.

After completing a MO **100%** of members who completed the post-test survey in February 2024 reported knowing when to get their IHA, compared to only **14.1%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 23-24\Q3\2. February 2024**

FY 2022-2023 FEBRUARY 2023 TOTALS

1 COMMUNITY EVENTS
0 MEMBER EDUCATION EVENTS
108 MEMBER ORIENTATIONS
0 MEETINGS/ PRESENTATIONS/
0 COMMUNITY TRAINING
4 TOTAL INITIATED/ INVITED EVENTS
109 TOTAL COMPLETED **EVENTS**

12 CITIES

Alameda
Albany
Castro Valley
Dublin
Fremont
Hayward
Newark
Oakland
Pleasanton
San Francisco
San Leandro
Union City

7 TOTAL REACHED AT COMMUNITY EVENTS
0 TOTAL REACHED AT MEMBER EDUCATION EVENTS
108 TOTAL REACHED AT MEMBER ORIENTATIONS
0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
0 TOTAL REACHED AT COMMUNITY TRAINING
113 MEMBERS REACHED AT ALL EVENTS
115 **TOTAL REACHED AT ALL EVENTS**

$250.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2023-2024 FEBRUARY 2024 TOTALS

2 COMMUNITY EVENTS
2 MEMBER EDUCATION EVENTS
142 MEMBER ORIENTATIONS
0 MEETINGS/ PRESENTATIONS
0 COMMUNITY TRAINING
6 TOTAL INITIATED/ INVITED EVENTS
146 TOTAL COMPLETED **EVENTS**

13 CITIES**

Alameda
Antioch
Berkeley
Castro Valley
Fremont
Hayward
Livermore
Oakland
Pittsburg
Pleasanton
San Leandro
San Lorenzo
Union City

335 TOTAL REACHED AT COMMUNITY EVENTS
560 TOTAL REACHED AT MEMBER EDUCATION EVENTS
142 TOTAL REACHED AT MEMBER ORIENTATIONS
0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
0 COMMUNITY TRAINING
586 MEMBERS REACHED AT ALL EVENTS
1037 **TOTAL REACHED AT ALL EVENTS**

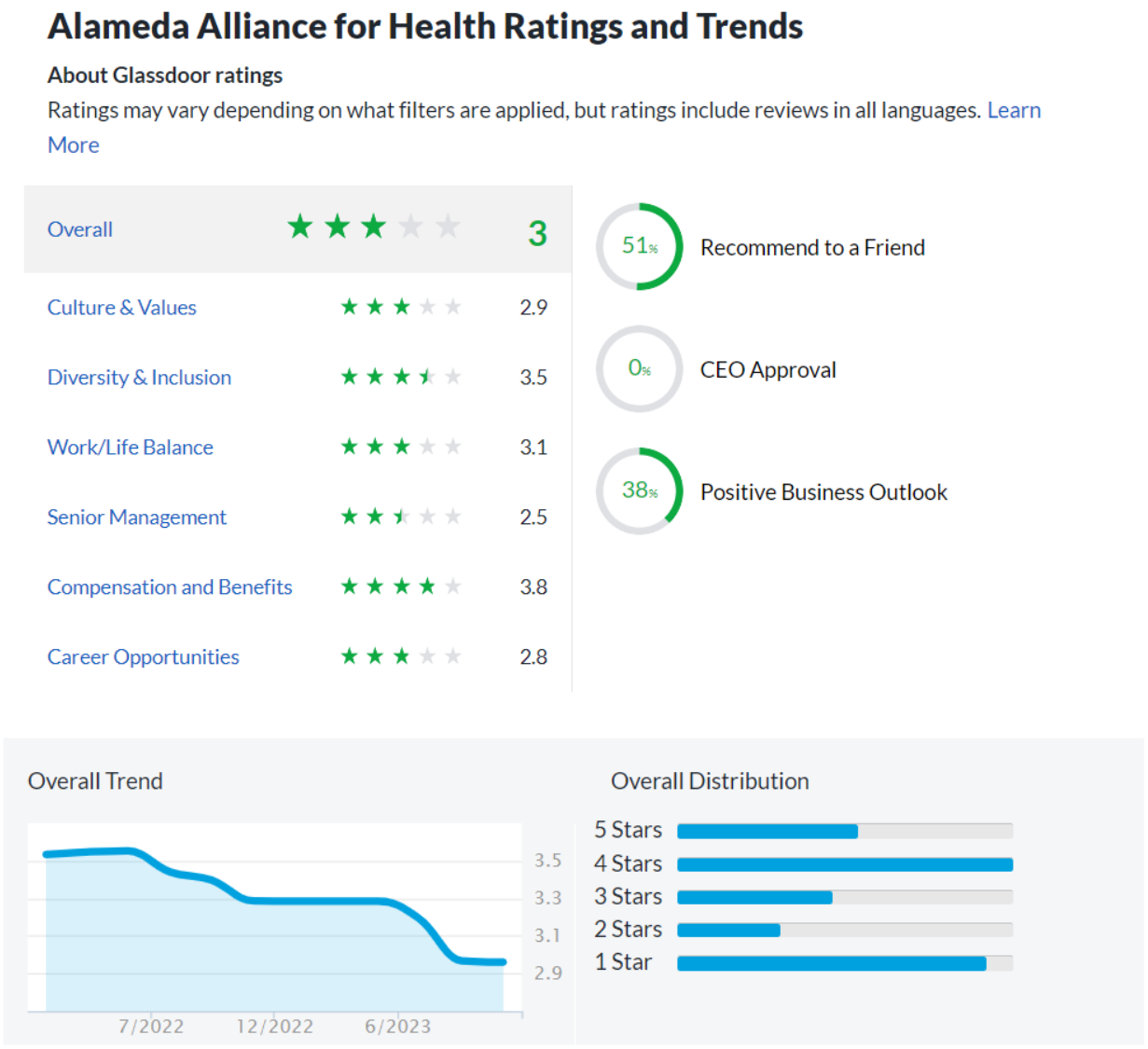
$312.10
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

***Cities represent the mailing address designations for members who completed a member orientation by phone and community event. The italicized cities are outside of Alameda County. The C&O Department started including these cities in the Q3 FY21 Outreach Report.*

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 **February 1, 2024**, and **February 29, 2024**:

1. Alliance Website:
    - Received **16,000** unique visits
    - Received **13,000** new user visits
    - The top **10** website page visits were:
        i. Homepage
        ii. Provider Page
        iii. Find a Doctor
        iv. Medi-Cal Benefits and Services
        v. Careers
        vi. Members Medi-Cal
        vii. Contact Us
        viii. Members
        ix. Get a New ID Card
        x. About Us
2. Facebook Page:
    - Slight increase in Fans from **629 to 631**
    - Did not receive any reviews in **February 2024**
3. Glassdoor Page:
    - **3** out of a **5-star** overall rating
    - Received 1 review in **February 2024**
4. Instagram Page:
    - Page debuted **June 10, 2021**
    - Increase in followers from **487** to **498**
5. Twitter Page:
    - Slight increase in followers from **356 to 358**
6. LinkedIn Page:
    - Increased followers from **4.9k to 5.1k**
    - Received **208-**page clicks
7. Yelp Page:
    - Page visits **64**
    - Appeared in Yelp searches **141** times
    - Did not receive any reviews in **February 2024**
8. Google Page:
    - **4,787** website clicks made from the business profile
    - **1,536** calls made from the business profile
    - Received **2** reviews in **February 2024**
    - Received **15** chat messages in **February 2024**

GLASSDOOR OVERVIEW

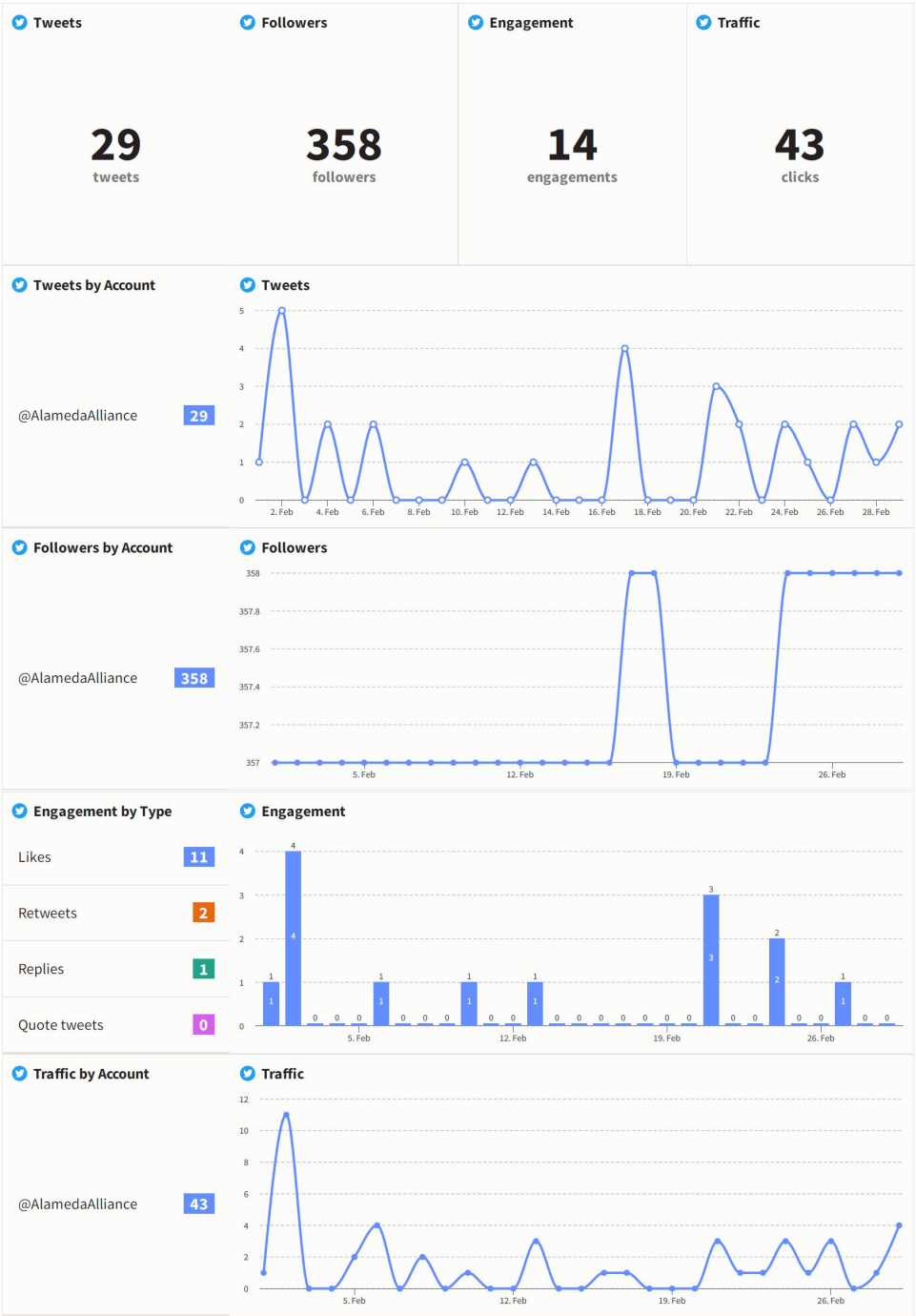


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\2. February 2024

FACEBOOK OVERVIEW

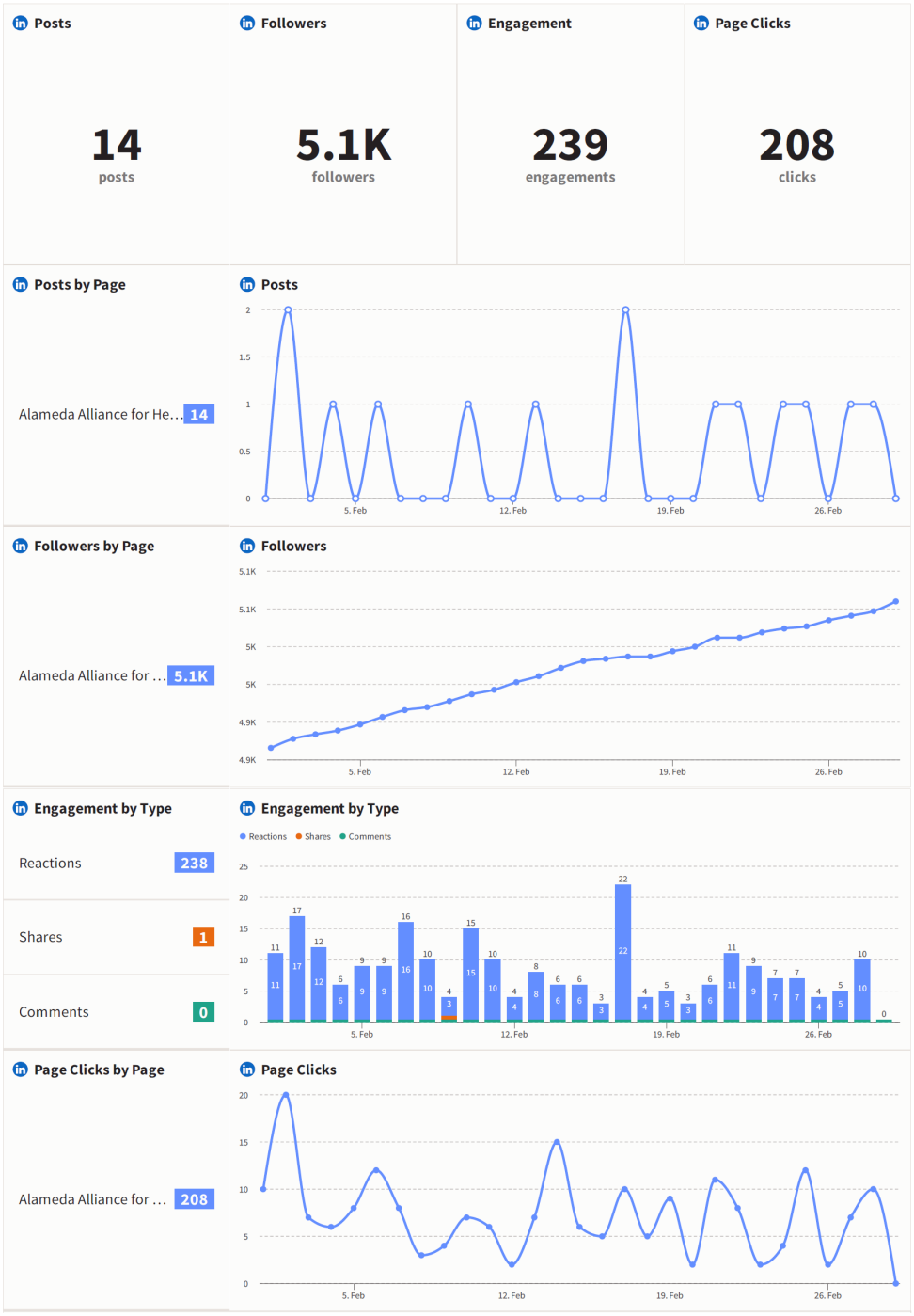
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\2. February 2024

TWITTER OVERVIEW



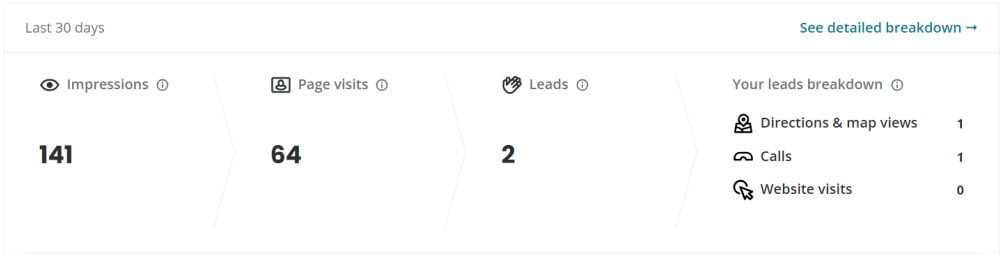
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\2. February 2024

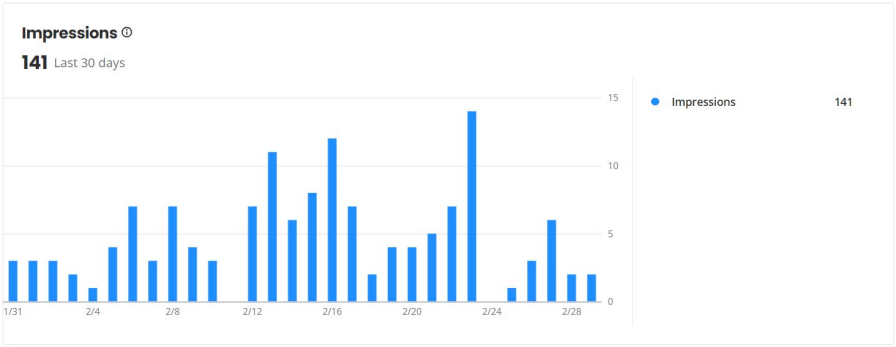
LINKEDIN OVERVIEW

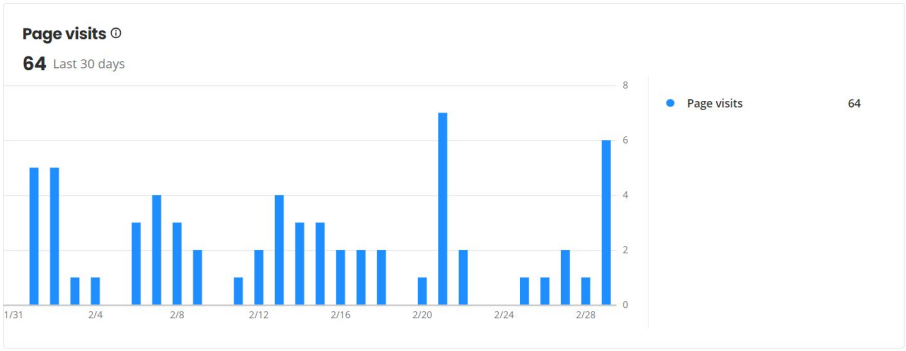


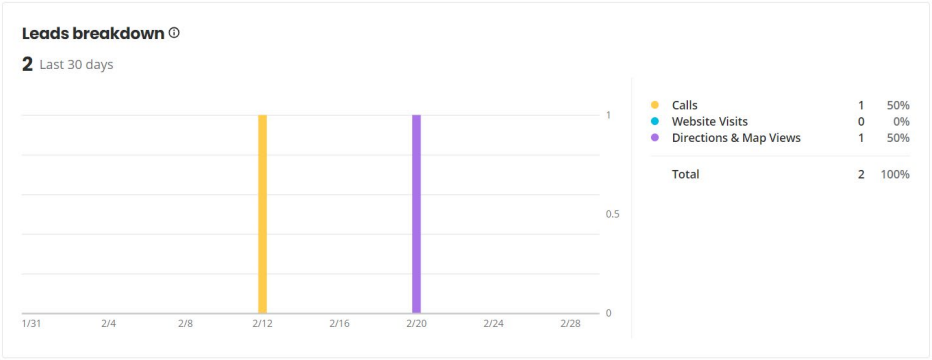
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\2. February 2024

YELP OVERVIEW



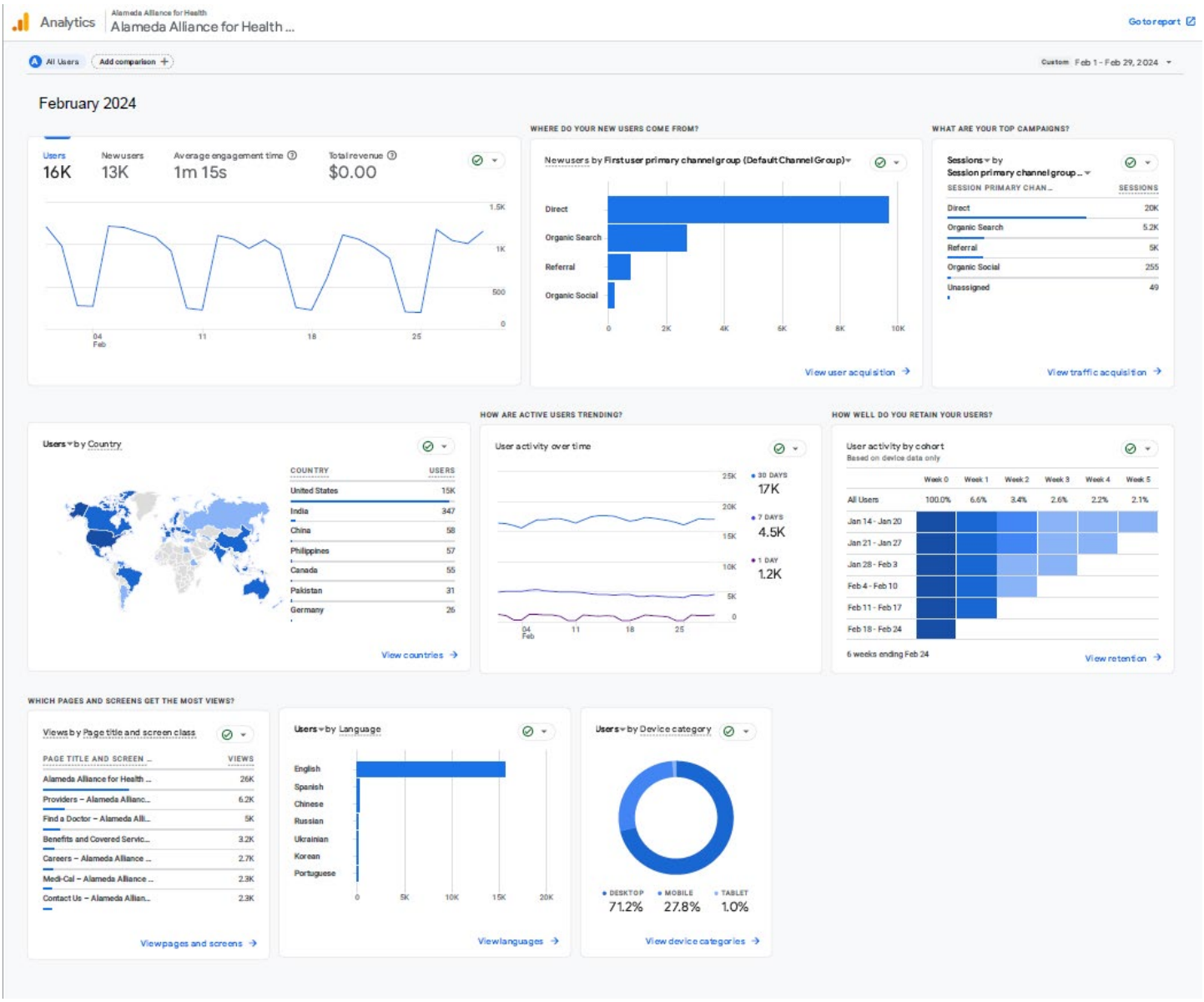






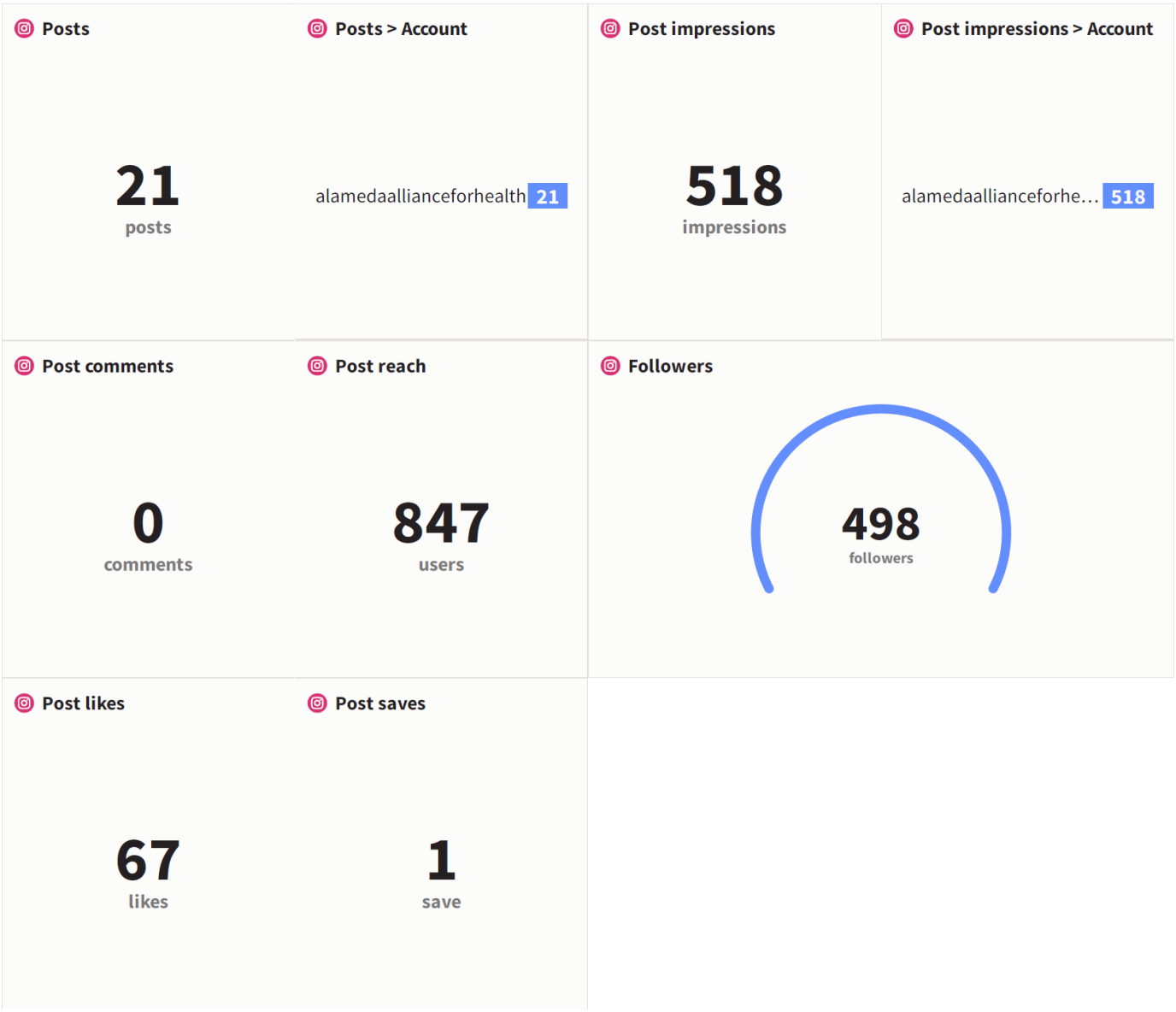
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\2. February 2024

ALLIANCE WEBSITE OVERVIEW:



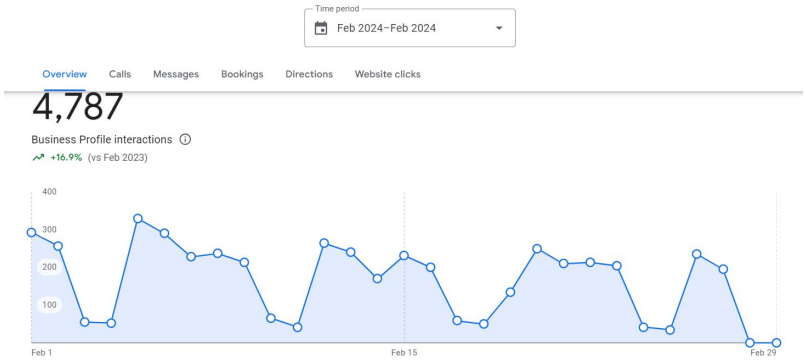
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\2. February 2024

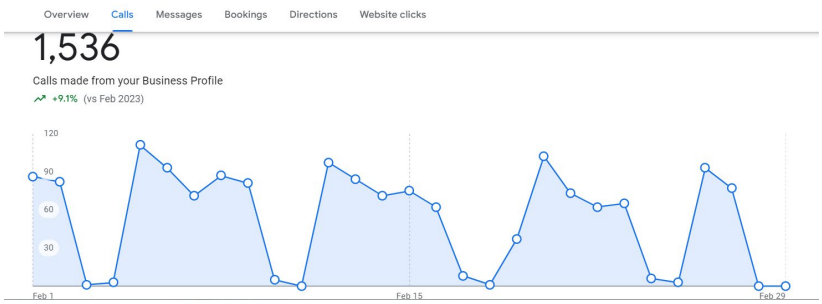
Instagram OVERVIEW:

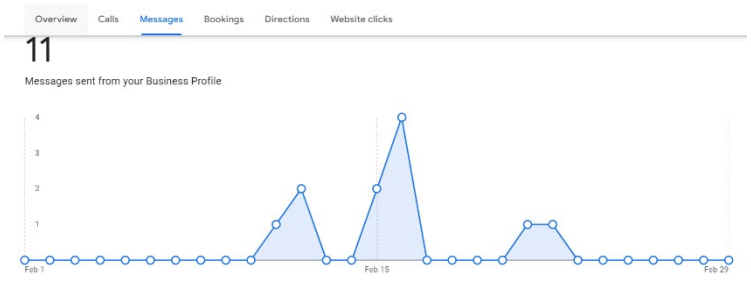


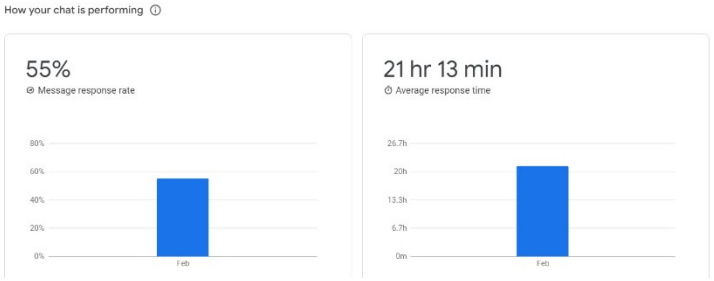
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\2. February 2024

Google OVERVIEW:









All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\2. February 2024

Integrated Planning

Ruth Watson

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

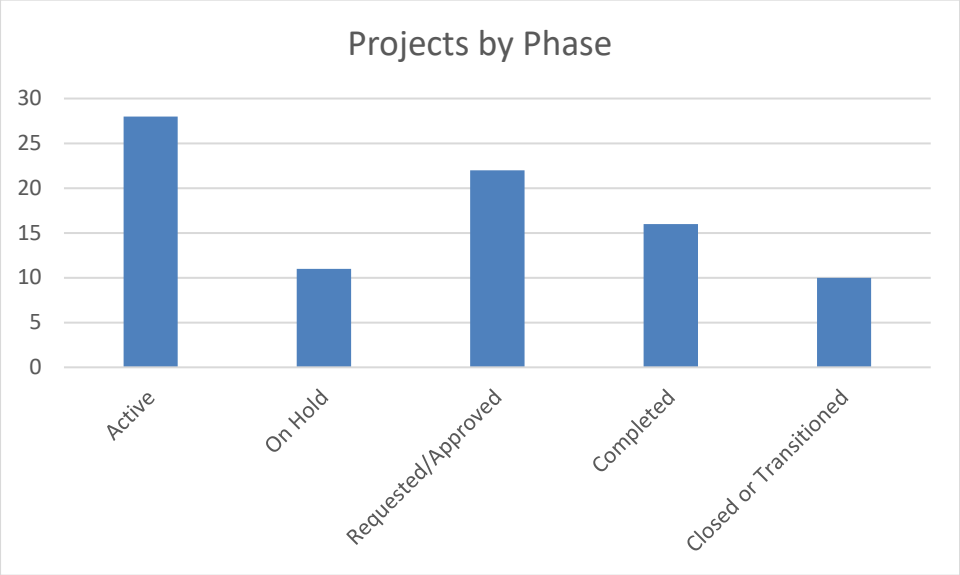
From: **Ruth Watson, Chief Operating Officer**

Date: **March 8th, 2024**

Subject: **Integrated Planning Division Report – February 2024 Activities**

Project Management Office

- 87 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 28 Active projects (discovery, initiation, planning, execution, warranty)
    - 11 On Hold projects
    - 22 Requested and Approved Projects
    - 16 Complete projects
    - 10 Closed/Transitioned to Department or IT Led



Integrated Planning

- **<u>CalAIM Initiatives:</u>**
    - Community Supports (CS):
        - MOC for January 2024 CS elections submitted to DHCS on July 5th, 2023, and approved by DHCS on December 26th
            - AAH added two (2) additional CS services effective January 1st, 2024
                - Nursing Facility Transition/Diversion to Assisted Living Facilities

        - Community Transition Services/Nursing Facility to a Home
        - Sobering Centers has been delayed to July 1st, 2024
    - AAH received interest from various providers to contract for the provision of these new CS services
    - DHCS required all MCPs to submit an updated CS MOC for July 2024 by January 1st, 2024
        - Updated CS MOC was submitted to DHCS on December 29th

- Justice-Involved (JI) Initiative:
    - CalAIM Re-entry
        - Go-live date for the CalAIM Re-Entry initiative is October 1st, 2024, for all MCPs
            - Correctional facilities will have the ability to select their go-live date within a 24-month phase-in period (10/1/2024 – 9/30/2026)
            - Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of October 1st, 2024, even if facilities in their county will go-live at a later date
        - Bi-weekly workgroup meetings with Alameda County Sheriff's Office, Probation, Alameda County Behavioral Health, Social Security Administration, Kaiser Permanente and AAH continue to support collaboration on the strategy for this initiative
        - Additional meetings will be held internally to further define the data requirements for AAH to share with external agencies in support of the JI initiatives
        - AAH met with representatives from the Alameda County Office of Education's Division of Student Programs and Services (ACOE SPaS) to learn about their programs serving justice involved youth and youth at risk of incarceration
            - A follow-up meeting will be scheduled in March
        - AAH met with Wellpath (clinical provider within Santa Rita Jail) to continue discussions about data sharing and also to learn about discharge planning
            - Monthly meetings have been scheduled through Q1 in support of ongoing collaboration with Wellpath
        - California Department of Corrections and Rehabilitation (CDCR) expressed their interest in collaborating directly with the plans to develop re-entry processes for individuals released from state prisons
            - CDCR would like to form a workgroup with the MCPs to support this work and collaboration; as of February 29th, we have not heard any updates on when this workgroup will initiate
        - Summary of changes in the legislation 42 CFR, Part 2:
            - These changes are not in effect until April 16th, 2024, with a Compliance date of February 16th, 2026

- The purpose of the changes is to bring 42 CFR Part 2 into closer alignment with HIPAA Rules
- SUDS information remains a sensitive service, consent is needed to share
- Consent – Patient Consent
    - Allows a single consent for all future uses and disclosures for treatment, payment, and health care operations
    - Allows HIPAA covered entities and business associates that receive records under this consent to redisclose the records in accordance with the HIPAA regulations

- Justice Involved ECM Population of Focus:
    - Justice-Involved (JI) ECM Population of Focus (PoF) went live on January 1st, 2024
        - AAH has onboarded one new provider to support the JI ECM PoF; three (3) existing ECM providers are adding the JI population to the ECM populations they are already serving
        - Testing for submission of ECM encounters continues with our new ECM provider, Pair Team Medical; this is expected to be completed within the next week
    - DHCS reviewed all materials submitted by AAH in the initial MOC process and requests for additional information and has given us a "pre-CAP" letter
        - DHCS has indicated our submission was inadequate in the following areas: A) At least one (1) experienced JI ECM Provider in each county of operation and B) Network sufficiency to meet the estimated ECM capacity needs
    - DHCS held two (2) technical assistance calls with all plans February 14th and February 22nd. AAH has requested a one-on-one call with DHCS to discuss our plan specific question; this call is scheduled for March 5th.
    - AAH will look to revise our MOC submissions based on the outcomes of the call with DHCS and consultation with our ECM provider network
    - Submission of our response to the pre-CAP letter is due to DHCS by March 22nd

- AAH/Roots JI Pilot Project:
    - AAH's pilot for post-release services began in July 2023 in preparation for the 2024 programs related to this population
        - The team has started analyzing the data we received from Roots to support the development of our strategy for the re-entry initiative that commences in 2024
        - Initial data analysis has shown a disparity between the number of males vs. females seeking help upon release (roughly 10% of males vs. near 100% females)

        - Housing assistance is also a top need for this population
        - Monthly check-ins with Roots will continue in 2024

- Long Term Care (LTC) Carve-In – AAH became responsible for all members residing in LTC facilities as of January 1st, 2023, except for Pediatric and Adult Subacute Facilities and Intermediate Care Facilities-Developmentally Disabled (ICF-DD), which went live January 1st, 2024
    - First Post Transition Monitoring report was submitted to DHCS on 1/17/2024
    - Bi-Weekly Post Transition Monitoring Reporting to DHCS will continue thru March
    - ICF/DD homes are reporting challenges with timely payment, need for updated contract language, and communication with MCPs
        - AAH attends the ad hoc mandatory calls scheduled by DHCS and has contributed with activities the MCP is doing to address provider concerns
        - AAH's LTSS Liaison, the Utilization Department, and Provider Services has been in communication via telephone and email with ICF/DD homes to resolve any challenges

- Population Health Management (PHM) Program – effective January 1st, 2023:
    - PHM Disease Management Deliverables
        - DHCS-approved letters sent out to notify members of the availability of Asthma and Diabetes programs
        - Cardiovascular Disease (CVD) letters were mailed out in February
        - Depression member letter has been approved by DHCS; goal is to mail out Depression member letters in March
    - 2023 DHCS PHM Strategy Deliverable
        - Held multiple meetings with Alameda County Health Care Services Agency (HCSA), City of Berkeley, Health Housing and Community Services, and Kaiser Permanente regarding Alliance collaboration with the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP)
        - Team will be proposing opportunities for collaborative goals that align with the Alliance PHM Strategy and the DHCS Clinical Quality Strategy Bold Goals
    - 2023 DHCS PHM Monitoring Requirements
        - Work continued to establish internal monitoring processes for PHM Key Performance Indicators (KPIs) and Quality metrics, including stratification by race, ethnicity, language, and age
        - DHCS has put a hold on quarterly KPI reporting as they relook at the metric specifications
        - Reviewing KPI performance and identifying areas for improvement

- Community Health Worker (CHW) Benefit – Medi-Cal benefit effective July 1st, 2022, designed to promote the MCP's contractual obligations to meet DHCS broader Population Health Management standards as an adjunctive service as part of the interventions to positively impact health outcomes

- Operational Status Update:
  - DHCS released a new redline draft All Plan Letter (APL) on February 16th; major changes include the elimination of the Population Risk Stratification language and the need for a CHW integration plan
    - DHCS requested feedback by March 1st, 2024; AAH provided a response on February 28th
  - The CHW workgroup has developed a Proposal for a $100K grant to support CHW network providers with infrastructure development
  - AAH has been in preliminary negotiation with Family Resource Navigators who will bring expertise in working with families with Disabilities into contract as a CHW provider
  - AAH has executed a contract with Journey Health
  - Contracting activities continue with Pear Team and Youth Alive

- Dual Eligible Special Needs Plan (D-SNP) Implementation - All Medi-Cal MCPs will be required to implement a Medicare Medi-Cal Plan (MMP) as of January 1st, 2026:
  - Rebellis provided their Final Draft System Review; AAH internal review is in process
  - A decision on whether to continue to use the existing Claims (HEALTHsuite) and Medical Management (TruCare) platforms or move to new systems to support the addition of the D-SNP line of business is pending
  - Development of the project schedule and project status reporting continues

Other Initiatives

2024 Single Plan Model - activities related to the conversion from a two-plan model to a single plan model are included under one comprehensive program:

- Managed Care Contract Operational Readiness (OR)
  - Group 2 Deliverables Status
    - Total Deliverables submitted to DHCS – 226
      - Approved by DHCS – 226
      - In Review – 0
      - Additional Information Requests (AIR) – 0
      - On Hold – 0
    - Single Plan Model was transitioned to Regulatory Affairs for continued management and support on January 30th, 2024
- MCP Member Transition:
  - MCP member transition project has moved into the closing phase
  - AAH will continue to receive refreshed data from Anthem for transitioning members on a weekly basis through March 2024
  - AAH continues to outreach to out-of-network providers and is focusing contracting efforts on providers in Alameda County and larger medical groups as our top priority; providers in contiguous counties will be the second priority
  - CHCN informed AAH they have received members assigned to them by Anthem with effective date after January 2024

        - AAH reached out to DHCS for guidance and clarification and is awaiting feedback
    - DHCS Bi-weekly monitoring and oversight reporting began on November 22nd and will continue throughout 2024
        - The latest report was submitted on February 28th; the next report will be due on April 3rd
        - DHCS continues to request additional information on our network outreach and contracting efforts
    - The Member Sampling Report is a new DHCS deliverable AAH will complete monthly to demonstrate adequate use of the data received from DHCS and Anthem, particularly to monitor CoC efforts for the Special Populations
        - The February report was completed on February 13th; the next report will be due on March 8th
- Business Continuity Plan - required as part of our 2024 Operational Readiness:
    - Disaster Recovery Plan
        - Included in the overall Business Continuity Plan (BCP)
        - Development of the Disaster Recovery Plan is complete
    - Engagement with BCP Consultant – Quest
    - Quest is working with AAH business areas on the completion of the BCP Questionnaire
    - Go Live date was extended from March 1st, 2024, to March 31st
- Memorandums of Understanding (MOUs) with Third Parties - required as part of our 2024 Operational Readiness (OR):
    - MOUs associated with OR requirements were submitted to DHCS on December 29th
    - DHCS has published seven (7) final DHCS MOU templates; one (1) MOU template for Women, Infant, and Children (WIC) is pending from DHCS
    - Two (2) MOUs have been moved from 12/29/2023 to 7/1/2024
        - Drug Medi-Cal/DMC-ODS MOU – Alcohol and Substance Use Disorder (SUD) treatment.
        - LGA MOU – Targeted Case Management (TCM)
    - MOU Quarterly Report
        - Next submission is due April 30, 2024, for reporting period Q1 January 2024 thru March 31, 2024

- CYBHI Fee Schedule – Effective January 1st, 2024, the Alliance is partnering with the Alameda County Office of Education (ACOE) to implement the CYBHI Fee Schedule
    - Cohort 1 is intended to be a “learning” cohort
    - DHCS is holding a series of meetings with Cohort participants; the first session was held on 2/22/2024
    - AAH’s Behavioral Health Leadership is meeting with ACOE Leadership to discuss the Third Party Administrator (TPA) usage

Recruiting and Staffing

Integrated Planning Open position(s):

- Recruitment for new positions effective February 2024 – pending
- Backfill for Business Analyst – Integrated Planning

Integrated Planning

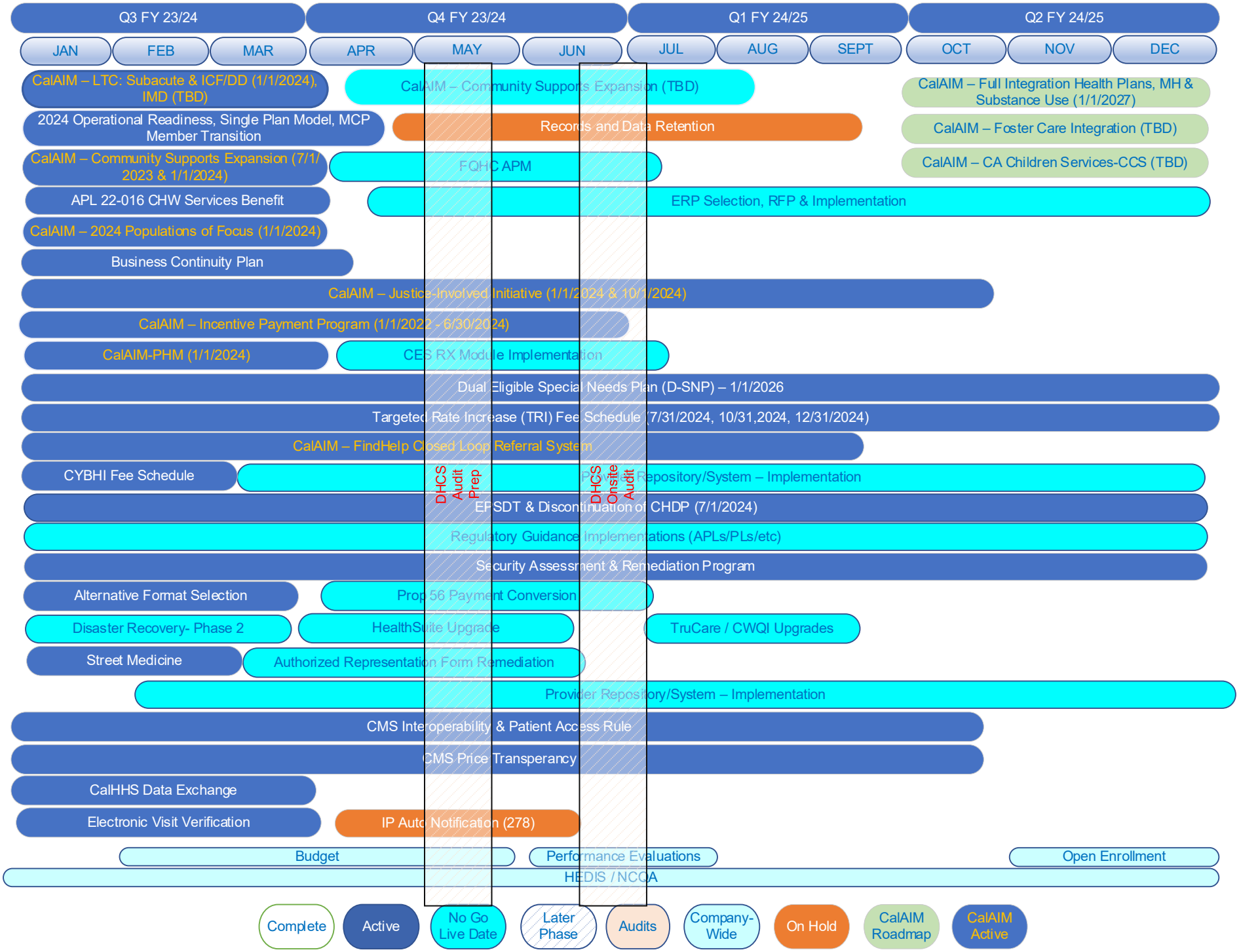
Supporting Documents

Project Descriptions

Key projects currently in-flight:

- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs
  - Enhanced Care Management (ECM) – ECM will target eight (8) specific populations of vulnerable and high-risk children and adults
    - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022
    - Two (2) additional PoF became effective on January 1st, 2023
    - One (1) PoF became effective on July 1st, 2023
    - Two (2) PoF will become effective on January 1st, 2024
  - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays
    - As of January 1st, 2024, AAH will offer twelve (12) of the fourteen (14) DHCS-designated CS services
      - January 1st, 2022 – Six (6) Community Supports were implemented
      - July 1st, 2023 – Three (3) additional CS services went live
      - January 1st, 2024
        - Two (2) CS services that support the LTC PoFs that were effective January 2023 are being piloted in 7/1-12/31/2023 and will go live in January
        - One (1) additional CS service is also targeted for implementation in July 2024
  - Long Term Care - benefit was carved into all MCPs effective January 1st, 2023, with the exception of Subacute and ICF-DD facilities which are scheduled for implementation January 1st, 2024; IMD facilities implementation date TBD
  - Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
    - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
      - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024
      - MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by October 1st, 2024
      - Correctional facilities will have two years from 10/1/2024-9/30/2026 to go live based on readiness
  - Population Health Management (PHM) – all Medi-Cal managed care plans were required to develop and maintain a whole system, person-centered population health management strategy effective January 1st, 2023. PHM is a comprehensive, accountable plan of action for addressing Member needs and preferences, and building on their strengths and resiliencies across the continuum of care that:
    - Builds trust and meaningfully engages with Members

        - Gathers, shares, and assesses timely and accurate data on Member preferences and needs to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes
        - Addresses upstream factors that link to public health and social services
        - Supports all Members staying healthy
        - Provides care management for Members at higher risk of poor outcomes
        - Provides transitional care services for Members transferring from one setting or level of care to another; and
        - Identifies and mitigates social drivers of health to reduce disparities
    - Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 in order to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary
- Community Health Worker Services Benefit – Community Health Worker (CHW) services became a billable Medi-Cal benefit effective July 1st, 2022. CHW services are covered as preventive services on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law for individuals who need such services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being
- 2024 Single Plan Model
    - 2024 Managed Care Plan Contract Operational Readiness – new MCP contract developed as part of Procurement RFP; all MCPs must adhere to new contract effective January 1st, 2024
        - Business Continuity Plan required as part of Operational Readiness
        - MOUs with third parties required as part of Operational Readiness
    - MCP Member Transition
        - Anthem members will transition to AAH effective January 1st, 2024
        - Members currently delegated to Kaiser will transition to Kaiser as part of their direct contract with DHCS effective January 1st, 2024
- CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed and a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site. CYBHI requires commercial health plans and the Medi-Cal delivery system, as applicable, to reimburse, at or above the published rates, these school-linked providers, regardless of network provider status, for services furnished to students pursuant to the fee schedule. Effective January 1st, 2024, the Alliance is partnering with the Alameda County Office of Education (ACOE) and several Local Education Agencies (LEAs) who were selected to participate in the CYBHI Fee Schedule Cohort 1.


Q3 FY 23/24
Q4 FY 23/24
Q1 FY 24/25
Q2 FY 24/25
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEPT
OCT
NOV
DEC
CalAIM – LTC: Subacute & ICF/DD (1/1/2024), IMD (TBD)
CalAIM – Community Supports Expansion (TBD)
CalAIM – Full Integration Health Plans, MH & Substance Use (1/1/2027)
2024 Operational Readiness, Single Plan Model, MCP Member Transition
Records and Data Retention
CalAIM – Foster Care Integration (TBD)
CalAIM – Community Supports Expansion (7/1/2023 & 1/1/2024)
FQHC APM
CalAIM – CA Children Services-CCS (TBD)
APL 22-016 CHW Services Benefit
ERP Selection, RFP & Implementation
CalAIM – 2024 Populations of Focus (1/1/2024)
Business Continuity Plan
CalAIM – Justice-Involved Initiative (1/1/2024 & 10/1/2024)
CalAIM – Incentive Payment Program (1/1/2022 - 6/30/2024)
CalAIM-PHM (1/1/2024)
CES RX Module Implementation
Dual Eligible Special Needs Plan (D-SNP) – 1/1/2026
Targeted Rate Increase (TRI) Fee Schedule (7/31/2024, 10/31,2024, 12/31/2024)
CalAIM – FindHelp Closed Loop Referral System
CYBHI Fee Schedule
Provider Repository/System – Implementation
DHCS Audit Prep
DHCS Onsite Audit
EPSDT & Discontinuation of CHDP (7/1/2024)
Regulatory Guidance Implementations (APLs/PLs/etc)
Security Assessment & Remediation Program
Alternative Format Selection
Prop 56 Payment Conversion
Disaster Recovery- Phase 2
HealthSuite Upgrade
TruCare / CWQI Upgrades
Street Medicine
Authorized Representation Form Remediation
Provider Repository/System – Implementation
CMS Interoperability & Patient Access Rule
CMS Price Transperancy
CalHHS Data Exchange
Electronic Visit Verification
IP Auto Notification (278)
Budget
Performance Evaluations
Open Enrollment
HEDIS / NCQA
Complete
Active
No Go Live Date
Later Phase
Audits
Company-Wide
On Hold
CalAIM Roadmap
CalAIM Active

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

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

Date: **March 8th, 2024**

Subject: **Incentives & Reporting Board Report – February 2024 Activities**

Current Incentive Programs

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

- For Program Year 1 (1/1/2022 - 12/31/2022):
  - AAH was allocated $14.8M and earned 100% of the allocated funds
  - AAH distributed funding to ten (10) providers and organizations to support the ECM and CS programs
- For Program Year 2 (1/1/2023 - 12/31/2023):
  - AAH was allocated $15.1M for potential earnable dollars
  - AAH was notified by DHCS in November that it earned 60% of earnable dollars based on the Submission 3 report
  - AAH is still awaiting the release of Payment 3
  - AAH has distributed funding to twelve (12) providers and organizations to support the ECM and CS programs
- Work has begun on the Submission 4 report, reflecting the lookback period of 7/1/2023-12/31/2023; this report is due to DHCS on March 1st, 2024
- AAH is currently reviewing the Wave 4 IPP Provider Applications

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

- The second Bi-Quarterly Report (BQR) for the measurement period of July – December 2023, was submitted to DHCS on December 21st, 2023; if approved by DHCS, payment in the amount of $1.1M (100% of eligible funds) is expected in April 2024
- Partner meetings continued with Local Education Agencies (LEAs) regarding project plan activities for successful completion of the milestones
- The Alameda County SBHIP Steering Group became a part of an Alameda County Office of Education (ACOE) and Alameda County Center for Healthy Schools and Communities (CHSC) led School Health Steering Committee, which includes the Alliance, Kaiser, and Alameda County Behavioral Health
- CHSC is partnering with the Alliance through SBHIP to support LEAs through monthly Professional Learning Communities, through the development and coordination of resources (i.e., Coordination of Services Team (COST) toolkit, School-Based Behavioral Health framework, culturally appropriate resources, and Crisis Protocols), and through analysis of current behavioral based workforce

- ACOE is partnering with the Alliance through SBHIP to build infrastructure to sustain program activities post-SBHIP through regularly scheduled Learning Exchanges and Office Hour sessions
- To-date, $6.3M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $5.5M has paid to LEA and SBHIP partners

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

- The Submission 2 (S2) Report for reporting period January – October 2023 was submitted to DHCS on December 27th, and payment for earned dollars is expected from DHCS in March/April 2024
    - DHCS requested clarification on three (3) measures for the S2 report on February 21st and the request was fulfilled the same day
- To-date, $20.4M has been awarded to the Alliance by DHCS and a total of $17.6M has been paid to HHIP partners
- HCSA continues to complete deliverables and milestones outlined in the December 2022 MOU:
    - To date, HCSA has completed deliverables related to:
        - HHIP data reporting
        - Housing Financial Supports Progress Report
        - Street Medicine Data and Program Model as well as Contracting recommendations
        - 2023 Q1 and Q2 Housing Community Supports Capacity Building progress reports
        - Housing Community Supports Legal Services Pilot grant agreement execution with a legal services provider, hiring of 1.0 FTE staff attorney, and completion of progress report(s)
        - An executed contract with a Data Reporting firm and Project Manager for the 2024 Point-in-Time (PIT) Count
    - As of February 29th, $12.8M in total payments has been paid to HCSA for HHIP milestone completion
- Internal and external workgroup meetings continue to plan for and implement initiatives related to HHIP program goals, which includes:
    - A new opportunity available to SBHIP LEAs to address the challenge of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.); SBHIP LEAs were notified of the opportunity on February 6th and informational and listening sessions will be held in March
    - Development of an application process to increase partnerships within the community to support HHIP program goals of reducing and preventing homelessness; funds available to applicants will be dependent on dollars earned from the S2 report

Equity and Practice Transformation (EPT) Payments Program – DHCS is implementing a one-time $700M primary care provider practice transformation program called the Equity and Practice Transformation (EPT) Payments Program. The five-year program is designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment models.

- A total of 14 program applications were submitted to DHCS on October 23rd, 2023, with the Alliance as the selected MCP
- AAH evaluated all 14 applications (6 are considered as small/medium sized practices) according to DHCS criteria and submitted scored applications to DHCS on November 21st, 2023
- DHCS made final decisions on practices selected for program participation on January 12th, 2024, and only one of the 14 AAH practices was selected by DHCS to participate in the EPT Provider Directed Payments Program
    - A total of 719 practices statewide submitted an application, and 211 were selected by DHCS to participate in the program
    - DHCS did not commit all dollars originally allocated for the EPT Provider Directed Payments Program and has mentioned the potential for future cohorts
- The MCP Initial Planning Incentive Payment Program milestone submission, specific to activities associated with small/medium sized practices, was due to DHCS on January 19th, 2024, and was submitted January 4th, 2024
    - DHCS has not indicated the amount of the incentive payment or the date it will be paid to MCPs

New Programs in Development

The Community Reinvestment Program is designed to strengthen existing and new partnerships with community-based organizations and help build capacity to best serve Alliance Medi-Cal members. The Alliance has allocated funding over the next two (2) years to support new and innovative approaches focused on vulnerable populations and addressing health disparities. Priority initiatives include:

- HEDIS
- Access to care
- Social determinants of health
- Complex case management, including populations of focus
- Behavioral health

The Alliance is currently working to develop program materials, including provider-facing program overview documents, application materials, evaluation criteria, governance structure, and policy and procedures. A Board designee(s) will provide final approval of applications selected for funding; the program is anticipated to launch April 1st, 2024.

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

- Expanding the Alameda Alliance Provider network by approximately 10 to 15 providers a year

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

The Alliance is currently working to develop program materials, including provider-facing program overview documents, application materials, evaluation criteria, governance structure, and policy and procedures. A Board designee(s) will provide final approval of applications selected for funding; the program is anticipated to launch April 1st, 2024.

Recruiting and Staffing

Incentives & Reporting Open position(s):

- There are no open positions at this time

Incentive Program Descriptions

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

- Build appropriate and sustainable ECM and ILOS capacity
- Drive MCP investment in necessary delivery system infrastructure
- Incentivize MCP take-up of ILOS
- Bridge current silos across physical and behavioral health care service delivery
- Reduce health disparities and promote health equity
- Achieve improvements in quality performance

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

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

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

Equity and Practice Transformation (EPT) Payments Program – new program released by DHCS in August 2023 and is a one-time $700M primary care provider practice transformation program designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment models

- EPT is for primary care practices, including Family Medicine, Internal Medicine, Pediatrics, Primary Care 0B/GYN, and/or Behavioral Health in an integrated primary care setting
- Medi-Cal Managed Care Plan (MCP) Initial Provider Planning Incentive Payments
    - $25 million over one (1) year to incentivize MCPs to identify and work with small- to medium-sized independent practices as they develop practice transformation plans and applications to the larger EPT Provider Directed Payment Program
- EPT Provider Directed Payment Program
    - $650 million over five (5) years to support delivery system transformation, specifically targeting primary care practices that provide primary care pediatrics, family medicine, internal medicine, primary care OB/GYN services, or behavioral health services that are integrated in a primary care setting to Medi-Cal members; $200 million of the $650 million will be dedicated to preparing practices for value-based care

- The Statewide Learning Collaborative
  - $25 million over five (5) years to support participants in the Provider Directed Payment Program in implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of stated quality and equity goal

Compliance

Richard Golfin III

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

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

Date: **March 8th, 2024**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2024 DHCS Routine Medical Survey:
    - The DHCS has confirmed that this year's audit is scheduled for June 2024. The virtual interview sessions are scheduled to be conducted from June 17th, 2024- through June 28th, 2024. The Plan is expecting to receive the formal audit notification letter around the week of March 11th, 2024. The lookback period is expected to cover April 1st, 2023, through March 31st, 2024, and include the following areas:

        Routine Survey:
        - Utilization Management.
        - Case Management & Care Coordination.
        - Access & Availability;
        - Member's Rights & Responsibilities;
        - Quality Improvement System, and;
        - Organization and Administration
        - Transportation
        - Behavioral Health

    - 2024 Plan Mock Audits: The Compliance Division will hold Mock audit interviews with the subject matter experts (SMEs) in preparation for the 2024 DHCS Audit. The Mock audits are scheduled from April 22nd, 2024, through May 3rd, 2024 and will cover all sections of the DHCS audit.

- 2023 DHCS Routine Medical Survey:
    - The onsite virtual interview took place from April 17th, 2023, through April 28th, 2023. There were 15 findings and 4 identified repeat findings. The Plan submitted its Corrective Action Plan to the Department on November 22nd, 2023.
    - Internal meetings have been held with stakeholders to review CAP plans and implementation efforts to eliminate repeat findings and lower the number of overall deficiencies year-over-year.

- DHCS is requesting a monthly update of the CAP progress. The January update was submitted on January 18th, 2024. The Plan received the DHCS response to the January update on February 12th, 2024. The DHCS has additional questions for 8 out of the 15 findings. The Plan submitted the February update timely on February 26th, 2024.

- 2022 DMHC Behavioral Health Investigation
  - The Plan received Final Audit Findings for the 2022 DMHC Behavioral Health Investigation (BHI). The audit focused on the Plan's mental health and substance use disorder services. The 2022 BHI audit concluded that the Plan violated 2-provisions of the Knox-Keene Act in the areas of:

    1. Utilization Management: The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855)

    2. Quality Assurance: The Plan does not ensure its delegate consistently documents quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.

  - The Department also found the Plan to have unaddressed barriers to care in Pharmacy Services, Cultural Competency, Health Equity and Enrollee Experience. Internal Audit will add the Barriers to Care to the Internal Audit Plan, where they will be risk assessed to determine the best approach and timeframe for auditing. The Plan submitted its Corrective Action Plan on February 4th , 2024.

Compliance Activity Updates

- DMHC Material Modification – 2024 RFP Readiness Submission
  - The Plan developed policies and procedures for Operational Readiness, as well as future financial projections. The prepared documents demonstrate to the agency how an increase in membership will affect the Plan from a financial perspective.
  - The DMHC provided comments to Filing #20234323 on January 9th, 2024, to which the Plan provided responses on February 7th, 2024. Thus far, the DMHC has not made comments related to the Financial Exhibits.

- 2023 Annual Corporate Compliance Training
  - Annual Corporate Compliance Training was assigned on September 11th, 2023. Currently, 100% of staff have completed the training. The Annual Training covered the following areas:

    - Health Insurance Portability and Accountability Act (HIPAA)
    - Fraud, Waste, and Abuse
    - Cultural Competence and Sensitivity Training

- DHCS Annual Network Certification
  - 2023 Annual Subcontractor Network Certification (SNC) was submitted to DHCS on January 5th, 2023. Phase one of the 2023 Annual Network Certification (ANC) was submitted on February 1st, 2024. Per DHCS' request the Alliance submitted additional information on February 22nd, 2024. Instructions for Phase Two were released on February 26th, 2024, with a due date of March 25th ,2024. The Plan is preparing its strategy to complete Phase Two.

- Behavioral Health Insourcing:
  - The Alliance received approval from the Department of Managed Health Care (DMHC). The DMHC's approval was subject to and conditioned upon the Alliance's full performance of eight Undertakings to the Department's satisfaction.

Undertaking Compliance Chart			
Undertaking #	**Deliverable**	**Next Milestone**	**Progress**
No. 6	Submit electronically an Amendment filing to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") (42 USC § 300 gg-26) and its regulations (45 CFR § 146.136) and Section 1374.76 of the Act.	March 4, 2024	The Plan received extensive comments (E-filing No. 20233231) to which the Plan responded on January 30th,2024. On February 29th, DMHC informed the Plan to expect additional comments on or around March 4th, 2024.

Compliance

Supporting Documents

COMPLIANCE DASHBOARD SUMMARY										
	Resource	Type							TOTAL	% Completed
			2018	2019	2020	2021	2022	2023		
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	15	136	
		Total Self-Identified Issues	12	0	0	2	0	2	16	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**17**	**152**	
		Total In Progress	0	0	0	0	0	3	3	
		Total Completed	50	28	7	35	15	14	149	**98%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**17**	**152**	
	DMHC	Total State Audit Findings			5	6	8		19	
		Total Self-Identified Issues			3	0	0		3	
		Total Findings			**8**	**6**	**8**		**22**	
		Total In Progress			0	0	1		1	
		Total Completed			8	6	7		21	**95%**
		Total Findings	**NA**	**NA**	**8**	**6**	**8**	**NA**	**22**	
	DMHC Financial Services	Total State Audit Findings		5			4		9	
		Total Self-Identified Issues		0			0		0	
		Total Findings		**5**			**4**		**9**	
		Total In Progress		0			0		0	
		Total Completed		5			4		9	**100%**
		Total Findings	**NA**	**5**	**NA**	**NA**	**4**	**NA**	**9**	
STATE AUDIT FINDINGS		In Progress	0	0	0	0	1	3	4	
		Completed	38	33	12	39	26	12	160	**98%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**15**	**164**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	0	
		Completed	12	0	3	2	0	2	19	**100%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**19**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**17**	**183**	

COMPLIANCE DASHBOARD SUMMARY			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	164	90%
	Total Self-Identified Issues	19	10%
	Total Findings	**183**	
	Total In Progress	4	2%
	Total Completed	179	98%
	Total Findings	**183**	
STATE AUDIT FINDINGS	In Progress	4	2%
	Completed	160	98%
	Total Findings	**164**	
SELF-IDENTIFIED FINDINGS	In Progress	0	0%
	Completed	19	100%
	Total Findings	**19**	

2023 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	15	88%
	Total Self-Identified Issues	2	12%
	Total Findings	**17**	
	Total In Progress	3	18%
	Total Completed	14	82%
	Total Findings	**17**	

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

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

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

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

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

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

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

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

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

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
Yellow = Plan Observations (Included in the Preliminary Report)
Orange = Plan Observations (Not Included in the Preliminary Report)
R = Repeat Findings

2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
1	UM	(1.5.1) Notice of Action (NOA) Letters The Plan did not ensure a delegate sent NOA letters to providers and members.	The Plan received CHCN's Root Cause Analysis (RCA) and CAP on 04/14/2023. After review and evaluation of CHCN's document the Plan issued a formal CAP to CHCN on 05/31/2023 and received CHCN's CAP response on 06/27/2023. The initial corrective actions completed by CHCN includes updating their IT script and ensuring the identified missing NOA letters were sent out to the members and that outreach was completed to confirm that services approved or had denial modification authorizations were utilized by members. CHCN also developed workflows to detect and mitigate failures. The CAP includes CHCN's implementation of a remediation plan. The remediation plan includes updates in their workflow, training, and an internal monthly audit- with results submitted to AAH for review. The Plan reviewed and evaluated CHCN's CAP implementation and progress during the interim and provided guidance. The CAP was approved and closed on 09/25/2023. (Completed) CHCN is expected to continue its internal monthly audit for the NOA letters and fax confirmation. The Plan will continue to monitor the audit results for compliance. Please see document 1.5.1_AAH Response for full details. (On Track) Additionally, the Plan will review the UM delegates' P&P's to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation and these will be evaluated annually at minimum. (On Track) 1a. Monitoring of CHCN's monthly internal audit is ongoing. (On Track) 2. Review the UM delegates' policies and procedures to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation. (On Track) **Update 3/8/2024** CHCN P&P review complete and P&P deemed adequate. Review of CFMG P&P regarding NOAs is ongoing and AAH will continue to meet with CFMG to have P&P appropriately updated	In Progress	Closed 9/25/2023 Closed 8/31/2023 3/31/2024	Compliance UM	State	DHCS	2023
2	QI	(2.1.1) Provision of an Initial Health Assessment (IHA) The Plan did not ensure the provision of a complete IHA for new members.	1. Update IHA policy 124 (On Track) 1a. Update IHA policy 124 to include requirement regarding outreach attempts (On Track) 2. Provider education and feedback through Joint Operational Meetings (On going) 2a. Deliver provider education webinars with information about IHA requirements (On Track) 2b. Develop a "Measure Highlights" tool for providers. This tool will encompass outreach requirements, IHA elements, USPSTF screenings, and claim codes used to account for IHA completion 3. Expand code set to include additional codes for capturing IHA-related activities (On Track) **Update 3/8/2024**: Codes updated and included in policy QI-124. 3a. Communicate and provide code sets to providers (On Track) 4. Monitor IHA rates (Ongoing) 5. Enhance the volume of medical records subjected to review for completeness, including review of USPSTF requirements. (On Track)	In Progress	3/30/2024 3/30/2024 3/30/2024 3/30/2024 Completed **Completed 2/28/2024** 3/30/2024 3/30/2024 Completed 12/31/2023	Quality	State	DHCS	2023

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
Yellow = Plan Observations (Included in the Preliminary Report)
Orange = Plan Observations (Not Included in the Preliminary Report)
R = Repeat Findings

2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	**Department Responsible**	**State/Self Identified**	**Agency**	**Year**
3	BHT	(2.3.1) Behavioral Health Treatment (BHT) Plan Elements The Plan did not ensure members' BHT treatment plans contained all the required elements.	1. The Behavioral Heath team developed the attached Treatment Plan Guidelines for our ABA Providers (please see attachment). This document outlines the treatment plan elements that are listed in APL 23-010. All treatment plans and prior-authorization requests for ABA services are reviewed by Board Certified Behavior Analysts (BCBA).The guidelines were emailed to all providers and will also be available on-line for providers to access. In addition to the document, the ABA clinicians worked with the Provider communication team to send out updates/reminders to providers regarding the treatment plan guidelines. Our team is also available to meet with providers and educate them on how to apply the guidelines to their treatment plan templates. (Completed) 1a. Pending Project: We are currently developing an on-line treatment plan template/form that will be utilized by our ABA providers when completing the initial assessment and subsequent progress reports. This form includes the treatment plan elements required in APL 23-010 and providers will be required to complete this form when submitting the initial assessment/FBA and subsequent progress reports. This will ensure that all ABA providers use the same template and include the required elements in their reports/assessments. (On Track) In the interim while the project is pending, if information is missing from the Treatment Plan, the Plan will inform the provider and ask that they add the information and re-submit. 1b. The Plan intends to conduct audits on our Treatment Review documentation to ensure that all required elements are covered in the review process in compliance with the requirements in the APL. The expected implementation date of this audit is Q1 of 2024. (On Track) 1c. The Provider/PCP Manual is also pending updates that will include a FAQ for PCPs, provider education regarding the prior authorization process, and the referral process. This is currently under review-pending completion. (On Track)	In Progress	4/1/2023 Q1 2024 Audit Q1 2024 Q1 2024 Q1 2024	Behavioral Health	State	DHCS	2023
4	Access and Availability	(3.1.1) First Prenatal Visit The Plan's policies and procedures for a first prenatal visit for a pregnant member is not compliant with the standard of two weeks upon request.	The Plan has edited Timely Access Standard table, policy QI-107 and QI-114 to reflect the first prenatal visit standard within 2 weeks of the request. (Completed)	Q4 2023	Completed	Quality	State	DHCS	2023
5	Family Planning and State Supported Services	(3.6.1) Non-contracted Provider Payments The Plan did not pay non-contracted providers at the appropriate Medi-Cal fee-for-service rate.	A Change Request was entered to change non-contract mid-level providers reimbursements to 100% of the Medi-Cal rate moving forward. (Completed)	11/16/2023	Completed	Claims	State	DHCS	2023
6	Family Planning and State Supported Services	(3.6.2) Proposition 56 Family Planning Payments The Plan did not distribute add-on payments for institutional family planning service claims as required by APL 22-011.	1. P&P has been revised to ensure that Family Planning services paid on institutional claims are paid As part of Prop 56 payments. 1a. The Plan's Analytics Team is in the midst of preparing the payment details for the retro payment on the FP institutional data and looking to complete by 11/30/2023 timeline. (On Track) 2. The Analytics dept has calculated the retroactive payments due to facilities as a result of finding 3.6.2, APL 22-011 and APL 23-008. (On Track) 2a. Payments will be distributed to providers prior to or latest by Nov 30, 2023. (On Track) 2b. Facility providers with qualifying Family Planning services as per APL 23-008 will be included as part of our monthly Prop 56 payment processing going forward starting Dec 2023. (On Track)	**1/15/2024**	**Completed**	Claims	State	DHCS	2023

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
Yellow = Plan Observations (Included in the Preliminary Report)
Orange = Plan Observations (Not Included in the Preliminary Report)
R = Repeat Findings

2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
7	NMT & NEMT	(3.8.1) **R** Physician Certificate Statement (PCS) Forms The Plan did not ensure PCS forms were on file for members receiving NEMT services.	1.The Plan made the decision to no longer allow courtesy NEMT trips for members without a PCS form on file and the decision to insource PCS form acquisition to the Plan's Case Management Department beginning 3/1/23. Working alongside the Plan's transportation subcontractor, ModivCare, the Plan created new workflows to ensure ModivCare was not scheduling NEMT trips for members unless there was a confirmed valid PCS form on file, or the Plan provided a verbal authorization due to a trip being of an urgent nature. The Plan hired two transportation coordinators to focus on PCS acquisition leveraging the Plan's preexisting relationships with the provider network and access to EHR's. Through the end of 2022 and beginning of 2023, the Plan's subcontractor, ModivCare, trained its call center agents on the new workflow. On 2/14/23, the Plan trained its transportation coordinators on PCS acquisition. On 2/21/23, the Plan trained its entire case management team, that participates in phone shifts for the Plan's case management phone line, on the parameters for verbal authorizations for NEMT trips of an urgent nature. The Plan continues to report on the success of the new workflows at the Plan's UM Committee. (On Track) 1a.The Plan is working with its analytics team to create a report using PCS data elements to match up against subcontractor's report of all NEMT trips taken each month. This report will assist in finding any gaps in PCS compliance. The Plan estimates this report to go live 12/1/2023. (On Track)	**12/15/2023**	**Completed**	Case Management	State	DHCS	2023
8	NMT & NEMT	(3.8.2) Transportation Providers' Medi-Cal Enrollment Status The Plan did not ensure all transportation providers were enrolled in the Medi-Cal program.	The Plan has updated the P&P VMG-005 from reviewing the Transportation Providers (TP) on a quarterly review to a monthly review. Attached for reference is the updated P&P. The Plan began reviewing the TP monthly for the utilization from April 2023 to current. (Completed and Ongoing)	4/1/2023	Completed	Vendor Management	State	DHCS	2023
9	Member Rights	(4.1.1) **R** Grievance Acknowledgement and Resolution Letter Timeframes The Plan did not send acknowledgement and resolution letters within the required timeframes.	A grievance processing timeline was created to outline the grievance 30 calendar day process, day by day. The timeline outlines that by day 5, acknowledgement letters will be sent out. We will continue to monitor the daily aging report to ensure that acknowledgement letters are sent in a timely manner. The timeline also outlines that on Day 20, "If response is not received, after at least two follow-up attempts, task to a Medical Director in Quality Suite." Complying with this process will ensure that the Medical Director has sufficient time to reach out to the provider or facility to assist in obtaining a response. The Grievance and Appeals staff were trained on the new timeline on 08/01/2023, copies of the timeline were distributed to the department. (Completed and Ongoing)	8/1/2023	Completed	G&A	State	DHCS	2023

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
Yellow = Plan Observations (Included in the Preliminary Report)
Orange = Plan Observations (Not Included in the Preliminary Report)
R = Repeat Findings

2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
10	Member Rights	(4.1.2) R Grievance Letters in Threshold Languages The Plan did not send acknowledgement, resolution delay, and resolution letters in threshold languages.	The Plan's Grievance and Appeals Department has created a reporting mechanism in our daily aging reports to monitor what cases are still pending translation and when was the request for translation sent out, this was implemented on 04/12/2023. We have then assigned one specific team member to be responsible for following up on translation letters to ensure that they are getting the attention that they need to be completed in a timely manner. The Grievance Processing Timeline will be updated to include when a request for translation needs to be sent out and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted on 10/10/2023. (Completed and ongoing)	10/10/2023	Completed	G&A	State	DHCS	2023
11	Member Rights	(4.1.3) R Written Notification of Grievance Resolution Delays The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days and did not resolve grievances by the estimated resolution date in the delay letters.	The Plan's Grievance and Appeals Department will be updating our system, Quality Suite, to better capture data on if and/or when a delay letter is sent out. Once the system is updated, we will be able to create a reporting mechanism in our daily aging reports to monitor for when a case needs a delay letter and if the letter was sent out. The Grievance Processing Timeline will also be updated to include the process for sending out a delay letter and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted. (Completed and Ongoing)	12/1/2023	Completed	G&A	State	DHCS	2023
12	Member Rights	(4.1.4) Grievance Delay Timeframes The Plan inappropriately utilized a 14 calendar day delay timeframe for grievance resolutions.	In review of our current policy and procedures, and workflows; they were in line with the APL requirements. There was miscommunication in the staff training to use 14 calendar days instead of an estimated resolution date in the delay letters. There was a refresher training for the Grievance and Appeals staff held on 04/18/2023, the staff was provided the requirement and were reminded to provide an estimated resolution date in the delay letters if a resolution is not reached within 30 calendar days. (Completed)	4/18/2023	Completed	G&A	State	DHCS	2023
13	Member Rights	(4.1.5) Exempt Grievance Resolution The Plan did not resolve exempt grievances by close of the next business day.	In conjunction with the Grievance Department, the Member Services Grievance Guide was revised on 10/9/23. (Completed) Training was provided to all Member Services staff on these revisions by 11/1/23. (Completed)	11/1/2023	Completed	Member Services	State	DHCS	2023
14	Member Rights	(4.1.6) Grievance Identification The Plan did not process and resolve all member expressions of dissatisfaction as grievances.	Member Services has implemented a process to identify expressions of dissatisfaction that were not classified appropriately. (Completed) A Member Services Supervisor works with the agent to ensure the case is classified accurately and resolved in a timely manner. (Completed)	3/15/2023	Completed	Member Services	State	DHCS	2023
15	State Supported Services	(SSS.1) Minimum Proposition 56 Payments The Plan did not distribute minimum payments for a State Supported Services claim as described in APL 19-013.	The claims system configuration team has corrected the fee schedule for the provider and adjusted the impacted claims to pay the correct rate. (Completed)	4/26/2023	Completed	Claims	State	DHCS	2023
16	CM	(2.2) PCP and members are not consistently notified of Case Management case closures	Configuration made in TruCare to ensure consistent notification	4/26/2023	Completed	Case Management	Self	DHCS	2023
17	Fraud and Abuse	(6.2) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness Training provided to staff and new tools being used consistently	4/26/2023	Completed	Compliance	Self	DHCS	2023

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY	
Yellow = Plan Observations (Included in the Preliminary Report)	
Orange = Plan Observations (Not Included in the Preliminary Report)	
R = Repeat Findings	

2022 DMHC Behavioral Health Investigation - ***Audit Review Period*** **4/1/2020 - 4/30/2022**
Audit Onsite Dates - September 7, 2022 - September 8, 2022

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
1	UM	The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855)	Alameda Alliance for Health (Alliance) reviews and/or updates all policy and procedures at least annually, to ensure our policy and procedures content is reflective of current regulatory requirements. All UM policy and procedures including any updates and the UM Program Description, are reviewed in the Utilization Management Committee (UMC), subsequently reviewed, and approved at our Board Delegated Quality Improvement Health Equity Committee (QIHEC) which reports directly to the Alliance Board of Governors. In response and in compliance with SB 855, the Alliance has updated UM-063 - Gender Affirmation Surgery and Transgender Services and the Alliance UM Program Description. Both bodies of work are aligned with current WPATH Standards of Care. The Alliance is contracted with WPATH to provide training on WPATH Standards of Care - all UM decision makers (including RNs and physicians) are required to complete WPATH training to ensure the most current WPATH standards required by SB 855 are used for medical necessity decision-making. 100% of current UM reviewers will complete WPATH Training by Q2 2024 & 100% of newly hired UM reviewers will complete WPATH Training within 90 days of their start date The Alliance also conducts annual Inter-Rater Reliability Studies (IRR) with all UM decision makers to ensure that documented criteria is being applied consistently and accurately by decision makers. Additional training and testing is conducted when a passing score is not met. Annual IRR: 100% of UM reviewers will complete the Annual IRR Studies by Q3 2024	In Progress	Closed 9/27/2022 Q2 2024 Q3 2024	UM Behavioral Health	State	DMHC	2022
2	Quality Assurance	The Plan does not ensure its delegate consistently documents quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.	As of April 1, 2023, Alameda Alliance for Health (AAH) has terminated its contract with Beacon Health Options. Since termination, the Alliance has insourced all mental and behavioral health services and processes all quality of care issues identified. The Alliance follows its internal policy and procedures and workflows to ensure that all quality of care problems are identified, reviewed and further, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.	4/1/2023	Completed	UM Quality Assurance Behavioral Health Compliance	State	DMHC	2022

#	Category	Barriers to Care	Plan Response	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
1	Pharmacy Services	The Plan has limited ability to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy and lacks policies and procedures for these treatments.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	UM Behavioral Health Pharmacy Provider Contracting	State	DMHC	2022
2	Cultural Competency and Health Equity	Neither the Plan nor its delegate conduct assessments pertaining to cultural competency and health equit specific to the Plan's enrollee population.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	Quality Assurance Behavioral Health	State	DMHC	2022
3	Enrollee Experience	Enrollees experience difficulties obtaining appointments.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	Quality Assurance Behavioral Health	State	DMHC	2022

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

2022 DMHC RBO Audit: CHCN - *Audit Review Period* 1/1/2022 - 3/31/2022							INTERNAL AUDITS			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
1	Claims Payment Accuracy	The Department's examination disclosed that the RBO failed to reimburse one paid claim correctly due to a systematic error. The claims system failed to classify Sutter Bay Medical Foundation as a contracted provider. The claim was paid incorrectly at the non-contracted rate, which was less than the contracted rate. The RBO represented to the Department that this deficiency was due to a contract amendment, effective February 1, 2021, that was not updated in their claims system. This deficiency was noted in paid claims sample number P-18.	CHCN updated claims system to accurately reflect all providers listed on the provider roster as contracted with the effective date of 02/01/2021 to align with the contract amendment. A claims sweep was completed with a lookback to 02/01/2021. All claims previously paid noncontracted were reprocessed as contract and have been paid with any accrued interest and/or penalties associate with each claim reprocessed on 10/12/2022. Evidence of the complete claims audit sweep associated with Alameda Alliance for Health members was sent to Alameda Alliance for Health on 01/19/2023 via secure email. Draft policy was created to ensure provider contracts and rosters are appropriately loaded within CHCN's claims system. Draft policy will be presented to CHCN's Compliance Committee on 03/29/2023 for review and approval. Update 4/14/2023: CHCN Compliance Committee rescheduled to 4/26/2023. The updated policy will be approved at that time. Update 5/12/2023: CHCN approved the policy at their Compliance Committee	5/12/2023	**Completed**	Claims Compliance		State	DMHC	2022
2	Claims Payment Accuracy	The Department's examination disclosed that the RBO failed to reimburse two high dollar claims correctly due to a systematic error. The contracted provider, Contra Costa Oncology, was not paid per contract for laboratory procedures. The RBO stated the laboratory procedures were based on an old boiler plate and should not have been included in the contract. The contract was amended on September 1, 2022. This deficiency was noted in high dollar claims sample numbers HD-18 and HD-24	There were no Alameda Alliance for Health members impacted by this deficiency. Effective 10/12/2022 all claims were reprocessed and paid.	10/12/2022	Completed	Claims Compliance		State	DMHC	2022
3	Incorrect Claim Denials	The Department's examination disclosed that the RBO failed to reimburse one denied claim correctly due to a systematic error. The RBO incorrectly denied claims for podiatric and chiropractic services at federally qualified health centers and rural health clinics. The denial reason instructed the provider to bill "Medi-Cal EDS" when it should have been paid. This deficiency was noted in denied claims sample number D-29.	There were no Alameda Alliance for Health members impacted by this deficiency. Effective 10/12/2022 all claims were reprocessed and paid.	10/12/2022	Completed	Claims Compliance		State	DMHC	2022

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	G&A	(1.3.1) The Plan did not send acknowledgement letters for standard appeals within the required timeframe of five calendar days.	1. The Daily Clerk Report is received daily by Grievance & Appeals Clerks and Leadership. The report will be reviewed by the Grievance & Appeals Leadership team to ensure acknowledgment letters are mailed timely. 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement letters.	10/1/2022	Completed	G&A		State	DHCS	2022
2	G&A	(1.3.2) The Plan did not comply with existing APLs to notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days in addition to the initial 120 days allowed to request a SFH.	1. Your Rights enclosure was updated to reflect enrollees have 240 days to request a State Fair Hearing 2. Policy & Procedure G&A-007 State Hearings has been updated to reflect the member has 240 calendar days to request a State Hearing. The policy will go to committee for review and approval in December. Update 03/10/2022: Plan submitted draft policy G&A-007 State Fair Hearings that reflects current timeframe to request a SFH (240 calendar days) per the PHE. Policy pending internal committee approval. Plan will need to monitor end of PHE in order to revise policy to reflect normal regulatory requirement of 120 calendar days. PHE was extended through 1/11/23. Update 4/14/2023: The updated policy was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022
3	Provider Relations	**R** (1.5.1) The Plan did not ensure that its subcontractors submitted complete ownership and control disclosure information.	1. The Alliance has made updates to its Provider Services Standard Operating Procedure (SOP) – Ownership and Control Disclosure Reviews for Delegates. This includes an additional layer of review from the Alliance Compliance Department when ownership and control forms are received from delegates. The SOP and tracking sheet has been updated. 2. The findings specifically mentioned two (2) forms: • Kaiser who provided the Alliance with the email confirming that the form they submitted to the Alliance is the same form that Kaiser files with DHCS. According to Kaiser, DHCS confirmed acknowledgement of the form from Kaiser with no additional feedback. • Community Health Center Network (CHCN) who does not have a sole owner and provided a list of their leadership team with the FEIN for each of the clinics. The Alliance will notify the impacted delegates of the findings to receive forms that meet requirements by DHCS. 3. The Alliance will collect the new forms starting Q1 2023 Update 03/10/2023: Kaiser has submitted an updated form and CHCN is currently working toward completion of the form for submission to the Plan. Provider Services and Compliance will review to validate all fields are complete once all forms are received Update 4/15/2023: Kaiser form received on 3/2/2023, and two levels of review completed 3/10/2023.	3/10/2023	Completed	Provider Relations		State	DHCS	2022
4	QI	(2.1.1) The Plan did not document attempts to contact members and schedule the IHA	1. The plan will continue to inform members of the IHA through the EOC, welcome letters to all new members, and videos. - In addition, all members are eligible for a new member orientation (including a financial incentive). - Information regarding the IHA will be included in the member newsletter. AAH will initiate a new phone campaign where all new members will receive a phone call encouraging the member to receive an IHA. This phone log will be appropriately documented. The Alliance will create a call script for new member phone calls. 2. The plan will create a report to identify new plan members Update 5/12/2023: Fulfillment Report created to track mailing of member Orientation reports that contain reminder to schedule IHA to new members. Member Orientation Service Request tracking report tracks outreach attempts to members to complete new member orientation, which includes communication about scheduling IHAs 3. The plan will create workflows for informing members of the IHA Update 5/12/2023: Clinical QI Program Coordinator will review IVR reports to determine all new members have received an outreach call.	9/8/2023	Completed	QI		State	DHCS	2022

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
			4. The plan will update the IHA P&P to reflect the updated workflowsUpdate 3/10/2023: Draft policy QI-124 completed, IVR outreach is pending DHCS approval of script. Upon DHCS approval we will continue to develop the process for IVR outreach and develop desktop procedures. Update 4/15/2023: The updated P&P was approved at Compliance Committee 3/21/2023 5. The plan will create a phone call campaign, create a script, and work with the state for approvalUpdate 3/10/2023: Awaiting DHCS approval of script. Update 6/9/2023: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreac attempts via providers, by reviewing documentation as part of FSRs.							
5	CM	**R** (2.5.1) The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.	1. The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with Alameda County Behavioral Health (ACBH) to review redline changes to the MOU. ACBH is currently under review of the redline changes and will notify the Alliance when they can move forward with signing the MOU. ACBH MOU vetting process includes County Board of Supervisor (BOS) approval. Therefore, the Alliance is hoping to execute the MOU by the end of 2022.	12/31/2023	Completed	Provider Relations		State	DHCS	2022
6	Provider Relations	**R** (3.1.1) The Plan did not monitor the network providers' compliance with requirements for when appointments were extended.	1. The Provider Manual was edited to update the requirements, providers were advised in the Quarterly Provider Packet, and AAH Provider Representatives advised providers during PCP visits. Additionally, fax blasts were sent to providers regarding the updated requirements, and the Provider Education document was updated to reflect the requirements. 2. Edit P&P and Quality of Access Workflow to ensure all cases are reviewed by a QI Nurse. If a case is determined to be related to access, QI / A&A staff will review data for ED / Inpatient Stays as a result of delay in appointment. If the member does have an ED / IP Claim, the QI RN will then work the case up as a PQI / Quality of Care. This will be reviewed by the Medical Director and follow the PQI process. Finally, all QOA cases with available MRs will be reviewed to ensure the appropriate provider documentationUpdate 03/10/2023: Policy QI-114 has been updated and is awaiting approval at committeeUpdate 4/14/2023: P&P Q1-114 was approved at Compliance Committee 3/21/2023	3/21/2023	Completed	Provider Relations QI		State	DHCS	2022
7	Claims	(3.6.1) The Plan improperly denied emergency services claims.	1. Case #7 – The claim was paid on 8/11/2021. The vendor was notified of the finding on 5/19/2022 and asked to review their internal process to ensure that codes on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. 2. Case #20 –The vender was notified of the issue on 5/19/2022 and asked to review their internal process to ensure that dates on clams are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. In addition, an edit was enhanced to ensure that the date range order is correct. 3. The claim was paid on 1/5/2022 correctly. The Claims Processor was shown the claim finding for review along with the correct workflow document that shows the correct process to help ensure moving forward this does not occur again. This workflow was also reviewed by the Claim Processor team and training occurred.	10/11/2022	Completed	Claims		State	DHCS	2022

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
8	Access and Availability	**R** (3.8.1) The Plan did not use PCS forms for NEMT services.	1. The Plan will educate providers on PCS requirements. Update 03/10/2023: Provider Alert PCS Form Reminder and Form was sent out to Providers in a fax blast on Tuesday, 12/27/22 2. Refine PCS workflows to meet all regulatory requirements. Update 03/10/2023: Workflow updated 3. The Plan will conduct staff trainings on process workflow changesUpdate 4/15/2023: Training completed 1/31/2023 4. The Plan will ensure that the transportation vendor trains their staff on the PCS process workflow changes. Vendor will provide training materials and sign in sheetsUpdate 4/15/2023: Training completed 1/31/2023 5. The Plan will develop reports on PCS form outcomes using both transportation vendor information and the Plan's process to obtain PCS forms.Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022 6. The Plan will monitor process workflows from the vendor and the Plan to obtain missing PCS forms Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022 7. The Plan will analyze trends in provider practices and provide feedback to providers regarding PCS form requirements. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022, where trends analyzed 8. The plan will evaluate whether to continue having the transportation vendor manage the PCS forms or take the direct management of PCS forms back into the Plan.Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. Will continue to analyze quarterly 9. The Plan will provide a quarterly report to UM CommitteeUpdate 4/15/2023: Reports developed and presented at UM Committee Q4 2022	4/1/2023	Completed	UM		State	DHCS	2022
9	Member Rights	**R** (4.1.1) The Plan did not send acknowledgement and resolution letters within the required timeframes.	1. The G & A Department Leadership and Quality Assurance Specialist will reference the daily reports to ensure the acknowledgment and resolution letters are sent timely 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement and resolution letters. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/20222	Completed	G&A		State	DHCS	2022
10	Member Rights	**R** (4.1.2) The Plan did not send acknowledgement and resolution letters in threshold languages.	1. Updated our system of record to capture the dates the resolution letter was submitted for translation and the date it was mailed to the member 2. The Plan provided training to the Grievance & Appeals staff on the updates made to the system of record. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	9/20/2022	Completed	G&A		State	DHCS	2022
11	Member Rights	(4.1.3) The Plan was not compliant with grievance extension letter timeframes; in some cases, it did not send extension letters for grievances that were not resolved within 30 calendar days and in other cases it did not resolve grievances by the estimated completion date specified in the extension letter	1. The Plan provided training to the Grievance & Appeals staff on the system updates to capture extension letters. 2. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month. 3. Updated Policy & Procedure G&A- 003: Grievance and Appeals, Receipt, Review and Resolution. The policy will be sent to Committee for approval. Update 03/10/2023: Draft policy updated and awaiting approval at committee.Update 4/15/2023: P&P G&A-003 was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
12	Member Rights	**R** (4.1.4) The Plan did not thoroughly investigate and resolve grievances prior to sending resolution letters	1. The Alliance will review resolution letters prior to mailing to the member. 2. The Alliance provided training to the Grievance & Appeals staff to ensure the resolution letter clearly addresses all of the member's concerns 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/2022	Completed	G&A		State	DHCS	2022
13	Member Rights	**R** (4.3.1)The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes.	The Plan has created an interdepartmental team to work in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify HIPAA and FWA incidents and the method for immediate reporting to compliance<u>Update 03/10/2023:</u> Training created and provided to AAH staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022
14	Member Rights	(4.3.2) The Plan did not notify the DHCS Program Contract Manager and DHCS ISO of suspected security incidents or unauthorized disclosure of PHI or PI.	Due to human error, reporting to the three (3) entities at DHCS; DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer was not completed for all possible HIPAA incidents. Reporting Policy CMP-013 has been updated to reflect the current reporting email address for possible HIPAA incidents to DHCS incidents@dhcs.ca.gov . This change was reviewed and approved by the Compliance Committee on 11/23/2021.	11/23/2021	Completed	Compliance		State	DHCS	2022
15	Fraud and Abuse	**R** (6.2.1) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness.<u>Update 03/10/2023:</u> Training created and provided to AAH staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

			2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*					**INTERNAL AUDITS**			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
1	UM	(1.2.1) The Plan did not have appropriate processes to ensure that limitations on speech therapy services would not be imposed. In addition to using Medi-Cal guidelines, the Plan used MCG as its evidence-based criteria to make decisions. MCG criteria dictates the amount of visits that can be approved based on a diagnosis and therefore imposes limits.	1. The Plan developed workflow outlining standard review process for speech therapy Prior Authorization (PA) requests, ensuring that no limitations on speech therapy would be imposed on members under age 21. 2. The Plan will conduct a current staff training on standard process, and include it in new staff training. Update 10/8/2021: Training complete 9/29/2021 3. The Plan will revise 10748 Daily Auth Denial report to incorporate service type to capture PA requests for Speech Therapy. Update 11/12/2021: The report request has been submitted, estimated completion is 11/15/2021. Update 12/10/2021: Report has been created and is being completed weekly. 4. The Plan will monitor PA requests for Speech Therapy on a quarterly basis. Update 11/12/2021: The report request has been submitted, estimated completion is 11/15/2021. Update 12/10/2021: Requests for Speech Therapy are being monitored quarterly. 5. The Plan will report results quarterly to UMC. Update 12/10/2021: The first report will be given to the UMC in January 2022. Update 09/09/2022: Speech therapy is now being tracked on a quarterly basis and was reported out at the Q1 2022 UM Committee	Medium	Q1 2022	Completed	UM		State	DHCS	2021
2	UM	(1.2.2) The Plan did not ensure that a qualified health care professional reviewed dental anesthesia prior authorization requests which includes a review of clinical data. The Plan did not ensure the use of appropriate criteria/guidelines when reviewing dental anesthesia requests.	1. The Plan developed workflow outlining standard review process for dental anesthesia Prior Authorization (PA) requests. 2. The Plan will develop mitigation plan until auto auth programming is removed. Update 10/8/2021: Mitigation plan developed and put into place 9/29/2021 3. The Plan will conduct a staff training on the mitigation plan to identify and use standard UM review process for dental anesthesia (DA) and include it in new staff training. Update 10/8/2021 Training complete 9/29/2021 4. The Plan's UM and IT teams will collaborate to remove DA requests from Auto Authorization programming in TruCare (TC). Update 12/10/2021: DA requests have been removed from Auto Authorization programming in TruCare as of 10/1/2021 5. The Plan will develop a Tracking Report to capture and report on PA requests for Dental Anesthesia. Update 12/10/2021: The quarterly report (03127) Dental General Anesthesia Report will be utilized for monitoring 6. The Plan will monitor PA requests for Dental Anesthesia quarterly. Update 10/14/2022: PA requests for Dental Anesthesia are now being monitored quarterly 7. The Plan will report results quarterly to UMC. Update 10/14/2022: PA requests for Dental Anesthesia are now being tracked on a quarterly basis and was reported out at the Q1 2022 UM Committee	High	Q1 2022	Completed	UM		State	DHCS	2021

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

2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
3	UM	(1.5.1) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The Delegate inappropriately denied medical prior authorization requests.	1.The Plan will inform CHCN of DHCS findings about inappropriately denied medical prior authorization requests. Update 11/12/2021: On 10/8/2021 a letter was sent to the delegate to advise of the audit findings. 2.The Plan will re-educate delegates on requirements for standard UM processes, including application of appropriate criteria guidelines. Update 11/12/2021: On 10/12/2021 a meeting was held with CHCN leadership do educate on requirements for the standard UM process. 3.The Plan will audit CHCN denied cases for appropriateness of denial elements using annual audit tool. Update 2/11/2022: The annual CHCN delegation audit began 12/17/2021 and includes an audit of denied cases for appropriateness of denial elements. 4.The Plan will review denied cases at monthly CHCN meeting for education. Update 2/11/2022: Denied cases are now being reviewed at the monthly CHCN meeting for education. Update 5/13/2022: The Q1 2022 audit has commenced as of 5/5/2022. Update 08/09/2022: The CHCN audit is in progress and is expected to be completed by 8/12/2022 Update 09/06/2022: The audit for Q2 2022 is in progress, preliminary findings have been submitted to CHCN. The audit for Q3 2022 is beginning. There will be four total quarters of reviews completed in order to close out this finding. 4/3/2023: Four quarters of the audit have been completed. Results under review. Update 6/9/2023: A Trend Report for 2022 Quarterly Focused Audit findings regarding medical necessity denials was issued to CHCN along with the Final Report for their Annual Audit on 4/11/23. CHCN CAP response due 6/16/2023. **Update 9/8/2023:** The 2022 CAP is ongoing. CHCN's CAP included updates to UM workflows, staff training, and internal audits. The CAP is in progress. Workflows, trainings, and internal audits have been completed and are under review by AAH SMEs.	Medium	Q4 2023	Completed	UM		State	DHCS	2021
4	UM	(1.5.2) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The delegate did not ensure that requests to see out of network providers were reviewed and decisions were made by a qualified health care professional. It did not include the decision-maker's name in the NOA.	1.The Plan will inform Delegate of DHCS findings about qualified health care professional did not always make decisions to deny or only authorized an amount, duration, or scope that was less than requested, and the lack of name and contact information on the NOA of the decision-maker. Update 11/12/2021: On 10/8/2021 a letter was sent to delegate to advise of the audit findings. 2.The Plan will re-educate delegates on standard UM requirement that only qualified health care professionals make decisions to deny or authorize an amount, duration, or scope that is less than requested, including out of network requests, and on the requirement to have the decision-makers' name and contact information on the NOA. Update 11/12/2021: The Alliance met with the delegate on 10/28/2021 to provide re-education. 3.The Plan will audit delegate's cases during the annual audit to ensure that only qualified health care professionals make decisions on denials and authorizations of the amount, duration, and scope less than requested, and contact information for the decision maker. Update 02/11/2022: The annual delegation audit started on 12/20/2021 and is in progress. The audit is expected to be completed on 4/1/2022. Update 09/09/2022: The delegate audit is in progress. And is expected to be completed by 9/23/2022	Medium	12/20/2021	Completed	UM Compliance		State	DHCS	2021
5	UM	**R** (1.5.3) The Plan did not ensure complete ownership and control disclosure information were collected from its delegates.	1.The Plan has updated its documentation, Provider Services Standard Operating Procedure – Ownership and Control Disclosure Reviews for Delegates, to include collecting required disclosures from the managing employees, or board of directors and senior management team in cases where the entity is a non-profit with no majority ownership and/or owned by physician shareholders.	Low	9/14/2021	Completed	Provider Network Vendor Management		State	DHCS	2021

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

2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
6	UM	(1.5.4) The Plan did not ensure the written agreements with its delegates included the requirement to allow specified departments, agencies, and officials to audit, inspect, and evaluate the Plan's facilities, records, and systems related to good and services provided to Medi-Cal members.	1.The Plan is adding the Comptroller General in the Behavioral Health contract, Amendment 7. Update 11/12/2021: The Comptroller General was added to the contract, Amendment 7, as of 10/13/2021 2.The Plan is currently working with its delegate, CFMG on a new contract and delegation agreement which will include the provision and requirement to allow governmental and specified agencies and officials to audit records and systems. Update 1/14/2022: The draft agreement has been completed and is expected to be fully executed in January 2022. Update 2/11/2022: Full execution of the draft agreement is still in progress. Update 09/09/2022: Full execution of the draft agreement is expected by the end of September 2022 3.The Plan will conduct a review of all of its delegated agreements and update the agreements to ensure that all of the language requirements are included. Update 1/14/2022: The agreement has been reviewed and updated. Update 2/11/2022: The Plan conducts annual oversight of its Delegates via an Annual Delegation Audit, as described in CMP-019 – Delegation Oversight. The Plan has updated its Compliance Audit tool to ensure the audit includes a review of the Delegation Agreement to confirm it contains the required language.	Medium	12/31/2022	Completed	Provider Network Vendor Management Compliance		State	DHCS	2021
7	UM	(1.5.5) The Plan did not have policies and procedures for imposing financial sanctions on its delegate and delegated entities.	1.The Plan has created a new Policy, CMP-030 Sanction and Escalation. This Policy describes the standards by which the Plan may impose sanctions against Delegated Entities (DE), providers and vendors for non-compliance or failure to comply with Corrective Actions Plan (CAP) deficiencies, or for breach of any material term, covenant or condition of an agreement and/or for failure to comply with applicable federal or state statutes, regulations, and rules. Update 12/10/2021: Policy CMP-030 was approved at Compliance Committee on 11/23/2021	Low	12/1/2021	Completed	Compliance		State	DHCS	2021
8	Case Management	**R** (2.1.1) The Plan did not conduct HRAs within the required timeframes for newly enrolled SPD members in 2019 and 2020.	1. The Plan revised the HRA process to track all incoming HRAs via a Log, documenting date of receipt. 2. The Plan revised current process for HRAs received past due to be entered into the system of record TruCare (TC) during the month of receipt. 2.a. The Plan updated workflows. 3. The Plan re-trained staff on the HRA process. 4. The Plan will monitor the Log weekly to ensure adherence to the new process. Update 10/8/2021: The log has been created and is being monitored weekly 5. The Plan will report outcomes up to UMC quarterly. Update 2/11/2022: As of the December UM Committee meeting, outcomes are now being reported at the UMC.	Low	12/31/2021	Completed	Case Management		State	DHCS	2021
9	Case Management	(2.1.2) The Plan did not ensure coordination of care in certain cases where EPSDT services were medically necessary.	1.The Plan will develop training on EPSDT PA requests to identify and refer members who need coordination of their care. Update 11/12/2021: Training developed 2.The Plan will provide training to UM and CM staff. Update 11/12/2021: Training completed for UM and CM staff 3.The Plan will create a reporting system to capture referrals to CM and the provision of care coordination. Update 11/12/2021: Reporting system to capture referrals has been created, change in reporting will be reflected mid-December 4.The Plan will report outcomes at UMC on a quarterly basis. Update 5/13/2022: Outcomes reported at January and March 2022 UMC Meetings.	Medium	5/13/2022	Completed	Case Management		State	DHCS	2021

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

2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
10	Case Management	(2.2.1) The Plan did not ensure the completion of Individualized Care Plans for members enrolled in Complex Case Management.	1. The Plan revised its CCM ICP workflow and added the requirement that all staff complete ICPs for all members in CCM. 2. The Plan re-trained staff to complete ICPs for all members in CCM. 3. The Plan will revise its CM Aging Report to capture completion of ICPs for daily management and reporting outcomes. Update 10/8/2021: Aging report has been updated to capture completion of ICPs 4. The Plan will develop a monitoring workflow. Update 10/8/2021: The monitoring workflow has been completed 5. The Plan will routinely monitor completion of the ICPs. Update 10/8/2021: The log has been created and is being monitored weekly 6. The Plan will report outcomes at UMC quarterly. Update 09/09/2022: Monitoring of the ICPs is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
11	Case Management	(2.2.2) The Plan did not ensure development of care plans in collaboration with the PCP.	1. The Plan re-trained staff on policy regarding developing care plans in collaboration with PCP. 2. The Plan will revise its CM Aging Report to capture the date the letter regarding Care Plans was sent to the PCP.10/8/2021: The CM Aging Report has been updated to capture the date the letter regarding Care Plans was sent to the PCP 3. The Plan will monitor, on an ongoing basis, the CM Aging Report to ensure CP letters are being sent to PCPs. Update 10/8/2021: Monitoring has begun, automation of this report is in progress 4. The Plan will report outcomes to UMC quarterly. Update 09/09/2022: Monitoring of the development of care plans with the PCP is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
12	Case Management	(2.2.3) The Plan did not conduct periodic evaluations to ensure the provision of complex case management based on the member's medical needs. The Plan did not implement procedures for monitoring time frame standards or maintaining monthly contact with members.	1. The Plan developed a workflow to maintain regular contact with members and ensure that the continuation of CCM is based on medical needs by using the Complex Criteria Checklist. 2. The Plan conducted staff training. 3. The Plan will revise its CM Aging Report to capture provision of CCM and maintaining monthly contact with member. 10/8/2021: The CM Aging Report has been revised to capture the provision of CCM and maintaining monthly contact with member 4. The Plan will monitor, on an ongoing basis, the CM Aging Report. 10/8/2021: Monitoring has begun, automation of this report is in progress 5. The Plan will report outcomes quarterly to UMC. Update 09/09/2022: Monitoring of the CM Aging Report is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021

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

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

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

2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
17	Access	(3.1.2) The Plan did not continuously review, evaluate and improve access to and availability of the first prenatal appointment.	1.The Plan revised P&P QI-107 to indicate current Access Standards for First Prenatal Appointment from 2 weeks from date of request to 10 days for PCP OB/GYN and 15 days from request for OB/GYN Specialty Care. P&P will be submitted to committee for approval. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: QI-107 was approved at the Compliance Committee on 11/23/2021. 2.The Plan revised Timely Access Standards Provider Communications Sheet. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021. 3.The Plan will be implementing a tracking and trending report of First Prenatal PQIs. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: The Tracking and Trending report of First Prenatal PQIs has been implemented	Medium	11/23/2021	Completed	QI		State	DHCS	2021
18	Access	(3.4.1) The Plan did not ensure standing referral determinations and processing were made within the required timeframes.	1. The Plan will develop a standing referral workflow. 11/12/2021: Standing referral workflow has been developed 2. The Plan will update the AAH system of record for UM and CM, TruCare (TC) to add user define field in order to identify standing referral status to ensure correct TAT, which would include a reportable field for monthly reporting. Update 12/10/2021: TruCare has been updated to add the user defined field. 3. The Plan will revise TruCare (TC) to capture timeframes for processing Standing Referrals. Update 12/10/2021: The reporting TAT has been scheduled to begin in December, with the first report, containing December data, due in January. 4. The Plan will revise Authorization Aging report for day to day management and to report on timeframes for Standing Referrals. Update 01/14/2022: Revision of aging report complete 5. The Plan will conduct staff training on standard work for Standing Referrals. Update 01/14/2022: Staff training on standing referrals completed 11/16/2021 6. The Plan will monitor Standing Referral timeframes with the daily Authorization Aging report. 7. The Plan will report results quarterly to UMC. Update 09/09/2022: Standing referrals are now being tracked and reported on during UM Committee quarterly	High	3/25/2022	Completed	UM Case Management	Completed	State	DHCS	2021
19	Access	(3.6.1) The Plan improperly denied emergency services claims and family planning claims.	1.The Plan updated its monitoring report criteria to include a denial code (code:0630) which would allow us to identify claims prior to finalizing adjudication.	Low	3/26/2021	Completed	Claims IT (Config)		State	DHCS	2021
20	Access	(3.6.2) The Plan did not pay interest for family planning claims not completely reimbursed within 45 working days of receipt.	1. The Plan reviewed the issue thru Claims Processor & Specialist training to ensure staff understands the issue that resulted in no interest. The trainings were completed in May 2021.	Low	5/1/2021	Completed	Claims		State	DHCS	2021
21	Access	(3.8.1) The Plan did not ensure its transportation broker's NEMT providers were enrolled in the Medi-Cal program.	1. The Plan notified its transportation broker that remaining unenrolled NEMT providers need to complete PAVE application by 12/01/2021. Update 12/10/2021: The notification letter was sent to the transportation broker on 12/1/2021, 2. The Plan will audit transportation broker providers to ensure drivers are enrolled in the Medi-Cal program. This was last completed August 27, 2021. Monitoring will be conducted on an annual basis.	Low	12/31/2022	Completed	Vendor Management		State	DHCS	2021

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

2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
22	Access	(3.8.2) The Plan did not require PCS forms for NEMT services.	1. The Plan will require transportation vendor to provide ongoing reports on rates of obtaining PCS forms from providers: Update 11/12/2021: UM Team working with Vendor Management and ModivCare to obtain needed reports. Update 12/10/2021: The report was received from ModivCare on 10/28/2021. 2. The Plan will analyze trends in provider practices on a quarterly basis. Update 12/10/2021: The first report will be given at UMC in January 2022. Update 2/11/2022: Awaiting reports from ModivCare 3. The Plan will educate providers on PCS requirements and provide data on their performance: Update 2/11/2022: Awaiting reports from ModivCare 3.a. Provider newsletter. Update 2/11/2022: Awaiting reports from ModivCare 3.b. Individual office contacts 4. The Plan will finalize process workflow to obtain missing PCS forms. Update 11/12/2021: UM Team working with Vendor Management and ModivCare to obtain needed reports. Update 12/10/2021: The workflow has been finalized based on the reports received from ModivCare 5. The Plan will conduct staff trainings on process workflow. Update 12/10/2021: Training was completed 11/8/2021. 6. The Plan will provide a quarterly report to UMC. Update 01/14/2021: Reporting will begin at UMC in Q1 2022. Update 2/11/2022: Awaiting reports from ModivCare Update 09/09/2022: NEMT services are now being tracked and reported quarterly at the UM Committee.	Medium	12/31/2022	Completed	Vendor Management UM		State	DHCS	2021
23	Member Rights	(4.1.1) The Plan did not ensure that the medical director fully resolved QOC grievances prior to sending resolution letters.	1. The Plan updated G&A-003 Grievance and Appeals Receipt, Review and Resolution to include the process for the medical director's review and resolution of all levels of quality of care grievances prior to sending a resolution letter to members. The policy will be reviewed at the Health Care Quality Committee on November 18, 2021 and the Compliance Committee Meeting on November 23, 2021. Update 12/10/2021: G&A-003 was approved at the Compliance Committee meeting on 11/23/2021 2.The Plan will provide training to the medical directors to review G&A-003 Grievance and Appeals Receipt, Review and Resolution by November 30, 2021. Update 3/11/2022: Training was completed 1/12/2022	Medium	1/12/2022	Completed	G&A		State	DHCS	2021
24	Member Rights	(4.1.2) The Plan did not consistently implement its procedure for processing grievances. The Plan considered member's grievances resolved and classified as exempt without conducting investigation.	1. The Plan is updating its policy and procedures for processing Exempt Grievances to reflect its current process. The policy MBR-0024 will be reviewed at the Compliance Committee Meeting on November 23, 2021. Update 12/10/2021: MBR-024 was approved at Compliance Committee on 11/23/2021 2. The Plan will provide staff training by November 30, 2021. Update 1/14/2022: Training was completed 11/19/2021	Low	11/30/2021	Completed	Member Services		State	DHCS	2021
25	Member Rights	(4.1.3) The Plan did not send acknowledgement and resolution letters within the required timeframes. The Plan did not promptly notify the members that expedited grievances would not be resolved within the required timeframe.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-003 Grievance and Appeals Receipt, Review and Resolution and G&A-005 Expedited Review of Urgent Grievances. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent within the required timeframes, and to also notify members when expedited grievances would not be resolved within the required timeframe.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
26	Member Rights	(4.1.4) The Plan did not send acknowledgement and resolution letters in threshold languages.	1.The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description and CLS-003 Language Assistance Services. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent to members in their threshold languages.	Low	9/21/2021	Completed	G&A		State	DHCS	2021

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

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

ALAMEDA ALLIANCE FOR HEALTH

COMPLIANCE DASHBOARD

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

ALAMEDA ALLIANCE FOR HEALTH

COMPLIANCE DASHBOARD

2020 DHCS STATE AUDIT FINDINGS - *Audit Review Period: 10/01/2018 - 9/30/2020*					INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
4	UM	The Plan did not notify members and the hospital of continued denial of long term acute care (LTAC) services through NOA letters and "Your Rights" attachments for each concurrent review throughout the members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021 Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised Alameda Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
5	UM	The Plan provided unclear information about the Plan's decision for denial of long term acute care (LTAC) services in the only NOA letters that were issued to members and the Hospital. Letters contained inaccurate information about denied dates and requesting providers.	1. The automated section of the NOA letter generated by the Plan's system of record, TruCare, was incorrectly configured and displayed inaccurate information about the requesting LTAC provider and the dates of denial. The Plan's system of record, TruCare, was re-configured to display the correct dates and correct requesting provider in the automated portion of the NOA letters. 2. The Plan's In-Patient Utilization Management Leadership will continue to audit the NOA letters to ensure that they contain accurate information and meet the regulatory requirements. Update 5/15/21: Identified deficiencies have been added to the audit tool and audits of inpatient NOA letters are currently taking place. 3. The Plan will report the results of NOA letter audit at Utilization Management Committee on a quarterly basis, starting Q3 2021. Update 7/9/2021: Manual tracking continues, report will be provided starting in Q3 2021 Update 10/8/2021: Manual tracking continues, awaiting completion of automated report. First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised Alameda Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
6	Delegation	The Plan did not ensure the Delegate met standards set forth by the Plan and DHCS. The Delegate did not ensure that concurrent review denials were reviewed and made by a qualified physician. It did not send NOA letters with "Your Rights" information for denial of services that occurred after initial denial. It did not include the decisions maker's name in the initial and only NOA sent to providers.	1. The Plan's revised policy UM-003 Concurrent Review and Discharge Planning Process and the revised process expectations were shared with Delegate on 3/26/2021. 2. The Plan will require the Delegate to do the following: a. Adopt the Plan's policies, to reflect that the concurrent review denials are reviewed and made by a qualified physician, that the clinical case is reviewed using the regulatory requirements on a regular cadence after the initial denial, that NOA letters with "Your Rights" information are sent after every subsequent review, and that the decision-maker's name is on each NOA. Update 6/11/2021 AAH Health Care Services is working with the delegate to update the policies. b. Provide evidence of policy and procedure approval. Update 7/9/2021: Delegate has provided evidence that the revised policy was approved on 6/23/2021 c. Train its staff on the new Concurrent review process. Update 7/9/2021: Delegate states they are developing the training for their staff and are on track to provide the documents to AAH. Update 9/10/2021: Staff training completed, training documents provided. d. Provide evidence of the training, including the training materials and the attendance records. Update 9/10/2021: Delegate provided attestations to show training completed 6/23/2021 3. The Plan will audit the Delegate on a quarterly basis to ensure that the process is implemented, starting at the end of Q3 2021, and report the results of the audit at the Plan's UM Committee on a quarterly basis. Update 10/8/2021: Q3 2021 audit completed 9/29/2021, and initial audit results provided to the	**9/23/2022**	Completed	UM		State	DHCS	2020	In Progress

ALAMEDA ALLIANCE FOR HEALTH

COMPLIANCE DASHBOARD

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

2020 DMHC STATE AUDIT FINDINGS - *Audit Review Period: 1/01/2019 - 9/30/2019*

INTERNAL AUDITS

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Grievances & Appeals	The Plan failed to accurately and consistently identify grievances received by telephone. Coverage Dispute issues were processed as an exempt grievance and not a standard grievance as required.	The G&A current procedures appropriately process coverage disputes as a standard grievance. Member Services will provide a refresher staff training of the procedures by 3/31/20 to ensure coverage disputes are processed appropriately. Update as of 4/10/2020 Refresher training for benefits coverage disputes was completed on 3/12/2020.	3/12/2020	Completed	Member Services/ G&A	✓	State	DMHC	2020	Completed
2	Grievances & Appeals	The Plan does not consistently provide immediate notification to complainants of their right to contact the Department regarding expedited appeals.	G&A staff training was conducted to review regulations on 1/30/20. G&A application was updated to include a new log type for expedited DMHC rights notification that was implemented on 2/6/20.	2/6/2020	Completed	G&A	✓	State	DMHC	2020	Completed
3	UM	The Plan does not include the statement required by Section 1363.5(c) when disclosing medical necessity criteria for UM decisions.	Cover sheet being created in the TruCare system for all requests by providers for clinical criteria used to adjudicate requests. Creation of tracking log, workflow and training to be completed by 3/31/20. Update as of 4/10/20: Tracking log workflow and training completed as of 3/12/20.	3/12/2020	Completed	UM	✓	State	DMHC	2020	Completed
4	Access to Emergency Services	The Plan does not provide all non-contracting hospitals in the state with Plan contact information needed to request authorization of post-stabilization care. DMHC expects the onus to be on the Plan to reach out to the hospitals and notices should be mailed at least annually.	The Plan is working with the Hospital Association to assist in sending out the notices to non-contracted hospitals. Update as of 6/12/20: Notices were mailed to non-contracted hospital providers on May 26.	5/31/2020	Completed	Provider Relations	✓	State	DMHC	2020	Completed
5	Access & Availability	The Plan failed to adequately review and address access issues as part of its quality assurance (QA) program.	The QI Team and Member Services team perform an annual training to ensure that the appropriate process is followed. The Alliance is working on additional training to ensure the appropriate referral of PQIs. All access-related exempt grievances are compiled in a track and trend report and referred to Quality Improvement via the Access and Availability Sub-Committee	4/30/2020	Completed	Quality Management	✓	State	DMHC	2020	Completed

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Compliance Internal Audit	State/Self Identified	Agency	Year	Status
1	Quality Assurance	The Plan failed to ensure that all potential quality of care issues were identified and processed in accordance with its Quality Assurance (QA) Program. Cases were found to misclassified and include documentation issues.	1. RN Staff In-Service on PQI definition, classification, review, processing and documentation conducted by Quality Sr. Director on 2/7/20. 2. Deleted "Not a PQI" from classification drop down selections. 3. All new PQI submissions are reviewed and classified (as QOS/QOA/QOC) by Quality Director. 4. RN PQI Classification IRR conducted by Quality Director on 2/25/20. 5.Department wide IRR Conducted by Medical Director on 2/27/20 6.Quality Director to process all QOAs and QOSs 7. Medical Director is auditing random sample of QOA and QOS cases processed by nurse management staff as of 4/6/20. 8. Quality Director to conduct weekly auditing of RN documentation of all QOCs as of 3/5/20. 9. Medical Director continues to level and audit all QOC cases 10. Ongoing weekly team meeting continues to ensure case discussion and review Update as of 4/30/2020: QI team has completed all steps listed above.	4/30/2020	Completed	Quality Improvement	✓	Self Identified	AAH	2020	Completed
2	UM	The Plan does not consistently provide enrollees with a clear and concise reason for denials based in whole or in part on medical necessity.	Quality checklist for review of NOA letters for all requirements prior to being sent out to be developed, then train staff, by 3/31. Quality checks of all NOAs by management before sending out continues. Weekly review by external consultants continue with MDs to improve decision notices. Update as of 4/10/20: NOA checklist training and implementation done as of 4/2/20. Weekly review by external consultants continues.	4/2/2020	Completed	UM	✓	Self Identified	AAH	2020	Completed
3	UM	In letters to providers denying or modifying requested services on the basis of medical necessity, the Plan does not include a direct telephone number or extension of the professional responsible for the decision. The peer to peer process to improve its oversight and tracking process.	Phone numbers in all UM template letters being checked for accuracy and corrected in TruCare as needed. Standardized tracking workflow of Peer to Peer communication is being developed, trained and implemented by 3/31/20. Update as of 4/10/20: Training and tracking implemented as of 3/12/20.	3/12/2020	Completed	UM	✓	Self Identified	AAH	2020	Completed

3
5

ALAMEDA ALLIANCE FOR HEALTH

COMPLIANCE DASHBOARD

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

ALAMEDA ALLIANCE FOR HEALTH

COMPLIANCE DASHBOARD

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

s

ALAMEDA ALLIANCE FOR HEALTH

COMPLIANCE DASHBOARD

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

ALAMEDA ALLIANCE FOR HEALTH

COMPLIANCE DASHBOARD

2019 DHCS AUDIT FINDINGS - *Audit Review Period: 6/1/2018-5/31/2019*						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
10	Prior Authorizations	The Plan did not ensure that all contracting practitioners were aware of the procedures for orthotic items; the Plan provided inaccurate information about authorization requirements for orthotic items	The Alliance's Authorization Grid will be updated to include the accurate information about authorization requirements for orthotics. The updated grid will be uploaded on the website. Update as of 12/5/19: A meeting will be scheduled the week of 12/9 to discuss changes. Update as of 1/8/20: Meeting was conducted and PA grid will be updated to reflect corrections. Update as of 2/7/20. PA grid is being updated for all services requiring PA, so that MDs do not receive repeat communication about changes to the PA grid. Orthotics will be included in the comprehensive update. Update as of 3/5/20 Prior Auth requirement for Orthotics was added to the PA grid on the Provider Portal	No	3/2/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
11	Appeals	The Plan's appeal notification letters did not comply with contractual regulations. NAR letters were not clear or concise, and contained inaccurate information	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/19: Training conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
12	Case Management & Care Coordination - HRAs	The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members. The Plan did not ensure that HRAs were completed within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk, and within 105 calendar days of enrollment for those identified as lower risk.	HRA tracking had been implemented in early 2019, and continues at present. HRAs are sent out within the required timeframes. Robo calls are made to low risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls are made by CM staff on high risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log is kept to ensure that the required timelines are met.	No	9/16/2019	Completed	Case Management		State	DHCS	2019	Completed
13	Case Management & Care Coordination - Initial Health Assessment (IHA)	The Plan did not ensure that all providers documented all required components of an IHA. Preventive services identified as USPSTF "A" and "B" recommended services were not provided, or status of these recommended services was not documented	The QI Department revised its provider medical record request letter to include: all categories that support IHA completion; a hyperlink and/or copy of the SHA/IHEBA form; and sample documentation of a compliant SHA/IHEBA. Providers were re-educated on the SHA/IHEBA requirements.	No	9/30/2019	Completed	Quality		State	DHCS	2019	Completed
14	Complex Case Management (CCM)	2.2.1 The Plan did not implement its monitoring of the CCM program to address member needs. The Plan did not close its CCM cases after 90 days, or present them at Case Rounds as stated in its policy	Existing aging reports are being utilized by the Case Management Department in CCM Rounds to ensure that members' cases are either reviewed and closed, or extended past 90 days.	Yes	10/14/2019	Completed	Case Management	✓	State	DHCS	2019	Completed
15	Access & Availability	3.1.1 The Plan did not maintain an accurate provider directory.	The Plan will continue to verify 10 providers per week and has added the following two processes to continuously maintain an accurate provider directory: 1. Provider Data Comparison to manually review provider data received from our delegates (AHS, CHCN, and CFMG) started September 2019 and 2. Provider Data Validation Yearly Project to review directly contracted providers who appear in the Provider Directory. In addition, the Provider Relations Department includes a Provider Demographic form in all provider quarterly packets and work with providers to obtain the completed forms during provider visits.	Yes	11/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
16	Emerg Family Planning Claims/SSS	The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-For-Service rate. The Plan's claim system misclassified non-contracted family services as non-billable. The Plan is required to pay all covered family planning services regardless if these services are contracted with the Plan.	This finding is specific to one provider, Planned Parenthood, based on the list of services identified in the contract. No other provider was impacted by this issue. The claims system has been re-configured to reimburse services as follows: * services listed in the Planned Parenthood contract will be reimbursed at the contracted rate * covered Medi-Cal services not listed in the contract will be reimbursed at 100% of the prevailing Medi-Cal rate	No	9/5/2019	Completed	Claims	✓	State	DHCS	2019	Completed
17	Emerge Family Planning Claims	The Plan did not inform members of the correct minor consent provision for family planning services in its Evidence of Coverage (EOC).	The Plan has updated its 2020 EOC to include the appropriate minor consent provisions. The EOC was submitted to DHCS for review and approval on 10/7/19.	No	10/7/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
18	Access to Pharm Services	The Plan did not monitor the provision of drugs prescribed in emergency situations.	The Pharmacy Department is working with the PBM to create routine monitoring reports of drugs prescribed in emergency situations. Update as of 1/8/20: Internal meeting was conducted to ensure requirements are clear and next steps for updating policy and monitoring reports. Update as of 2/11/20: Draft P&P and monitoring log have been created and are under review. Update as of 4/10/20: The P&P and monitoring log were approved at the most recent P&T Committee meeting.	Yes	3/17/2020	Completed	Pharmacy	✓	State	DHCS	2019	Completed
19	Grievances	4.1.1 The Plan did not document review and final resolution of clinical grievances by a qualified health care professional	The G&A workflow for Quality of Care review was updated and implemented on 4/15/2019 to include the CMOs review and final resolution.	Yes	4/15/2019	Completed	G&A	✓	State	DHCS	2019	Completed
20	Grievances	4.1.2 The Plan's grievance system did not capture all complaints and expressions of dissatisfaction reported by members.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/19: Training was conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
21	Grievances	The Plan's grievance system did not capture all complaints and expressions of dissatisfaction filed through Plan providers.	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. Clinics will be trained by the delegate to ensure that the Alliance is capturing all complaints. Update as of 1/8/20: AHS provided training sign in sheet. CHCN is working on next steps of educating providers. Update as of 2/7/20: CHCN provided an attestation to complete its provider training by the end of Q1 2020. Update as of 4/10/20: Meeting AHS week of 4/6 to discuss implementation. Update as of 4/20/20: Process for forwarding complaints received by AHS has been implemented as of 4/20/20.	Yes	~~3/31/2020~~ 5/1/2020	Completed	G&A/Provider Services/ Compliance	✓	State	DHCS	2019	Completed
22	Grievances	4.1.4 The Plan sent member resolution letters without completely resolving all complaints.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/19: Training was conducted on 11/14/2019.	Yes	11/22/2019	Completed	G&A		State	DHCS	2019	Completed

ALAMEDA ALLIANCE FOR HEALTH

COMPLIANCE DASHBOARD

2019 DHCS AUDIT FINDINGS - *Audit Review Period: 6/1/2018-5/31/2019*						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
23	Quality Program	The QIPD did not list the individuals' qualifications, which was inconsistent with Plan policy.	The 2019 Annual Quality Improvement Program Description (QIPD) was revised to include the leadership positions and their qualifications (Licensure, Education, Work Exp) The program description was presented and approved in the July 18, 2019 Health Care Service oversight committee.	No	7/18/2019	Completed	Quality	✓	State	DHCS	2019	Completed
24	Provider Training	The Plan did not ensure provider training was conducted within 10 working days	During the last review period of June 2017 through May 2018, the Plan acknowledged deficiencies in the NPO process to be corrected by the end of December 2018. Since January 2019, the plan is meeting its goal of conducting training with the 10 day working timeframe 100% of the time.	Yes	1/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
25	Fraud, Waste, and Abuse (FWA)	The Plan did not conduct preliminary investigations of all suspected cases of fraud and abuse.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. Staff training of the revised procedure will be completed by 12/01/19. Update as of 12/5/19: Staff training will be conducted on 12/11/19 to review the updated procedure. Update as of 1/8/20: Staff training was conducted on 12/11/19	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
26	Fraud, Waste, and Abuse (FWA)	The Plan did not investigate all suspected fraud and abuse incidents promptly. The Plan did not conduct a preliminary or follow-up investigation of 4 of 12 suspected fraud and abuse cases until two to six months after it became aware of the incidents.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. All cases will be resolved and closed within 90 days of receipt. Staff training of the revised procedure will be completed by 12/01/19. Update as of 12/5/19: Staff training will be conducted on 12/11/19 to review the updated procedure. Update as of 1/8/20: Staff training was conducted on 12/11/19	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
27	Fraud, Waste, and Abuse (FWA)	The Plan's compliance officer did not develop and implement fraud, waste, and abuse policies and procedures	The Plan's designated compliance officer will develop and attest to all new and updated policies and procedures prior to committee review.	No	12/13/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
28	State Supportive Services Claims	The Plan did not forward all misdirected claims within 10 working days.	The post-adjudication script that adds the forwarding action was corrected and deployed.	No	7/11/2019	Completed	IT/ Claims	✓	State	DHCS	2019	Completed

ALAMEDA ALLIANCE FOR HEALTH

COMPLIANCE DASHBOARD

2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
1	Utilization Management (UM) Program	1.1.1 The Plan did not continuously update and improve its UM program during the audit period.	The Plan's policy and procedure UM-001 includes the annual review process of the UM program. The 2018 UM program was approved by Committee timely this year on 3/20/18. The Plan will continue to update its UM program annually and track for a timely approval by Committee.	3/31/2018	Completed	Utilization Management	✓	State	DHCS	2018	Completed
2	Prior Authorizations	1.2.1 The Plan did not conduct IRR testing to evaluate the consistency of UM criteria application during the audit period.	The Plan has implemented an IRR testing policy and procedure to ensure clinical staff is evaluated on an annual basis to ensure consistency in decision making and criteria application. - UM/Appeals IRR conducted on 5/25/18 - Pharmacy IRR conducted on 12/17/18 Update as of 1/31/19: IRR testing for Health Care Services (Pharmacy & UM) has been completed as of 1/31/19.	12/17/2018	Completed	Utilization Management/ Pharmacy	✓	State	DHCS	2018	Completed
3	Prior Authorizations	1.2.2 The Plan did not use appropriate processes to determine medical necessity for PA requests. The Plan's UM staff used outdated criteria and criteria that did not meet the case details.	The Plan has updated its policy and procedure to ensure the Plan's criteria is reviewed at least annually. IRR testing of clinical staff is completed annually to ensure consistency in decision making and criteria application. - UM/Appeals IRR conducted on 5/25/18 - Pharmacy IRR conducted on 12/17/18 Update as of 1/31/19: IRR testing for Health Care Services (Pharmacy & UM) has been completed as of 1/31/19.	12/17/2018	Completed	Utilization Management	✓	State	DHCS	2018	Completed
4	Prior Authorizations	1.2.3 The Plan denied retrospective service requests for medical services without documentation of a qualified health care professional's review for medical necessity.	The Plan updated its policy and procedure for the retrospective authorization request process to include details of the review process. The P&P and workflow will be reviewed and approved on 1/17/2019. Staff training will then be conducted on 1/22/19. Update as of 1/31/19: Updated P&P and workflow retro authorization request processes were approved at HCQC on 1/17/2019. Staff training was conducted on 1/29/2019.	1/22/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
5	Prior Authorizations	1.2.4 The Plan did not respond to pharmacy requests within 24 hours or one business day.	The Plan monitors pharmacy authorization request timeframes by a daily aging report. Staff training of the turnaround timeframe requirements was provided on 10/02/18. Update as of 1/07/19: The Plan has determined that timeframe requirements were not consistently met due to a lack of coverage on weekends and holidays. The Plan has updated its Pharmacy Benefit Management contract to include coverage for weekends and holidays as of 12/1/18. Staff training of the updated procedures will be completed by 1/22/19. Update as of 1/31/19: Staff training was completed on 1/23/2019.	1/22/2019	Completed	Pharmacy	✓	State	DHCS	2018	Completed
6	Prior Authorizations	1.2.5 The Plan's NOA letters were not clear and concise, or at sixth grade reading level.	Update as of 3/5/19: Continuing internal audits revealed issues with how TruCare generates letters, leading to potentially confusing language for members. A team is working on a plan to mitigate the issues. Once the TruCare issues are resolved, staff will be retrained on the mitigation procedures. In the meantime, audits continue to ensure that the language is clear and concise and a process for final review before sending out is being developed. The updated timeline for completion is 4/30/19. Update as of 4/10/19: Denial rationale language has been updated. Staff training was completed on 3/29/19.	4/30/2019	Completed	Utilization Management/ Pharmacy		State	DHCS	2018	Completed
7	Prior Authorizations	1.2.6 The Plan provided incorrect appeal, grievance, and state fair hearing information in translated pharmacy member notifications. The translated "Your Rights" attachments did not follow the required format.	The Plan will update its pharmacy member notifications to ensure the translated versions are in the required format with updated member rights information by 1/25/19. Update as of 2/4/19: Updated translated versions of the "Your Rights" attachments have been provided to the Pharmacy Benefits Manager. Update as of 2/19/19: Updated translated versions of the "Your Rights" attachments have been placed into production by the Pharmacy Benefits Manager.	1/25/2019	Completed	Pharmacy	✓	State	DHCS	2018	Completed
8	Prior Authorizations	1.2.7 The Plan provided conflicting information to providers about podiatry benefits, which required PA; it therefore did not communicate to providers the services that required PA.	The Plan will be updating its Prior Authorization Grid and Provider Training Presentation to include clear communication of the prior authorization process including clarification of the podiatry benefit.Update as of 1/07/19: The Plan will be updating its prior authorization grid and provider training materials by 1/25/19. Update as of 1/31/19: The PA Grid and Provider Training Presentation have been updated. The PA Grid and updated Provider Manual have been posted to the Plan website.	1/25/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
9	Referral Tracking process	1.3.1 The Plan did not track authorized PAs to completion and inform providers of the referral tracking process.	The Plan has updated its referral tracking policy and procedure. Routine reporting has been developed to track authorization PAs to completion. The Plan's provider manual has been updated to include information on the Plan's referral tracking process for providers. Update as of 1/07/19: The Plan will be uploading the provider manual to the website by 1/25/19. Update as of 1/31/19: The updated Provider Manual has been posted to the Plan website.	1/25/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
10	Appeal	1.4.1 The Plan did not ensure health care professionals with appropriate clinical expertise in treating the member's condition resolved pharmacy appeals. The Plan allowed the Pharmacy Director to resolve appeals for medication requests instead of requiring a clinical professional with expertise in treating the member's condition.	The Plan updated its appeal procedures to reflect MD review for final decision for pharmacy appeals on 09/26/2018 and conducted staff training on 10/30/2018.	10/30/2018	Completed	Health Care Services	✓	State	DHCS	2018	Completed

ALAMEDA ALLIANCE FOR HEALTH

COMPLIANCE DASHBOARD

2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
11	Appeal	1.4.2 The Plan did not translate acknowledgement and resolution appeal letters into the required threshold languages.	The Plan's appeal policies and procedures in place are compliant with the translation requirements. Staff training refresher of translation of letters was conducted on 10/30/2018.	10/30/2018	Completed	Grievance & Appeals	✓	State	DHCS	2018	Completed
12	Appeal	1.4.3 The Plan did not update its provider manual to include the new timeframes for filing a state fair hearing that became effective July 1, 2017.	The Plan updated its provider manual on 12/25/2018 to include the correct new SFH filing timeframes. Update as of 1/07/19: The Manual is scheduled to be uploaded on our website on 1/25/19. Update as of 1/31/19: The updated Provider Manual has been posted to the Plan website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
13	Delegation Oversight	1.5.1 The Plan did not collect and review ownership and control disclosure information for their UM delegates.	The Plan's subcontractor policy & procedure addresses the ownership and control disclosure information requirements. Update as of 1/07/19: The Plan has requested ownership and control disclosure information of its UM delegates as of 1/4/19. Update as of 1/30/19: All forms from the Plan's UM delegates have been received as of 1/31/2019 with the exception of the Plan Pharmacy Benefits Manager (PBM). Update as of 3/6/19: All forms from the Plan's UM delegates have been received.	3/15/2019	Completed	Provider Relations	✓	State	DHCS	2018	Completed
14	Delegation Oversight	1.5.2 The Plan did not require corrective action for all identified deficiencies as a part of their annual oversight audits.	The Plan updated its corrective action plan policy and procedure on 11/08/18 to ensure all identified deficiencies are a part of annual audits such as policy and procedure deficiencies. UM annual delegation audits conducted for 2018 reflect the policy and procedure deficiencies in the corrective action.	11/8/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
15	Delegation Oversight	1.5.3 The Plan did not continuously monitor and evaluate the functions of its UM delegates. The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan has updated its monitoring of UM delegates to ensure all contractual and regulatory reports are being tracked for review. The Plan's delegation reporting tracking log has been updated to document all UM delegation reporting.Update as of 1/07/19: The Plan will update the desktop procedure and conduct staff training on the monitoring process by 1/22/19. Update as of 1/31/19: The Plan completed staff training on 12/20/2018.	1/22/2019	Completed	Compliance	✓	State	DHCS	2018	Completed
16	Initial Health Assessment (IHA)	2.4.1 The Plan did not ensure that new members receive an IHA within 120 days from enrollment. The Plan's IHA completion records were inaccurate.	The Plan updated its procedures to monitor IHA completion and validate the procedure codes. Medical record auditing procedures will be conducted to monitor IHA completion and conduct validity testing.Update as of 1/07/19: The Plan completed the audit and is completing the summary report for Committee by 1/17/19.	1/17/2019	Completed	Quality Management	✓	State	DHCS	2018	Completed
17	Complex Case Management (CCM)	2.5.1 The Plan did not implement its policy and did not consistently monitor its CCM program.	The Plan monitors its daily aging report to ensure compliance with its CCM program.	12/1/2018	Completed	Health Services	✓	State	DHCS	2018	Completed
18	Complex Case Management (CCM)	2.5.2 The Plan did not ensure PCP participation in the provision of CCM services to each eligible member.	The Plan's updated CCM policy and procedure includes a process for PCP participation. The PCP Input Form was implemented for use on 5/31/18.	5/31/2018	Completed	Health Services	✓	State	DHCS	2018	Completed
19	Access & Availability	3.1.1 The Plan did not initiate and implement steps to monitor wait times for providers to answer members' telephone calls.	The Plan will be updating its policy and procedure to include the telephone wait times standards for answering and returning calls. The Plan will monitor wait times for providers and answering member telephone calls through a quarterly survey. Update as of 1/31/19: The Plan has updated its P&P to include all wait time standards. The Plan conducted a survey in January 2019 to assess and monitor wait times as required.	1/31/2019	Completed	Quality Management	✓	State	DHCS	2018	Completed
20	Access & Availability	3.1.2 The Plan did not maintain an accurate and complete provider directory.	The Plan implemented an audit process of the provider directory. The Plan expanded its annual audit for its Pharmacy Benefit Manager (PBM) to include monitoring its provider data included in the directory.Update as of 1/30/2019: Provider Directory Data P&P and desktop procedure for internal auditing have been updated.	2/28/2019	Completed	Provider Services/ Pharmacy	✓	State	DHCS	2018	Completed
21	Emergency & Family Planning Claims	3.5.1 The Plan denied emergency room (ER) service and family planning (FP) claims containing procedures that normally require prior authorization outside of an ER or FP setting.	The Plan updated its system configuration to ensure ER and FP claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
22	Emergency & Family Planning Claims	3.5.2 The Plan did not pay the greater of $15 or 15 percent interest annually for emergency service claims not reimbursed within 45 working days of receipt.	The Plan updated its system to ensure interest is paid based on the greater of the $15 or 15 percent interest annually for emergency services not reimbursed timely.Update as of 1/07/19: The Plan will run a pre-payment monitoring report prior to each check run to ensure interest is paid based on the greater of the $15 or 15% per annum for emergency services claims not adjudicated timely. Update as of 1/31/2019: The Plan's pre-payment monitoring report process is now in place prior to each check run to ensure interest is paid accurately for emergency services claims when interest is required. All claims identified on the weekly report are manually adjusted as needed prior to payment to providers.	1/25/2019	Completed	Claims	✓	State	DHCS	2018	Completed

ALAMEDA ALLIANCE FOR HEALTH

COMPLIANCE DASHBOARD

2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
23	Emergency & Family Planning Claims	3.5.3 The Plan improperly denied family planning claims for out of network, non-contracted providers. These claims were denied based on edits in the Plan's claims system and subsequent review by claims analysts.	The Plan provided staff training on 6/11/2018 to ensure FP claims edits for out of network claims are reviewed and not inappropriately denied. Monitoring reports have been implemented to review any claims denied incorrectly. Any claims identified as denied incorrectly are adjusted the following week manually.	12/31/2018	Completed	Claims	✓	State	DHCS	2018	Completed
24	Emergency & Family Planning Claims	3.5.4 The Plan did not disclose the specific rationale used in determining why claims are rejected.	Update as of 3/6/19: The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by May 31, 2019. Update 4/8/2019: The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
25	Emergency Pharmacy Provisions	3.6.1 The Plan did not ensure the provision of sufficient amounts of drugs prescribed in emergency situations.	The Plan updated its policy and procedure to ensure emergency provisions of drugs are prescribed in emergency situations. The monitoring report was updated to include all supply claims to ensure members have access to medically necessary drugs.	12/11/2018	Completed	Pharmacy	✓	State	DHCS	2018	Completed
26	Grievances	4.1.1 The Plan's process omitted medical director review of QOC grievances prior to sending resolution letters.	The Plan updated its grievance procedures and letters to include MD review for quality of care grievances.Update as of 1/07/19: Implementation will be completed by 3/31/19 once RN staff are on board and trained on the updated process. Update as of 3/5/2019: Health Care Services has successfully recruited one nurse, and is in the process of filling the remaining vacancy. Update as of 4/10/19: Training is to be completed by 4/11/19. The checklist for standard and expedited grievances has been updated. Update as of 5/8/19: The review process for QOC grievances was implemented on 4/15/2019.	4/15/2019	Completed	Health Care Services	✓	State	DHCS	2018	Completed
27	Grievances	4.1.2 The Plan sent member resolution letters without completely resolving all complaints.	The Plan updated its grievance procedure to include a process for resolving all complaints and resolutions resolved outside the 30 day timeframe. Staff training was conducted on 7/17/18.	7/17/2018	Completed	Grievance & Appeals		State	DHCS	2018	Completed
28	Grievances	4.1.3 The Plan did not update its provider manual to include the new timeframes for filing grievances that became effective July 1, 2017.	The Plan updated its Provider Manual on 12/25/2018 to include the correct new grievance filing timeframes. Update as of 1/07/19: The Manual is scheduled to be uploaded on our website on 1/25/2019. Update as of 1/25/19: The Plan has posted the updated Provider Manual to its website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
29	Grievances	4.1.4 The Plan's grievance system did not capture and process all complaints and expressions of dissatisfaction	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. New provider orientation materials and the provider manual will include education materials of the Plan's grievance process for new and existing providers.Update as of 1/07/19: The Plan will be uploading the provider manual to the website by 1/25/19. Update as of 1/25/19: The Plan has posted the updated Provider Manual to its website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
30	HIPAA	4.3.1 The Plan did not report the discovery of PHI breaches to the DHCS Information Security Officer.	The Plan updated its procedures to ensure reporting of PHI incidents are reported to all DHCS contacts including the DHCS Information Security Officer. Staff training on updated procedures was conducted on 8/22/18 and 10/3/18.	10/3/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
31	HIPAA	4.3.2 The Plan did not report all suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery.	The Plan updated its procedures and tracking log to ensure monitoring of reporting to DHCS occurs timely. Staff training on updated procedures was conducted on 8/22/18 and 10/3/18.	10/3/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
32	Provider Training	5.2.1 The Plan did not ensure provider training was conducted within 10 working days.	The Plan monitors its tracking log to ensure provider training is conducted within 10 working days. Staff training of the required timeframe was conducted on 12/17/18.	12/31/2018	Completed	Provider Services	✓	State	DHCS	2018	Completed
33	Provider Training	5.2.2 The Plan did not specify in its written agreement provider training responsibilities for two delegated entities.	The Plan updated its contract with the two delegated entities to ensure provider training requirements.Update 12/31/2018: The Plan has updated its contract with one of the delegates to include delegation of provider training requirements. The other delegate's contract is in progress to be finalized. Estimated time for contract to be completed is 2/28/19.Update as of 3/4/19: The remaining delegate has agreed to the provider training responsibilities; the final contract will be signed once the delegate agrees to terms for non-related items. Update as of 8/5/19: Both delegates involved in the finding (CHCN and Beacon) delegation agreements were updated. CFMG contract still needs to be finalized.	6/30/2019	Completed	Provider Services	✓	State	DHCS	2018	Completed
34	Provider Training	5.2.3 The Plan did not ensure training materials provided by two delegated entities included information on Plan policies, procedures, services, and member rights and responsibilities.	The Plan's delegated entities have updated their training materials to include the required information. Update 12/31/2018: The Plan is currently working with the delegate to incorporate this information. Target date for materials to be updated is 1/31/19. Update as of 1/30/2019: CHCN and Beacon have revised their training materials to include member rights and responsibilities, grievances and AAH services.	1/31/2019	Completed	Provider Services	✓	State	DHCS	2018	Completed

ALAMEDA ALLIANCE FOR HEALTH												
COMPLIANCE DASHBOARD												
2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS							
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
35	Fraud, Waste, and Abuse (FWA)	6.3.1 The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10-working days.	The Plan updated its fraud and abuse policy and procedure as of 7/17/18 to ensure timely reporting of incidents to DHCS. Staff training on updated procedures was conducted on 7/17/18. The Plan updated its monitoring tracking log to monitor the reporting timeframe requirement.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
36	Fraud, Waste, and Abuse (FWA)	6.3.2 The Plan did not conduct prompt and complete investigations of all suspected fraud and abuse incidents.	The Plan updated its fraud and abuse policy and procedure as of 7/17/18 to investigate all suspected incidents and update DHCS until the case closure. Standardized investigation form for documentation was implemented as of 7/17/18. Staff training on updated procedures was conducted on 7/17/18.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed

ALAMEDA ALLIANCE FOR HEALTH

COMPLIANCE DASHBOARD

2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
37	State Supportive Services	SSS.1 The Plan denied state supported services (SSS) claims containing procedures that normally require prior authorization outside of a SSS setting. These claims were denied based on edits in the Plan's claims system and review by claims analysts; the Plan's process did not include exceptions for FP or ER services.	The Plan updated its system configuration to ensure SSS claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
38	State Supportive Services	SSS.2 The Plan did not disclose the specific rationale used in determining why claims are rejected.	The Plan's Remittance Advice (RA) includes the specific rationale for claims denials. Denial codes can be applied at the Header level, line level or both. The Plan's claims processing system edits each claims and assigns all denial or informational codes that are applicable to the claim. Update as of 1/31/2019: The Plan will provide training to providers to ensure comprehension concerning the remittance advice set-up. Update as of 3/6/19: The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by May 31, 2019. Update 4/8/2019: The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
1	Prior Authorizations	Authorizations were auto-approved for Sutter hospital.	Effective 9/17/18, the Plan started to review and impose standard UM authorization guidelines for Sutter hospital authorizations.	9/17/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
2	Appeal	The Plan's expedited appeals checklist does not include a reminder to call the member when the case is de-escalated from urgent to routine.	The expedited appeals checklist has been updated. Staff training will be conducted by 10/01/18. Checklist includes requirements of De-expedited: Decision to de-expedite must be made within 24 hours. Send ack letter within 3 calendar days notifying of priority change and right to contact DMHC. Follow standard appeal process. If 24 hour TAT is not met, proceed with expedited appeal.	10/1/2018	Completed	Grievance & Appeals	✓	Self Identified	AAH	2018	Completed
3	Delegation Oversight	Some authorization cases included many errors with EviCore's notices of actions. Plan oversight of authorizations and notices is in process.	Reestablished bi weekly meetings with EviCore and conducted monthly focused file audit which included NOAs, conducted clinical case rounds for overturned appeals. The plan will continue to monitor during annual audit review process. The Plan will be terminating services with EviCore and consuming this function to review authorization effective 4/1/19.	12/1/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
4	Care Coordination	The Plan did not annually review the County MOU for CCS services.	Update 9/27/2019: MOUs have transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including CCS. Update as of 12/2/19: The MOUs have been transitioned to the Provider Services team. The BHCS MOU was executed with an effective date of August 1, 2019	8/1/2019	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
5	Care Coordination	The Plan did not annually review the County MOU for Early intervention/development disabilities.	Update 9/27/2019: MOUs have been transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including EI/DD services. Update as of 12/2/19: The Plan is currently working on developing a full county MOU to include services for early intervention and development disabilities services Update 7/10/20: The MOU was sent to the County for review on June 16, 2020. Update 10/9/20: The County has accepted the Alliance's edits and the MOU is currently under review for final approval with the County. Update 11/10/20: The County has cancelled the November 3rd meeting. This agenda item will be carried over to the December 15th docket. **Update 5/14/21**: The MOU was approved by the county board on April 6, 2021.	~~2/28/20~~ TBD	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
6	Initial Health Assessment (IHA)	The Plan did not have a process for validating the procedure codes used for IHA completion.	P&P will be updated to include the detail of the process for annual validation and codes. The validated for this year will occur prior to 11/1/18. Update 11/06/18: Codes were validated and updated by QM department.	11/1/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
7	Initial Health Assessment (IHA)	The Plan does not have a system in place for monitoring member's missed appointments.	Missed appointments are identified during the Medical Record Review that is part of a FSR. The criteria for missed primary care appointments and outreach efforts, which is part of DHCS's tool. The FSR review nurse evaluates this information and if a deficiency is identified the provider is educated on the importance of outreaching to the member and that documentation of the outreach attempts is required.	11/26/2019	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
8	Access & Availability	The Plan did not monitor appointment wait times.	Policy and procedure is in place for monitoring appointment wait time standards. Standardized process for monitoring and corrective action plan in place as of 9/20/18.	9/20/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
9	Grievances	Some exempt grievance cases were not resolved within the next business day timeframe (applied to 1 3 cases).	Policies and procedures in place are compliant with the exempt grievance resolution timeframe requirements. Staff training refresher of resolving all exempt grievances by close of next business day was conducted on 10/12/18.	10/12/2018	Completed	Member Services	✓	Self Identified	AAH	2018	Completed
10	Quality Improvement	Reporting of the HCQC was not consistently reported to the Board.	The Chief Medical Officer will provide HCQC summary updates to the Board starting in November. The meeting minutes will be included in the Board materials.	11/9/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
11	Utilization Management	The Plan did not routinely review overturned UM denials for trends & to develop plans for intervention where needed.	The Plan will pull reporting of UM denial trends that will be presented at the UM committee. The first UM committee for presenting the overturn UM denial trends at UM committee will be on 9/28/18. These findings will be presented to the HCQC and subsequently to the Board of Governors.	9/28/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed

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

Q4 2023 - Present APL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
56	DHCS	23-028	10/3/2023	Dental Services – Intravenous Sedation and General Anesthesia Coverage	MEDI-CAL	The purpose of this All Plan Letter (APL) is to describe the requirements for Medi-Cal managed care health plans (MCPs) to cover intravenous (IV) moderate sedation and deep sedation/general anesthesia services provided by a physician in conjunction with dental services for MCP Members in hospitals, ambulatory surgical settings, or dental offices. This APL supersedes APL 15-012.1 This APL identifies information that MCPs must review and consider during the prior authorization process as described and detailed in the attached guidelines for IV moderate sedation and deep sedation/general anesthesia for dental procedures (Attachment A).
57	DHCS	23-029	10/11/2023	Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify the intent of the Memorandum of Understanding (MOU) required to be entered into by the Medi-Cal managed care plans (MCPs) and Third Party Entities (defined below) under the Medi-Cal Managed Care Contract (MCP Contract) with the Department of Health Care Services (DHCS), and to specify the responsibilities of MCPs under those MOUs. In addition, this APL contains an MOU template with general provisions required to be included in all MOUs (Base Template) that the MCPs must execute pursuant to the MCP Contract and MOU templates tailored for certain programs, which contain the required general MOU provisions and program-specific provisions (Bespoke Templates). Further, this APL addresses DHCS' expectations and oversight of MCP obligations under this APL and the MOUs, including MCP reporting requirements.
58	DHCS	23-030	10/24/2023	Medi-Cal Justice-Involved Reentry Initiative-Related State Guidance	MEDI-CAL	The purpose of this All Plan Letter (APL) is to announce the release of the "Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative" for county welfare departments, state prisons, county correctional facilities, county youth correctional facilities, and/or their designated entity(ies). The Policy and Operational Guide (herein referred to as "The Guide") memorializes policy and operational requirements for implementing the Medi-Cal Justice-Involved Reentry Initiative.
59	DMHC	23-020	10/26/2023	Amendments to Rule 1300.67.2.2 and Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2024	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to inform health care service plans (health plans) of new amendments to 28 CCR § 1300.67.2.2 and the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for the reporting year (RY) 2024 Annual Network Report submission. These amendments are made in accordance with Senate Bill (SB) 221 (Wiener, Chapter 724, Statutes of 2021) and SB 225 (Wiener, Chapter 601, Statutes of 2022) which provided the DMHC with two exemptions from the Administrative Procedure Act (APA) to develop mandatory reporting methodologies and standards for the Annual Network Report and Timely Access Compliance submission.
60	DMHC	23-021	11/14/2023	Payment of COVID Claims for COVID-19 Tests Delivered Between March 4, 2020 and December 31, 2021	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 23-021, which provides information in regards to payment of COVID claims for COVID-19 tests delivered between March 4, 2020 and December 31, 2021.
61	DHCS	23-012	12/4/2023	Enforcement Actions: Administrative and Monetary Sanctions (REVISED)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) of the Department of Health Care Services' (DHCS) policy regarding the imposition of administrative and monetary sanctions, which are among the enforcement actions DHCS may take to enforce compliance with MCP contractual provisions and applicable state and federal laws. This APL supersedes APL 22-015.
62	DMHC	23-022	12/13/2023	Compliance with Senate Bill 1419 - Health Information	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-022, delaying the January 1, 2024 effective date of SB 1419 (2022) until January 1, 2025.
63	DMHC	23-023	12/14/2023	Notice of Amendments to Rules 1300.51 and 1300.67.2 and Incorporated Documents – Network Adequacy Requirements and Mental Health Standards and Methodology for RY 2024	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-022, delaying the January 1, 2024 effective date of SB 1419 (2022) until January 1, 2025.
1	DHCS	24-001	1/12/2024	Street Medicine Provider: Definitions and Participation in Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on opportunities to utilize street Medicine providers to address clinical and non-clinical needs of their Medi-Cal Members experiencing unsheltered homelessness.

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
2	DMHC	24-001	1/12/2024	Amendment to Rule 1300.71.31 regarding calculation of the “Average Contracted Rate” for AB 72 (2016) purposes	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-001 to provide guidance to plans on the Amendment to section 1300.71.31 of title 28 of the California Code of Regulations (Rule 1300.71.31).
3	DMHC	24-002	1/22/2024	Large Group Renewal Notice Requirements	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-002 to provide guidance to plans on the timing and content requirements for renewal notices to large group contract holders under HSC section 1374.21 and HSC section 1385.046.
4	DMHC	24-003	1/29/2024	Plan Year 2025 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-003 to assist in the preparation of Plan Year 2025 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules).
5	DHCS	24-002	2/8/2024	Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members	MEDI-CAL	The purpose of this All Plan Letter (APL) is to summarize and clarify existing federal and state protections and alternative health coverage options for American Indian Members enrolled in Medi-Cal managed care plans (MCPs). Additionally, this APL consolidates various MCP requirements pertaining to protections for Indian Health Care Providers (IHCPs), including requirements related to contracting with IHCPs and reimbursing claims from IHCPs in a timely and expeditious manner. This APL also provides guidance regarding MCP tribal liaison requirements and expectations in relation to their role and responsibilities.
6	DMHC	24-004	2/22/2024	Coverage of Over-the Counter FDA Approved Contraceptives	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-004 to remind health plans, effective January 1, 2024, the rules changed regarding health plan coverage of over-the-counter (OTC) contraceptive drugs, devices, and products approved by the federal Food and Drug Administration (FDA).

2024 Mock Audit Schedule			
Category	**Date/Time**	**SMEs**	**Interviewers**
Mental Health and Substance Abuse/BHT	Monday, 4/22/2024 10:00 AM-11:00 AM		(Compliance Team)
Non-Emergency and Non-Medical Transportation (NEMT/NMT)	Monday, 4/22/2024 1:00 PM-2:00 PM		(Compliance Team)
Complex Case Management (CCM)	Tuesday, 4/23/2024 10:00 AM-11:00 AM		(Compliance Team)
Delegation of Utilization Management	Tuesday, 4/23/2024 1:00 PM-2:00 PM		(Compliance Team)
Prior Authorization (Medi-Cal)	Wednesday, 4/24/2024 1:00 PM-2:00 PM		(Compliance Team)
Privacy and Security	Thursday, 4/25/2024 10:00 AM-11:00 AM		(Compliance Team)
FWA	Thursday, 4/25/2024 1:00 PM-2:00 PM		(Compliance Team)
Grievance and Prior Auth Appeals	Friday, 4/26/2024 10:00 AM-11:00 AM		(Compliance Team)
Basic Case Management and Initial Health Assessment (IHA)	Monday, 4/29/2024 10:00 AM-11:00 AM		(Compliance Team)
Provider Qualifications	Monday, 4/29/2024 1:00 PM-2:00 PM		(Compliance Team)
Quality Improvement	Tuesday, 4/30/2024 10:00 AM-11:00 AM		(Compliance Team)
Access & Availability of Care	Tuesday, 4/30/2024 1:00 PM-2:00 PM		(Compliance Team)
Emergency Services, Family Planning, and State Supported Services Claims	Wednesday, 05/1/2024 10:00 AM-11:00 AM		(Compliance Team)
Non-Emergency and Non-Medical Transportation (NEMT/NMT)-ModivCare Team	Thursday, 05/2/2024 10:00 AM-11:00 AM	ModivCare Team	AAH Team
ADHOC/Delegate	Friday, 5/3/2024 10:00 AM-11:00 AM	TBD	AAH Team

Mock Audit Interview Questions

ALAMEDA Alliance FOR HEALTH

Helping People in Our Community Since 1996

"By failing to prepare you are preparing to fail.,' -Benjamin Franklin

Helpful Suggestions for DHCS Audit 2024

Dress in business attire during the virtual onsite audit visit: April 22, 2024, through May 03, 2024.

1. **Ensure coverage of proper personnel during the audit period, limit PTO.**

2. **Be on-time to your scheduled interviews, pay attention and limit any distractions during interviews (email/phone). We recommend logging on/dialing in at least 5 minutes prior to the start of your session.**

3. **Tell the truth, be honest and open. Show your confidence since you are the SME.**

4. **Be nice & smile. Attitude can shape an audit.**

5. **Don't argue if confronted, don't speculate or guess.**

6. **If asked a Yes or No question, answer with a Yes or No.**

7. **It's not your job to fill uncomfortable silence by continuing to speak and add to your response.**

8. **It's okay to talk to the auditor about neutral topics before or after the interviews, (neutral topics include Alameda Area, restaurants, weather, pets, sports).**

9. **During your interview you can take notes but do not bring internal documents to "show the auditors".**

10. **Do not supply ANY documents to auditors without prior approval from the Compliance Department (even in the most minimal case). Any additional information will be evaluated by Compliance before being supplied to "clarify facts."**

11. **If you do not know an answer, simply say you would like to research the questions and respond when you have all the information you need to provide an accurate response.**

12. **If asked a question and you're not sure what is being asked, request they elaborate or give you more clarifying facts or repeat the question.**

13. **Please remember that we are representing the Alliance to the state auditors, please dress in a professional manner.**

14. **Be prepared to speak to the answers that you provided on the questionnaire.**

Access & Availability

1. **Could you explain how the Provider packet for Q1 2023 is distributed.**

2. **For fax blast, when was the last approximate date the Plan sent out the fax?**
    a. **What other provider materials were sent out as part of education?**
    b. **How often were they sent out?**

3. **Is there a P&P that speaks to the timely access standards first prenatal visit?**
    a. **Why did the plan use 10 business days instead of 2 weeks and when did it change?**

4. **If a member wants to see an OBGYN specialist, what is the plan's policy for appointments?**

5. **Does the plan monitor delegated providers network for timely access standards?**

6. **Where in policy QI-114 is that item regarding MR documentation of member related to extending appointment timeframes?**

7. **Walk us through your Provider Enrollment process.**
    a. **What type of information and documents do you collect? Is there an application fee?**
    b. **Are providers screened against the OIG sanctions list?**
        i. **How often?**
    c. **Does AAH collect and review Ownership and Control information of your providers?**
    d. **Does AAH conduct site visits?**
        i. **If so, how often? How are offices selected (at random, for cause)?**
    e. **How long does AAH take to complete and provide an applicant with a written determination?**

8. **Walk us through your credentialing and recredentialing process.**
    a. **What type of information and documentation do you collect and verify?**
    b. **When does AAH recredential its network providers?**

9. **Regarding disclosures, have they been resolved?**

10. **Please describe the onboarding process of PPGs.**

11. **Have there been instances where you have had to withdraw excluded providers?**
    a. **How were those providers identified and how were they notified?**
    b. **Do they have the right to appeal against the decision?**

12. **How do you confirm that a provider is no longer receiving payment in connection to Medi-Cal?**

13. **Please explain the roles of the following as it relates to Provider Training:**
    a. **Oversight and Monitoring**
    b. **Engagement and Strategy**

14. **Please explain your new provider orientation process and the timeframes used to ensure all new providers to AAH receive training when they become active.**

15. **How is it determined that a physician is "active"?**

16. **How does AAH ensure that the training is completed by the physician, and not just that the training materials are received?**

17. **What is your process for updating the training material to capture new regulatory requirements?**

18. **To ensure the Credentialing Committee (CC) does not consider an applicant whose credentials have changed, what timeframe do you use to evaluate an applicant and are you using NCQA guidelines for these decisions?**

19. **How are members informed of standard timeframes?**
    a. **How do they report dissatisfaction with access to seeing a PCP or Specialist?**
    b. **How are the member comments tracked and is there oversight?**
    c. **Do you monitor trends?**

20. **What actions do Provider Services take to ensure timeliness with non-compliant providers?**
    a. **Is this documented and reported at any other committee meetings?**

21. **Regarding emergency services, how does AAH ensure that a member can be seen on an emergency basis and that emergency services will be available and accessible within the members' service area?**

22. **How does AAH monitor transportation services to ensure members' timely access to appointments?**
    a. **What is the role of the Member Services team regarding transportation vendors?**
    b. **Has there been an increase in transportation requests?**
    c. **Are transportation vendors monitored at the operational or committee level?**

23. **AAH is required to maintain adequate numbers and types of specialists within their network to accommodate the needs for specialty care, are there gaps in the network?**
    a. **How does AAH work to close these gaps?**
    b. **How does AAH define provider network adequacy?**
    c. **How often is network adequacy reviewed?**

24. **Are there after-hours pharmacies available to members?**
    a. **Is AAH's network sufficient with after-hours pharmacies?**

25. **How does AAH track suspended providers?**

26. **How are you currently tracking and monitoring waiting times in provider offices, telephone calls (answer & return), and times to obtain appointments (routine care, urgent care, routine specialty referral appointments, pre-natal care etc.)?**

27. **Are there any concerns regarding the wait time for a member to make an appointment?**
    a. **What are your current wait times for BH and other specialists for a member to make an initial appointment to see a new provider?**

28. **When do providers need to be credentialed? When do they become recredentialed?**

29. **How are providers added into the network?**

30. **Can you describe the Credentialing Committee (CC) and Peer Review Committee (PRC) and their functions?**

31. **Are all providers that are enrolled in Medi-Cal FFS also credentialed by AAH?**

32. **Does AAH conduct any oversight of a new provider application?**
    a. **Can you describe the oversight from low vs. medium vs. high-risk providers?**

33. **Does AAH delegate credentialing? If so, whom do you delegate credentialing and recredentialing to?**
    a. **Can you describe the relationship?**

34. **What type of oversight do you conduct on your delegates?**
    a. **How often?**
    b. **Can we view these results?**
    c. **When do you plan to audit?**
    d. **Why have you not audited them yet?**

35. **How does the Plan ensure that providers are aware of appointment access standards?**
    a. **How often does training occur?**
    b. **How does the Plan document training?**
    c. **Please provide training completion.**

36. **How does the Plan ensure that AAH staff are aware of appointment access standards?**
    a. **How often does training occur?**
    b. **How does the Plan document training?**
    c. **Please provide training completion.**

37. **How does the Plan ensure that members are aware of appointment access standards?**

38. **Explain how the Plan monitors timely access to appointments.**
    a. **What happens when the Plan identifies providers as non-compliant with appointment access standards?**
    b. **Who currently reviews monitoring results?**

39. **Explain how the Plan monitors timely in office wait time?**
    a. **What happens when the Plan identifies providers as non-compliant with timely in office wait time?**
    b. **Who's currently reviewing monitoring results?**

40. **Explain how the Plan monitors provider compliance with the DHCS two (2) week first prenatal visit standard?**
    a. **What happens when the Plan identifies providers as non-compliant?**
    b. **Who's included/excluded from the review?**
    c. **Who currently reviews monitoring results?**

41. **Explain how the Plan monitors to ensure provider compliance with after-hours access and emergency instructions standards, per the DHCS, DMHC, and NCQA regulatory and accreditation requirements?**
    a. **Who currently reviews monitoring results?**

42. **Explain how the Plan monitors the Telephone Access Standards – For the Providers Office?**
    a. **What happens when the Plan identifies providers as non-compliant with telephone access standards?**
    b. **Who currently reviews monitoring results?**

43. **Explain the Plan's expectation for providers when a member's scheduled appointment is missed?**
    a. **How does the Plan monitor miss, canceled, and rescheduled appointments?**
    b. **What happens when the Plan identifies providers as non-compliant?**
    c. **Who currently reviews monitoring results?**

44. **Explain how the Plan ensures adequate member to provider ratio?**
    a. **What happens when the Plan is over the ratio limit?**

ALAMEDA Alliance FOR HEALTH

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

Health Care Services

Donna Carey, MD

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

From: **Dr. Donna Carey, Chief Medical Officer (Interim)**

Date: **March 8th, 2024**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

- CoC volume is currently running at 10-15% of all incoming authorizations at any given time. This is down from a high of 40% in January.

- Reporting is being analyzed to identify members who DHCS has categorized as special populations to ensure enhanced CoC benefits are managed properly for our new members. Provider relations contracting team continuing to engage in contract negotiations with identified OON providers to bring them into AAH.

- We have developed an internal flag within our eligibility database to identify Anthem transition and adult expansion members.

- Reporting requirements for DHCS began November 22nd and will continue through 12/31/2024 as part of the DHCS monitoring and oversight process.

- We have begun to analyze claims data for claims submitted without prior authorization on file. We are identifying members who appear to be in active care and may require ongoing services as well as members that we have an auth on file, for the same category of service, but not the same services that may require ongoing care for those services as well.

- OP processed a total of 3,861 authorizations in the month of February. The top 5 categories remain as radiology, OP Rehab, TQ, Home Health and Outpatient facility

Outpatient Authorization Denial Rates			
Denial Rate Type	**December 2023**	**January 2024**	**February 2024**
Overall Denial Rate	**4.1%**	**3.4%**	**4.1%**
Denial Rate Excluding Partial Denials	**3.9%**	**3.1%**	**3.9%**
Partial Denial Rate	**0.3%**	**0.3%**	**0.3%**

Turn Around Time Compliance			
Line of Business	**December 2023**	**January 2024**	**February 2024**
Overall	**99%**	**99%**	**100%**
Medi-Cal	**99%**	**99%**	**100%**
IHSS	**100%**	**100%**	**100%**
Benchmark	***95%***	***95%***	***95%***

Utilization Management: Inpatient

- The Inpatient UM team processed a total of 2,505 reviews in the month of February. This is a decrease from the volume reported in January 2024, but still overall markedly higher than December 2023 before the integration of the Anthem and Adult Expansion members in addition to the seasonal influx in acute admissions during the typical Winter Flu Season Months. Volumes of reviews were as follows: Acute Hospitalizations (1823), Skilled (337), Short Term Custodial (140) Skilled Bedholds (58) and Acute Rehab/ LTAC (36). We continue to see an increase in the SNF Admissions related to 2023 volume increases from both the Long-Term Care carve-in and the dually eligible (MediCare and Medi-Cal) population throughout Q4 and into Q1 of this year. These new populations have a higher hospitalization rate, which contributed to increases in acute inpatient admissions.

- IP UM has begun completing authorizations for Inpatient Admissions for the members transitioning from Anthem, the Adult Expansion Population and the LTC Phase 2 Carve in Populations.

- Overall, Auth TAT compliance was 99% for the months of December and January and in February it dropped slightly to 98%. This still exceeded the benchmark TAT of 95% for both our Medical and Commercial Lines of Business.

- IP UM is receiving ADT feed for Authorization automation from Alameda Health Sytem's, Alta Bates Summit Medical Center, Eden Hospital, Washington Hospital, and St Rose. IP UM team has, in working with IT, automated the auth request process for these hospitals. This will cut down on the administrative burden on the hospital provider side while facilitating real time communication on member admissions.

- As part of the Transitional Care Services (TCS) requirement for Population Health Management, the IP UM team is identifying high-risk members admitted to a hospital, conducts discharge risk assessment, provides the name of Care Manager for inclusion in the discharge summary, and refers to Case Management department for follow up. Starting in 2024, TCS also includes simplified requirements for low-risk members, and the IP team has operationalized the enhanced TCS requirements.

- IP UM continues weekly hospital rounds with tertiary care centers UCSF and Stanford, as well as contracted hospital providers; Alameda Health System, Sutter, Kindred LTACH, Kentfield LTACH, and Washington, to discuss UM issues, address discharge barriers, and improve throughput and real time communication.

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**October 2023**	**November 2023**	**December 2023**
Authorized LOS	**5.3**	**5.1**	**5.1**
Admits/1,000	**52.6**	**52.5**	**57.2**
Days/1,000	**282.2**	**267.4**	**289.9**

****** January 2024 data is not yet available at the time of completion. Anticipated on March 1st after 5p.m.***

Turn Around Time Compliance			
Line of Business	**December 2023**	**January 2024**	**February 2024**
Overall	**98%**	**98%**	**98%**
Medi-Cal	**98%**	**98%**	**98%**
IHSS	**100%**	**96%**	**100%**
Benchmark	***95%***	***95%***	***95%***

Inpatient Authorization Denial Rates			
Denial Rate Type	**November 2023**	**December 2023**	**January 2024**
Full Denials Rate	**1.6%**	**1.8%**	**1.0%**
Partial Denials	**0.7%**	**1.8%**	**1.3%**
All Types of Denials Rate	**2.3%**	**3.6%**	**2.3%**

Utilization Management: Long Term Care

- LTC census during January 2024 was 2582members, this does not include the Anthem membership loaded 02/01/24. This is an increase of 40.48% from December 2023.

- During Q4 2023, LTC members had a total of 289 admissions with an average LOS of 6.4 days, which is slightly up from the 6.2 days reported last quarter.

Totals	Q3 2023	Q4 2023
Admissions	227	289
Days	1,401	1,850
Readmissions	62	66

- LTC Deliverables all submitted, awaiting DHCS approval.

- Met with Regional Center of East Bay, monthly meetings have been scheduled to have a “rounds” discussion to touch base on the members and their possible needs while in the ICF/DD facilities.

- LTC Staff continue to participate in SNF collaboratives around the county to ensure that our facility partners are kept up to date with the processes and program enhancements.

- LTC Director is attending the DHCS PHM Transitional Care Summit in Los Angeles on 03/06/24, to align the transitional care process for the Long-Term Care members.

- Continue to reconcile census and authorizations, as well as generate referrals to TCS and other internal/external programs to provide wraparound supports to members preparing to discharge from an LTC custodial facility.

- We have loaded the ICF/DD and Subacute authorizations from DHCS, there are some that were not sent to us from DHCS. We are working with the homes to get those authorizations loaded. We currently have 129 members in ICF/DD and 69 in subacute.

- Anthem transition: Batch load was performed 02/01/24, 245 LTC auths were entered.

- Authorization volume has increased by 8% in February 2024 compared to January 2024.

Authorization Count	December 2023	January 2024	February 2024
Post Service/ Retrospective	NA	56	87
Routine (Non-Urgent) Pre-Service	NA	1315	1169
Urgent Pre-Service	NA	14	15

**December 2023 LTC Authorization volume was not captured in detail*

- Authorization processing turn-around time (TAT) **meets** benchmark:

	December 2023	January 2024	February 2024
Numerator	267	1321	1223
Denominator	334	1385	1271
Met %	80%	95%	96.2%
Benchmark	95%	95%	95%

- LTC team continues the following activities to manage increased production volumes and maintain TAT compliance:
    - Hiring additional staff to assist with the increase in volume
    - Continue staff education so that TAT is calculated correctly
    - Working with analytics to help capture line level TAT correctly

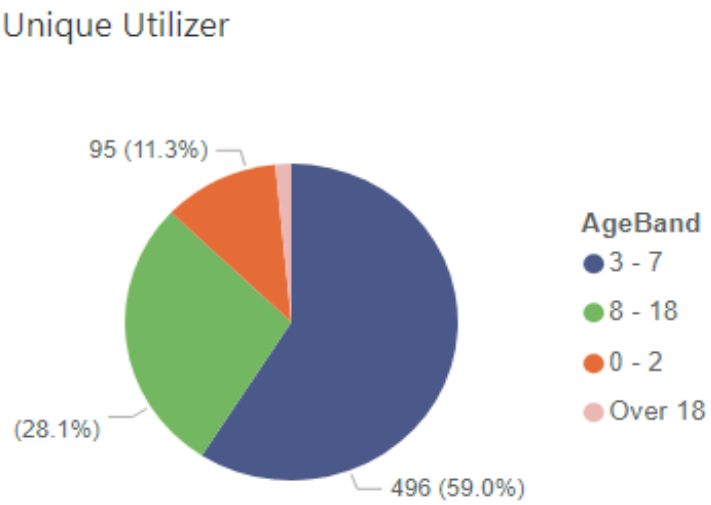
Behavioral Health

BH UM Outpatient

- MCP transition- Mental health and BHT/ABA authorization volume in January by approximately 50%. This was driven by the Anthem transition. Call volume increased by close to 80%. The AAH behavioral health team is responding to members seeking to start services and those seeking to continue care with their existing providers. Continuity of Care (CoC) is being implemented for members requesting to continue services with their existing behavioral health provider, and providers who are not currently credentialed and contracted (non-Par) are offered letters of agreement (LOAs).

- An analytics report request was submitted on 02/06/2024 for an out-of-network report that mirrors medical UM. The report will track the Continuity of Care requests. Approximately 62 out-of-network requests were reviewed in January 2024.

- A priority for the Behavioral Health Department is to increase utilization of both mental health and BHT/ABA services since insourcing management of these benefits in April of 2023. To track and measure our progress, we track and trend the Unique utilizers of behavioral health services monthly by age band.



- We are seeing a steady increase in unique utilizers of BHT/ABA services from the baseline (Ave # of children receiving ABA services in the four months prior to April 1, 2023) of 550 as of Go Live to 764 as of November 2023.

- We are seeing a steady increase in the unique utilizers of mental health services from the baseline (Ave # of members receiving mental health services in the four months prior to April 1, 2023) of 6,157 as of Go Live to 11,378 as of November 2023.

- Authorization Determinations and Notifications to members and rendering providers turnaround time (TAT) was impacted by the volume of services requested and processes that were not implemented fully for the Mental Health team. Process improvement resulted in improvement in January intending to achieve 100% Notification TAT by March 2024. Please see graphs below which delineate TAT by service line.

MH TAT			
	23-Dec	24-Jan	24-Feb
Determination TAT%	94%	97%	99%
Notification TAT%	49%	73%	81%

BHT TAT			
	23-Dec	24-Jan	24-Feb
Determination TAT%	91%	94%	97%
Notification TAT%	100%	100%	100%

BH Denial Rates		
23-Dec	24-Jan	24-Feb
0.01%	0.01%	0.01%

*Overall, denial rates remain low.

BH Case Management

- AAH completes mental health screening tools per DHCS requirements. This is a shared responsibility between member services and behavioral health team.

Total # Medi-Cal Screening Tools			
	Dec-23	Jan-24	Feb-24
Youth Screenings	8	65	63
Adults Screenings	85	140	111

- AAH completes mental health screening tools per DHCS requirements. This is a shared responsibility between member services and the behavioral health team. AAH completes mental health screening tools per DHCS requirements. This is a shared responsibility between member services and the behavioral health team.

MH Case Coordination			
	202312	202401	202402
In Progress	**30**	**50**	**90**
Closed	**73**	**148**	**76**
Total	**103**	**198**	**166**

BHT Case Coordination			
	202312	202401	202402
In Progress	88	141	159
Closed	18	58	2
Total	106	199	161

- The AAH Behavioral Health Department in collaboration with Provider Services, published Guidance for our behavioral health provider network, including:
    - Instructions for ABA providers in completing the required Treatment Plans that are reviewed every six months. Additionally, we have published FAQs and EOC update for ABA providers.
    - Training for the mental health provider network was provided to ensure they understand how to submit coordination of care treatment reports securely via the AAH provider portal. Additionally, training was provided to ensure mental health providers are submitting the DHCS required Transition of Care Tool when referring members to ACBH for specialty mental health services. This training was followed up with the publication of a "Behavioral/Mental Health Provider Portal Guide" in January 2024.
    - The Behavioral Health Team in collaboration with the AAH IT team is working on providing mental health coordination of care treatment reports that are now submitted by mental health providers to PCPs in response to the longstanding concern that PCPs were not receiving feedback from mental health providers about their patient's treatment. Similarly, the Behavioral Health Team is working with the AAH IT Team to develop a similar coordination of care treatment report that will enable feedback regarding their patient's BHT/ABA treatment to be sent to the patient's PCP/Pediatrician.

- To address the behavioral health findings from the 2023 DHCS audit that focused on Beacon's performance in reviewing BHT/ABA treatment plans the Behavioral Health Team has taken several steps to ensure this is not a repeat finding in the upcoming 2024 DHCS audit.
    - The Behavioral Health Team in collaboration with Provider Services published guidance on all the required elements that must be contained in the BHT/ABA treatment plans that are submitted to AAH for review and authorization.
    - In follow up to this training guidance, we have instituted treatment plan review processes that identify missing elements in treatment plans when they are received to then request the missing information prior to completion of the authorization.

- The Behavioral Health Team collaborated with pediatricians from the Special Needs Committee to design a PCP referral form that is now published and available to all PCPs who seek to refer members for mental health and/or BHT/ABA services.

- The Behavioral Health Department has participated in the CYBHI initiatives that began with the SBHIP program. The SBHIP program has been successful meeting all the requirements established by DHCS and in our participation AAH has forged collaborative relationships with the Alameda County Office of Education (ACOE) as well as many school districts (LEAs) in Alameda County in anticipation of the expansion of our responsibilities to provide mental health and BHT/ABA services in and near schools. AAH is participating in the first cohort of MCPs, and LEAs selected to implement the new school based mental health services for which school based providers will begin billing AAH for services.

BH Grievance & Member Experience

- Behavioral Health Grievances increased significantly during the first four months following insourcing. Analysis of these Grievances helped identify the factors impacting member experience including:
    - Network Limitations resulting in increased wait times for BHT/ABA services.
    - Increased wait times for afternoon / evening hours and for non-English speaking families.
    - High volume of children awaiting access to services has resulted in our development of needed internal resources to respond to the complex case management and coordination of care needs for members seeking BHT/ABA services. We have more than doubled the size of the Behavioral Health Team in response and we are measuring our response time to member calls and requests.
    - Insufficient and inaccurate information about the services our mental health providers offer resulting in frustrating barriers to access to the right services that match a member's needs. We are collaborating with AAH Operations to re-survey all in network mental health providers to obtain up to date and accurate information about the populations they serve.

Accreditation

- In January 2024 the BH Team participated in NCQA mock audit to prepare for the 2025 NCQA audit. The team presented files that were reviewed by our NCQA consultant and overall, the files looked good. Specific recommendations from the consultant are now being used to adjust our Behavioral Health UM processes.

Community Relationships and Collaboration

- The Behavioral Health Team in collaboration with Operations continues to Meet with high volume mental health and BHT/ABA providers to better understand their needs and seek input on how we can better support them as they grow capacity to serve our members.
    - In meeting with our largest in network Psychiatric Group we adjusted our Coordination of Care Treatment Plan submission process to make coordination of care feasible and ensure they can continue to serve our members.
    - In meeting with several of our BHT/ABA provider groups, known as "Qualified Autism Service Providers" (QASPs) we learned that there are significant barriers to retain the para-professional level providers within their groups which is impacting access and continuity of care for our members. We are collaborating with AAH Operations to explore ways we can support our QASPs in hiring and retaining these providers that are essential in delivering face to face ABA services.

- The Behavioral Health Team meets bi-monthly with the ACBH ACCESS Team to coordinate care for our members who are receiving specialty mental health services.
    - Since April of 2022 the Behavioral Health Team has participated in monthly meetings to implement DHCS's "No Wrong Door" initiatives. We have initiated a data sharing process in collaboration with the AAH IT team to develop a bi-directional data exchange process to support the new requirements related to care coordination, closed loop referrals and transitions of care that DHCS has mandated.
    - Currently, the BH Team is meeting with ACBH clinical leadership to collaborate on several areas where improvement is needed including the implementation of screening tools, Transition of care tools and crisis services.

Pharmacy

- Pharmacy is leading initiatives on PAD (physician administered drugs) focused internal and external partnership and reviewed PAD related UM authorizations as follows:

- Top 10 Requested Drugs Submitted for Authorizations:

HCPCS Code	Drug Name	Authorizations
J9035	INJECTION BEVACIZUMAB 10 MG	412
J1453	INJECTION FOSAPREPITANT 1 MG	197
J0585	BOTULINUM TOXIN TYPE A PER UNIT	179
J0178	INJECTION AFLIBERCEPT 1 MG	175
J2930	INJ METHYLPRDNISLN SODIM TO 125 MG	155
J0897	INJECTION DENOSUMAB 1 MG	155
J2469	INJECTION PALONOSETRON HCL 25 MCG	141
J9271	INJECTION PEMBROLIZUMAB 1 MG	113
J2506	INJ PEGFILGRASTIM EXC BIOSIM 0.5 MG	100
J9045	INJECTION CARBOPLATIN 50 MG	93

Authorization Overview

Line of Business	November 2023	December 2023	January 2024
IHSS	9	12	8
Medi-Cal	340	317	621
NULL*	0	1	0

***** Sum of authorizations processed by Pharmacy Team (includes Determinations and Voids (authorizations closed))

Null=PA sent for Members who have zero eligibility with the Alliance

Turnaround Time and Determinations By Line of Business

LOB	Determination	November 2023	December 2023	January 2024
Medi-Cal	Approved	238	213	427
	Denied/Partials	4	5	6
	TAT	99%	98%	98%
IHSS	Approved	6	10	6
	Denied/Partials	---	---	---
	TAT	100%	100%	100%

Case and Disease Management

- CM has extended Transitional Care Services (TCS) to all members, starting January 1, 2024. CM continues to collaborate with hospital and clinic partners to ensure TCS requirements, such as post discharge follow up appointments, are met.

- CM continues to work with UM on Continuity of Care requests for former Anthem members.

- Major Organ Transplant (MOT) CM Bundle continues to be offered to members needing evaluation and transplantation of major organs and bone marrow. The volume continues to increase, (currently 561 members). Case management nurses support members throughout the MOT process, and coordinate services with the AAH UM department and the Centers of Excellence staff.

- CM is working to include high utilizers in its population health telephone outreach, where complex case management eligible members are invited to engage in complex case management.

- 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.

- As of January 1, 2024, Disease Management programming is offered for Asthma, Diabetes, Cardiovascular Disease and Depression diseases in accordance with the Population Health Management Policy Guide. CM is working closely with the IPD team and Anthem to ensure effective transition for members formerly with Anthem regarding case management and transportation services.

Case Type	Cases Opened in January 2024	Total Open Cases as of January 2024	Cases Opened in February 2024	Total Open Cases as of February 2024
Care Coordination	775	1261	513	1283
Complex Case Management	14	114	13	62
Transitions of Care (TCS)	1228	1399	478	1135

CalAIM

Enhanced Case Management

- January 1, 2024, was the launch of the final Populations of Focus (Justice Involved & Birth Equity).

- The ECM team received Continuity of Care authorization requests for members formerly assigned to Anthem. The team is working closely with each provider to confirm all appropriate Continuity of Care authorizations are on file with the Alliance.

- The Alliance is continuing to meet with Roots regarding the Justice Involved (JI) Pilot. The Alliance is gaining a better understanding of how members previously incarcerated are assisted post-release, including member interest in any level of case management service.

- AAH continues to collaborate with Health Care Services Agency (HCSA) to discuss Street Medicine alignment. 2 of the 4 Street Medicine teams have finalized their contracts for ECM. The ECM team has started to receive referrals and have processed 62 authorizations to date.

ECM Outreach in November 2023	Total Open Cases as of November 2023	ECM Outreach in December 2023	Total Open Cases as of December 2023	ECM Outreach in January 2024	Total Open Cases as of January 2024
441	1693	356	1819	279	1766

Community Supports (CS)

- Community Supports received authorizations for Continuity of Care for members previously assigned to Anthem. The CS team continues to work closely with each provider to confirm all authorizations are on file with the Alliance.

- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance now offers:
    - Housing Navigation
    - Housing Deposits
    - Tenancy Sustaining Services
    - Medical Respite
    - Medically Tailored/Supportive Meals
    - Asthma Remediation
    - (Caregiver) Respite Services
    - Personal Care & Homemaker Services
    - Environmental Accessibility Adaptations (Home Modifications)
    - Nursing Facility Transition/Diversion to Assisted Living Facilities
    - Community Transition Services/Nursing Facility Transition to a Home

- AAH CS staff team continues to meet regularly with each CS provider to work through logistical issues as they arise, including referral management, claims payment and member throughput.

- To meet the regulatory requirements of a closed loop referral process, AAH continues to work with FindHelp as the support platform. AAH continues with onboarding Community Supports providers and the CS team is working closely with each CS provider to bring them onto the platform.

- Sobering Center go-live has been pushed out to 7/1/24 at the recommendation of DHCS due to delays in contracting.

Community Supports	Services Authorized in November 2023	Services Authorized in December 2023	Services Authorized in January 2024
Housing Navigation	655	702	1009
Housing Deposits	122	113	96
Housing Tenancy	841	822	999
Asthma Remediation	54	64	58
Meals	1277	1124	1012
Medical Respite	79	78	80
Transition to Home	4	4	5
Nursing Facility Diversion	13	15	21
Home Modifications	5	4	4
Homemaker Services	80	130	181
Caregiver Respite	2	2	3

Grievances & Appeals

- All cases were resolved within the goal of 95% of regulatory timeframes.

- Total grievances resolved in January were 8.82 complaints per 1,000 members.

- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of January 2024; we met our goal at 17.7% overturn rate.

January 2024 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,023	30 Calendar Days	95% compliance within standard	1,021	99.8%	2.32
Expedited Grievance	2	72 Hours	95% compliance within standard	2	100.0%	0.00
Exempt Grievance	2,918	Next Business Day	95% compliance within standard	2,906	99.5%	6.50
Standard Appeal	45	30 Calendar Days	95% compliance within standard	45	100.0%	0.11
Expedited Appeal	0	72 Hours	95% compliance within standard	N/A	N/A	0.00
Total Cases:	3,988		95% compliance within standard	3,974	99.6%	8.83

*Calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1000.

Grievances

- 394 of 1,025 (38.4%) cases were related to Coverage Dispute, the top 3 categories are:
  - (179) Provider Direct Member Billing
  - (144) Provider Balance Billing
  - (37) Reimbursement

- 332 of 1,025 (32.3%) cases were related to Access to Care, the top 3 grievance categories are:
  - (152) Timely Access
  - (74) Provider Availability
  - (46) Technology/Telephone

- 193 of 1,025 (18.8%) cases were related to Quality of Service, the top 3 categories are:
  - (42) Transportation
  - (41) Plan Customer Service
  - (38) Member Informing Materials

Appeals:

- 8 out of 45 (17.7%) cases were overturned for the month of January 2024:
  - (4) Disputes Involving Medical Necessity
  - (4) Out of Network

Quality

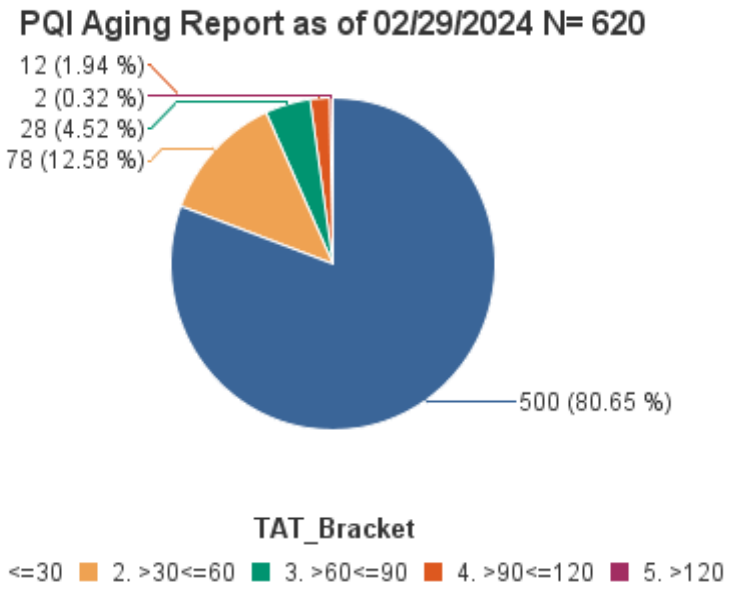
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

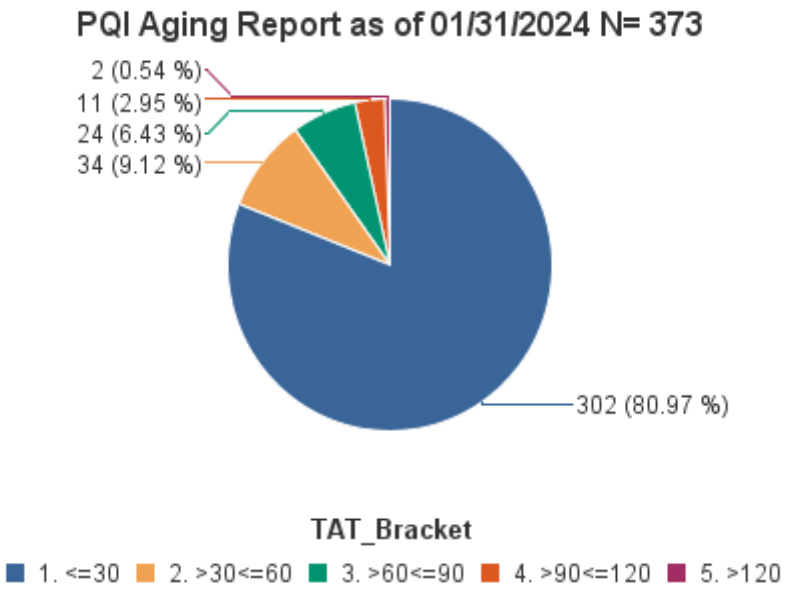
- As part of an effort to streamline the PQI review process, Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics team after they are triaged by the QI Clinical team. Quality of Care and Service issues continue to be reviewed by the QI Clinical staff.

- 99.46% of cases in January and 99.68% of cases in February were leveled and closed within the required 120-day turnaround timeframe. Therefore, turnaround times for case review and closure remain well within the benchmark of 95% per PQI P&P QI-104 for this lookback period.

- When cases are open for >120 days, the reason continues to be primarily due to delay in receipt of medical records or provider responses. Ongoing efforts are made to identify barriers with specific providers to find ways to better collaborate to achieve resolution.

- As membership has increased since the beginning of the year, QI is seeing an increase in PQIs, the majority of which are Quality of Service issues. TATs will be closely monitored to ensure timely closure of cases within the standard 95%.





- On December 5, 2023, the Department of Health Care Services (DHCS) notified the Alameda Alliance for Health (AAH) of financial sanctions totaling $80,000 due to failure to meet minimum performance levels (MPL) in the HEDIS/Medi-Cal Managed Care Accountability Set Performance (MCAS) measures for the measurement year 2022. The measures include: Follow-Up After Emergency Visit for Mental Illness (FUM), Lead Screening for Children (LSC), Well-Child Visit 0-15 months (W15), Controlling Blood Pressure (CBP), and Cervical Cancer Screening (CCS).

- To address these shortcomings and ensure compliance with the required 2024 milestones, AAH has devised a revised comprehensive quality strategy. This strategy outlines new interventions aimed at surpassing MPL and details the allocation of resources and staff to achieve these goals.

- AAH has earmarked $5 million to invest in various quality initiatives, each targeting HEDIS/MCAS performance enhancement and member care:
    - Provider Engagement: Increase Pay for Performance funds by $3.5 million, initiate a $1 million Health Equity Incentive Pilot, and provide provider training focused on preventive care services.
    - Member Engagement: Maintain partnership with First 5 for member engagement, conduct non-utilizer outreach to involve members in care, and conduct multiple member outreach programs led by internal quality staff.
    - Data Collection/Sharing: Contract with Manifest MedEx, a Health Information Exchange (HIE), to facilitate continuous data submission through an HIE with providers.
    - Innovative Funding/Resources for QI Provider Support: Introduce practice coaching consultants to offer on-site support for low-performing providers, and provide documentation and coding resources to assist providers with accurate coding methods.
    - Organizational Alignment: Coordinate efforts to address health equity gaps and launch campaigns promoting preventative care.

- Additionally, AAH has hired or plans to hire multiple new Quality Improvement Staff in the 2023-2024 budget year to bolster support for quality improvement initiatives, access to care, and language services.

- By adopting an integrated approach encompassing providers, members, and the community, including data collection/sharing, innovative funding/resources, and organizational alignment, AAH aims to achieve notable improvements in HEDIS/MCAS performance. Preliminary rates for MY 2023 indicate significant progress toward or attainment of MPL benchmarks.

ALAMEDA Alliance FOR HEALTH

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

Health Equity

Lao Paul Vang

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

From: **Lao Paul Vang, Chief Health Equity Officer**

Date: **March 8th, 2024**

Subject: **Health Equity Report**

Internal Collaboration:

- **Population Health Management (PHM), Quality Improvement (QI), and Utilization Management (UM) Update** –
    - Discussed feedback on the Board Retreat.
    - Discussed upcoming Health Equity projects and health equity staffing.
    - Discussed Alameda County collaboration regarding the Community Health Assessment and Community Health Improvement Plan (CHA/CHIP).

- **Vendor Management (VM) Update –**
    - **Supplier Diversity Project:**
        - We continue to work with the Vendor Management team and Elevated Diversity to complete the scope of work for supplier diversity.

External Collaboration

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) –**
    - Conducted a presentation to the CHEO group regarding the need to analyze non-utilization data to identify health disparities.

- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update** –
    - Discussed the possibility of using sanction funds to support health equity initiatives for local health plans, as DHCS has not made a clear decision on how sanction funds will be used.

- **In-Person Meeting and Tour of AAH Office –**
    - The Chief Cultural Officer for the Native American Health Center (NAHC) came for an in-person meeting and tour of the AAH Office

as part of a collaboration on health equity efforts between AAH and NAHC.

- **ITUP Conference in Sacramento –**
    - On 2/6/2023, CHEO attended the ITUP conference in Sacramento, highlighting California's health policy leadership, such as Mark Ghaly, MD, MPH, Secretary, California Health and Human Services Agency, and Mia Bonta, Chair, Assembly Health Committee.
    - The Conference also cultivated discussions on building an equitable and inclusive workforce, addressing the social determinants of health, advancing CalAIM for justice-involved Californians, supporting healthy aging, and creating and fostering an anti-racist health workforce.

- **Introduction Meeting - Stacey D. Hunt, MD –**
    - Introductory meeting with Dr. Hunt, President of Sinkler Miller Medical Association, Department of Dermatology, Santa Clara Regional Medical Director, Medical Specialties; Health Equity and Inclusion. Discussed potential partnership with Sinkler Miller on health equity initiatives. Dr. Hunt will follow up with more meetings to discuss specific health equity issues that AAH and Sinkler Miller can potentially collaborate on.

Advancing Health Equity Initiative (AHEI)

- **Assessments –**
    - The consultant has completed all assessments with a total of 50 Key internal and external stakeholders interviewed.

- **Key Findings Report –**
    - The consultant presented the findings report and specific recommendations to Health Equity Officer Lao Paul Vang.
    - The consultant is scheduled to present the report to additional groups and individuals (CEO and SLT) in March.

- **The Data Committee Team (QI, UM, PHM, Analytics) Update –**
    - The consultant submitted recommendations and guidelines for data equity governance and oversight. They continue to respond to requests from the data team for assistance in data stratification analysis, particularly with the non–utilizer population.

- **Alliance Strategic Roadmap Committee Update –**
    - The consultant proposed an approach for us to guide the

organization in its strategic roadmap planning process. We are scheduling meetings in March to engage with key stakeholders.
    - The consultant has also developed communication touchpoints for committee members (including the committee invite, pre-work, etc.).

- **DEI Training Curriculum (APL 23–025) Update** –

    - **Segment: Employee Training**
    - Internal Contact: Chief Human Resources Officer.
        - The consultant is working with CHRO to review employee training elements to meet APL requirements compared to current internal educational offerings.
        - For new health equity requirements, they are recommending asynchronous training.

    - **Segment: Provider Training**
    - Internal Contact: Chief Medical Officer
        - A meeting is scheduled with the interim CMO for mid-March with the consultant.

    - **Segment: Vendor Training**
    - Internal Contact: Director of Vendor Management
        - The consultant is working with the Director to review and inventory existing vendor training efforts.

    .
    - **Training Delivery:**
        - The Health Equity Team and the consultant are conducting exploratory work to identify and recommend the most expeditious training delivery vehicles.

- **Communications Update –**

    - The Health Equity Department is developing an intranet page for the staff. We hope to go live shortly.

<u>Diversity, Equity, Inclusion, and Belonging Committee (DEIBC) and Values in Action Committee (VIAC):</u>

- **DEIB Committee Update –**

    - In February, the DEIB Committee had a special guest, Matt Woodruff. The agenda included developing a Black History Month PowerPoint for the upcoming All Staff Meeting. The Health Equity Incentive Pilot and ABC Membership were also discussed.

- **VIA Committee Update** –

    The February VIA Committee was canceled until March. The

Alliance Spring get-together will be held on Thursday, May 9th. A voting tally will help to determine the foods to be served.

ALAMEDA Alliance FOR HEALTH

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

Information Technology

Sasikumar Karaiyan

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

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

Date: **March 8th, 2024**

Subject: **Information Technology Report**

Call Center System Availability

- AAH phone systems and call center applications performed at 100% availability during the month of February 2024 despite supporting 97% of staff working remotely.

- As part of the call center processes of efficiency and effectiveness, IT is implementing Calabrio Analytics and Speech to Text features which will accurately and cost-effectively analyze customer interactions and agent activity along with its multichannel artificial intelligence and deep learning, all-in-one solution that captures and transforms data, turning raw interactions into usable data for reporting.

    - Tuning phrases activities for Calabrio Analytics and Speech to Text has been completed.
    - Completed working session with Calabrio and IT (Anthony) on February 29th, production server memory has been increased to improve load time performance.
    - The Project Manager will schedule an Analytics Training workshop in the second week of March 2024 with Calabrio and Business resources.
    - Final testing and system validation will be scheduled.

IT Security Incident

- We have been informed that Change Healthcare (HEDIS vendor) is experiencing a network interruption related to a cyber security issue, and they have taken immediate action to disconnect their systems to prevent further impact. On the other hand, the Alliance has taken proactive security measures, and have blocked all the communications and data exchanges with Change Healthcare/Optum.

- It has been identified that ALPHV/BlackCat ransomware gang was responsible for the security cyberattack, that CHC is working on multiple approaches to restore the impacted environments and will not take any shortcuts or take any additional risks as they bring their systems back online.

- The Alliance identified all the impacted areas, communicated to all the impacted stakeholders, and established a business continuity process.

- The Alliance security command center will continue to work with Change HealthCare, Optum, business stakeholders, and regulatory entities until the incident is completely resolved and closed.

IT Security Program

- IT Security 3.0 initiative is one of the Alliance's top priorities for fiscal year 2023 and 2024. Our goal is to continue to elevate and further improve our security posture, ensure that our network perimeter is secure from threats and vulnerabilities, and to improve and strengthen our security policies and procedures.

    - **Key initiatives include:**

        - Implement actionable items from the Azure Governance best-practices and recommendations document.
        - Remediating issues from security assessments. (e.g., Cyber, Microsoft Office 365, & Azure Cloud).
        - Continue to create, update, and implement policies and procedures to operationalize and maintain security level after remediation.

- Project has officially kicked off and project meetings have been scheduled to plan the security remediations.

IBM Hardware Upgrade

- HealthSuite application is housed using IBM hardware and software. The current hardware will reach its end-of-life in April 2024.

- This hardware upgrade will cover both production and DR sites, began in January 2024, provide larger capacity, and improved performance in preparation for anticipated growth and new environments.

- New IBM server hardware has been successfully installed, configured, and deployed at both the Alameda and Roseville data center locations in the month of February.

- Migration activities have started and the HealthSuite test environment has been completed.

IT Disaster Recovery (Phase 2)

- One of the Alliance primary objectives for fiscal year 2023/2024 is to complete the second phase of the implementation of an enterprise IT Disaster Recovery program that will focus on tier 2/3 applications and systems. This is to ensure that our core business areas have the ability to restore and continue operations when there is a disaster.

- IT Disaster Recovery involves a set of policies, tools, and procedures to enable the recovery or continuation of vital technology infrastructure and systems following a natural or human-induced disaster. IT Disaster Recovery focuses on technology systems supporting critical business functions, which involve keeping all essential aspects of the business functioning, despite significant disruptive events.

- The project has been presented to the project governance committee and has been approved. Project kickoff will be scheduled early this month.

Encounter Data

- In the month of February 2024, the Alliance submitted 146 encounter files to the Department of Health Care Services (DHCS) with a total of 342,316 encounters.

Enrollment

- The Medi-Cal Enrollment file for the month of February 2024 was received and loaded to HEALTHsuite.

HealthSuite

- The Alliance received 259,544 claims in the month of February 2024.

- A total of 269,278 claims were finalized during the month out of which 218,137 claims auto adjudicated. This sets the auto-adjudication rate for this period to 81.0%.

- HEALTHsuite application did not encounter any outages in February. This sets the uptime to 99.9% for the application.

TruCare

- A total of 14,458 authorizations were loaded and processed in the TruCare application.

- The TruCare application continues to operate with an uptime of 99.99%.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of February 2024”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of February 2024”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal and Group Care Member enrollment in the month of February 2024

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
February	402,163	7,793	6,912	5,610	156	150

1. MC – Medi-Cal Member 2. GC – Group Care Member

Table 1-2 Summary of Primary Care Physician (PCP) Auto-Assignment For the Month of February 2024

Auto-Assignments	Member Count
Auto-assignments MC	12,189
Auto-assignments Expansion	9,058
Auto-assignments GC	45
PCP Changes (PCP Change Tool) Total	5,493

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of February 2024”.
- There were 14,458 authorizations processed within the TruCare application.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of February 2024*

Transaction Type	Inbound automated Auths	Errored	Total Auths Loaded in TruCare
Paper Fax to Scan (DocuStream)	2554	2088	1431
Provider Portal Requests (Zipari)	4817	1271	4417
EDI (CHCN)	4993	1378	4891
Provider Portal to AAH Online (Long Term Care)	29	20	26
ADT	1296	657	767
Anthem	824	104	766
Behavioral Health COC Update - Online	16	14	10
Behavioral initial evaluation - Online	89	52	83
Manual Entry (all other not automated or faxed vs portal use)	N/A	N/A	2532
Total			14923

Key: EDI – Electronic Data Interchange

Web Portal Consumer Platform

- The following table 3-1 is a supporting document from the Web Portal summary section. (Portal reports always one month behind current month)

Table 3-1 Web Portal Usage for the Month of January 2024

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	6,467	4,890	493,103	679
MCAL	105,733	5,956	16,260	3,461
IHSS	3,596	120	126	23
Total	**115,796**	**10,966**	**509,489**	**4,163**

Table 3-2 Top Pages Viewed for the Month of January 2024

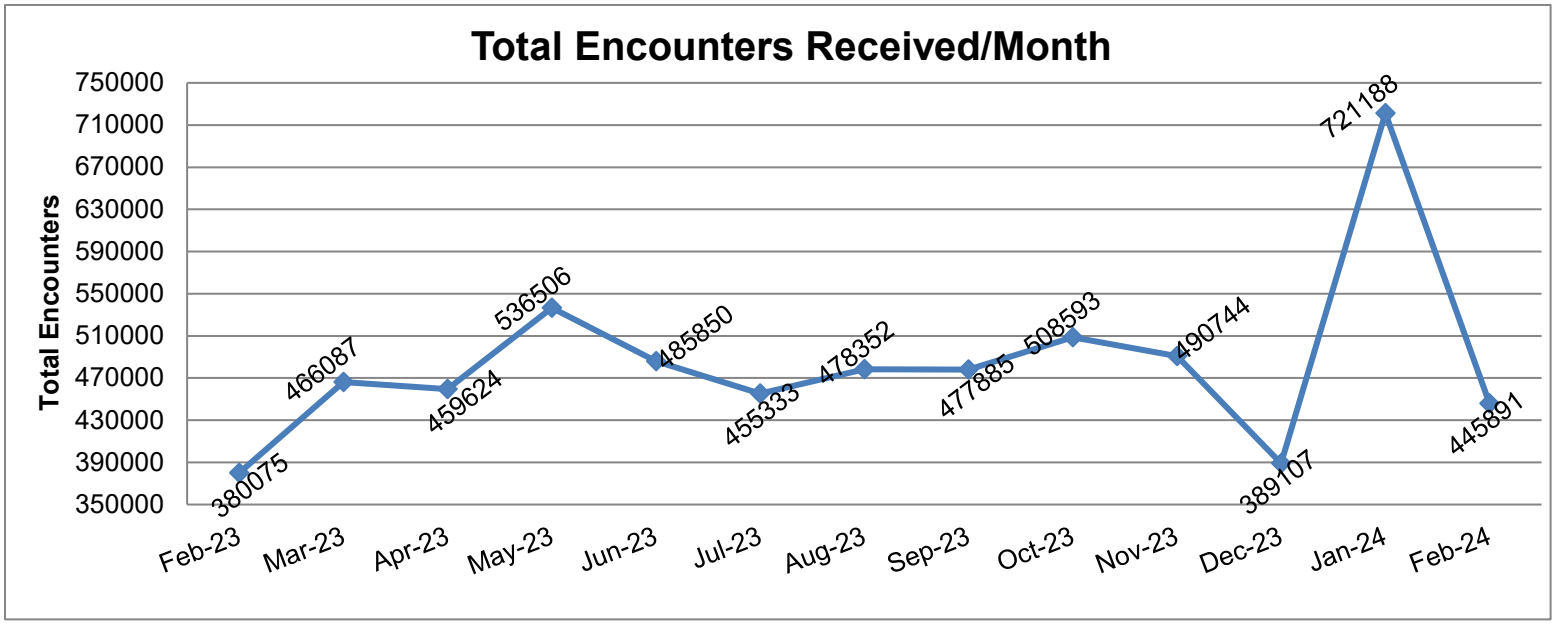
Category	Page Name	Page Views
Provider	Member Eligibility	1689283
Provider	Claim Status	215962
Provider - authorizations	Auth Submit	20984
Member	Provider Directory	18912
Provider - authorizations	Auth Search	8424
Member My Care	Member Eligibility	8361
Member Help Resources	ID Card	7494
Member Help Resources	Find a doctor or Hospital	4747
Provider	Member Roster	4048
Member Home	MC ID Card	4044
Provider - Claims	Submit professional claims	3962
Member Help Resources	Select or Change Your PCP	3335
Member My Care	My Claims Services	1801
Member My Care	Authorization	1142
Provider - Provider Directory	Provider Directory	1107
Provider - reports	Reports	937
Member My Care	My Pharmacy Medication Benefits	813
Member My Care	Member Benefits Materials	662
Provider	Behavior Health Forms SSO	632
Provider	Forms	625
Member Help Resources	FAQs	619
Member Help Resources	Forms Resources	545
Member Help Resources	Authorizations Referrals	436
Member Help Resources	Contact Us	429
Provider	Long Term Care Forms SSO	382
Provider - Provider Directory	Manual	312
Member Health Wellness	Health Care Basics	185
Member Health Wellness	Case Disease Management	177
Member Health Wellness	Online Wellness Programs	167
Member Health Wellness	Update My Contact Info	159
Member Health Wellness	Advice Nurse Line	151

Encounter Data From Trading Partners February 2024

- **ACBH**: February monthly files (0 records)
    - No longer receiving encounter files but through HCSA.
- **AHS**: February weekly files (7,736 records) were received on time.
- **BAC**: February monthly files (57 records) were received on time.
- **Beacon**: February weekly files (0 records)
    - No longer receiving encounter files.
- **CHCN**: February weekly files (10,3674 records) were received on time.
- **CHME**: February monthly files (5,560 records) were received on time.
- **CFMG**: February weekly files (10,557 records) were received on time.
- **Docustream**: February monthly files (814 records) were received on time.
- **EBI**: February monthly files (2,093 records) were received on time.
- **FULLCIR**: February monthly files (1,586 records) were received on time.
- **HCSA**: February monthly files (2,097 records) were received on time.
- **IOA**: February monthly files (1,233 records) were received on time.
- **Kaiser**: February bi-weekly files (3,725 records) were received on time.
- **LAFAM**: February monthly files (60 records) were received on time.
- **LogistiCare**: February weekly files (20,774 records) were received on time.
- **March Vision**: February monthly files (0 records) were received on time.
- **MED**: February monthly files (742 records) were received on time.
- **Quest Diagnostics**: February weekly files (17,658 records) were received on time.
- **SENECA**: February monthly files (222 records) were received on time.
- **TITANIUM**: February monthly files (154 records) were received on time.
- **Magellan**: February monthly files (403,980 records) were received on time.

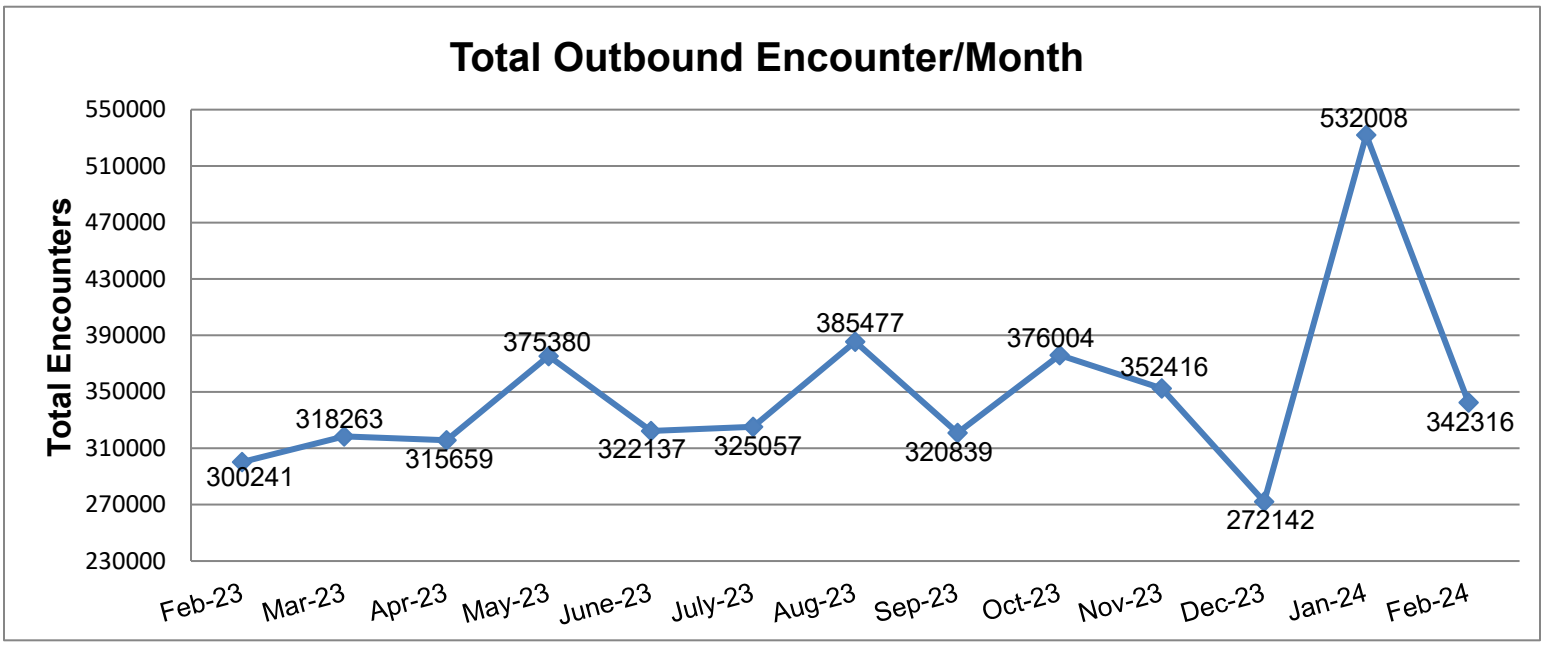
Trading Partner Encounter Inbound Submission History

Trading Partners	Feb-23	Mar-23	Apr-23	May-23	Jun-23	July-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Health Suite	167475	238283	218296	251858	267437	224540	244907	247423	241298	247537	215246	298465	266339
ACBH	39	95											
AHS	5377	5088	6353	5380	6250	4363	4380	5479	5371	5243	6284	4570	7736
BAC	34	32	38	40	37	39	38	38	57	73	55	59	57
Beacon	11036	12159	15799	5822	4559	620							
CHCN	83191	82394	84654	117764	90418	102081	85836	77060	111275	87839	58566	96124	103674
CHME	5303	4729	5277	4987	5692	5706	5704	6212	7609	6445	5694	5843	5560
Claimsnet	11694	8851	16155	12526	9986	12379	8946	12302	12167	11670	18995	12043	10557
Docustream	1794	1361	865	575	607	567	744	562	400	705	476	930	814
EBI			976	15	910	1664	814	867	718	823	811	1047	2903
FULLCIR									888	598	177	828	1586
HCSA	1976	590	78	72	5573	3824	3466	2490	1913	2403	2087	2223	2097
IOA	172	156	201	325	974	424	673	1086	967	1073	1250	1453	1233
Kaiser	56965	73095	68883	91196	53820	56673	76278	79751	81985	87005	26208	77407	3725
LAFAM									24				60
Logisticare	18034	21647	20558	28628	20859	22235	27129	22456	25509	20781	32181	182822	20774
March Vision	3434	3281	4275	3647	5101	4468	4563	4933	4427	4428	4562	9693	
MED						9	11	144	194	523	532	535	742
Quest	13551	14326	17216	13671	13627	15741	14859	17008	13712	13077	15834	27022	17658
SENECA							4	74	79	56	52	124	222
TITANIUM										465	97		154
Total	380075	466087	459624	536506	485850	455333	478352	477885	508593	490744	389107	721188	445891



Outbound Encounter Submission

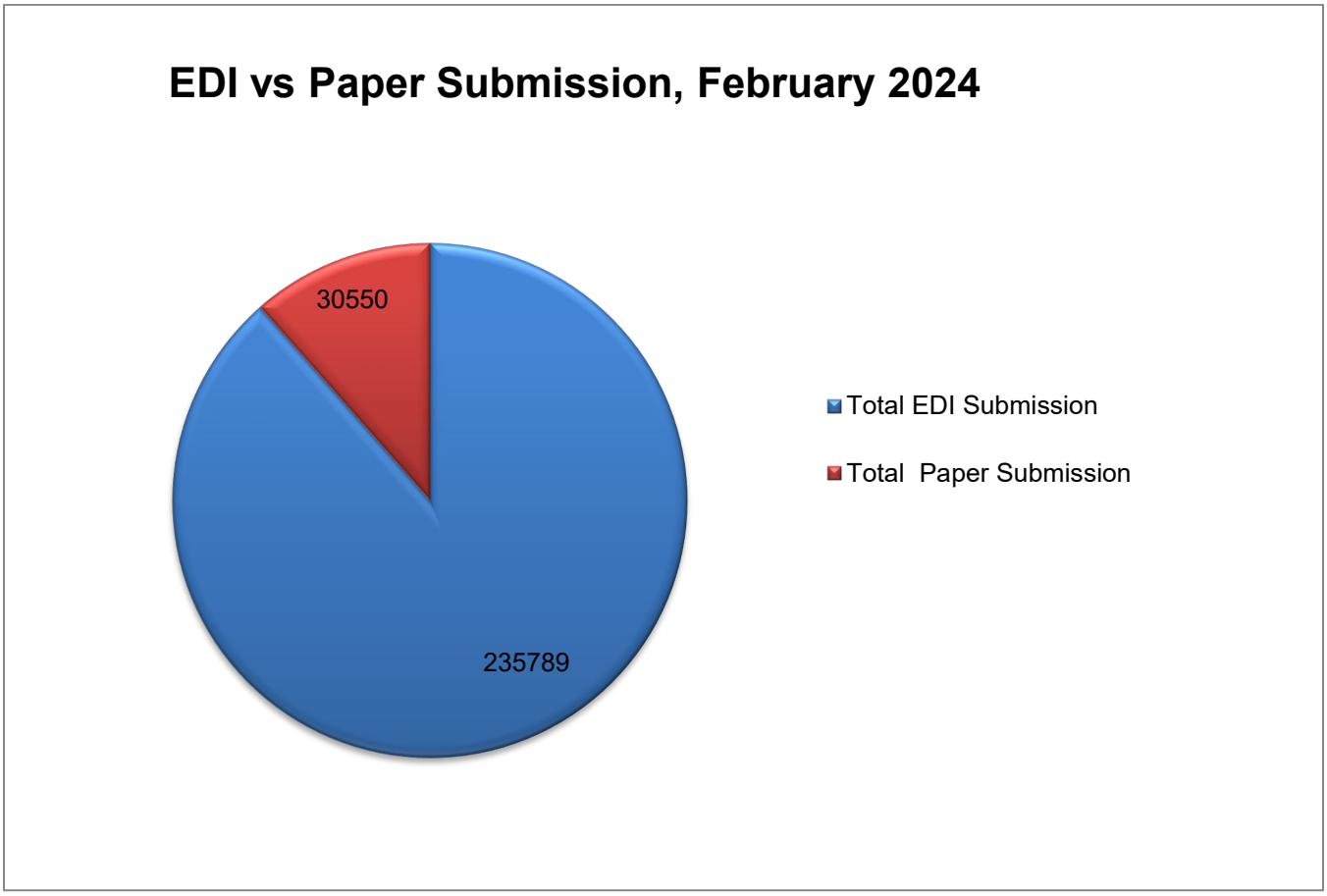
Trading Partners	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Health Suite	128102	117672	117823	151866	126674	147199	170751	127465	163149	134823	136233	172386	177658
ACBH	21	73											
AHS	5260	3845	7300	5236	5070	5318	4251	4253	6355	5147	4936	5667	7497
BAC	33	32	38	40	37	39	37	38	52	67	53	55	55
Beacon	8910	9674	11927	2879	2233	318							
CHCN	58279	59074	60373	79256	65595	56593	74313	55365	62962	73866	39846	67063	74336
CHME	5181	4606	5159	4864	5577	5595	5546	6063	7475	6321	5588	5703	5470
Claimsnet	8334	6361	9834	10891	7445	8849	6386	7075	7452	8031	11581	10145	7730
Docustream	1521	1232	481	411	378	347	529	441	270	573	404	387	600
EBI			906	15	872	1574	804	855	710	794	802	987	1347
FULLCIR									806	516	124	653	540
HCSA	1304	287	52	55	1781	3778	3405	2349	1876	2342	1991	2142	2013
IOA	168	152	45	276	751	410	654	984	65	934	1228	1378	1156
Kaiser	55930	72409	65652	72893	68887	55988	75591	78162	81165	85807	26113	76335	3542
LAFAM									2				
LogistiCare	12223	27071	20411	28455	20787	21686	26670	22142	24497	25951	31546	157548	40529
March Vision	2308	2400	3006	2366	3408	2720	2737	2992	2863	2661	2752	2700	2616
MED						9	11	126	145	438	428	446	624
Quest	12667	13375	12652	15877	12642	14634	13788	12456	16082	3655	8394	28299	16589
SENECA							4	73	78	52	48	114	14
TITANIUM										438	75		
Total	300241	318263	315659	375380	322137	325057	385477	320839	376004	352416	272142	532008	342316



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
24-Feb	235789	30550	266339

Key: EDI – Electronic Data Interchange

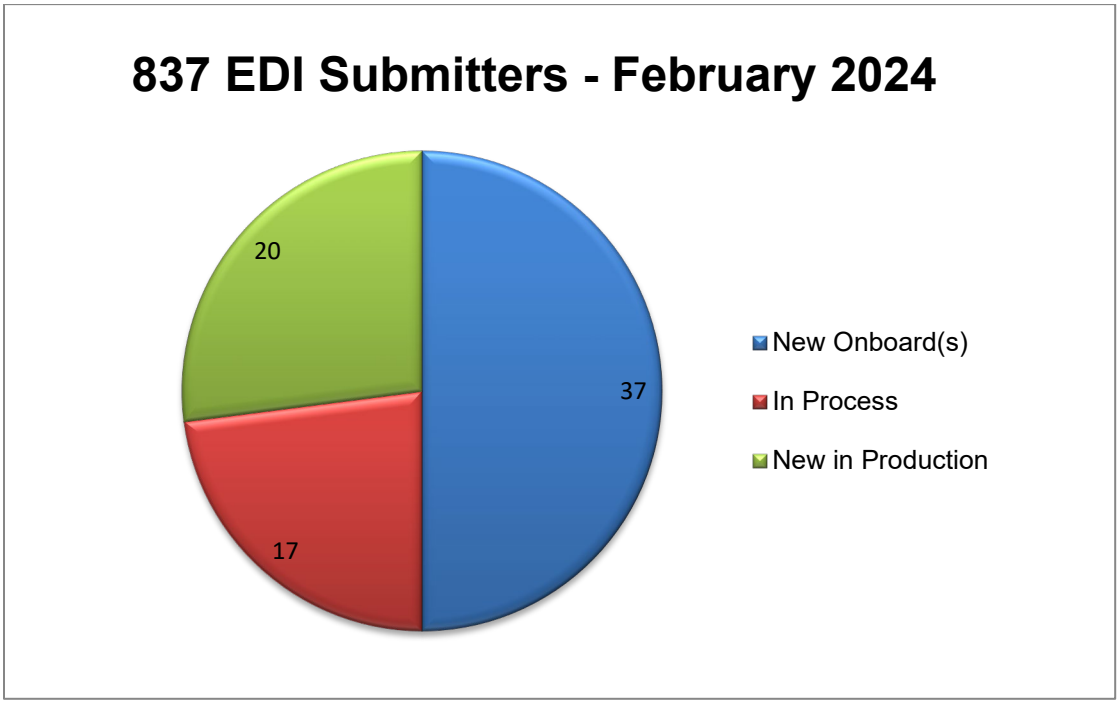


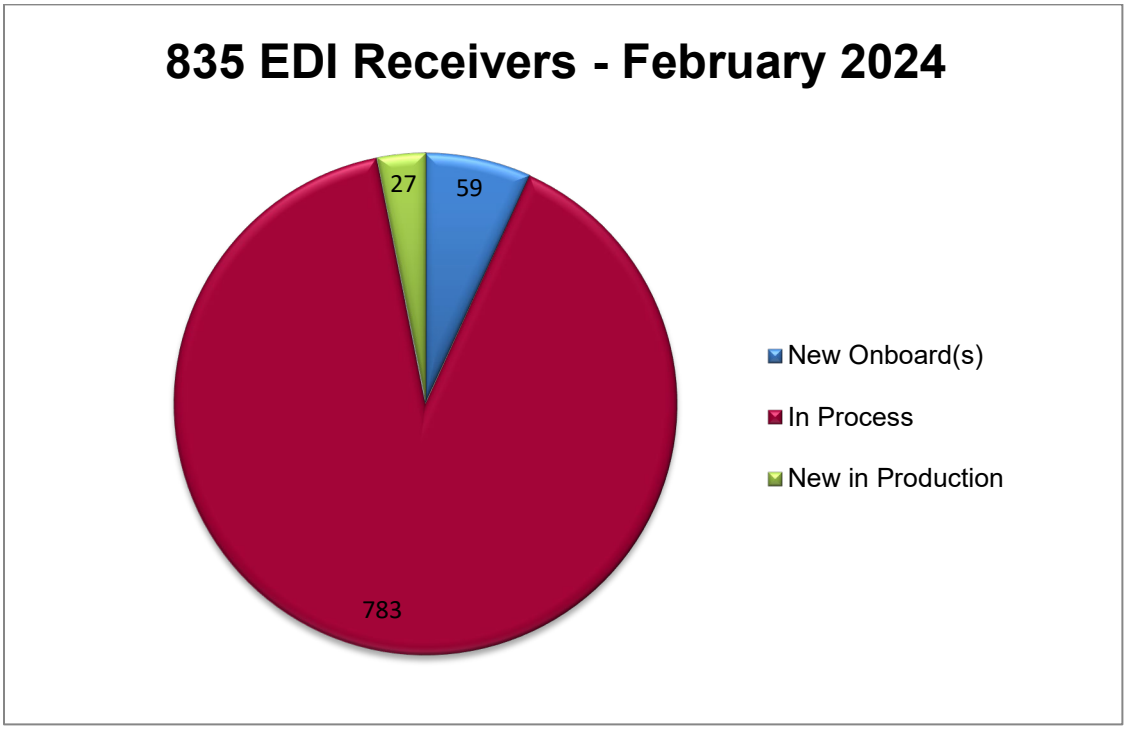
Onboarding EDI Providers – Updates

- February 2024 EDI Claims:
  - A total of 2074 new EDI submitters have been added since October 2015, with 20 added in February 2024.
  - The total number of EDI submitters is 2814 providers.

- February 2024 EDI Remittances (ERA):
  - A total of 921 new ERA receivers have been added since October 2015, with 27 added in February 2024.
  - The total number of ERA receivers is 937 providers.

	837				835			
	New on Boards	In Process	New In Production	Total in Production	New on Boards	In Process	New In Production	Total in Production
Mar-23	55	0	55	2323	78	472	63	709
Apr-23	50	3	47	2370	24	491	5	714
May-23	35	5	30	2400	44	527	8	722
Jun-23	79	7	72	2472	58	544	41	763
Jul-23	48	2	46	2518	62	583	23	786
Aug-23	44	1	43	2561	41	602	22	808
Sep-23	70	0	70	2631	46	621	27	835
Oct-23	36	2	34	2665	21	640	2	837
Nov-23	47	2	45	2710	45	679	6	843
Dec-23	25	2	23	2733	63	716	26	869
Jan-24	63	2	61	2794	76	751	41	910
Feb-24	37	17	20	2814	59	783	27	937





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 **February** 2024.

File Type	FEB-24
837 I Files	28
837 P Files	118
Total Files	146

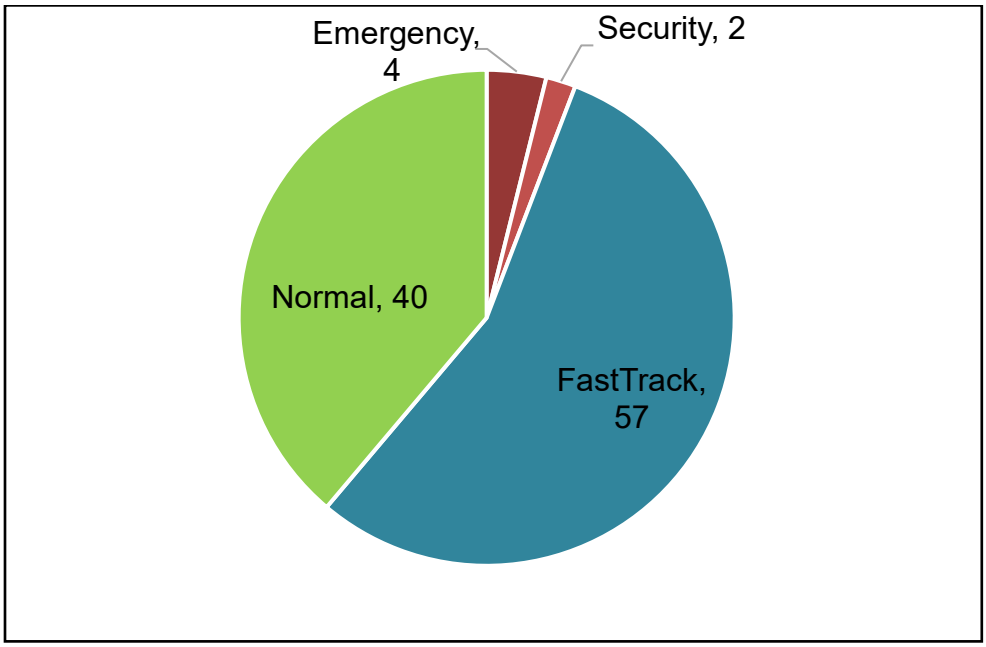
Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Feb-24	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	90%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	96%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	81%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	91%	80%

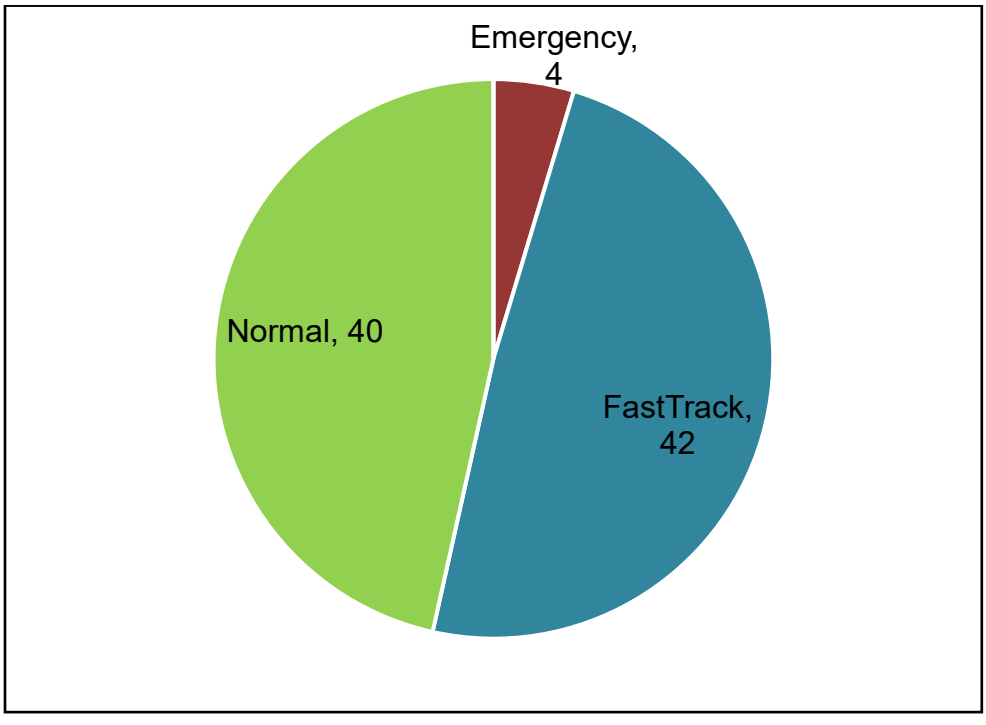
Change Management Key Performance Indicator (KPI)

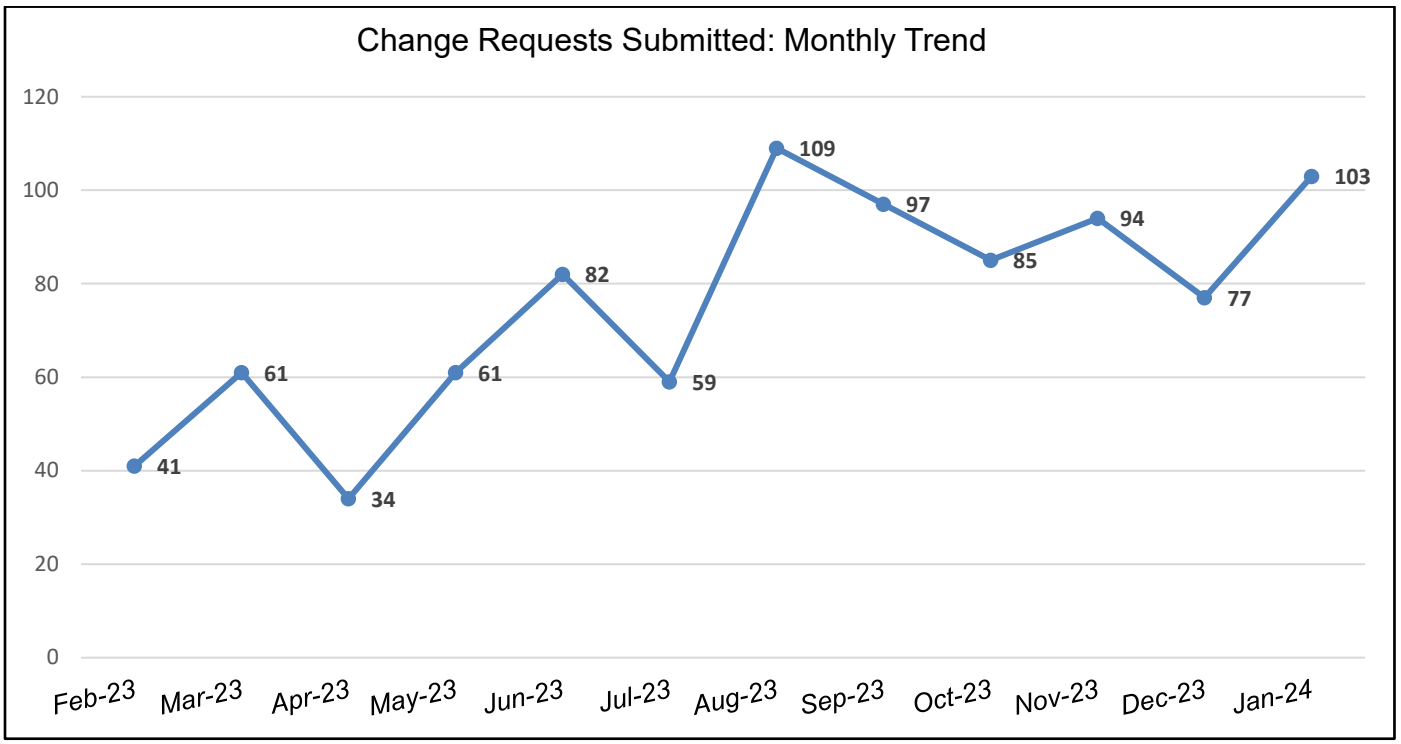
- Change Request Overall Summary in the month of January 2024 KPI:
  - 103 Changes Submitted.
  - 86 Changes Completed and Closed.
  - 168 Active Change Requests in pipeline.
  - 31 Change Requests Cancelled or Rejected.

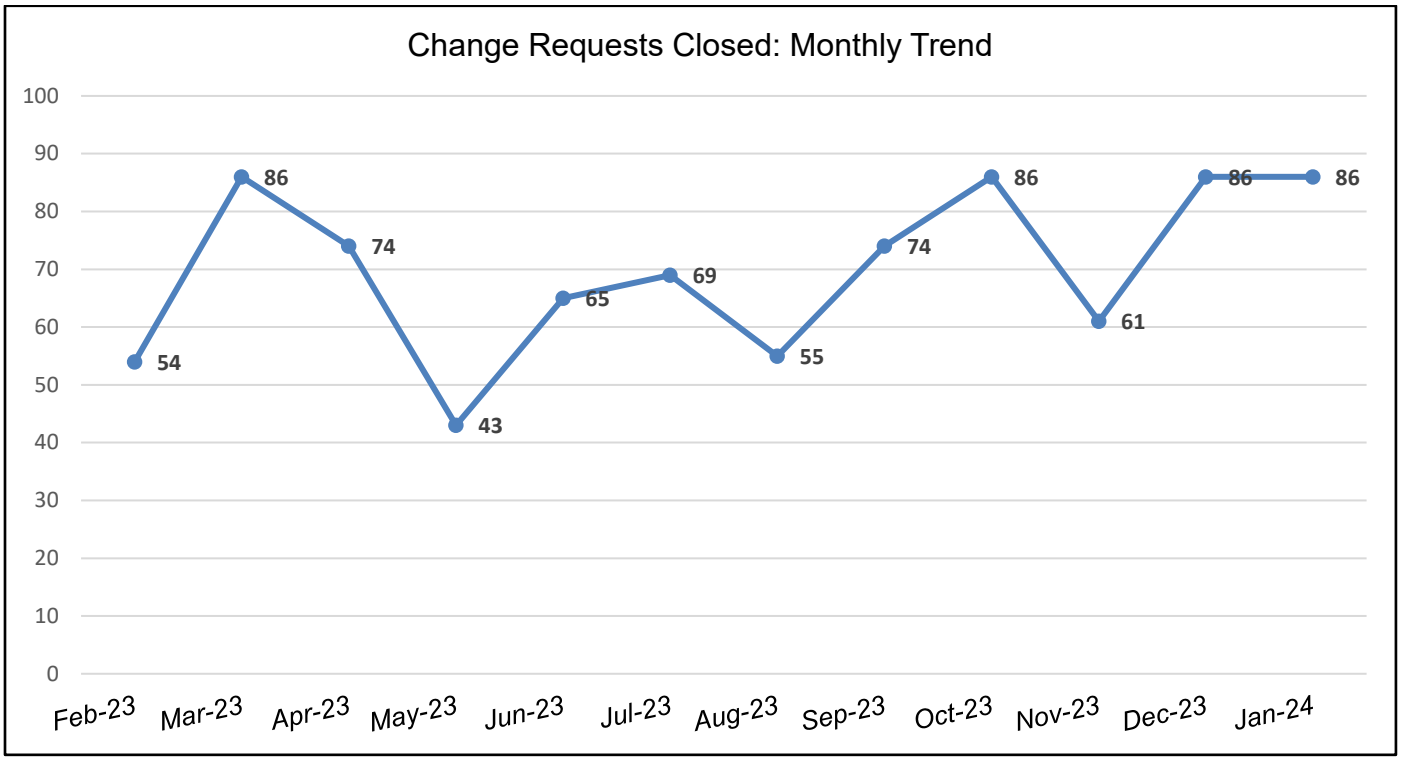
103 Change Requests Submitted/Logged in the month of January 2024



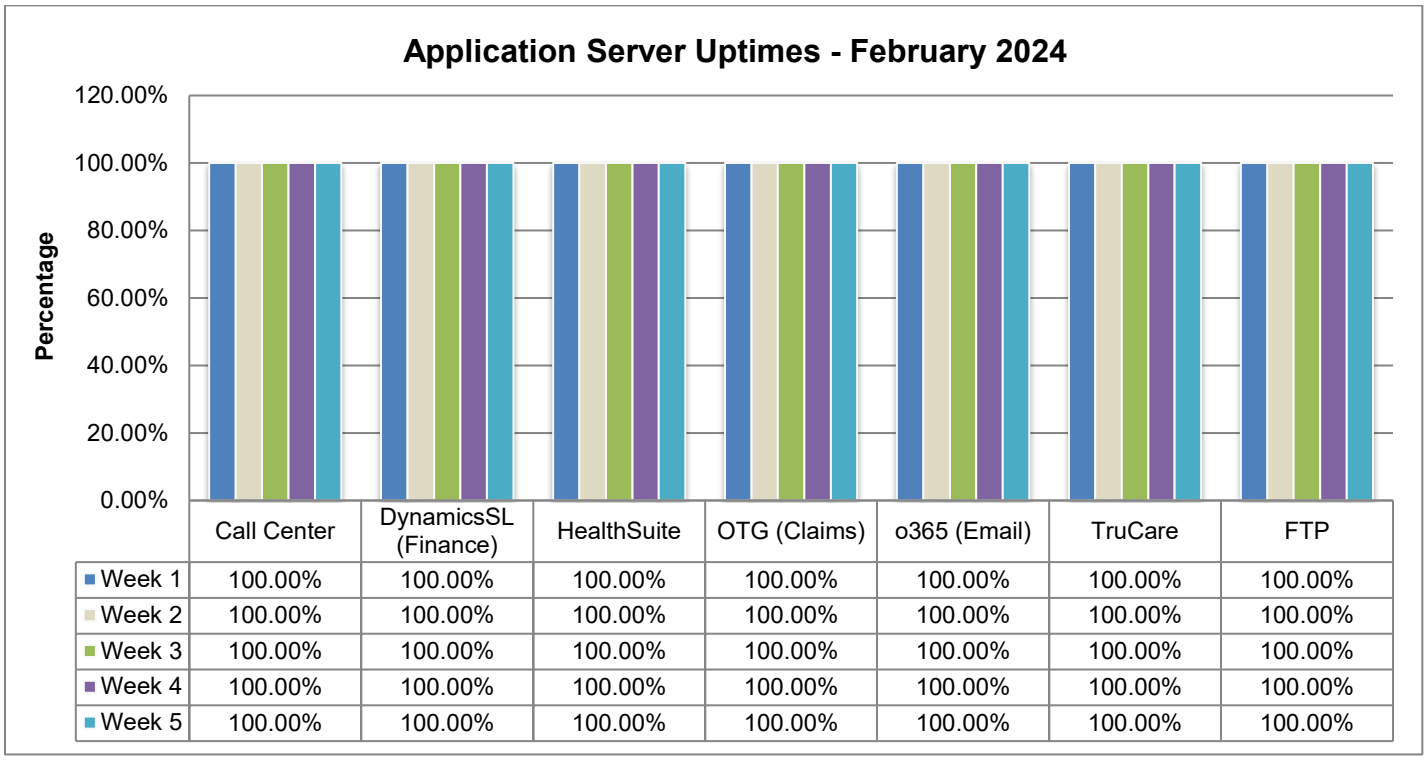
- 86 Change Requests Closed in the month of January 2024




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
41
61
34
61
82
59
109
97
85
94
77
103
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24


Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
54
86
74
43
65
69
55
74
86
61
86
86
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24

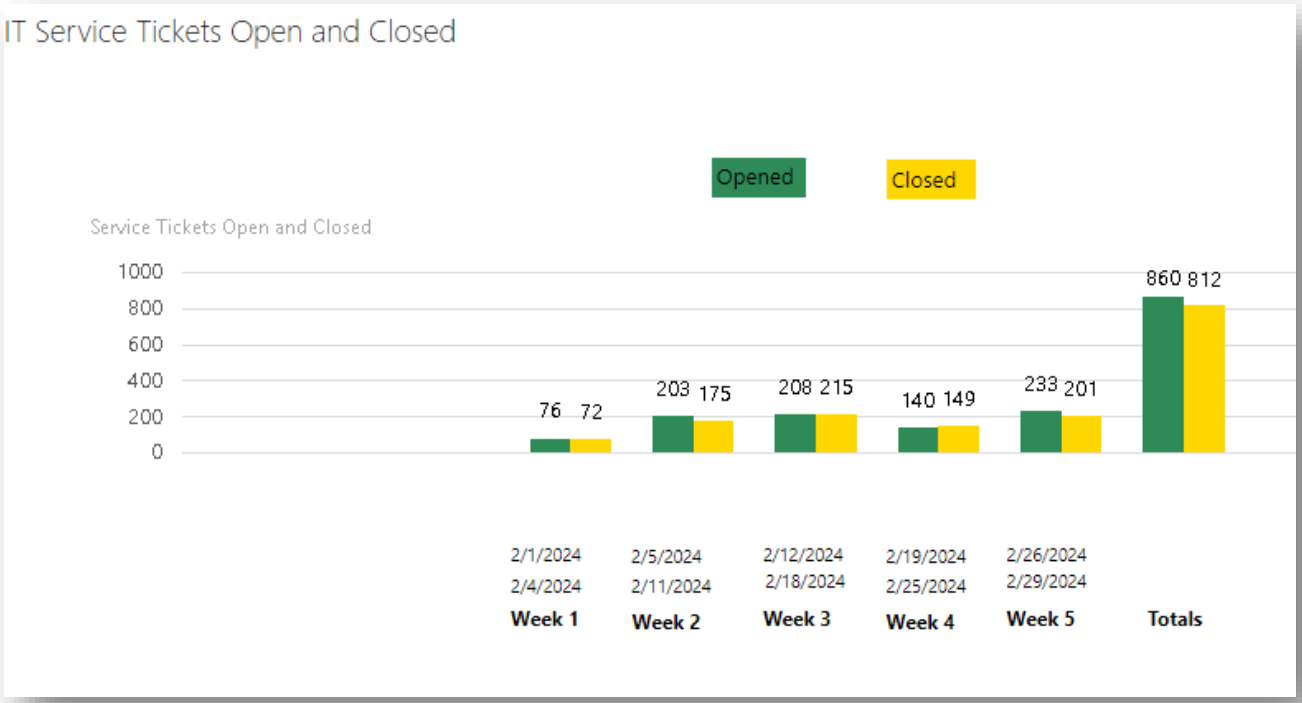
IT Stats: Infrastructure



	Call Center	DynamicsSL (Finance)	HealthSuite	OTG (Claims)	o365 (Email)	TruCare	FTP
Week 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 2	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 3	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 4	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- All mission critical applications are monitored and managed thoroughly.
- Remote users are experienced slowness when connected to VPN on Wednesday, February 28th at 8:00am.
    - This issue was determined to be related to multiple internet service providers (ISP) having widespread issues.
    - This issue was resolved at 9:40am.

- 860 Service Desk tickets were opened in the month of February 2024, which is 1.14% lower than the previous month (870) and 7.44% higher than the previous 3-month average of 796.

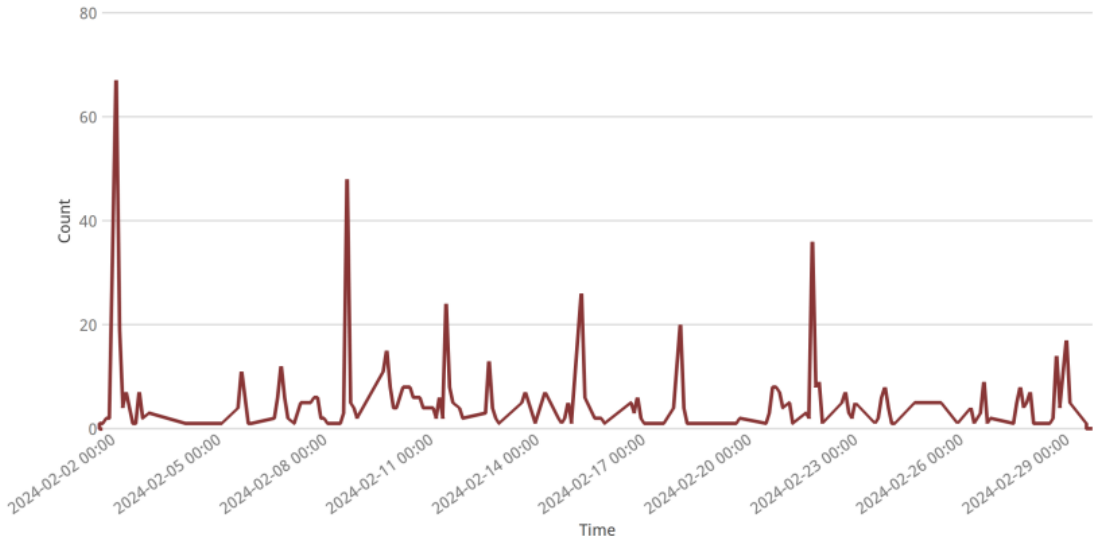


- 812 Service Desk tickets were closed, which is 6.01% lower than the previous month (864) and 2.09% higher than the previous 3-month average of 795.

February 2024

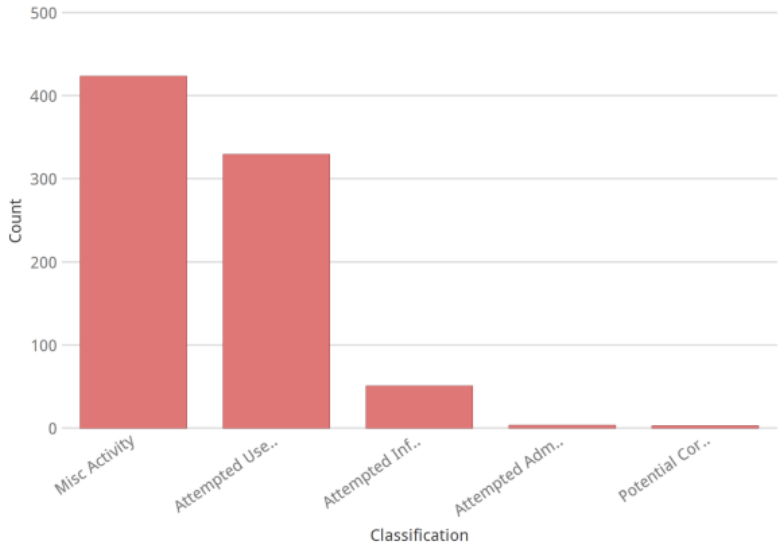
All Intrusion Events

Time Window: *2024-02-01 09:29:00 - 2024-02-29 09:29:00*



Dropped Intrusion Events

Time Window: *2024-02-01 09:30:00 - 2024-02-29 09:30:00*
Constraints: *Inline Result = !Alert,!Would **



Classification	Count
Misc Activity	424
Attempted User Privilege Gain	330
Attempted Information Leak	51
Attempted Administrator Privilege Gain	4
Potential Corporate Policy Violation	3

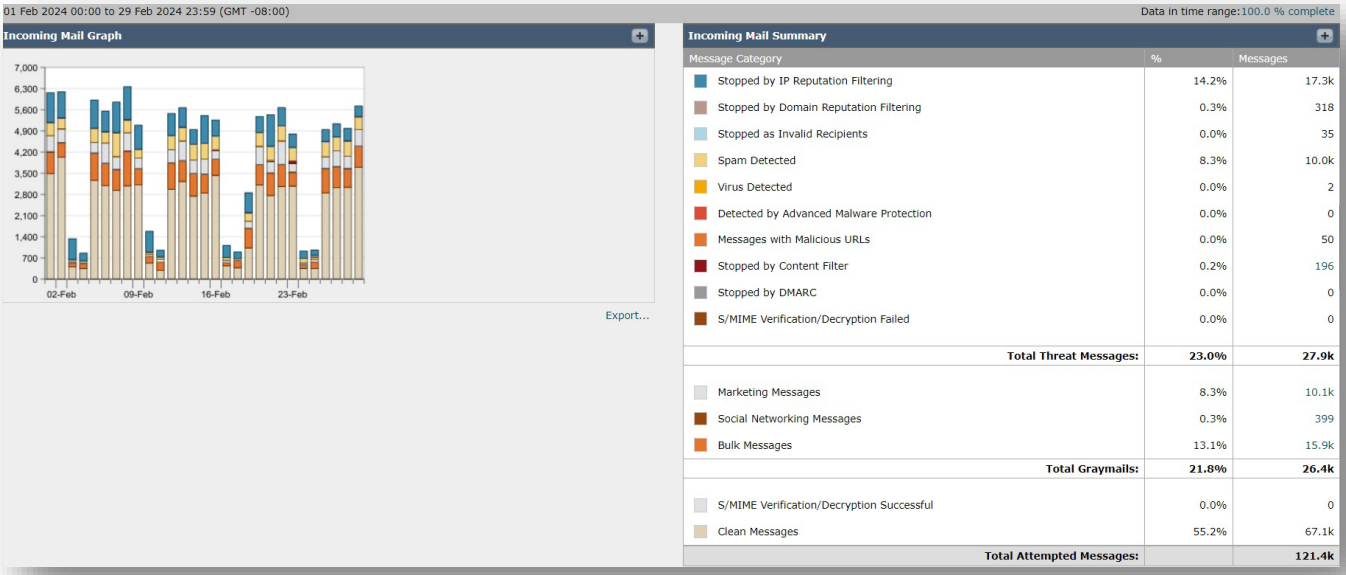
IronPort Email Security Gateways

Email Filters

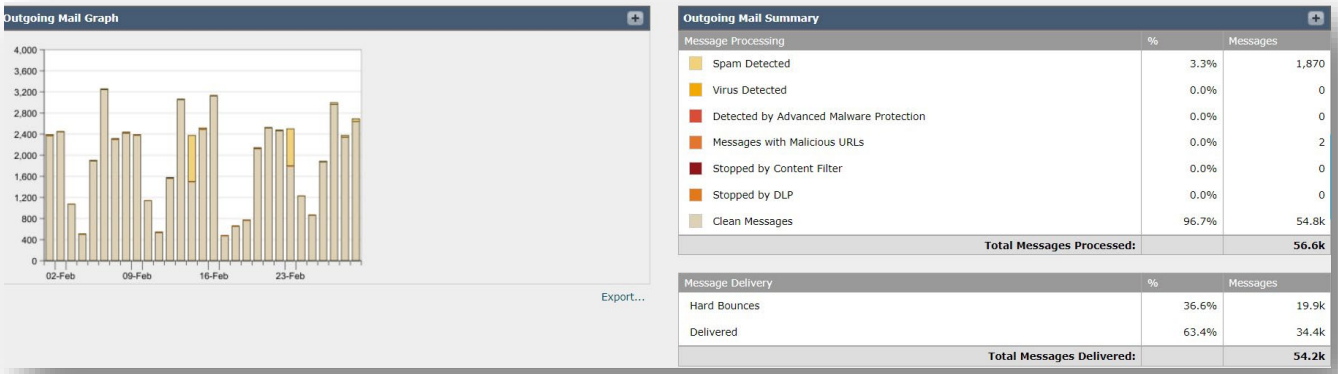
February 2024

MX4

Inbound Mail



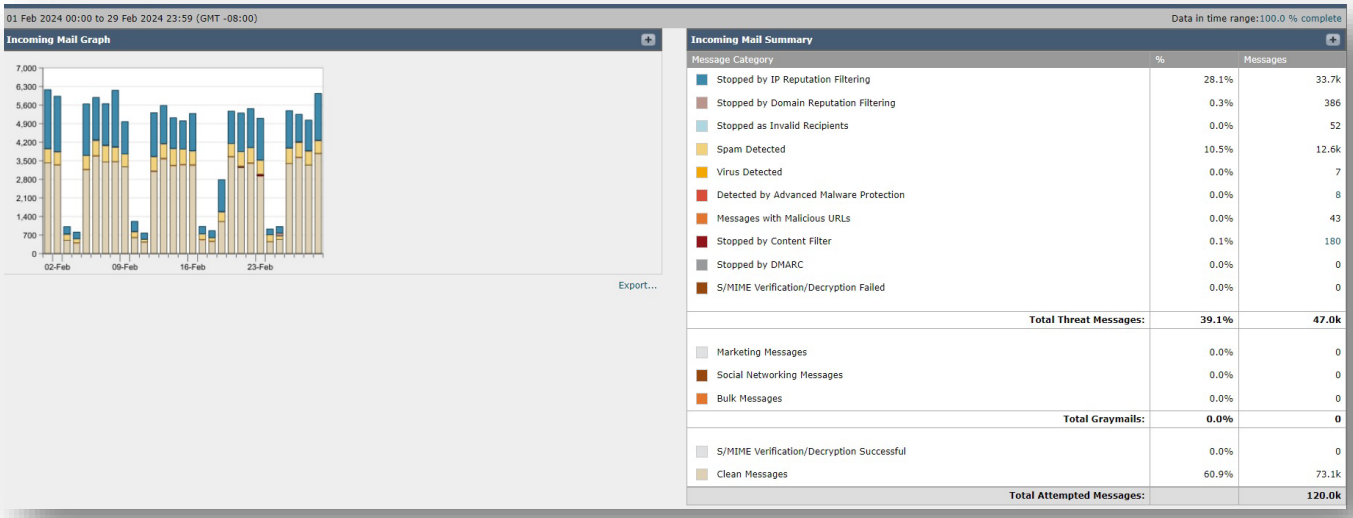
Outbound Mail



February 2024

MX9

Inbound Mail



01 Feb 2024 00:00 to 29 Feb 2024 23:59 (GMT -08:00) — Data in time range: 100.0 % complete

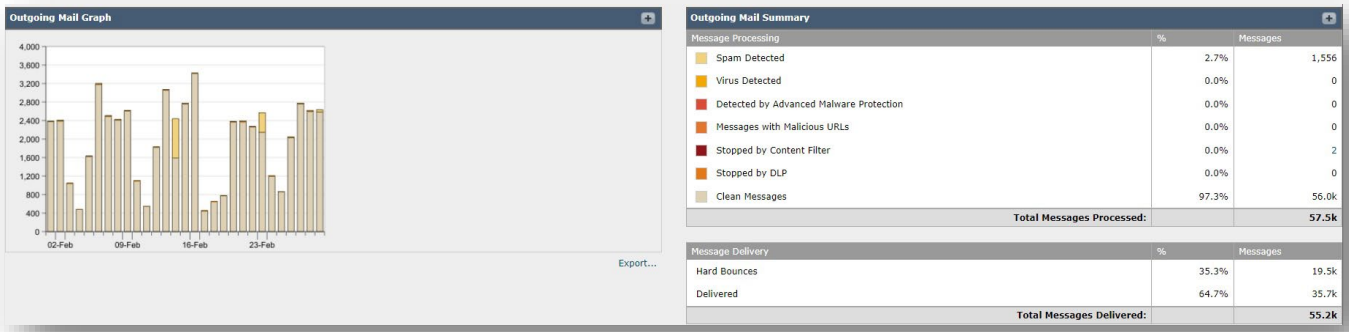
Incoming Mail Graph

Export...

Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	28.1%	33.7k
Stopped by Domain Reputation Filtering	0.3%	386
Stopped as Invalid Recipients	0.0%	52
Spam Detected	10.5%	12.6k
Virus Detected	0.0%	7
Detected by Advanced Malware Protection	0.0%	8
Messages with Malicious URLs	0.0%	43
Stopped by Content Filter	0.1%	180
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**39.1%**	**47.0k**
Marketing Messages	0.0%	0
Social Networking Messages	0.0%	0
Bulk Messages	0.0%	0
Total Graymails:	**0.0%**	**0**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	60.9%	73.1k
Total Attempted Messages:		**120.0k**

Outbound Mail



Outgoing Mail Graph

Export...

Outgoing Mail Summary

Message Processing	%	Messages
Spam Detected	2.7%	1,556
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	0
Stopped by Content Filter	0.0%	2
Stopped by DLP	0.0%	0
Clean Messages	97.3%	56.0k
Total Messages Processed:		**57.5k**

Message Delivery	%	Messages
Hard Bounces	35.3%	19.5k
Delivered	64.7%	35.7k
Total Messages Delivered:		**55.2k**

Item / Date	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	*Sep-23*	Oct-23	Nov-23	Dec-23	Jan-24	***Feb-24***
Stopped By Reputation	65.3k	60.9k	31.7k	33.2k	27.1k	30.4k	59.1k	*99.7k*	74k	74.1k	58k	91.9k	***51k***
Invalid Recipients	68	75	97	113	92	82	79	*98*	86	88	73	81	***87***
Spam Detected	12.5k	15.4k	14.5k	13.7k	14.1k	12.5k	27.9k	*33.1*	28.7k	25.8k	20.6k	26.9k	***22.6k***
Virus Detected	3	0	2	9	1	5	3	*22*	10	29	6	11	***9***
Advanced Malware	1	0	0	3	1	0	1	*55*	37	78	24	29	***8***
Malicious URLs	34	27	6	478	233	170	6	*50*	97	11	57	57	***43***
Content Filter	33	40	115	127	162	56	39	*110*	114	333	66	108	***376***
Marketing Messages	13.9k	15.5k	15.5k	18.5k	16.1k	15.7k	16.2k	*8.4k*	9.5k	8.9k	8.1k	9.4k	***10.1k***
Attempted Admin Privilege Gain	61	115	170	4	50	173	51	*250*	6	0	1	7	***4***
Attempted User Privilege Gain	307	87	428	42	66	162	47	*329*	146	48	48	69	***330***
Attempted Information Leak	17.1k	12.5k	24.4k	5	1	18	53	*118*	71	51	50	65	***51***
Potential Corp Policy Violation	0	0	0	4	2	0	0	*0*	0	0	0	0	***3***
Network Scans Detected	0	0	0	0	0	0	0	*0*	0	0	0	0	***0***
Web Application Attack	1	2	2	7	1	8	0	*15*	7	4	4	1	***0***
Attempted Denial of Service	0	2.9k	109	0	0	1	0	*4*	0	0	0	0	***0***
Misc. Attack	1,288	2	521	2	3	1,862	151	*2,901*	1,023	347	2,146	1	***424***

- All security activity data is based on the current month's metrics as a percentage. This is compared to the previous three month's average, except as noted.
- Email based metrics currently monitored have remained with a return to a reputation-based block for a total of 51k.
- Attempted information leaks detected and blocked at the firewall is at 51 for the month of **February 2024.**
- Network scans returned a value of 0, which is in line with previous month's data.
- Attempted User Privilege Gain increased at 330 from a previous six-month average of 161.

ALAMEDA Alliance FOR HEALTH

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

Analytics

Tiffany Cheang

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

From: **Tiffany Cheang, Chief Analytics Officer**

Date: **March 8th, 2024**

Subject: **Performance & Analytics Report**

Member Cost Analysis

- The Member Cost Analysis below is based on the following 12 month rolling periods:
  Current reporting period: Dec 2022 – Nov 2023 dates of service
  Prior reporting period: Dec 2021 – Nov 2022 dates of service
  (Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 9.8% of members account for 88.6% of total costs.

- In comparison, the Prior reporting period was slightly lower at 9.6% of members accounting for 83.6% of total costs.

- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:

  - The SPD (non-duals) and ACA OE categories of aid decreased to account for 56.1% of the members, with SPDs accounting for 23.9% and ACA OE's at 32.2%.
  - The percent of members with costs >= $30K increased from 2.2% to 2.7%.
  - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.6%.
    - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, increasing to 37.9%.
  - Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
  - However, the age distribution of the top 9.8% is more concentrated in the 45-66 year old category (38.2%) compared to the overall population (20.8%).

ALAMEDA Alliance FOR HEALTH

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

Human Resources

Anastacia Swift

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

From: **Anastacia Swift, Chief Human Resources Officer**

Date: **March 8th, 2024**

Subject: **Human Resources Report**

Staffing

- As of March 1st, 2024, the Alliance had 560 full time employees and 1-part time employee.

- On March 1st, 2024, the Alliance had 96 open positions in which 34 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 62 positions open to date. The Alliance is actively recruiting for the remaining 62 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by department:

Department	Open Position March 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	31	18	13
Operations	42	11	31
Healthcare Analytics	2	0	2
Information Technology	14	5	9
Finance	2	0	2
Compliance & Legal	2	0	2
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	96	34	62

- Our current recruitment rate is 15%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in February 2024 included:
    - 6 years:
        - Ashley Asejo (Quality Management)
        - Karina Rivera (Operations)
        - Cindy Rogers (IT Data Exchange)
    - 7 years:
        - Katrina Vo (Marketing & Communications)
        - Christine Corpus (Finance)
    - 8 years:
        - Anna Afuola (Grievance & Appeals)
        - Arwyn Gonzales (IT Infrastructure)
        - Roxana Beltran-Murillo (Claims)
        - Sharanjit Kaur (IT Ops & Quality Applications Management)
    - 9 years:
        - Andre Morgan (Apps Management, IT Quality & Process Improvement)
        - Errin Poston (Provider Services)
    - 11 years:
        - Tiffany Cheang (Healthcare Analytics)
    - 13 years:
        - Judy Rosas (Member Services)
    - 20 years:
        - Eric Val Verde (Finance)