Board of Governors

PACKET

FEBRUARY 9th, 2024

EXECUTIVE SUMMARY APPENDIX

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CEO Update

Matthew Woodruff

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

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

Date: **February 9th, 2024**

Subject: **CEO Report**

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

	December	YTD
Medi-Cal	$10.2M	$34M
Group Care	$315K	$1.4K
Total	$10.6M	$35.0M

  - **Revenue was $135.1 million in December 2023 and $823.0 million Year-to-Date (YTD)**.
    - Medical expenses were $122.2 million in December and $759.4 million for the fiscal year-to-date; the medical loss ratio is 90.4% for the month and 92.3% for the fiscal year-to-date.
    - Administrative expenses were $7.0 million in December and $44.7 million year-to-date; the administrative loss ratio is 5.2% of net revenue for the month and 5.4% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 724% of the required DMHC minimum, representing $309.7 million in excess TNE.
  - **Total enrollment in December 2023 was 351,980**, a decrease of 546 Medi-Cal members compared to November.

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - Two regulatory metrics were not met for January and December.
      - Claims – Claims missed compliant processing by 2% in January. This is attributed to the volume increase from moving to the single plan model. Claims is currently staffing based on volumes.
      - Encounter Data - Encounter data compliance was missed .1%. This was due to our transportation provider completing a cleanup of their files.

- **Non-Regulatory Metrics:**
  - The member services team did not meet internal metrics for service. The team's speed to answer was at 71%, and the abandonment rate was at 11%, compared to internal metrics of 80% and 5%, respectively.

- **Program Implementations:**
  - **Single Plan Model**
    - Good news. In a first look, the Alliance enrollment as of January 25th, 2024, is 400,217. Final numbers are delayed due to late reporting from the State and the large increase being audited to the aid code.
    - Member Services had the largest call volume in its history, almost surpassing 30,000 calls, compared to almost 14,000 calls in December.
    - Member Services had the largest Walk-In volume in its history, with 119 members coming onsite for help. That equates to over 5 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 largest volume of authorizations ever in January 2024. In January, the team received over 2,706 authorization requests as compared to December 2023, where the team received 1,282.
    - The Claims Department had its largest claims volume ever in January 2024. In December 2023, the claims volume was 215,000 claims, and in January, the claims volume rose to 298,000.
  - **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.

Alliance Public Affairs Department

ALAMEDA Alliance FOR HEALTH

Projected Budget and Shortfall

- On January 10th, Governor Newsom unveiled his 2024-25 $291.5 billion budget proposal.
- The Governor projects a $38 billion deficit which differs significantly from the Legislative Analyst Office's (LAO) projection of $68 billion deficit.
- Budget proposal will draw $13.1 billion from the state's reserves and the remaining gap will be pulled from delays and deferrals, borrowing, and reductions in funding.

ALAMEDA Alliance FOR HEALTH

Governor’s Proposed Budget Bill

- State law requires that the budget chair in each house of the State legislature introduce the Governor’s proposed budget bill.
- Assemblymember Gabriel, Chair of the Assembly Committee on Budget introduced Assembly Bill 1812
- State Senator Nancy Skinner, Chair of the Senate Budget and Fiscal Review Committee introduced Senate Bill 917.

ALAMEDA Alliance FOR HEALTH

Medi-Cal Budget

- The Medi-Cal budget includes $157.5 billion ($37.3 billion GF) in 2023-24 and $156.6 billion ($35.9 billion) in 2024-25.
- Projected Medi-Cal enrollment – projected to cover approximately 14.8 million Californians in 2023-24 and 13.8 million in 2024-25.
- Withdrawals and Reductions to address shortfall in Medi-Cal:
  - $900M withdrawal in Safety Net Reserve
  - $193.4 million reduction in Proposition 56 supplemental payment funding
  - Reversion of $14.9 million in Clinic Workforce Stabilization and Retention Payment Program
  - $22.9 million loan from the Managed Care Fund

Medi-Cal Budget Items

- **Managed Care Organization Tax** – Budget seeks early action by legislature to request federal approval to increase the tax by $1.5 billion for a total of$20.9 billion.
  - →$12.9 billion would support the Medi-Cal program while $8 billion would be targeted for rate increases and investments.
  - →The additional tax will be on Medi-Cal lives only with no changes to commercial lives.
  - →If approved, the added tax will be retroactive to January 1st, 2024.

- **Expansion of Medi-Cal to All Income Eligible Californians (regardless of immigration status)** – In order to continue expansion full-scope Medi-Cal to income-eligible adults 26-49 regardless of immigration status which began January 1st, 2024, the budget maintains $1.4 billion ($1.2 billion GF in 2023-24 and $3.4 billion [$2.9 billion GF], and $3.7 billion ongoing.

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Medi-Cal Budget Items

- **Medi-Cal Redeterminations and Caseload –** The budget assumes Medi-Cal caseload of 14.8 million in 2023-24, an increase of 583,000 individuals compared to the 2023 Budget Act. This results in an increase cost of $2.3 billion compared to the 2023 Budget Act.

- **CalAIM –** The budget maintains approximately $2.4 billion in 2024-25 to continue statewide CalAIM efforts, including maintaining $24.7 million in 2025-26 increasing to $197.9 million at full implementation to allow up to 6 months of rent or temporary housing to eligible individuals experiencing or at risk of homelessness.

- **Elimination of Asset Limit –** The budget includes $101.1 million in 2023-24 and $195.4 million in 2024-25 for the elimination of the Medi-Cal asset limit which began January 1st, 2024.

Medi-Cal Budget Items

- **Home and Community-Based Services (HCBA) Waiver Slot Increases –** The budget proposes to increase slots for the Assisted Living Waiver and Home and Community-Based Alternatives Waiver that provides care management services to persons at risk for nursing home or institutional care, resulting in$10.8 million in General Funds savings in 2024-25.
- **Behavioral Health**
  - →**Behavioral Health Continuum –** The budget maintains over $8 billion across various departments to expand the continuum of behavioral health treatment and infrastructure capacity and for behavioral health services to children and youth.
  - →**Behavioral Health Continuum Infrastructure Program –** Maintains $300 million in 2023-24 and $239.6 million in 2024-25. Includes a delay of$140.4 million in Round 6 funding from 2024-25 and 2025-26.

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Medi-Cal Budget Items

- **Behavioral Health Continued…**
  - → **Children and Youth Behavioral Health Initiative Wellness Coaches** - $9.5 million in 2024-25 increasing annually to $78 million in 2027-28 to establish a wellness coach benefit in Medi-Cal starting January 1st, 2025.
  - → **BH-Connect Demonstration Project** – The budget includes $40.6 million in 2024-25 for BH-Connect demonstration project, designed to increase access to and improve mental health services for populations most at risk, creating a full continuum of care for substance use disorder treatment and recovery services, starting January 1st, 2025.
  - → **Behavioral Health Bridge Housing** – The budget maintains $1.5 billion in funding to county behavioral health agencies and Tribal entities to operate bridge housing to address for this program and proposes to shift $265 million from the Mental Health Services Fund and delays $235 million from 2024-25 to 2025-26.

Executive Dashboard

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Financials

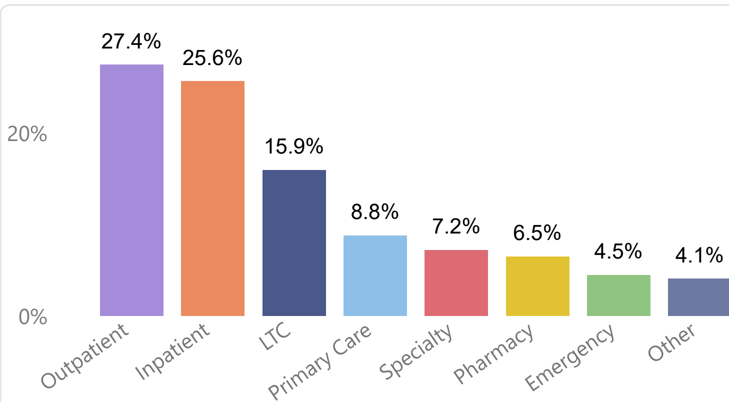
Income & Expenses

	DECEMBER 2023	FISCAL YTD
REVENUE	$ 135.1 M	$ 823.0 M
MEDICAL EXPENSE	$ (122.2) M	$ (759.4) M
ADMIN EXPENSE	$ (7.0) M	$ (44.7) M
OTHER	$ 4.7 M	$ 16.5 M
NET INCOME	$ 10.6 M	$ 35.4 M

Gross Margin %

7.7%

Medical Expenses



Liquid Reserves

MLR Net %

92.3%

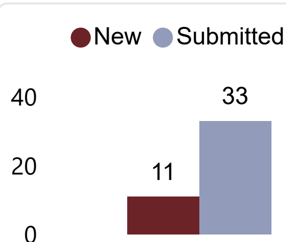
TNE %

724.2%

TNE $

$359.3M

Reinsurance Cases



Balance Sheet

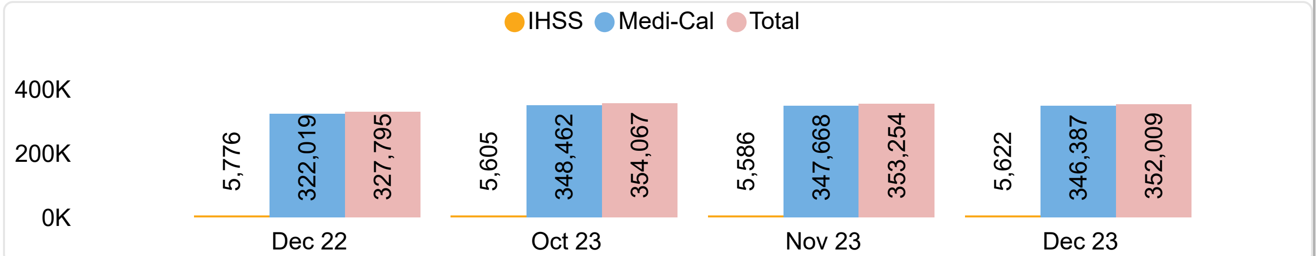
Cash Equivalents	$516.0M
Pass-Through Liabilities	$170.7M
Uncommitted Cash	$345.3M
Working Capital	$344.1M

Current Ratio

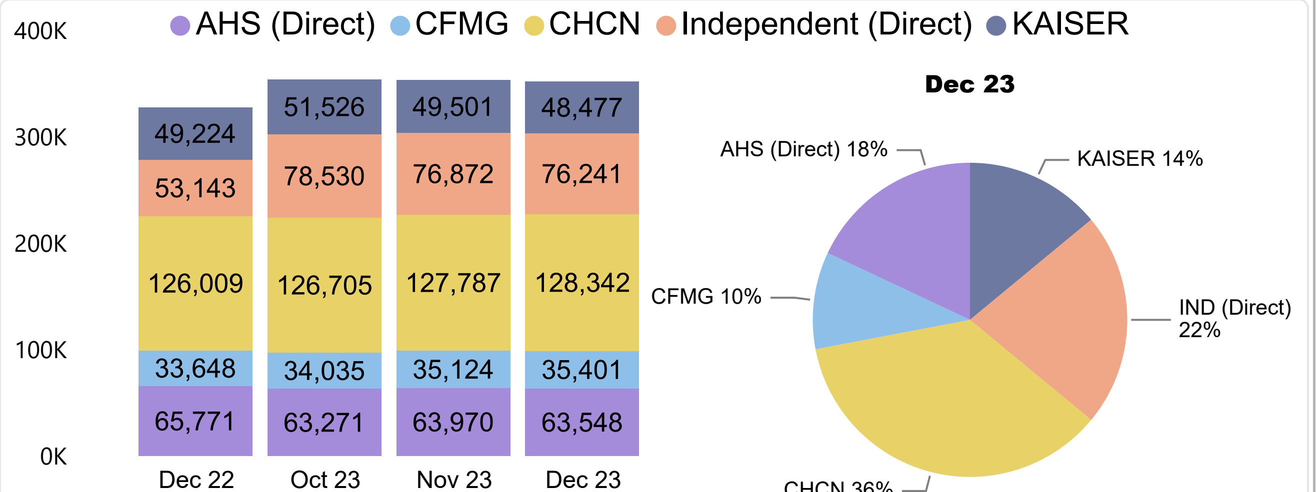
1.82

Membership

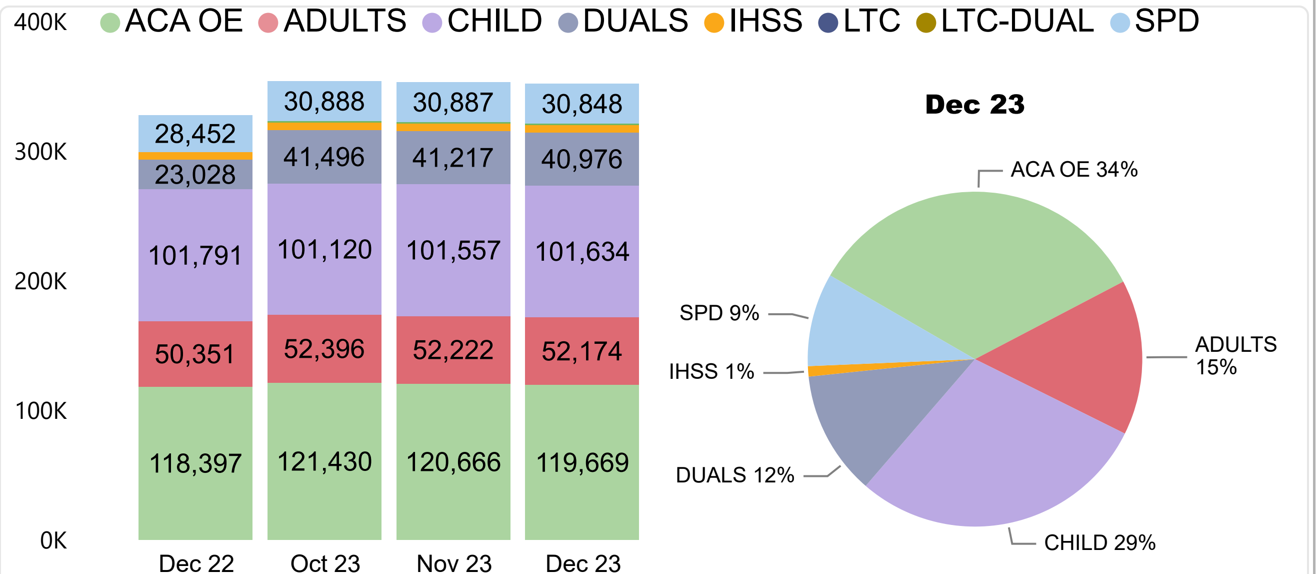
By Plan



By Network

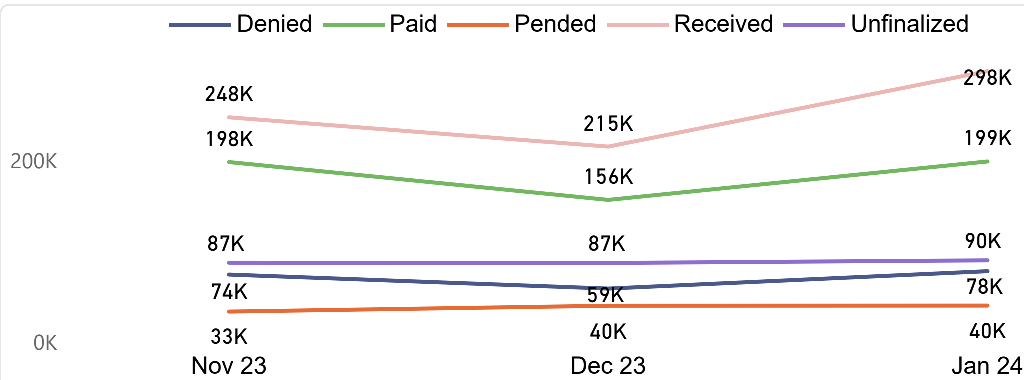


By Category

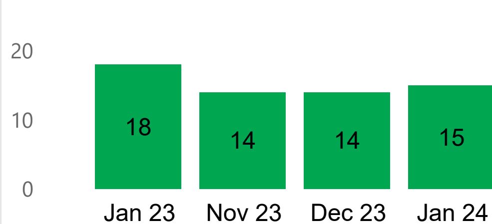


Claims

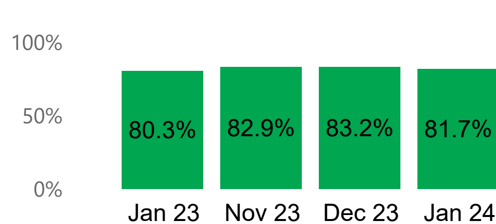
Claims Processing



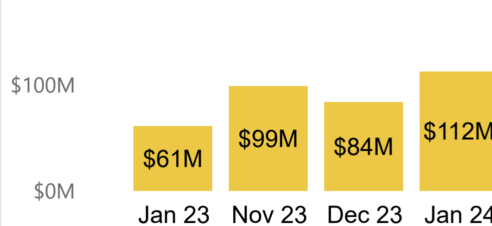
Average Payment TAT (Days)



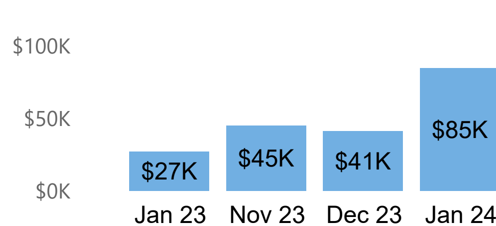
Auto Adjudication Rate (%)



Claims Paid ($)

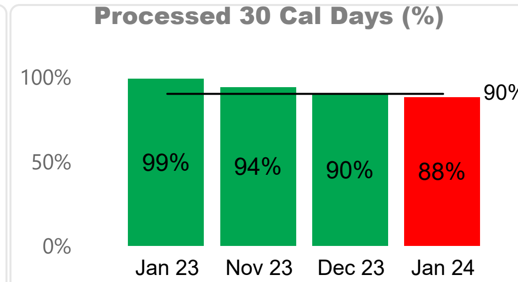


Interest Paid ($)

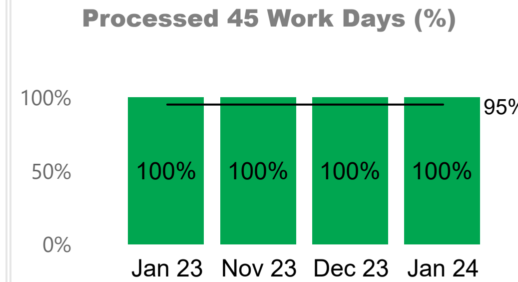


Claims Compliance

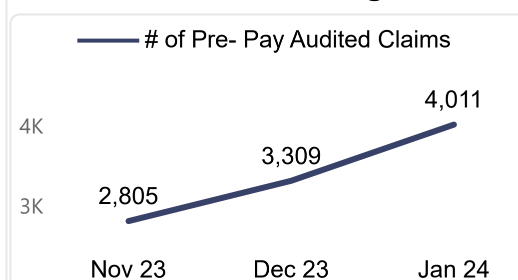
Processed 30 Cal Days (%)



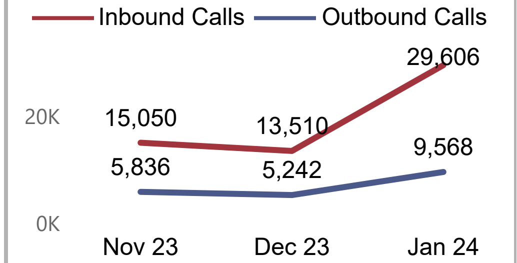
Processed 45 Work Days (%)



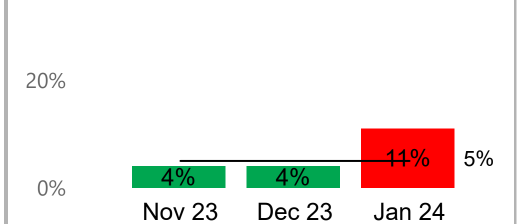
Claims Auditing



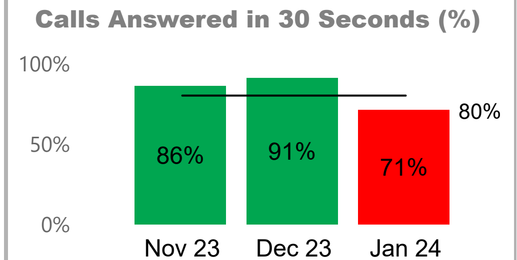
Member Services



Abandoned Call Rate (%)

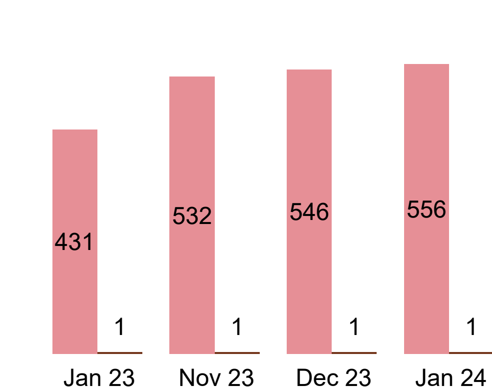


Calls Answered in 30 Seconds (%)

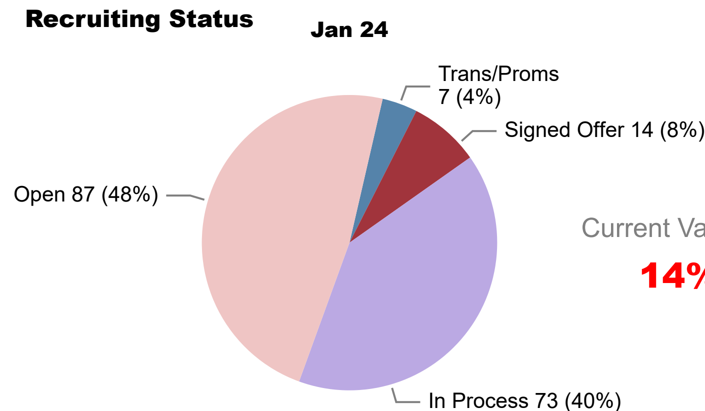


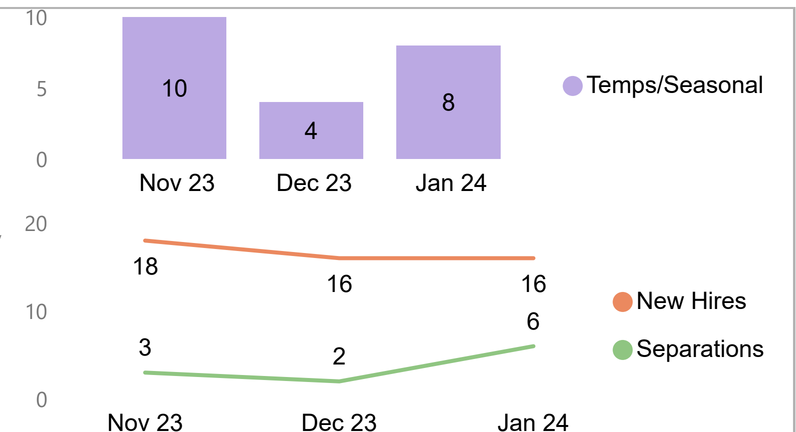
Average Call Times	Nov 23	Dec 23	Jan 24
Wait Time	00:27	00:23	01:26
Call Duration	06:48	06:42	06:58

Human Resources



Recruiting Status **Jan 24**





Provider Services

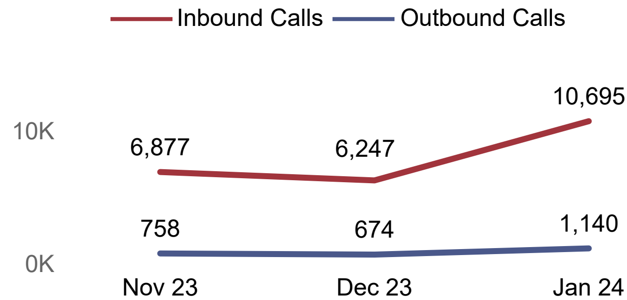
Provider Network

Hospital	17
Specialist	9,778
Primary Care Physician	786
Skilled Nursing Facility	103
Urgent Care	7
Health Centers (FQHCs and Non-FQHCs)	68
TOTAL	**10,759**

Provider Credentialing

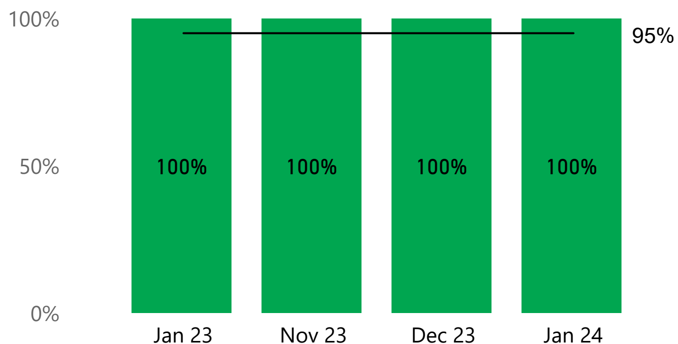
3,097

Provider Call Center



Provider Disputes & Resolutions

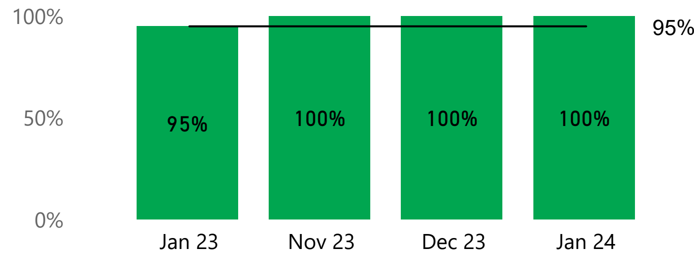
Turnaround Compliance (45 business days)



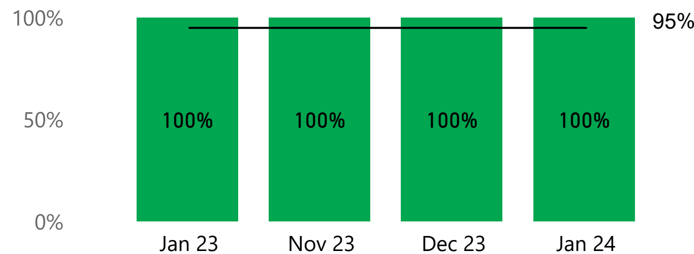
Compliance

Member Grievances

Standard (30 calendar days)

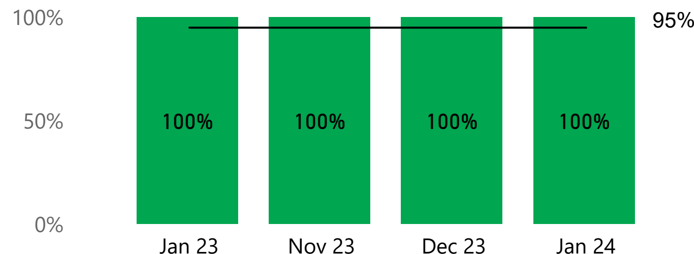


Expedited (3 calendar days)



Member Appeals

Standard (30 calendar days)



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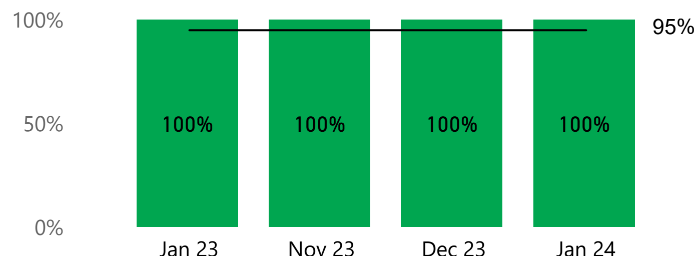
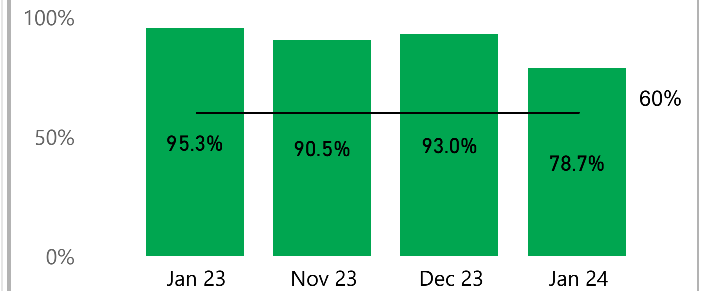
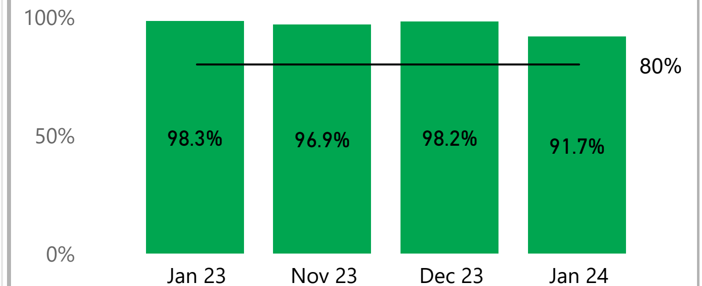


Encounter Data

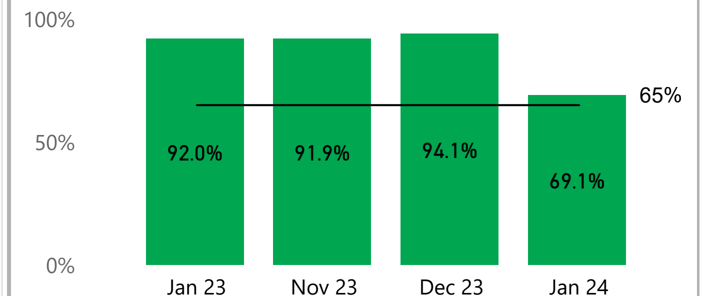
Institutional 0-90 days



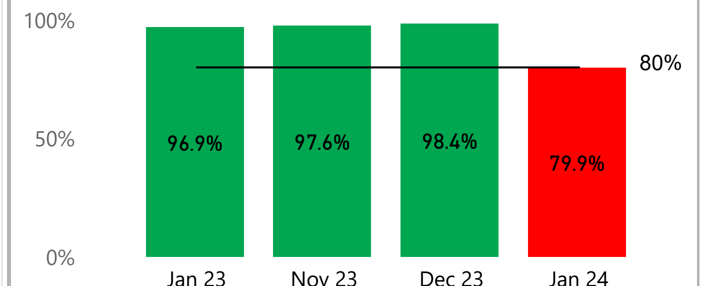
Institutional 0-180 days



Professional 0-90 days



Professional 0-180 days



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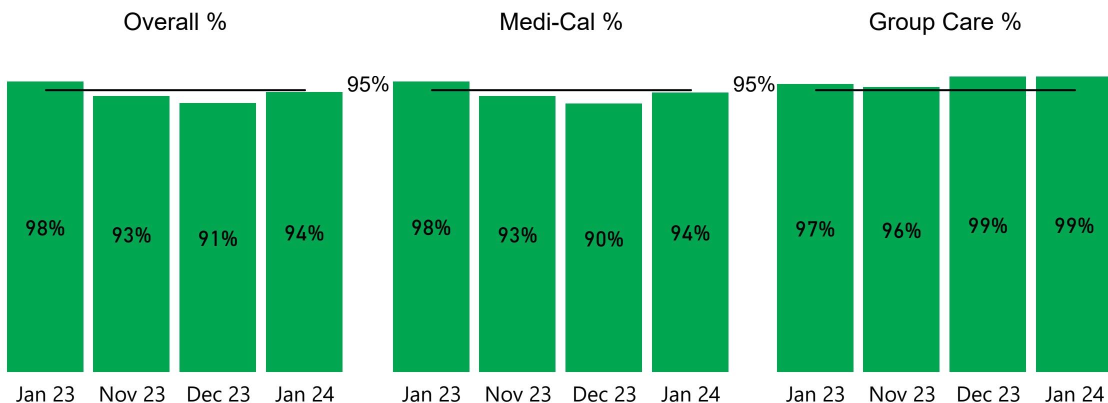
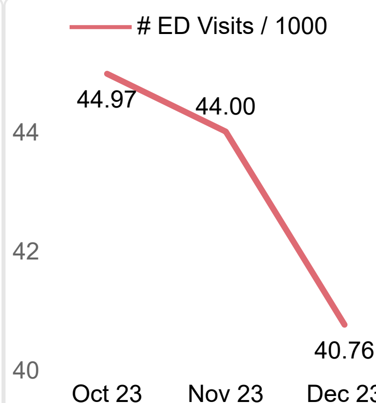
Health Care Services

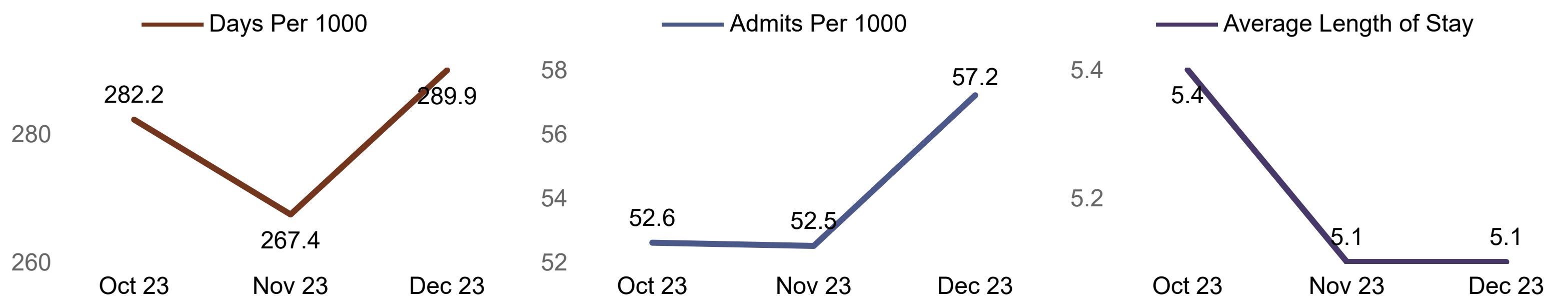
Authorization Turnaround



ED Utilization

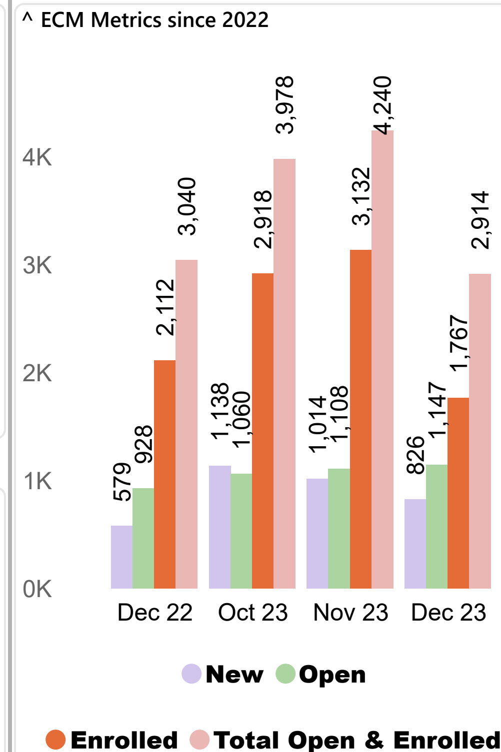


Inpatient Utilization



Case Management

Total Cases^

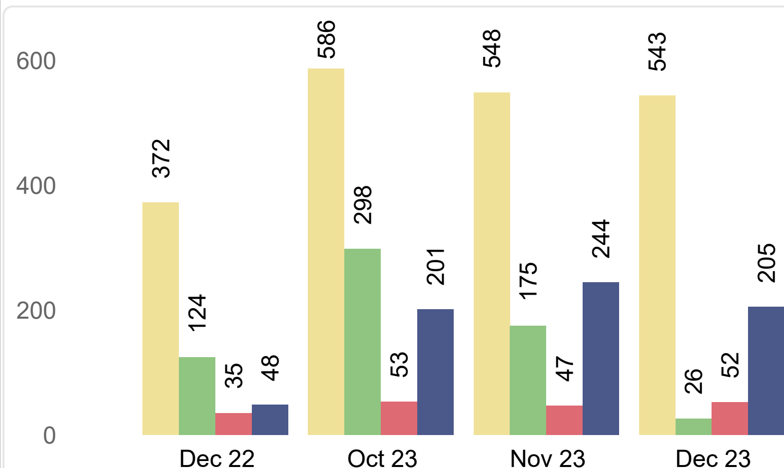


Case Management^

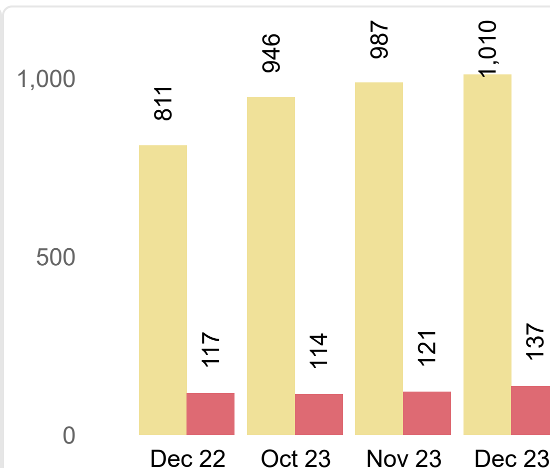
Care Coordination · Community Supports · Complex Cases · Enhanced Case Management

^ ECM Metrics since 2022

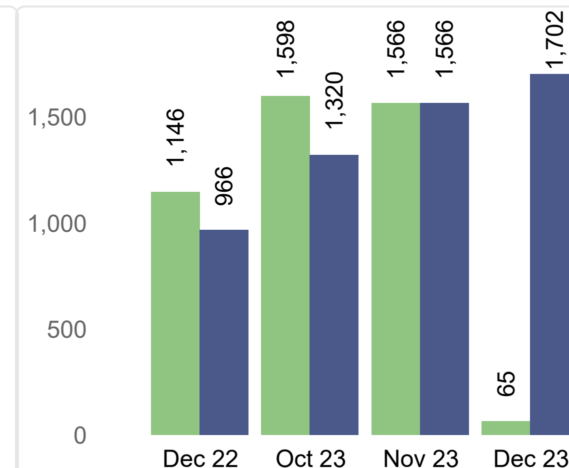
New Cases



Open Cases



Enrolled Cases



Technology (Business Availability)

Applications	Jan 23	Nov 23	Dec 23	Jan 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	Jan 23	Nov 23	Dec 23	Jan 24
Denial Rate Excluding Partial Denials (%)	3.5%	3.8%	3.9%	3.1%
Overall Denial Rate (%)	3.8%	4.1%	4.1%	3.5%
Partial Denial Rate (%)	0.4%	0.3%	0.3%	0.4%

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

Pharmacy Authorizations

Authorizations	Jan 23	Nov 23	Dec 23	Jan 24
Approved Prior Authorizations	28	37	22	30
Closed Prior Authorizations	66	67	58	107
Denied Prior Authorizations	23	39	27	43
Total Prior Authorizations	117	143	107	180

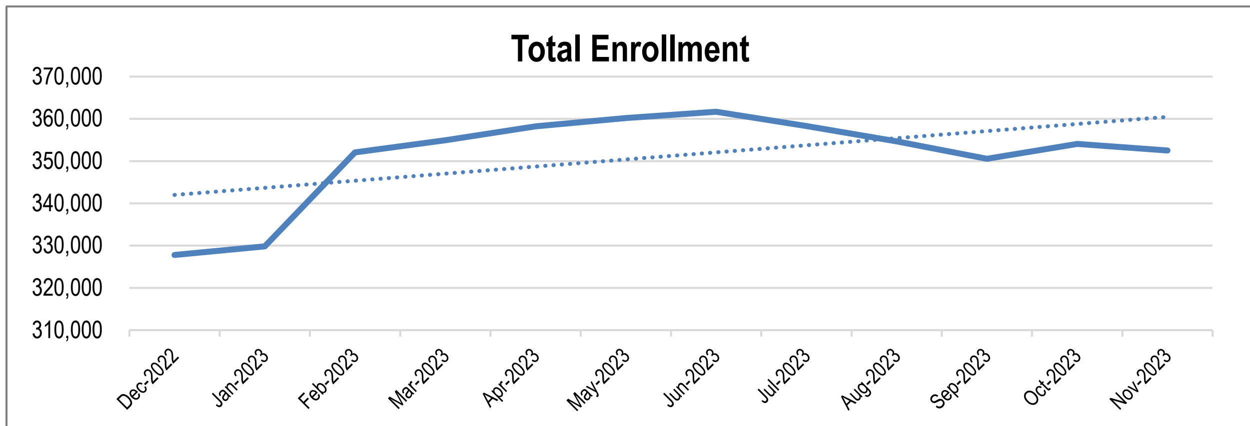
Finance

Gil Riojas

To: Alameda Alliance for Health Board of Governors
From: Gil Riojas, Chief Financial Officer
Date: February 9th, 2024
Subject: Finance Report – November 2023 Financials

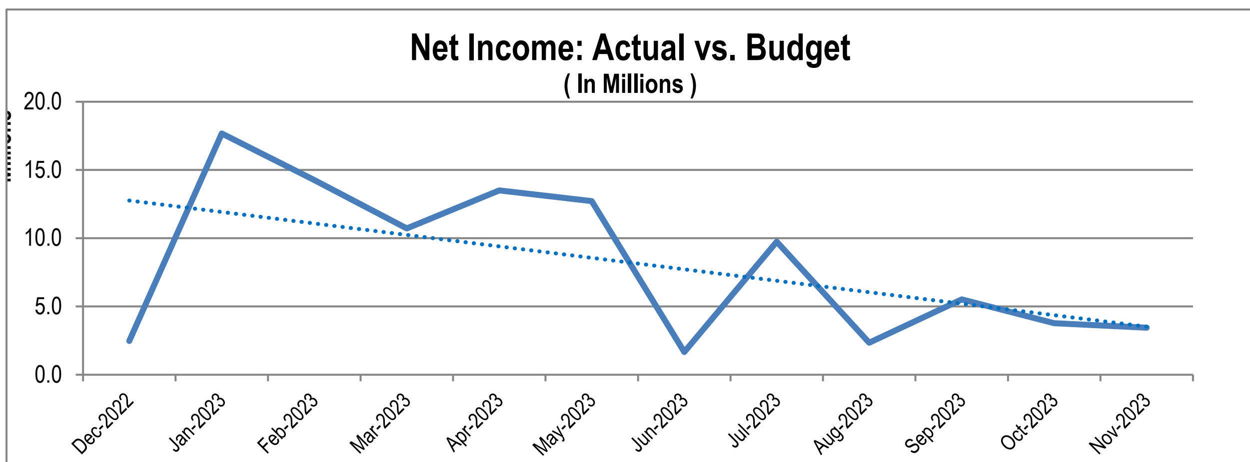
Executive Summary

For the month ended November 30th, 2023, the Alliance experienced a decrease in enrollment due to ongoing redetermination efforts. Enrollment decreased by 1,541 members to 352,526 members. Net Income of $3.4 million was reported in November. The Plan's medical expenses represented 93.1% of revenue. Alliance reserves increased slightly to 699% of required and remain well above minimum requirements.

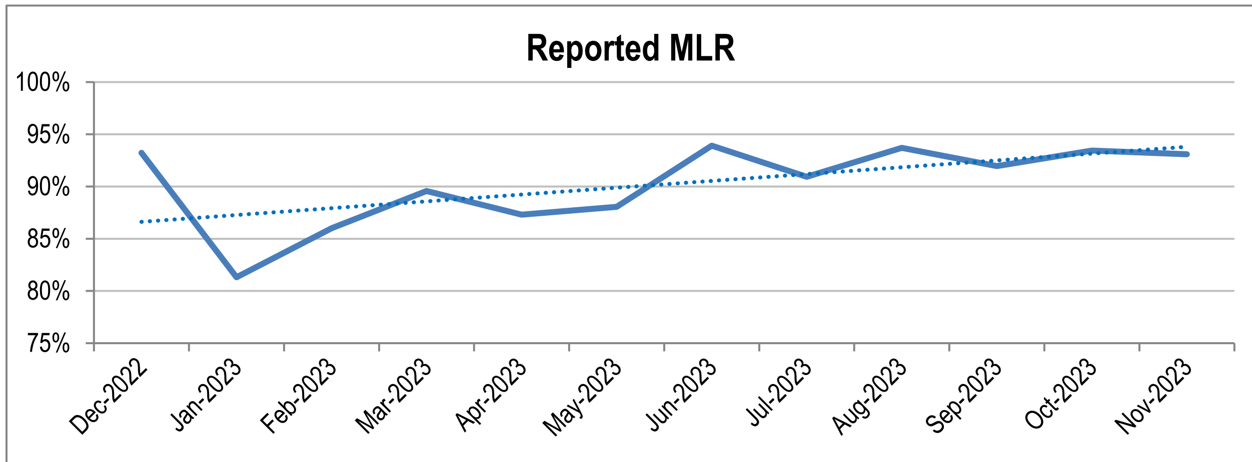


Enrollment – In November, enrollment decreased slightly by 1,541 members. DHCS is no longer assigning new members to Anthem, so all new members are Alliance members, which helped to offset continued redetermination disenrollments.

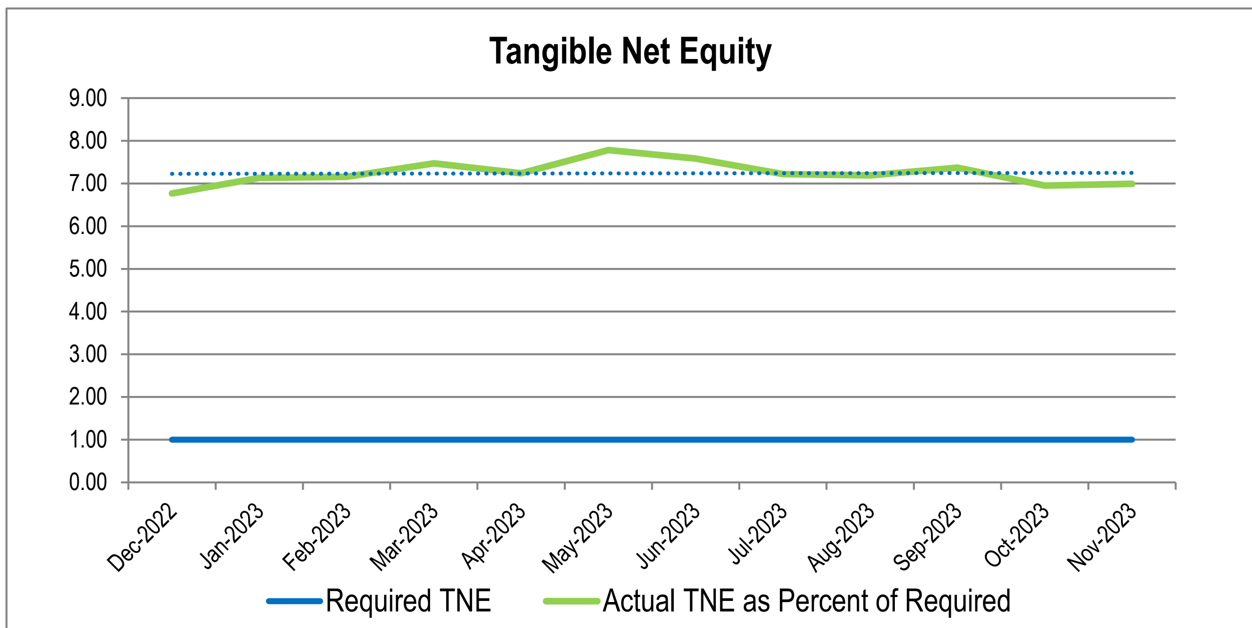
Net Income – For the month ended November 30th, 2023, actual Net Income was $3.4 million vs. budgeted Net Loss of $1.0 million. Fiscal year-to-date actual Net Income was $24.8 million vs. Budgeted Net Income of $20.4 million. The favorable variance of $4.4 million in the current month is due to higher than anticipated Investment Income and lower than anticipated Medical and Administrative Expenses.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 93.1% for the month and 92.6% 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 $49.9M in reserves, we reported $348.8M. Our overall TNE remains healthy at 699%.

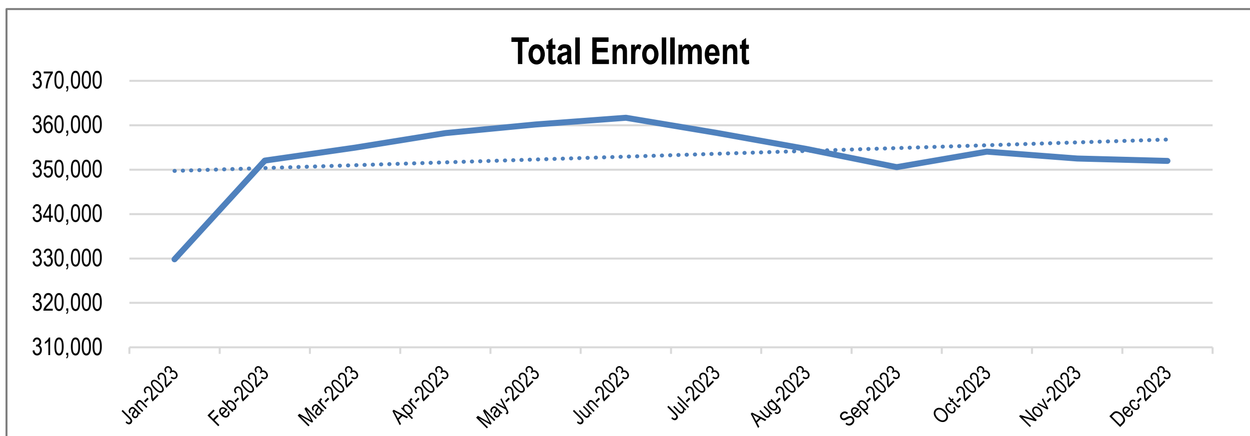


The Alliance continues to benefit from increased non-operating income. For November we reported returns of $941K, and year-to-date $12.0M, in the investment portfolio.

To: Alameda Alliance for Health Board of Governors
From: Gil Riojas, Chief Financial Officer
Date: February 9th, 2024
Subject: Finance Report – December 2023 Financials

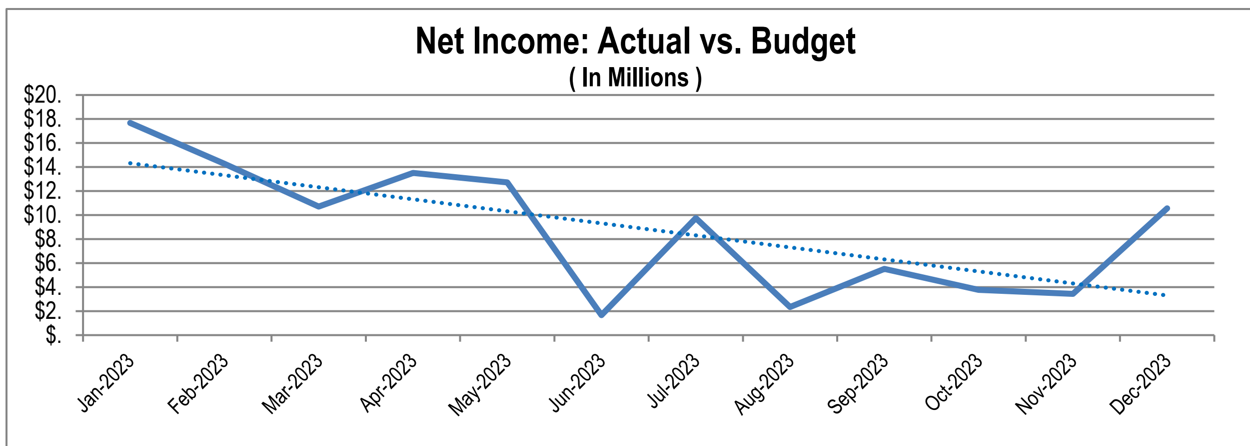
Executive Summary

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.

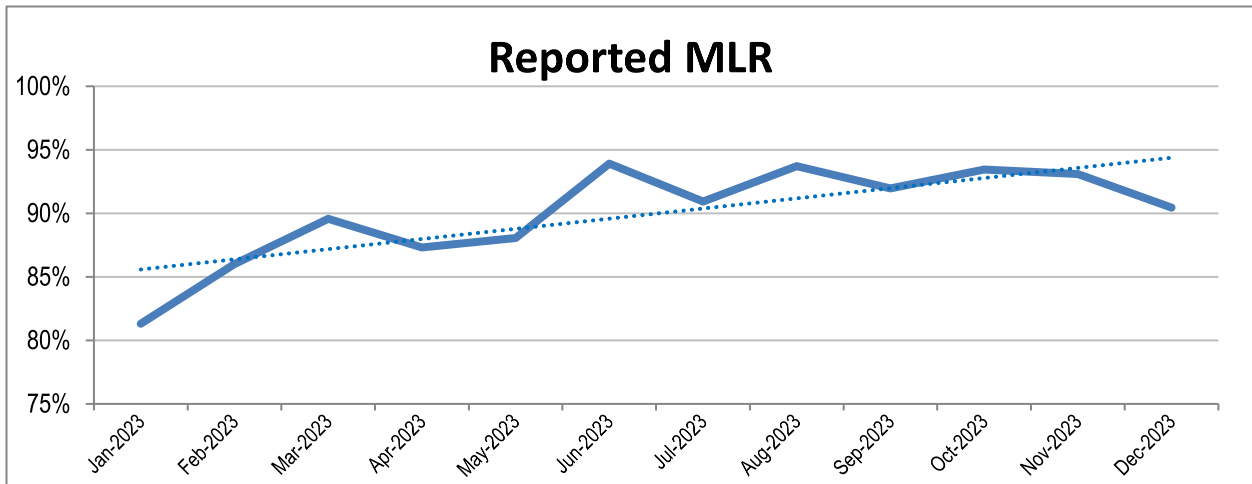


Enrollment – In December, enrollment decreased slightly by 546 members. DHCS is no longer assigning new members to Anthem, so all new members are Alliance members, which continues to help offset continued redetermination disenrollments.

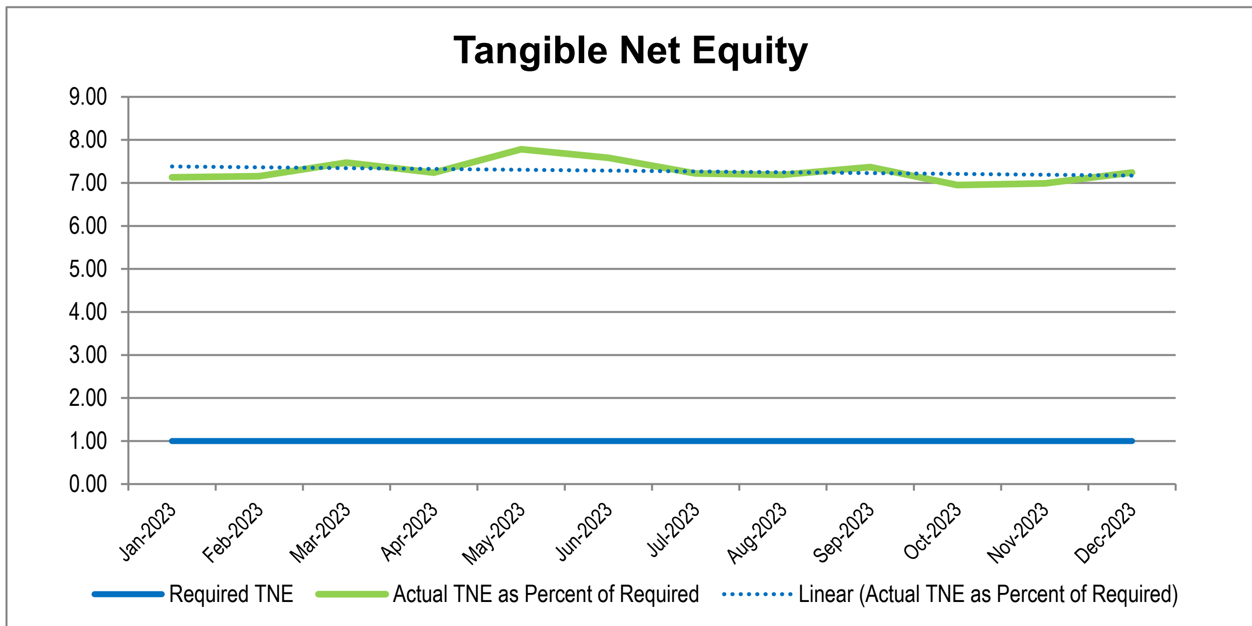
Net Income – For the month ended December 31st, 2023, actual Net Income was $10.6 million vs. budgeted Net Loss of $3.4 million. Fiscal year-to-date actual Net Income was $35.4 million vs. Budgeted Net Income of $17.0 million. The favorable variance of $13.9 million in the current month is due to higher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



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.

Finance

Supporting Documents

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: February 9th, 2024

Subject: Finance Report – November 2023

Executive Summary

- For the month ended November 30th, 2023, the Alliance had enrollment of 352,526 members, a Net Income of $3.4 million and 699% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$137,819	$687,972
Medical Expense	128,295	637,238
Admin. Expense	7,914	37,702
Other Inc. / (Exp.)	1,832	11,790
Net Income	**$3,441**	**$24,822**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	$3,328	$23,738
Group Care	113	1,084
	$3,441	**$24,822**

*Includes consulting cost for Medicare implementation.

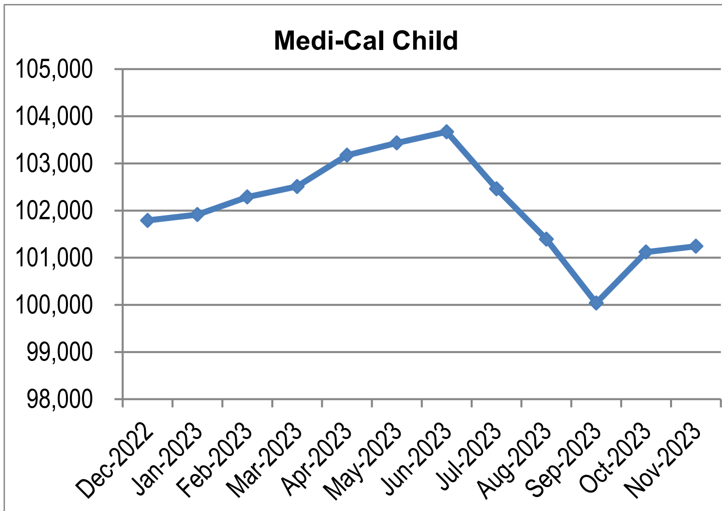
Enrollment

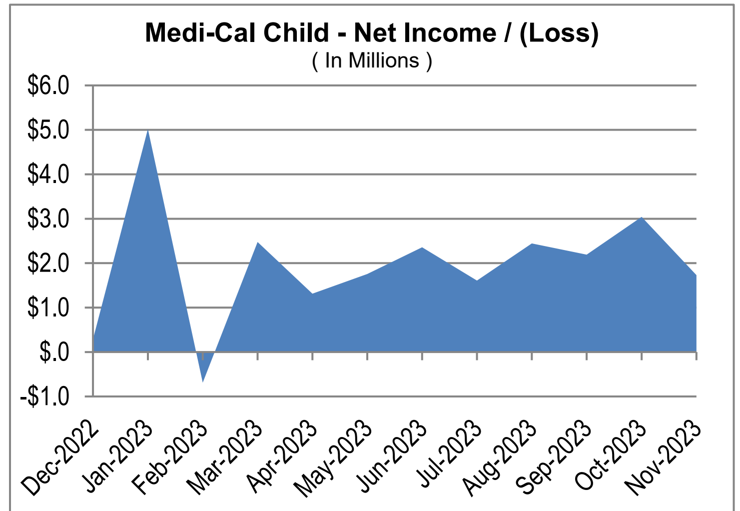
- Total enrollment decreased by 1,541 members since October 2023.
- Total enrollment decreased by 9,159 members since June 2023.

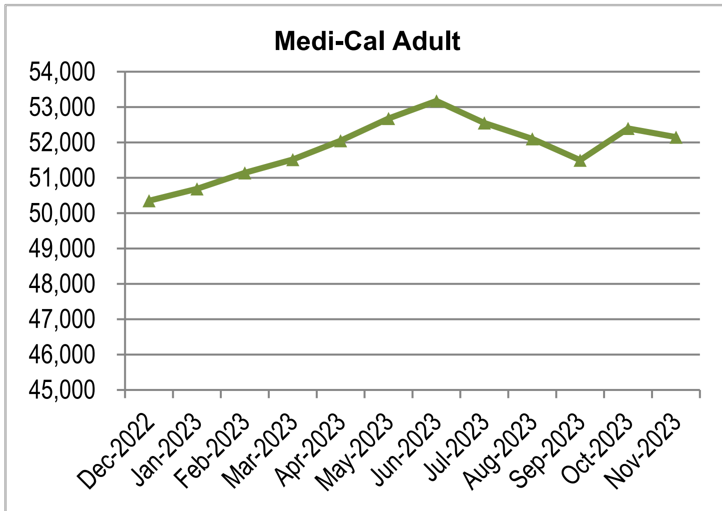
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

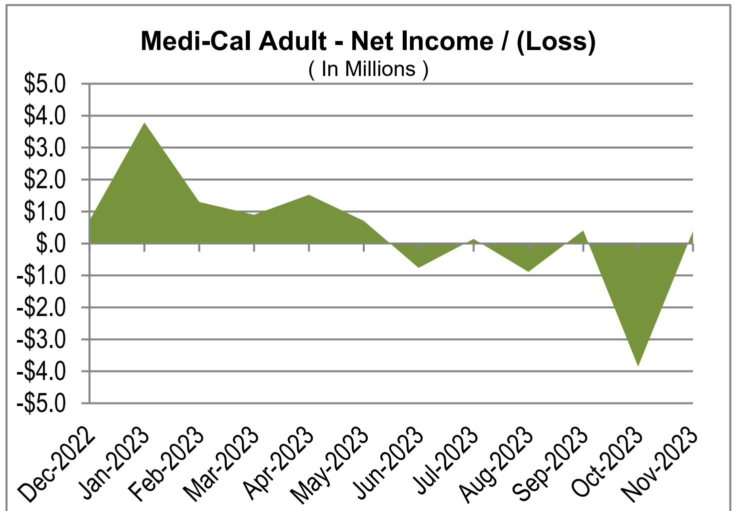
Enrollment November 2023					Member Months Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
52,151	51,872	279	0.5%	Adult	260,698	260,419	279	0.1%
101,243	100,109	1,134	1.1%	Child	506,257	505,123	1,134	0.2%
30,865	30,734	131	0.4%	SPD	154,240	154,109	131	0.1%
40,997	41,410	(413)	-1.0%	Duals	207,525	207,938	(413)	-0.2%
120,573	121,180	(607)	-0.5%	ACA OE	607,545	608,152	(607)	-0.1%
137	136	1	0.7%	LTC	690	689	1	0.1%
975	985	(10)	-1.0%	LTC Duals	5,028	5,038	(10)	-0.2%
346,941	**346,426**	**515**	**0.1%**	**Medi-Cal Total**	**1,741,983**	**1,741,468**	**515**	**0.0%**
5,585	5,591	(6)	-0.1%	Group Care	28,135	28,141	(6)	0.0%
352,526	**352,017**	**509**	**0.1%**	**Total**	**1,770,118**	**1,769,609**	**509**	**0.0%**

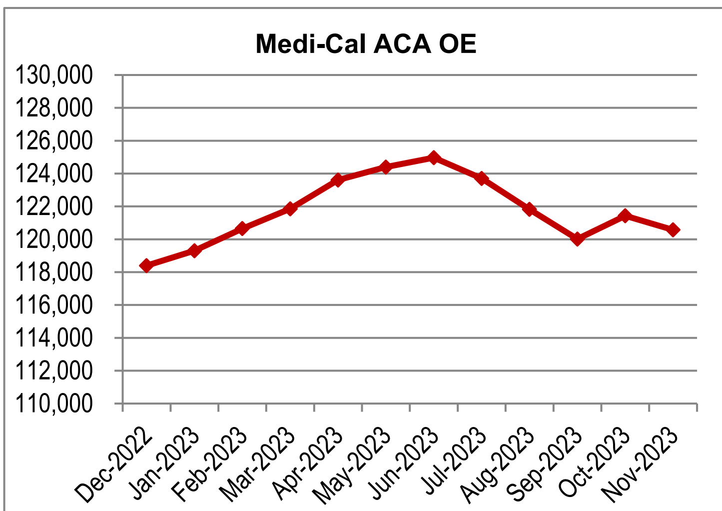
Enrollment and Profitability by Program and Category of Aid

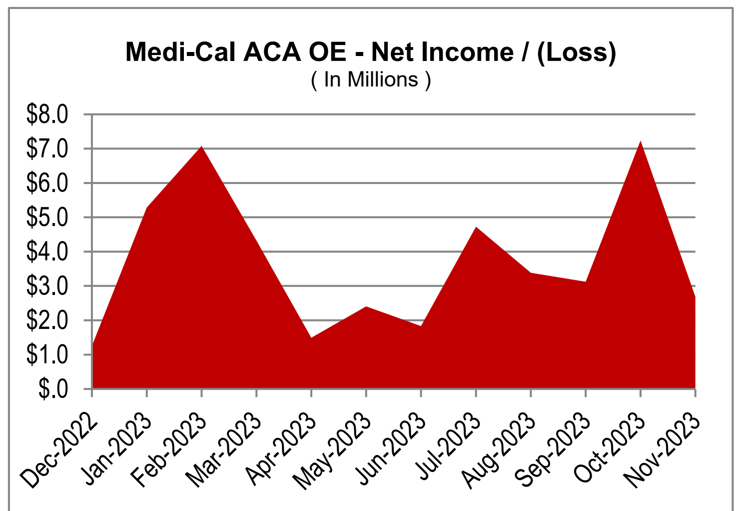




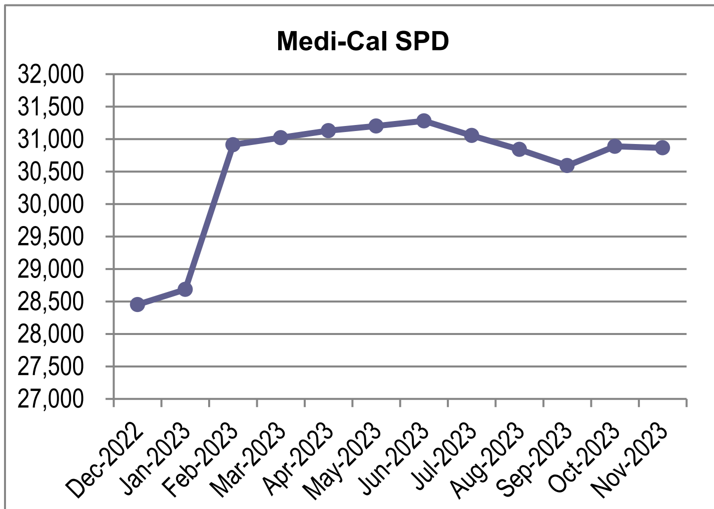


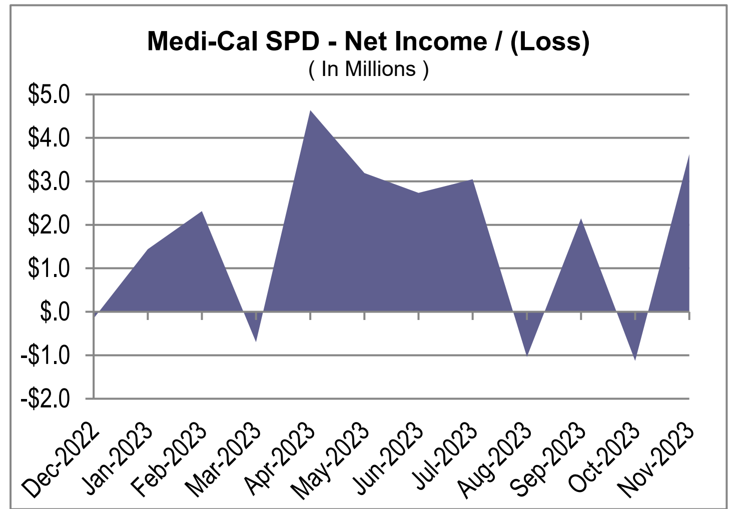


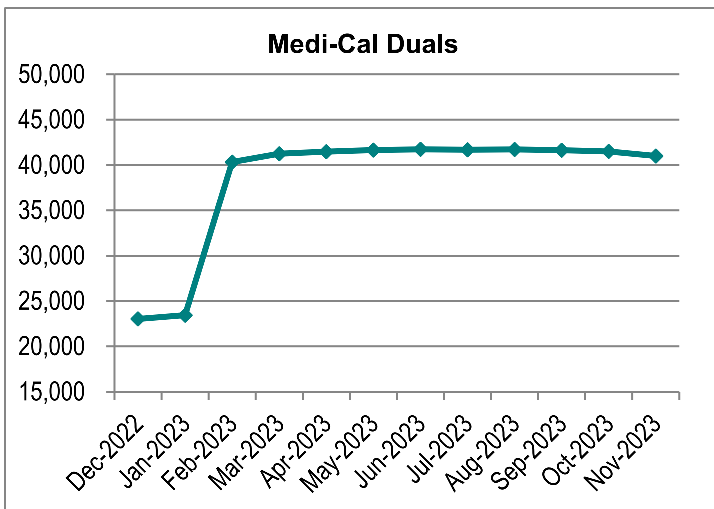


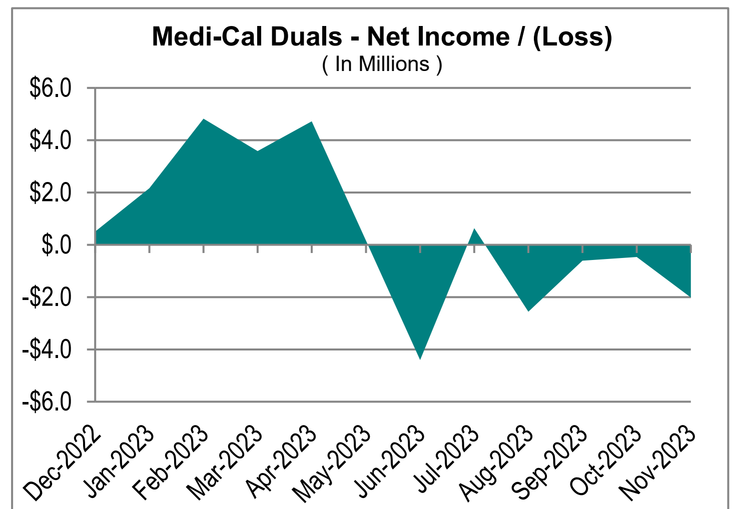


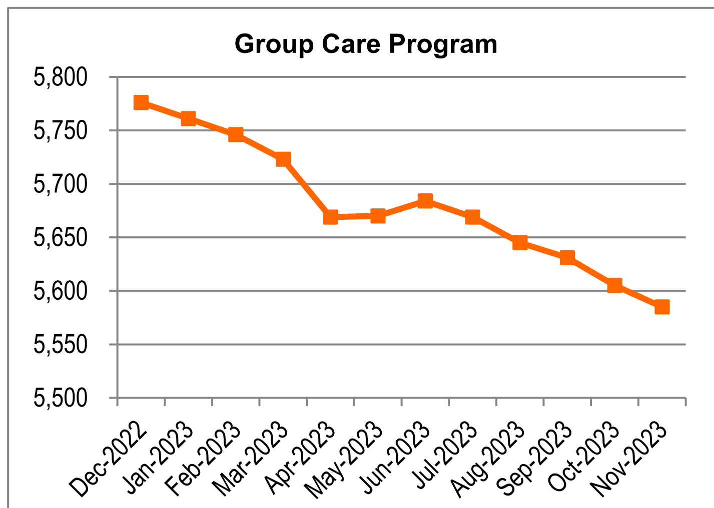
Enrollment and Profitability by Program and Category of Aid

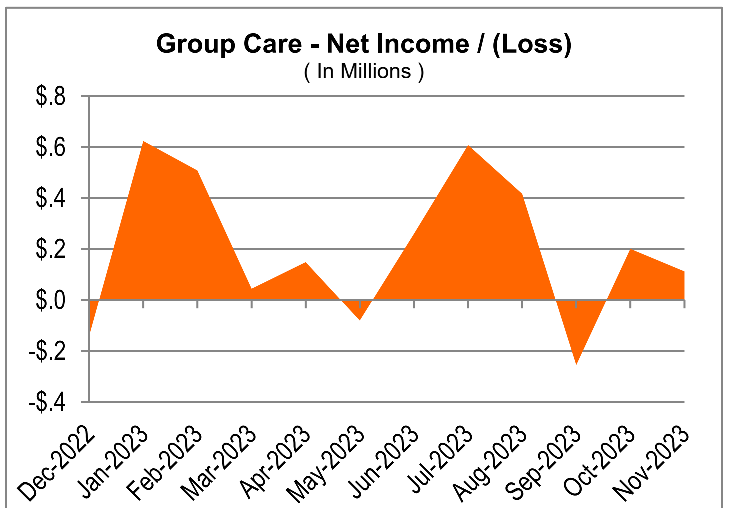




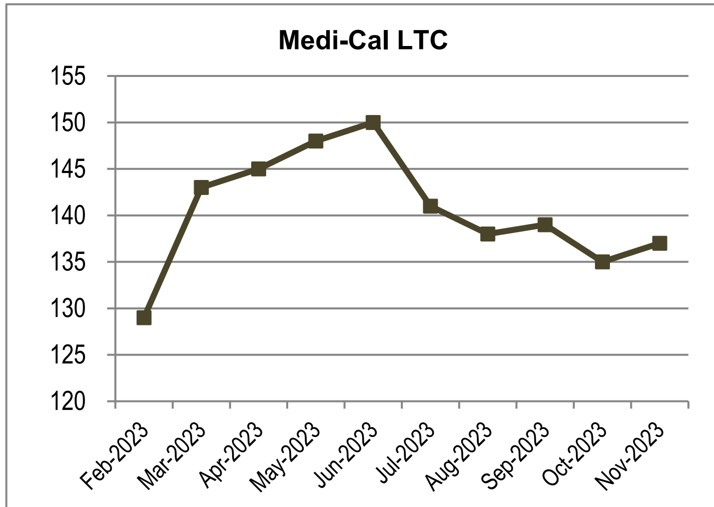


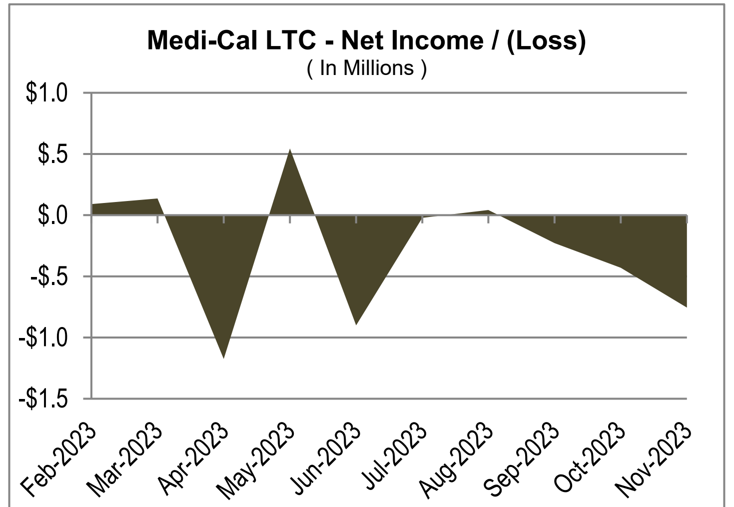


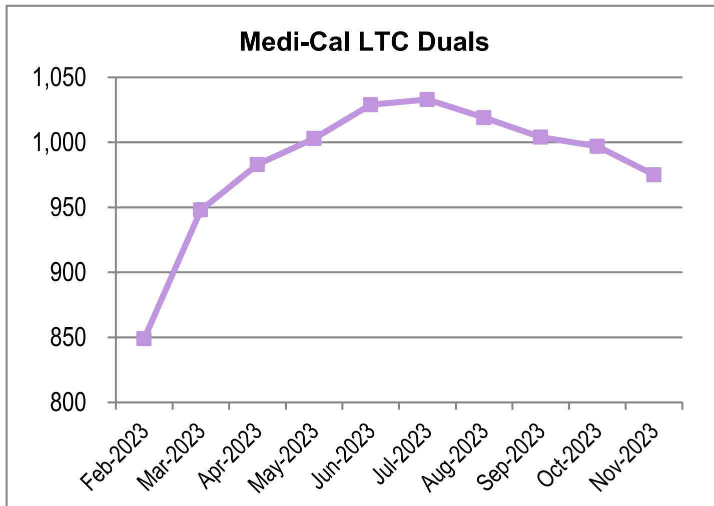


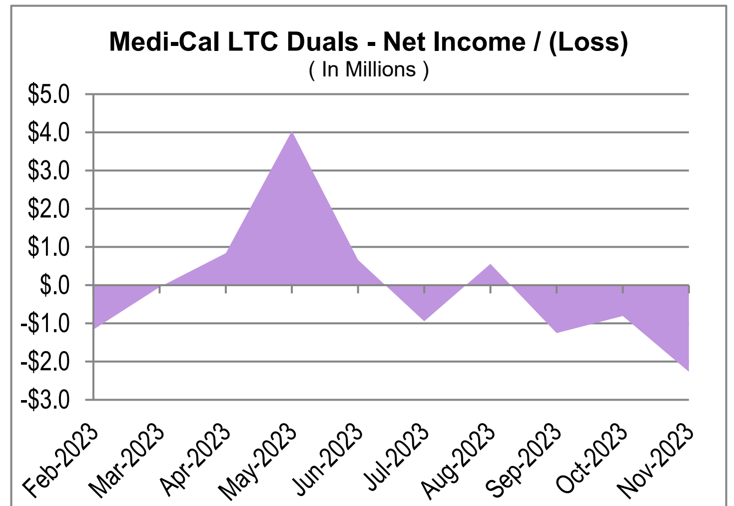


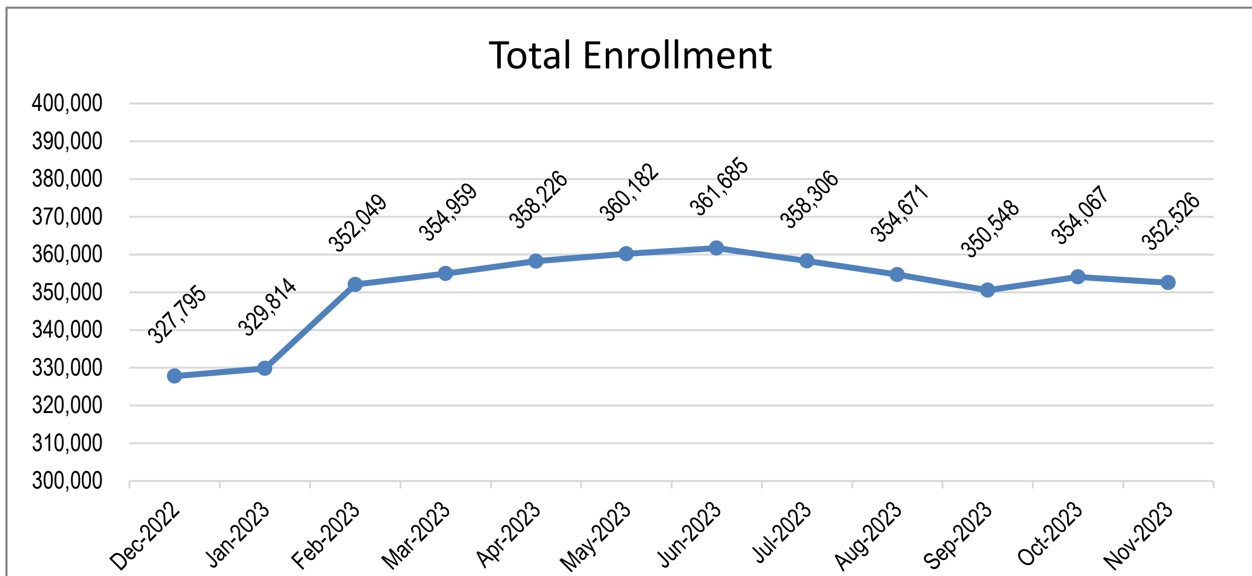
Enrollment and Profitability by Program and Category of Aid

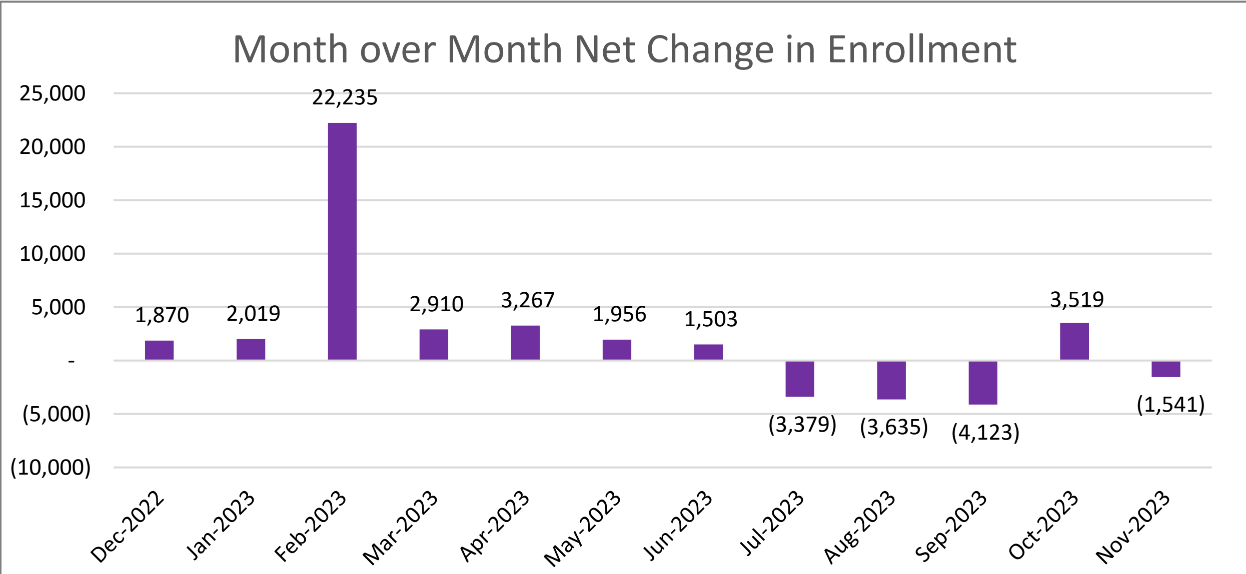










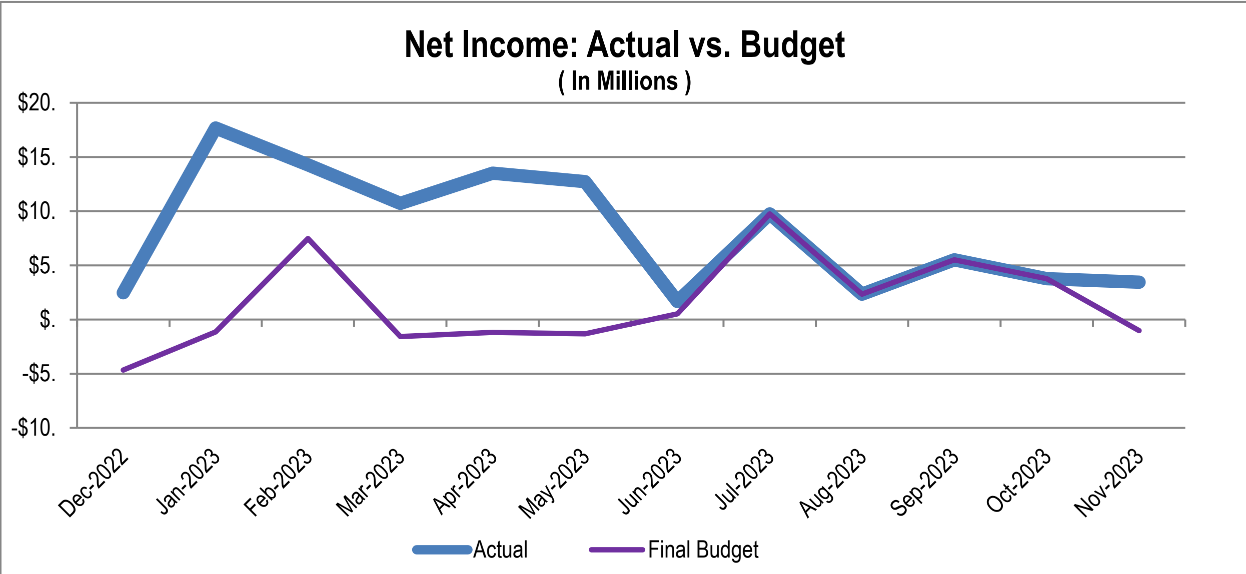


- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started in July 2023. In preparation for the Single Plan Model, DHCS is no longer assigning members to Anthem. New members are now all assigned to the Alliance.

Net Income

- For the month ended November 30th, 2023
  - Actual Net Income $3.4 million.
  - Budgeted Net Loss $1.0 million.

- For the fiscal YTD ended November 30th, 2023
  - Actual Net Income $24.8 million.
  - Budgeted Net Income $20.4 million.

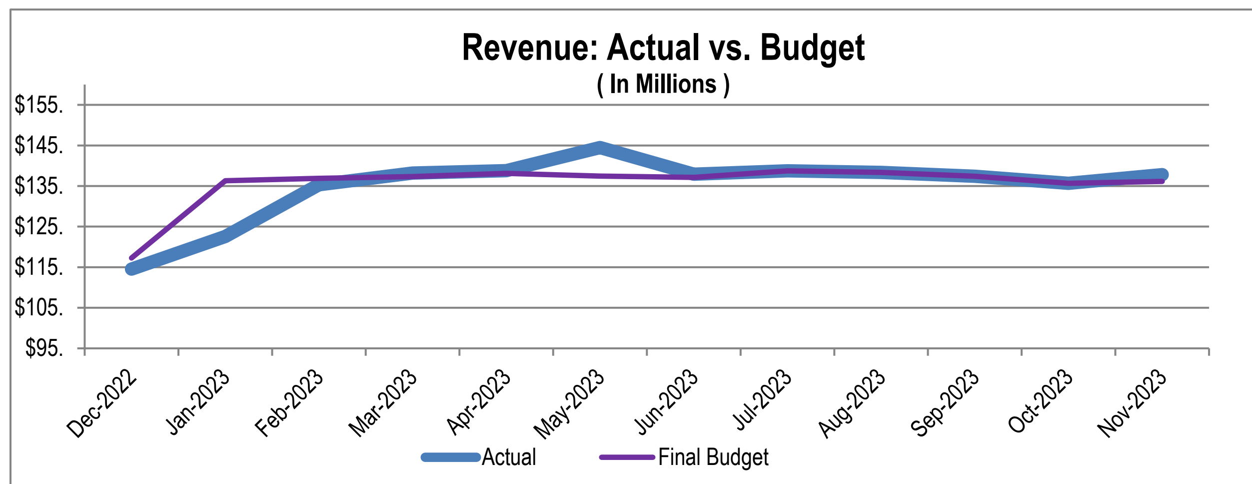


- The favorable variance of $4.5 million in the current month is primarily due to:
    - Favorable $2.3 million lower than anticipated Administrative Expense.
    - Favorable $1.7 million higher than anticipated Revenue.
    - Favorable $1.1 million lower than anticipated Medical Expense.
    - Unfavorable $628,000 lower than anticipated Other Income/Expense.

Revenue

- For the month ended November 30th, 2023
    - Actual Revenue: $137.8 million.
    - Budgeted Revenue: $136.2 million.

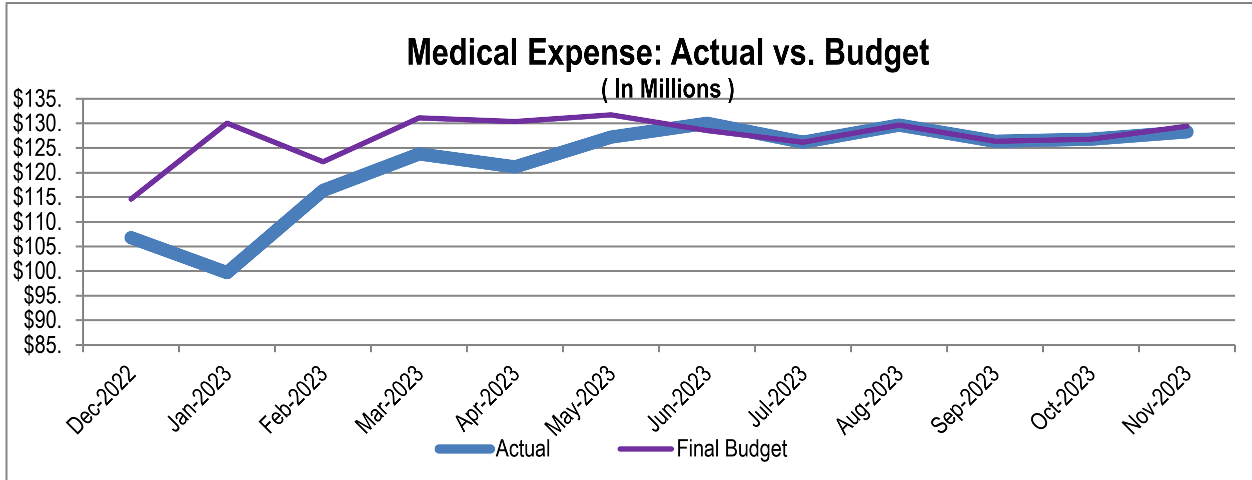
- For the fiscal YTD ended November 30th, 2023
    - Actual Revenue: $688.0 million.
    - Budgeted Revenue: $686.3 million.



- For the month ended November 30th, 2023, the favorable revenue variance of $1.7 million is primarily due to timing of revenue recognition:
    - Favorable $1.1 million Supplemental Maternity revenue due to timing.
    - Favorable $472,000 estimate to actual for October 2023.

Medical Expense

- For the month ended November 30, 2023
    - Actual Medical Expense: $128.3 million.
    - Budgeted Medical Expense: $129.4 million.
- For the fiscal YTD ended November 30, 2023
    - Actual Medical Expense: $637.2 million.
    - Budgeted Medical Expense: $638.4 million.



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

- For November, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $5.2 million. Year to date, the estimate for prior years increased by $4.5 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	$128,557,839	$0	$128,557,839	$129,223,302	$665,464	0.5%
Primary Care FFS	$27,987,825	$3,114	$27,990,940	$27,963,685	($24,141)	-0.1%
Specialty Care FFS	$24,979,139	$3,092	$24,982,231	$25,520,851	$541,713	2.1%
Outpatient FFS	$39,469,426	$79,420	$39,548,846	$40,031,207	$561,781	1.4%
Ancillary FFS	$53,050,204	$314,826	$53,365,030	$54,008,223	$958,019	1.8%
Pharmacy FFS	$42,070,071	($41,600)	$42,028,471	$42,596,192	$526,121	1.2%
ER Services FFS	$28,418,653	$11,164	$28,429,817	$28,465,840	$47,187	0.2%
Inpatient Hospital & SNF FFS	$161,991,941	$812,269	$162,804,210	$164,754,811	$2,762,870	1.7%
Long Term Care FFS	$99,754,299	$3,346,763	$103,101,062	$98,013,603	($1,740,696)	-1.8%
Other Benefits & Services	$22,694,639	$0	$22,694,639	$24,163,977	$1,469,339	6.1%
Net Reinsurance	$734,754	$0	$734,754	$613,953	($120,800)	-19.7%
Provider Incentive	$3,000,000	$0	$3,000,000	$3,000,000	$0	0.0%
	$632,708,789	**$4,529,049**	**$637,237,838**	**$638,355,643**	**$5,646,854**	**0.9%**

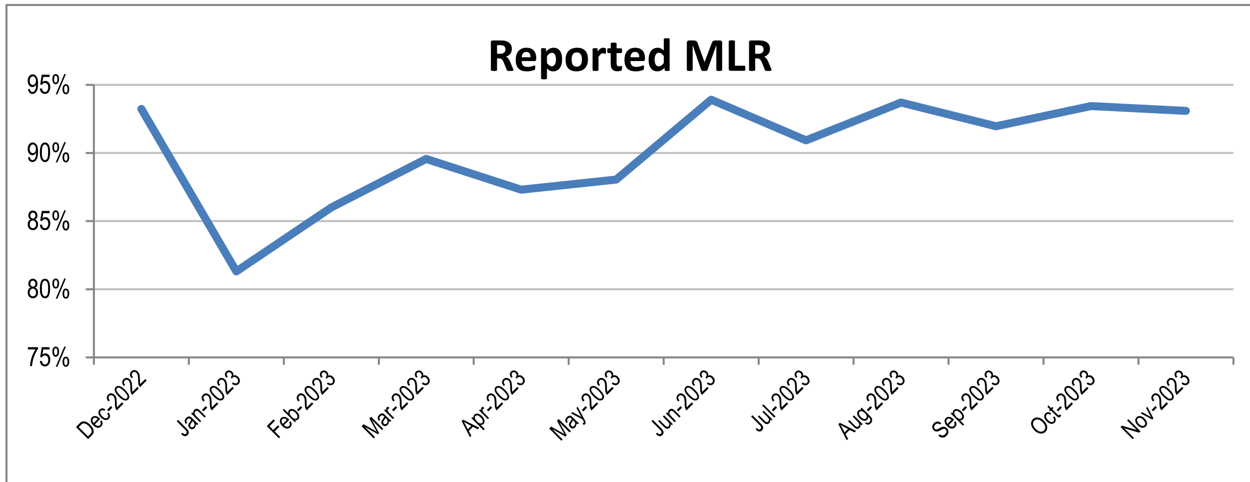
Medical Expense - Actual vs. Budget (Per Member Per Month) Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$72.63	$0.00	$72.63	$73.02	$0.40	0.5%
Primary Care FFS	$15.81	$0.00	$15.81	$15.80	($0.01)	-0.1%
Specialty Care FFS	$14.11	$0.00	$14.11	$14.42	$0.31	2.2%
Outpatient FFS	$22.30	$0.04	$22.34	$22.62	$0.32	1.4%
Ancillary FFS	$29.97	$0.18	$30.15	$30.52	$0.55	1.8%
Pharmacy FFS	$23.77	($0.02)	$23.74	$24.07	$0.30	1.3%
ER Services FFS	$16.05	$0.01	$16.06	$16.09	$0.03	0.2%
Inpatient Hospital & SNF FFS	$91.51	$0.46	$91.97	$93.10	$1.59	1.7%
Long Term Care FFS	$56.35	$1.89	$58.25	$55.39	($0.97)	-1.7%
Other Benefits & Services	$12.82	$0.00	$12.82	$13.65	$0.83	6.1%
Net Reinsurance	$0.42	$0.00	$0.42	$0.35	($0.07)	-19.6%
Provider Incentive	$1.69	$0.00	$1.69	$1.70	$0.00	0.0%
	$357.44	**$2.56**	**$360.00**	**$360.73**	**$3.29**	**0.9%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $5.6 million favorable to budget. On a PMPM basis, medical expense is 0.9% favorable to budget. For per-member-per-month expense:
  - Capitated Expense is slightly under budget, largely driven by favorable Supplemental Maternity, FQHC, and Global Subcontract expenses.
  - Primary Care Expense is slightly unfavorable compared to budget, driven mostly by the higher SPD utilization.
  - Specialty Care expenses are below budget, driven mostly by lower SPD and Dual utilization.
  - Outpatient Expense is under budget generally due to lower lab and radiology utilization offset by slightly higher facility other and dialysis unit cost.
  - Ancillary Expense is under budget mostly due to favorable unit cost and lower utilization across all member groups excluding the Group Care, Dual, and LTC Dual categories of aid.
  - Pharmacy Expense is under budget mostly due to favorable Non-PBM expense driven by lower utilization in the SPD, Child, ACA OE, LTC and Dual COAs.
  - Emergency Room Expense is under budget driven by lower utilization in the SPD, ACA OE, LTC and LTC Dual COAs.
  - Inpatient Expense is under budget mostly driven by lower utilization in the SPD, Adult, Child, and Group Care populations.
  - Long Term Care expense is over budget mostly due to higher utilization in the Dual, SPD, ACA OE and Adult populations and unfavorable LTC Dual unit cost.

- Other Benefits & Services is under budget, due to favorable CalAIM Incentives, community relations, subscriptions, 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 93.1% for the month and 92.6% for the fiscal year-to-date.



Administrative Expense

- For the month ended November 30, 2023
  - Actual Administrative Expense: $7.9 million.
  - Budgeted Administrative Expense: $10.2 million.

- For the fiscal YTD ended November 30, 2023
  - Actual Administrative Expense: $37.7 million.
  - Budgeted Administrative Expense: $40.0 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 %**
$6,045,939	$6,748,481	$702,542	10.4%	Employee Expense	$24,104,252	$24,806,793	$702,542	2.8%
56,828	60,752	3,924	6.5%	Medical Benefits Admin Expense	1,111,723	1,115,647	3,924	0.4%
798,063	1,405,615	607,551	43.2%	Purchased & Professional Services	5,464,438	6,071,990	607,551	10.0%
1,013,132	2,010,167	997,035	49.6%	Other Admin Expense	7,021,940	8,018,975	997,035	12.4%
$7,913,961	$10,225,014	$2,311,053	22.6%	Total Administrative Expense	$37,702,353	$40,013,405	$2,311,053	5.8%

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.
- Partially offset by unfavorable Salaries and Wages.

The Administrative Loss Ratio (ALR) is 5.7% of net revenue for the month and 5.5% of net revenue year-to-date.

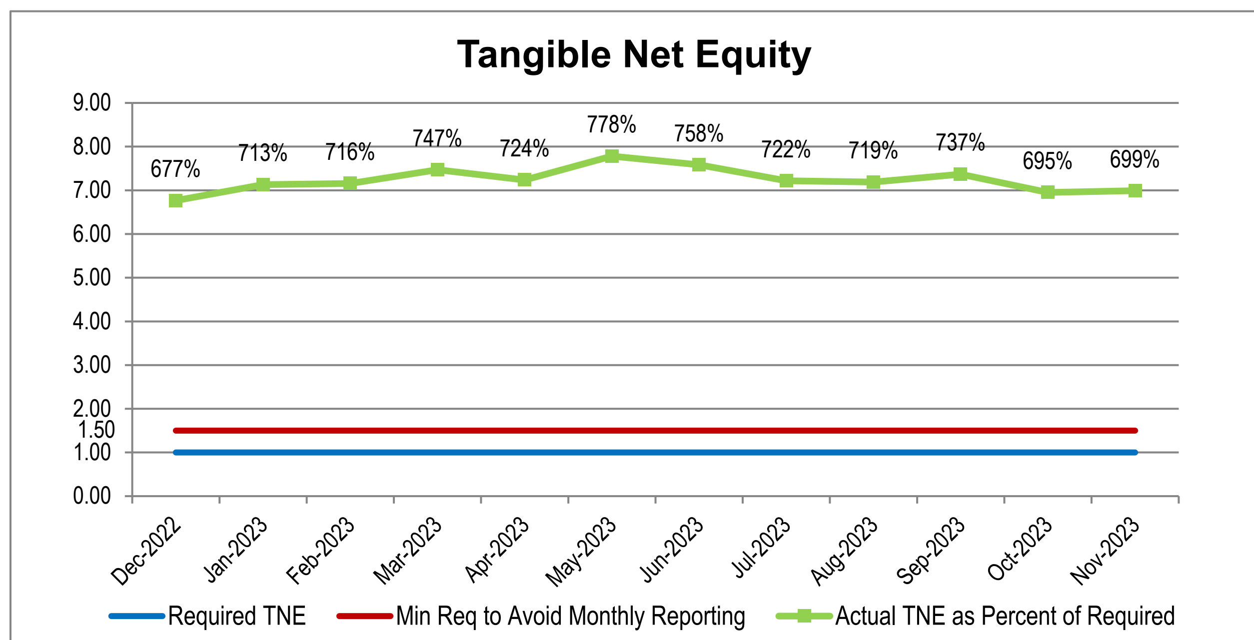
Other Income / (Expense)

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

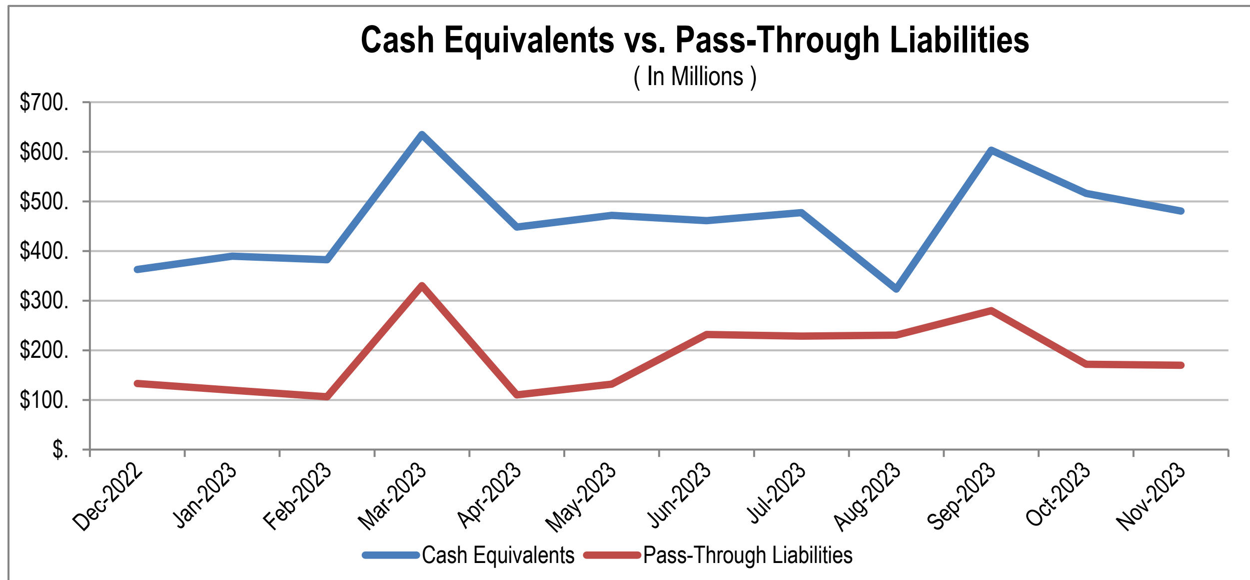
- Fiscal year-to-date net investments show a gain of $12.0 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $253,000.

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 a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
  - Required TNE $49.9 million
  - Actual TNE $348.8 million
  - Excess TNE $298.9 million
  - TNE % of Required TNE 699%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $480.5 million
    - Pass-Through Liabilities $169.8 million
    - Uncommitted Cash $310.7 million
    - Working Capital $331.7 million
    - Current Ratio 1.80 (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 (MEDICAL EXPENSE BY PAYMENT TYPE)
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2023

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
346,941	346,426	515	0.1%	1 - Medi-Cal	1,741,983	1,741,468	515	0.0%
5,585	5,591	(6)	(0.1%)	2 - GroupCare	28,135	28,141	(6)	0.0%
352,526	**352,017**	**509**	**0.1%**	**3 - TOTAL MEMBER MONTHS**	**1,770,118**	**1,769,609**	**509**	**0.0%**
				REVENUE				
$137,818,566	**$136,154,668**	**$1,663,898**	**1.2%**	**4 - TOTAL REVENUE**	**$687,972,062**	**$686,308,164**	**$1,663,898**	**0.2%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$25,573,840	$26,239,303	$665,464	2.5%	5 - Capitated Medical Expense	$128,557,839	$129,223,302	$665,464	0.5%
				Fee for Service Medical Expenses:				
$32,149,305	$34,099,906	$1,950,600	5.7%	6 - Inpatient Hospital FFS Expense	$162,804,210	$164,754,811	$1,950,600	1.2%
$5,462,202	$5,434,948	($27,255)	(0.5%)	7 - Primary Care Physician FFS Expense	$27,990,940	$27,963,685	($27,255)	(0.1%)
$5,009,628	$5,548,249	$538,621	9.7%	8 - Specialty Care Physician Expense	$24,982,231	$25,520,851	$538,621	2.1%
$10,425,866	$11,069,059	$643,193	5.8%	9 - Ancillary Medical Expense	$53,365,030	$54,008,223	$643,193	1.2%
$7,662,473	$8,144,834	$482,361	5.9%	10 - Outpatient Medical Expense	$39,548,846	$40,031,207	$482,361	1.2%
$5,762,082	$5,798,104	$36,022	0.6%	11 - Emergency Expense	$28,429,817	$28,465,840	$36,022	0.1%
$8,451,672	$9,019,393	$567,720	6.3%	12 - Pharmacy Expense	$42,028,471	$42,596,192	$567,720	1.3%
$22,437,328	$17,349,869	($5,087,459)	(29.3%)	13 - Long Term Care FFS Expense	$103,101,062	$98,013,603	($5,087,459)	(5.2%)
$97,360,557	$96,464,361	($896,197)	(0.9%)	14 - Total Fee for Service Expense	$482,250,607	$481,354,410	($896,197)	(0.2%)
$3,982,111	$5,451,450	$1,469,339	27.0%	15 - Other Benefits & Services	$22,694,639	$24,163,977	$1,469,339	6.1%
$378,865	$258,065	($120,800)	(46.8%)	16 - Reinsurance Expense	$734,754	$613,953	($120,800)	(19.7%)
$1,000,000	$1,000,000	$0	(0.0%)	17 - Risk Pool Distribution	$3,000,000	$3,000,000	$0	(0.0%)
$128,295,373	**$129,413,178**	**$1,117,805**	**0.9%**	**18 - TOTAL MEDICAL EXPENSES**	**$637,237,838**	**$638,355,643**	**$1,117,806**	**0.2%**
$9,523,193	**$6,741,490**	**$2,781,703**	**41.3%**	**19 - GROSS MARGIN**	**$50,734,224**	**$47,952,521**	**$2,781,703**	**5.8%**
				ADMINISTRATIVE EXPENSES				
$6,045,939	$6,748,481	$702,542	10.4%	20 - Personnel Expense	$24,104,252	$24,806,794	$702,542	2.8%
$56,828	$60,752	$3,924	6.5%	21 - Benefits Administration Expense	$1,111,723	$1,115,647	$3,924	0.4%
$798,063	$1,405,615	$607,552	43.2%	22 - Purchased & Professional Services	$5,464,438	$6,071,990	$607,551	10.0%
$1,013,132	$2,010,167	$997,035	49.6%	23 - Other Administrative Expense	$7,021,940	$8,018,975	$997,035	12.4%
$7,913,961	**$10,225,014**	**$2,311,053**	**22.6%**	**24 - TOTAL ADMINISTRATIVE EXPENSES**	**$37,702,353**	**$40,013,406**	**$2,311,053**	**5.8%**
$1,609,232	**($3,483,524)**	**$5,092,756**	**(146.2%)**	**25 - NET OPERATING INCOME / (LOSS)**	**$13,031,871**	**$7,939,115**	**$5,092,757**	**64.1%**
				OTHER INCOME / EXPENSES				
$1,831,679	**$2,460,000**	**($628,321)**	**(25.5%)**	**26 - TOTAL OTHER INCOME / (EXPENSES)**	**$11,790,266**	**$12,418,587**	**($628,321)**	**(5.1%)**
$3,440,910	**($1,023,524)**	**$4,464,434**	**436.2%**	**27 - NET INCOME / (LOSS)**	**$24,822,137**	**$20,357,702**	**$4,464,435**	**21.9%**
5.7%	**7.5%**	**1.8%**	**24.0%**	**28 - ADMIN EXP % OF REVENUE**	**5.5%**	**5.8%**	**0.3%**	**5.2%**

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

	11/30/2023	10/31/2023	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$24,020,681	$31,227,148	($7,206,467)	-23.08%
Short-Term Investments	456,476,983	484,847,892	(28,370,910)	-5.85%
Interest Receivable	941,384	966,511	(25,127)	-2.60%
Premium Receivables	246,298,660	233,721,402	12,577,258	5.38%
Reinsurance Receivables	3,649,520	3,425,381	224,139	6.54%
Other Receivables	289,506	260,024	29,482	11.34%
Prepaid Expenses	4,104,927	4,301,009	(196,082)	-4.56%
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	**$744,594,269**	**$767,561,974**	**($22,967,706)**	**-2.99%**
OTHER ASSETS:				
Long-Term Investments	7,098,007	7,050,306	47,701	0.68%
Restricted Assets	350,000	350,000	0	0.00%
GASB 87-Lease Assets (Net)	1,268,317	1,334,231	(65,913)	-4.94%
GASB 96-SBITA Assets (Net)	4,850,009	5,079,495	(229,486)	-4.52%
TOTAL OTHER ASSETS	**$13,566,333**	**$13,814,032**	**($247,699)**	**-1.79%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,149,359	10,131,064	18,295	0.18%
Furniture And Equipment	12,969,465	12,499,409	470,056	3.76%
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	$38,845,273	$38,356,922	$488,351	1.27%
Less: Accumulated Depreciation	($32,766,263)	($32,703,532)	($62,731)	0.19%
NET PROPERTY AND EQUIPMENT	**$6,079,009**	**$5,653,389**	**$425,620**	**7.53%**
TOTAL ASSETS	**$764,239,612**	**$787,029,396**	**($22,789,784)**	**-2.90%**
CURRENT LIABILITIES:				
Accounts Payable	2,278,704	1,206,137	1,072,567	88.93%
Other Accrued Liabilities	23,668,841	44,051,558	(20,382,717)	-46.27%
GASB 87 ST Lease Liabilities	778,049	785,528	(7,479)	-0.95%
GASB 96 ST SBITA Liabilities	2,132,894	2,190,238	(57,345)	-2.62%
Claims Payable	30,584,248	31,264,410	(680,163)	-2.18%
IBNP Reserves	163,472,423	169,177,600	(5,705,177)	-3.37%
Pass-Through Liabilities	169,810,295	171,867,405	(2,057,109)	-1.20%
Risk Sharing - Providers	6,629,337	5,629,337	1,000,000	17.76%
Payroll Liabilities	8,555,738	7,803,322	752,416	9.64%
Deferred Inflow	5,004,985	5,004,985	0	0.00%
TOTAL CURRENT LIABILITIES	**$412,915,513**	**$438,980,520**	**($26,065,007)**	**-5.94%**
LONG TERM LIABILITIES:				
GASB 87 LT Lease Liabilities	552,032	629,121	(77,090)	-12.25%
GASB 96 LT SBITA Liabilities	1,992,888	2,081,486	(88,598)	-4.26%
TOTAL LONG TERM LIABILITIES	**$2,544,920**	**$2,710,607**	**($165,687)**	**-6.11%**
TOTAL LIABILITIES	**$415,460,433**	**$441,691,127**	**($26,230,694)**	**-5.94%**
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)	24,822,137	21,381,227	3,440,910	16.09%
TOTAL NET WORTH	**$348,779,179**	**$345,338,269**	**$3,440,910**	**1.00%**
TOTAL LIABILITIES AND NET WORTH	**$764,239,612**	**$787,029,396**	**($22,789,784)**	**-2.90%**
Cash Equivalents	$480,497,664	$516,075,040	($35,577,376)	-6.89%
Pass-Through	$169,810,295	$171,867,405	($2,057,109)	-1.20%
Uncommitted Cash	$310,687,369	$344,207,635	($33,520,267)	-9.74%
Working Capital	$331,678,756	$328,581,455	$3,097,301	0.94%
Current Ratio	180.3%	174.9%	5.4%	3.1%

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 11/30/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,549,058	$7,688,780	$15,461,551	$12,861,880
Total	2,549,058	7,688,780	15,461,551	12,861,880
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	135,269,465	403,188,296	811,008,818	675,109,880
Premium Receivable	(12,577,259)	181,751,530	(63,920,833)	50,063,760
Total	122,692,206	584,939,826	747,087,985	725,173,640
Investment & Other Income Cash Flows				
Other Revenue (Grants)	88,514	216,871	455,343	412,066
Investment Income	1,795,021	6,759,494	13,275,585	11,666,427
Interest Receivable	25,127	(395,709)	(294,498)	(226,808)
Total	1,908,662	6,580,656	13,436,430	11,851,685
Medical & Hospital Cash Flows				
Total Medical Expenses	(128,295,374)	(381,423,467)	(767,307,451)	(637,237,841)
Other Receivable	(253,621)	(398,415)	(173,027)	(79,962)
Claims Payable	(680,162)	(3,009,060)	(27,621,592)	(8,115,676)
IBNP Payable	(5,705,177)	12,132,576	11,869,407	(1,031,980)
Risk Share Payable	1,000,000	3,001,000	1,009,418	1,022,154
Health Program	0	11,640	0	0
Other Liabilities	0	0	0	0
Total	(133,934,334)	(369,685,726)	(782,223,245)	(645,443,305)
Administrative Cash Flows				
Total Administrative Expenses	(7,965,771)	(23,698,230)	(46,290,508)	(37,990,280)
Prepaid Expenses	196,082	1,194,571	2,834,688	795,792
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	(19,311,441)	3,076,996	4,485,289	3,005,598
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	752,418	1,518,091	(381,357)	2,625,851
Net Lease Assets/Liabilities (Short term & Long term)	64,886	(187,427)	(869,452)	(157,528)
Depreciation Expense	62,732	176,942	342,109	289,139
Total	(26,201,094)	(17,919,057)	(39,879,231)	(31,431,428)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**(32,985,502)**	**211,604,479**	**(46,116,510)**	**73,012,472**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 11/30/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(47,701)	2,221,258	11,526,502	4,462,530
	(47,701)	2,221,258	11,526,502	4,462,530
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	(2,055,818)	(56,014,164)	44,251,313	(57,212,581)
Restricted Cash	0	0	0	0
	(2,055,818)	(56,014,164)	44,251,313	(57,212,581)
Fixed Asset Cash Flows				
Depreciation expense	62,732	176,942	342,109	289,139
Fixed Asset Acquisitions	(488,351)	(716,687)	(1,150,177)	(1,150,177)
Change in A/D	(62,732)	(176,942)	(342,109)	(289,139)
	(488,351)	(716,687)	(1,150,177)	(1,150,177)
Total Cash Flows from Investing Activities	**(2,591,870)**	**(54,509,593)**	**54,627,638**	**(53,900,228)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**(35,577,372)**	**157,094,886**	**8,511,128**	**19,112,244**
Rounding	(4)	(1)	3	5
Cash @ Beginning of Period	516,075,041	323,402,780	471,986,534	461,385,416
Cash @ End of Period	**$480,497,665**	**$480,497,665**	**$480,497,665**	**$480,497,665**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 11/30/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$3,440,910	$12,731,743	$26,603,338	$24,822,138
Add back: Depreciation	62,732	176,942	342,109	289,139
Receivables				
Premiums Receivable	(12,577,259)	181,751,530	(63,920,833)	50,063,760
Interest Receivable	25,127	(395,709)	(294,498)	(226,808)
Other Receivable	(253,621)	(398,415)	(173,027)	(79,962)
Total	(12,805,753)	180,957,406	(64,388,358)	49,756,990
Prepaid Expenses	196,082	1,194,571	2,834,688	795,792
Trade Payables	(19,311,441)	3,076,996	4,485,289	3,005,598
Claims Payable, IBNR & Risk Share				
IBNP	(5,705,177)	12,132,576	11,869,407	(1,031,980)
Claims Payable	(680,162)	(3,009,060)	(27,621,592)	(8,115,676)
Risk Share Payable	1,000,000	3,001,000	1,009,418	1,022,154
Other Liabilities	0	0	0	0
Total	(5,385,339)	12,124,516	(14,742,767)	(8,125,502)
Unearned Revenue				
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	752,418	1,518,091	(381,357)	2,625,851
Net Lease Assets/Liabilities (Short term & Long term)	64,886	(187,427)	(869,452)	(157,528)
Health Program	0	11,640	0	0
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	817,304	1,342,304	(1,250,809)	2,468,323
Cash Flows from Operating Activities	**($32,985,505)**	**$211,604,478**	**($46,116,510)**	**$73,012,478**
Difference (rounding)	(3)	(1)	0	6

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 11/30/2023

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$122,692,206	$584,939,826	$747,087,985	$725,173,640
Commercial Premium Revenue	2,549,058	7,688,780	15,461,551	12,861,880
Other Income	88,514	216,871	455,343	412,066
Investment Income	1,820,148	6,363,785	12,981,087	11,439,619
Cash Paid To:				
Medical Expenses	(133,934,334)	(369,685,726)	(782,223,245)	(645,443,305)
Vendor & Employee Expenses	(26,201,094)	(17,919,057)	(39,879,231)	(31,431,428)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	(32,985,502)	211,604,479	(46,116,510)	73,012,472
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	(488,351)	(716,687)	(1,150,177)	(1,150,177)
Net Cash Provided By (Used In) Financing Activities	(488,351)	(716,687)	(1,150,177)	(1,150,177)
Cash Flows from Investing Activities:				
Changes in Investments	(47,701)	2,221,258	11,526,502	4,462,530
Restricted Cash	(2,055,818)	(56,014,164)	44,251,313	(57,212,581)
Net Cash Provided By (Used In) Investing Activities	(2,103,519)	(53,792,906)	55,777,815	(52,750,051)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**(35,577,372)**	**157,094,886**	**8,511,128**	**19,112,244**
Cash @ Beginning of Period	516,075,041	323,402,780	471,986,534	461,385,416
Subtotal	$480,497,669	$480,497,666	$480,497,662	$480,497,660
Rounding	(4)	(1)	3	5
Cash @ End of Period	**$480,497,665**	**$480,497,665**	**$480,497,665**	**$480,497,665**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$3,440,910	$12,731,743	$26,603,338	$24,822,138
Depreciation	62,732	176,942	342,109	289,139
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	(12,805,753)	180,957,406	(64,388,358)	49,756,990
Prepaid Expenses	196,082	1,194,571	2,834,688	795,792
Trade Payables	(19,311,441)	3,076,996	4,485,289	3,005,598
Claims payable & IBNP	(5,385,339)	12,124,516	(14,742,767)	(8,125,502)
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	817,304	1,342,304	(1,250,809)	2,468,323
Subtotal	(32,985,505)	211,604,478	(46,116,510)	73,012,478
Rounding	3	1	0	(6)
Cash Flows from Operating Activities	**($32,985,502)**	**$211,604,479**	**($46,116,510)**	**$73,012,472**
Rounding Difference	3	1	0	(6)

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE NOVEMBER 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	506,257	260,698	154,240	607,545	207,525	690	5,028	1,741,983	28,135	-	1,770,118
Net Revenue	$67,637,956	$81,835,365	$177,998,548	$239,348,061	$60,279,388	$6,814,916	$41,195,948	$675,110,182	$12,861,880	$0	$687,972,062
Medical Expense	$54,826,002	$82,912,334	$163,280,568	$210,089,437	$62,783,634	$7,865,784	$44,285,380	$626,043,138	$11,194,699	$0	$637,237,838
Gross Margin	$12,811,954	($1,076,969)	$14,717,980	$29,258,624	($2,504,245)	($1,050,868)	($3,089,432)	$49,067,043	$1,667,181	$0	$50,734,224
Administrative Expense	$2,484,557	$3,946,646	$11,882,657	$11,810,811	$3,660,133	$511,696	$2,434,446	$36,730,947	$790,668	$180,738	$37,702,353
Operating Income / (Expense)	$10,327,397	($5,023,615)	$2,835,323	$17,447,813	($6,164,379)	($1,562,564)	($5,523,878)	$12,336,096	$876,512	($180,738)	$13,031,871
Other Income / (Expense)	$687,693	$1,224,900	$3,822,895	$3,717,208	$1,146,831	$171,040	$811,930	$11,582,495	$207,771	$0	$11,790,266
Net Income / (Loss)	$11,015,090	($3,798,715)	$6,658,217	$21,165,020	($5,017,548)	($1,391,524)	($4,711,948)	$23,918,592	$1,084,283	($180,738)	$24,822,137
PMPM Metrics:											
Revenue PMPM	$133.60	$313.91	$1,154.04	$393.96	$290.47	$9,876.69	$8,193.31	$387.55	$457.15	$0.00	$388.66
Medical Expense PMPM	$108.30	$318.04	$1,058.61	$345.80	$302.54	$11,399.69	$8,807.75	$359.39	$397.89	$0.00	$360.00
Gross Margin PMPM	$25.31	($4.13)	$95.42	$48.16	($12.07)	($1,523.00)	($614.45)	$28.17	$59.26	$0.00	$28.66
Administrative Expense PMPM	$4.91	$15.14	$77.04	$19.44	$17.64	$741.59	$484.18	$21.09	$28.10	$0.00	$21.30
Operating Income / (Expense) PMPM	$20.40	($19.27)	$18.38	$28.72	($29.70)	($2,264.59)	($1,098.62)	$7.08	$31.15	$0.00	$7.36
Other Income / (Expense) PMPM	$1.36	$4.70	$24.79	$6.12	$5.53	$247.88	$161.48	$6.65	$7.38	$0.00	$6.66
Net Income / (Loss) PMPM	$21.76	($14.57)	$43.17	$34.84	($24.18)	($2,016.70)	($937.14)	$13.73	$38.54	$0.00	$14.02
Ratio:											
Medical Loss Ratio	81.1%	101.3%	91.7%	87.8%	104.2%	115.4%	107.5%	92.7%	87.0%	0.0%	92.6%
Gross Margin Ratio	18.9%	-1.3%	8.3%	12.2%	-4.2%	-15.4%	-7.5%	7.3%	13.0%	0.0%	7.4%
Administrative Expense Ratio	3.7%	4.8%	6.7%	4.9%	6.1%	7.5%	5.9%	5.4%	6.1%	0.0%	5.5%
Net Income Ratio	16.3%	-4.6%	3.7%	8.8%	-8.3%	-20.4%	-11.4%	3.5%	8.4%	0.0%	3.6%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF NOVEMBER 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	101,243	52,151	30,865	120,573	40,997	137	975	346,941	5,585	-	352,526
Net Revenue	$13,530,178	$17,364,961	$36,094,988	$47,098,438	$11,868,195	$1,341,561	$7,971,187	$135,269,509	$2,549,057	$0	$137,818,566
Medical Expense	$11,423,808	$16,347,892	$30,538,811	$42,526,294	$13,301,070	$2,014,033	$9,842,555	$125,994,464	$2,300,909	$0	$128,295,373
Gross Margin	$2,106,371	$1,017,069	$5,556,177	$4,572,144	($1,432,875)	($672,471)	($1,871,368)	$9,275,045	$248,148	$0	$9,523,193
Administrative Expense	$481,737	$819,042	$2,529,254	$2,463,001	$760,549	$109,418	$520,561	$7,683,561	$167,787	$62,613	$7,913,961
Operating Income / (Expense)	$1,624,633	$198,026	$3,026,923	$2,109,143	($2,193,424)	($781,889)	($2,391,929)	$1,591,483	$80,361	($62,613)	$1,609,232
Other Income / (Expense)	$104,863	$188,864	$598,015	$577,935	$177,218	$26,631	$125,753	$1,799,278	$32,400	$0	$1,831,679
Net Income / (Loss)	$1,729,496	$386,890	$3,624,938	$2,687,078	($2,016,206)	($755,258)	($2,266,175)	$3,390,762	$112,761	($62,613)	$3,440,910
PMPM Metrics:											
Revenue PMPM	$133.64	$332.97	$1,169.45	$390.62	$289.49	$9,792.42	$8,175.58	$389.89	$456.41	$0.00	$390.95
Medical Expense PMPM	$112.84	$313.47	$989.43	$352.70	$324.44	$14,700.97	$10,094.93	$363.16	$411.98	$0.00	$363.93
Gross Margin PMPM	$20.81	$19.50	$180.02	$37.92	($34.95)	($4,908.55)	($1,919.35)	$26.73	$44.43	$0.00	$27.01
Administrative Expense PMPM	$4.76	$15.71	$81.95	$20.43	$18.55	$798.67	$533.91	$22.15	$30.04	$0.00	$22.45
Operating Income / (Expense) PMPM	$16.05	$3.80	$98.07	$17.49	($53.50)	($5,707.22)	($2,453.26)	$4.59	$14.39	$0.00	$4.56
Other Income / (Expense) PMPM	$1.04	$3.62	$19.38	$4.79	$4.32	$194.39	$128.98	$5.19	$5.80	$0.00	$5.20
Net Income / (Loss) PMPM	$17.08	$7.42	$117.44	$22.29	($49.18)	($5,512.83)	($2,324.28)	$9.77	$20.19	$0.00	$9.76
Ratio:											
Medical Loss Ratio	84.4%	94.1%	84.6%	90.3%	112.1%	150.1%	123.5%	93.1%	90.3%	0.0%	93.1%
Gross Margin Ratio	15.6%	5.9%	15.4%	9.7%	-12.1%	-50.1%	-23.5%	6.9%	9.7%	0.0%	6.9%
Administrative Expense Ratio	3.6%	4.7%	7.0%	5.2%	6.4%	8.2%	6.5%	5.7%	6.6%	0.0%	5.7%
Net Income Ratio	12.8%	2.2%	10.0%	5.7%	-17.0%	-56.3%	-28.4%	2.5%	4.4%	0.0%	2.5%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED November 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				
$6,045,939	$6,748,481	$702,542	10.4%	Personnel Expenses	$24,104,252	$24,806,794	$702,542	2.8%
56,828	60,752	3,924	6.5%	Benefits Administration Expense	1,111,723	1,115,647	3,924	0.4%
798,063	1,405,615	607,552	43.2%	Purchased & Professional Services	5,464,438	6,071,990	607,551	10.0%
513,920	539,845	25,925	4.8%	Occupancy	2,450,425	2,476,350	25,925	1.0%
524,244	665,764	141,520	21.3%	Printing Postage & Promotion	2,061,130	2,202,650	141,520	6.4%
(34,068)	772,867	806,935	104.4%	Licenses Insurance & Fees	2,392,840	3,199,775	806,935	25.2%
9,035	31,691	22,655	71.5%	Supplies & Other Expenses	117,545	140,200	22,655	16.2%
$1,868,022	$3,476,533	$1,608,511	46.3%	Total Other Administrative Expense	$13,598,101	$15,206,612	$1,608,511	10.6%
$7,913,961	$10,225,014	$2,311,053	22.6%	Total Administrative Expenses	$37,702,353	$40,013,406	$2,311,053	5.8%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
3,362,108	2,951,377	(410,730)	(13.9%)	Salaries & Wages	15,492,759	15,082,029	(410,730)	(2.7%)
265,082	302,417	37,335	12.3%	Paid Time Off	1,560,491	1,597,826	37,335	2.3%
1,650	1,904,599	1,902,949	99.9%	Incentives	10,538	1,913,487	1,902,949	99.4%
6,160	0	(6,160)	0.0%	Severance Pay	6,160	0	(6,160)	0.0%
55,289	53,998	(1,291)	(2.4%)	Payroll Taxes	248,268	246,976	(1,291)	(0.5%)
43,913	23,866	(20,047)	(84.0%)	Overtime	166,108	146,061	(20,047)	(13.7%)
267,965	248,260	(19,705)	(7.9%)	CalPERS ER Match	1,311,077	1,291,372	(19,705)	(1.5%)
726,931	725,524	(1,407)	(0.2%)	Employee Benefits	3,443,026	3,441,619	(1,407)	0.0%
(2,638)	0	2,638	0.0%	Personal Floating Holiday	6	2,644	2,638	99.8%
50,694	21,750	(28,944)	(133.1%)	Premium Bi/Multilingual Pay	50,694	21,750	(28,944)	(133.1%)
123	0	(123)	0.0%	Prizes	123	0	(123)	0.0%
1,135,012	0	(1,135,012)	0.0%	Holiday Bonus	1,135,012	0	(1,135,012)	0.0%
5,653	70,059	64,406	91.9%	Employee Relations	35,962	100,368	64,406	64.2%
16,330	19,000	2,670	14.1%	Work from Home Stipend	79,150	81,820	2,670	3.3%
431	5,300	4,869	91.9%	Transportation Reimbursement	2,371	7,241	4,869	67.2%
12,449	58,391	45,942	78.7%	Travel & Lodging	56,625	102,567	45,942	44.8%
78,206	216,963	138,757	64.0%	Temporary Help Services	354,848	493,605	138,757	28.1%
14,420	140,947	126,526	89.8%	Staff Development/Training	81,067	207,593	126,526	60.9%
6,162	6,031	(131)	(2.2%)	Staff Recruitment/Advertising	69,967	69,836	(131)	(0.2%)
$6,045,939	**$6,748,481**	**$702,542**	**10.4%**	**Total Employee Expenses**	**$24,104,252**	**$24,806,794**	**$702,542**	**2.8%**
				Benefit Administration Expense				
17,687	21,644	3,958	18.3%	RX Administration Expense	98,866	102,824	3,958	3.8%
0	0	0	0.0%	Behavioral Hlth Administration Fees	817,710	817,710	0	0.0%
39,141	39,108	(33)	(0.1%)	Telemedicine Admin Fees	195,147	195,114	(33)	0.0%
$56,828	**$60,752**	**$3,924**	**6.5%**	**Total Benefit Administration Expenses**	**$1,111,723**	**$1,115,647**	**$3,924**	**0.4%**
				Purchased & Professional Services				
115,762	500,765	385,003	76.9%	Consultant Fees - Non Medical	1,605,852	1,990,855	385,003	19.3%
288,848	346,098	57,250	16.5%	Computer Support Services	1,739,377	1,796,627	57,250	3.2%
11,875	12,500	625	5.0%	Audit Fees	59,375	60,000	625	1.0%
0	33	33	100.0%	Consultant Fees - Medical	0	33	33	100.0%
204,104	104,065	(100,039)	(96.1%)	Other Purchased Services	850,352	750,314	(100,039)	(13.3%)
2,786	1,574	(1,212)	(77.0%)	Maint.& Repair-Office Equipment	5,442	4,230	(1,212)	(28.7%)
0	0	0	0.0%	Maint.&Repair-Computer Hardware	1,180	1,180	0	0.0%
121,680	99,556	(22,124)	(22.2%)	Medical Refund Recovery Fees	570,236	548,112	(22,124)	(4.0%)
775	239,471	238,696	99.7%	Hardware (Non-Capital)	342,200	580,896	238,696	41.1%
38,865	41,702	2,837	6.8%	Provider Relations-Credentialing	151,690	154,528	2,837	1.8%
13,368	59,850	46,482	77.7%	Legal Fees	138,734	185,216	46,482	25.1%
$798,063	**$1,405,615**	**$607,552**	**43.2%**	**Total Purchased & Professional Services**	**$5,464,438**	**$6,071,990**	**$607,551**	**10.0%**
				Occupancy				
62,731	56,044	(6,687)	(11.9%)	Depreciation	289,139	282,451	(6,687)	(2.4%)
62,638	62,639	1	0.0%	Building Lease	311,033	311,033	1	0.0%
15,656	5,870	(9,786)	(166.7%)	Leased and Rented Office Equipment	48,075	38,289	(9,786)	(25.6%)
14,405	18,232	3,827	21.0%	Utilities	98,543	102,370	3,827	3.7%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
93,041	86,510	(6,531)	(7.5%)	Telephone	405,462	398,931	(6,531)	(1.6%)
35,962	61,415	25,452	41.4%	Building Maintenance	128,423	153,875	25,452	16.5%
229,486	249,136	19,649	7.9%	SBITA Amortization Expense-GASB 96	1,169,750	1,189,400	19,649	1.7%
$513,920	**$539,845**	**$25,925**	**4.8%**	**Total Occupancy**	**$2,450,425**	**$2,476,350**	**$25,925**	**1.0%**
				Printing Postage & Promotion				
21,985	119,859	97,874	81.7%	Postage	189,163	287,037	97,874	34.1%
5,739	5,700	(39)	(0.7%)	Design & Layout	22,254	22,216	(39)	(0.2%)
98,231	150,037	51,806	34.5%	Printing Services	428,890	480,696	51,806	10.8%
7,920	6,910	(1,010)	(14.6%)	Mailing Services	58,141	57,131	(1,010)	(1.8%)
11,152	10,187	(965)	(9.5%)	Courier/Delivery Service	48,392	47,427	(965)	(2.0%)
287	1,250	963	77.0%	Promotional Products	5,659	6,621	963	14.5%
0	3,150	3,150	100.0%	Promotional Services	1,450	4,600	3,150	68.5%
338,393	342,064	3,671	1.1%	Community Relations	1,206,929	1,210,599	3,671	0.3%
(60)	(60)	0	0.0%	Health Education-Member	0	0	0	0.0%
40,597	26,667	(13,930)	(52.2%)	Translation - Non-Clinical	100,252	86,322	(13,930)	(16.1%)
$524,244	**$665,764**	**$141,520**	**21.3%**	**Total Printing Postage & Promotion**	**$2,061,130**	**$2,202,650**	**$141,520**	**6.4%**
				Licenses Insurance & Fees				
80,000	0	(80,000)	0.0%	Regulatory Penalties	80,000	0	(80,000)	0.0%
30,172	28,000	(2,172)	(7.8%)	Bank Fees	137,759	135,587	(2,172)	(1.6%)
69,896	80,112	10,216	12.8%	Insurance Premium	398,694	408,910	10,216	2.5%
(254,939)	486,297	741,237	152.4%	Licenses, Permits and Fees	1,033,414	1,774,651	741,237	41.8%
40,804	178,458	137,654	77.1%	Subscriptions and Dues - NonIT	742,973	880,627	137,654	15.6%
($34,068)	**$772,867**	**$806,935**	**104.4%**	**Total Licenses Insurance & Postage**	**$2,392,840**	**$3,199,775**	**$806,935**	**25.2%**
				Supplies & Other Expenses				
8,784	6,001	(2,783)	(46.4%)	Office and Other Supplies	45,212	42,429	(2,783)	(6.6%)
0	4,289	4,289	100.0%	Furniture and Equipment	12,364	16,653	4,289	25.8%
2,953	1,200	(1,753)	(146.1%)	Ergonomic Supplies	16,578	14,825	(1,753)	(11.8%)
3,245	19,734	16,489	83.6%	Commissary-Food & Beverage	16,540	33,029	16,489	49.9%
(5,948)	0	5,948	0.0%	Miscellaneous Expense	22,000	27,948	5,948	21.3%
0	0	0	0.0%	Member Incentive Expense	4,850	4,850	0	0.0%
0	100	100	100.0%	Covid-19 IT Expenses	0	100	100	100.0%
0	367	367	100.0%	Covid-19 Non IT Expenses	0	367	367	100.0%
$9,035	**$31,691**	**$22,655**	**71.5%**	**Total Supplies & Other Expense**	**$117,545**	**$140,200**	**$22,655**	**16.2%**
$7,913,961	**$10,225,014**	**$2,311,053**	**22.6%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$37,702,353**	**$40,013,406**	**$2,311,053**	**5.8%**

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	$ 103,142	$ 457,510	**$ 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	**$ 12,546**	$ 13,000	$ 454
	Conference room upgrades	IT-FY24-11	$ -		**$ -**	$ 107,701	$ 107,701
Hardware Subtotal			**$ 644,332**	**$ 470,056**	**$ 1,114,388**	**$ 1,320,701**	**$ 206,313**
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			**$ 17,494**	**$ 18,295**	**$ 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			**$ 661,826**	**$ 488,351**	**$ 1,150,177**	**$ 1,601,701**	**$ 451,524**
5. Reconciliation to Balance Sheet:							
	Fixed Assets @ Cost - 11/30/23				**$ 38,845,273**		
	Fixed Assets @ Cost - 6/30/23				**$ 37,695,096**		
	Fixed Assets Acquired YTD				**$ 1,150,177**		

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

TANGIBLE NET EQUITY (TNE)

			QTR. END		
	Jul-23	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**
Current Month Net Income / (Loss)	$9,746,933	$2,343,460	$5,514,335	$3,776,499	$3,440,910
YTD Net Income / (Loss)	$9,746,933	$12,090,393	$17,604,728	$21,381,227	$24,822,137
Actual TNE					
Net Assets	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178
Subordinated Debt & Interest	$0	$0	$0	$0	$0
Total Actual TNE	**$333,703,974**	**$336,047,435**	**$341,561,770**	**$345,338,268**	**$348,779,178**
Increase/(Decrease) in Actual TNE	$9,746,933	$2,343,460	$5,514,335	$3,776,499	$3,440,910
Required TNE[1]	**$46,228,233**	**$46,744,204**	**$46,352,062**	**$49,676,617**	**$49,894,371**
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
TNE Excess / (Deficiency)	$287,475,741	$289,303,231	$295,209,708	$295,661,651	$298,884,807
Actual TNE as a Multiple of Required	**7.22**	**7.19**	**7.37**	**6.95**	**6.99**

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

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Net Assets	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178
Fixed Assets at Net Book Value	(5,169,098)	(5,539,264)	(5,608,622)	(5,653,388)	(6,079,010)
Net Lease Assets/Liabilities/Interest	(711,429)	(475,037)	(1,115,074)	(727,353)	(662,463)
CD Pledged to DMHC	(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**
Liquid TNE as Multiple of Required	**7.10**	**7.06**	**7.24**	**6.83**	**6.86**

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								506,257
Adult	52,550	52,102	51,499	52,396	52,151								260,698
SPD	31,055	30,840	30,592	30,888	30,865								154,240
ACA OE	123,707	121,819	120,016	121,430	120,573								607,545
Duals	41,688	41,715	41,629	41,496	40,997								207,525
MCAL LTC	141	138	139	135	137								690
MCAL LTC Duals	1,033	1,019	1,004	997	975								5,028
Medi-Cal Program	352,637	349,026	344,917	348,462	346,941								1,741,983
Group Care Program	5,669	5,645	5,631	5,605	5,585								28,135
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**								**1,770,118**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)	1,082	123								(2,427)
Adult	(624)	(448)	(603)	897	(245)								(1,023)
SPD	(225)	(215)	(248)	296	(23)								(415)
ACA OE	(1,260)	(1,888)	(1,803)	1,414	(857)								(4,394)
Duals	(43)	27	(86)	(133)	(499)								(734)
MCAL LTC	(9)	(3)	1	(4)	2								(13)
MCAL LTC Duals	4	(14)	(15)	(7)	(22)								(54)
Medi-Cal Program	(3,364)	(3,611)	(4,109)	3,545	(1,521)								(9,060)
Group Care Program	(15)	(24)	(14)	(26)	(20)								(99)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**								**(9,159)**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	29.1%	29.1%	29.0%	29.0%	29.2%								29.1%
Adult % of Medi-Cal	14.9%	14.9%	14.9%	15.0%	15.0%								15.0%
SPD % of Medi-Cal	8.8%	8.8%	8.9%	8.9%	8.9%								8.9%
ACA OE % of Medi-Cal	35.1%	34.9%	34.8%	34.8%	34.8%								34.9%
Duals % of Medi-Cal	11.8%	12.0%	12.1%	11.9%	11.8%								11.9%
Medi-Cal Program % of Total	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%
Total	**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								373,749
Alameda Health System	66,089	65,344	64,133	63,271	63,903								322,740
	140,636	138,371	136,637	141,801	139,044								696,489
Delegated:													
CFMG	34,810	34,649	34,144	34,035	35,105								172,743
CHCN	130,230	129,183	127,430	126,705	127,641								641,189
Kaiser	52,630	52,468	52,337	51,526	50,736								259,697
Delegated Subtotal	217,670	216,300	213,911	212,266	213,482								1,073,629
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**								**1,770,118**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(939)	(2,265)	(1,734)	5,164	(2,757)								(2,531)
Delegated:													
CFMG	(441)	(161)	(505)	(109)	1,070								(146)
CHCN	(1,721)	(1,047)	(1,753)	(725)	936								(4,310)
Kaiser	(278)	(162)	(131)	(811)	(790)								(2,172)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	1,216								(6,628)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**								**(9,159)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	39.3%	39.0%	39.0%	40.0%	39.4%								39.3%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	10.0%								9.8%
CHCN	36.3%	36.4%	36.4%	35.8%	36.2%								36.2%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.4%								14.7%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	60.6%								60.7%
Total	**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								1,134
Adult	0	0	0	0	279								279
SPD	0	0	0	0	131								131
ACA OE	0	0	0	0	(607)								(607)
Duals	0	0	0	0	(413)								(413)
MCAL LTC	0	0	0	0	1								1
MCAL LTC Duals	0	0	0	0	(10)								(10)
Medi-Cal Program	0	0	0	0	515								515
Group Care Program	0	0	0	0	(6)								(6)
Total	**0**	**0**	**0**	**0**	**509**								**509**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													0
Directly Contracted (DCP)	0	0	0	0	(3,033)								(3,033)
Alameda Health System	0	0	0	0	926								926
	0	0	0	0	(2,107)								(2,107)
Delegated:													
CFMG	0	0	0	0	1,396								1,396
CHCN	0	0	0	0	1,672								1,672
Kaiser	0	0	0	0	(452)								(452)
Delegated Subtotal	0	0	0	0	2,616								2,616
Total	**0**	**0**	**0**	**0**	**509**								**509**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 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:				
$1,192,125	$1,133,956	($58,170)	(5.1%)	PCP Capitation	$5,827,075	$5,768,905	($58,170)	(1.0%)
4,368,692	4,535,887	167,196	3.7%	PCP Capitation FQHC	21,828,274	21,995,470	167,196	0.8%
307,124	292,794	(14,330)	(4.9%)	Specialty-Capitation	1,500,207	1,485,877	(14,330)	(1.0%)
3,799,335	3,973,166	173,831	4.4%	Specialty-Capitation FQHC	19,007,676	19,181,507	173,831	0.9%
497,616	544,437	46,821	8.6%	Laboratory Capitation	2,472,919	2,519,740	46,821	1.9%
254,510	251,820	(2,691)	(1.1%)	Vision Cap	1,267,226	1,264,535	(2,691)	(0.2%)
89,281	85,273	(4,007)	(4.7%)	CFMG Capitation	436,499	432,491	(4,007)	(0.9%)
188,347	196,654	8,307	4.2%	Anc IPA Admin Capitation FQHC	942,013	950,320	8,307	0.9%
13,750,824	13,857,097	106,273	0.8%	Kaiser Capitation	70,197,341	70,303,614	106,273	0.2%
409,975	613,935	203,960	33.2%	Maternity Supplemental Expense	1,500,135	1,704,095	203,960	12.0%
716,010	754,285	38,274	5.1%	DME Cap	3,578,474	3,616,748	38,274	1.1%
$25,573,840	**$26,239,303**	**$665,464**	**2.5%**	**5 - TOTAL CAPITATED EXPENSES**	**$128,557,839**	**$129,223,302**	**$665,464**	**0.5%**
				FEE FOR SERVICE MEDICAL EXPENSES:				
(1,401,050)	0	1,401,050	0.0%	IBNR Inpatient Services	(3,707,348)	(2,306,298)	1,401,050	(60.7%)
(42,031)	0	42,031	0.0%	IBNR Settlement (IP)	(111,219)	(69,188)	42,031	(60.7%)
(112,084)	0	112,084	0.0%	IBNR Claims Fluctuation (IP)	(296,588)	(184,504)	112,084	(60.7%)
30,013,888	34,099,906	4,086,018	12.0%	Inpatient Hospitalization FFS	150,159,024	154,245,042	4,086,018	2.6%
2,566,982	0	(2,566,982)	0.0%	IP OB - Mom & NB	10,029,615	7,462,632	(2,566,982)	(34.4%)
94,889	0	(94,889)	0.0%	IP Behavioral Health	990,373	895,483	(94,889)	(10.6%)
1,028,711	0	(1,028,711)	0.0%	IP Facility Rehab FFS	5,740,353	4,711,642	(1,028,711)	(21.8%)
$32,149,305	**$34,099,906**	**$1,950,600**	**5.7%**	**6 - Inpatient Hospital & SNF FFS Expense**	**$162,804,210**	**$164,754,811**	**$1,950,600**	**1.2%**
(465,621)	0	465,621	0.0%	IBNR PCP	(418,638)	46,983	465,621	991.0%
(13,969)	0	13,969	0.0%	IBNR Settlement (PCP)	(12,560)	1,409	13,969	991.4%
(37,249)	0	37,249	0.0%	IBNR Claims Fluctuation (PCP)	(33,490)	3,759	37,249	990.9%
2,297,895	1,992,540	(305,355)	(15.3%)	Primary Care Non-Contracted FF	9,833,487	9,528,132	(305,355)	(3.2%)
451,467	234,398	(217,070)	(92.6%)	PCP FQHC FFS	2,509,800	2,292,731	(217,070)	(9.5%)
(3,000)	0	3,000	0.0%	Phys Extended Hours Incentive	3,000	6,000	3,000	50.0%
2,313,561	3,208,010	894,449	27.9%	Prop 56 Physician Exp	11,518,134	12,412,584	894,449	7.2%
14,754	0	(14,754)	0.0%	Prop 56 Hyde Exp	73,011	58,257	(14,754)	(25.3%)
79,701	0	(79,701)	0.0%	Prop 56 Trauma Exp	396,646	316,945	(79,701)	(25.1%)
96,160	0	(96,160)	0.0%	Prop 56 Develop. Screening Exp	479,942	383,782	(96,160)	(25.1%)
728,504	0	(728,504)	0.0%	Prop 56 Family Planning Exp	3,634,179	2,905,675	(728,504)	(25.1%)
0	0	0	0.0%	Prop 56 VBP Exp	7,428	7,428	0	0.0%
$5,462,202	**$5,434,948**	**($27,255)**	**(0.5%)**	**7 - Primary Care Physician FFS Expense**	**$27,990,940**	**$27,963,685**	**($27,255)**	**(0.1%)**
(1,151,031)	0	1,151,031	0.0%	IBNR Specialist	(1,855,302)	(704,271)	1,151,031	(163.4%)
329,750	0	(329,750)	0.0%	Psychiatrist FFS	1,257,247	927,497	(329,750)	(35.6%)
2,836,697	5,474,313	2,637,616	48.2%	Specialty Care FFS	11,940,063	14,577,679	2,637,616	18.1%
147,024	0	(147,024)	0.0%	Specialty Anesthesiology	880,112	733,088	(147,024)	(20.1%)
1,331,334	0	(1,331,334)	0.0%	Specialty Imaging FFS	5,663,887	4,332,553	(1,331,334)	(30.7%)
19,439	0	(19,439)	0.0%	Obstetrics FFS	91,264	71,825	(19,439)	(27.1%)
348,903	0	(348,903)	0.0%	Specialty IP Surgery FFS	1,495,280	1,146,377	(348,903)	(30.4%)
698,440	0	(698,440)	0.0%	Specialty OP Surgery FFS	3,078,599	2,380,160	(698,440)	(29.3%)
484,172	0	(484,172)	0.0%	Spec IP Physician	2,289,117	1,804,945	(484,172)	(26.8%)
91,514	73,936	(17,578)	(23.8%)	SCP FQHC FFS	346,046	328,468	(17,578)	(5.4%)
(34,530)	0	34,530	0.0%	IBNR Settlement (SCP)	(55,657)	(21,127)	34,530	(163.4%)
(92,083)	0	92,083	0.0%	IBNR Claims Fluctuation (SCP)	(148,425)	(56,342)	92,083	(163.4%)
$5,009,628	**$5,548,249**	**$538,621**	**9.7%**	**8 - Specialty Care Physician Expense**	**$24,982,231**	**$25,520,851**	**$538,621**	**2.1%**
(1,152,163)	0	1,152,163	0.0%	IBNR Ancillary	970,392	2,122,555	1,152,163	54.3%
(34,566)	0	34,566	0.0%	IBNR Settlement (ANC)	29,111	63,677	34,566	54.3%
(92,173)	0	92,173	0.0%	IBNR Claims Fluctuation (ANC)	77,632	169,805	92,173	54.3%
70,970	0	(70,970)	0.0%	IBNR Transportation FFS	116,690	45,720	(70,970)	(155.2%)
1,438,435	0	(1,438,435)	0.0%	Behavioral Health Therapy FFS	6,389,561	4,951,126	(1,438,435)	(29.1%)
1,212,821	0	(1,212,821)	0.0%	Psychologist & Other MH Prof.	5,428,285	4,215,464	(1,212,821)	(28.8%)
282,733	0	(282,733)	0.0%	Acupuncture/Biofeedback	1,358,071	1,075,338	(282,733)	(26.3%)
68,598	0	(68,598)	0.0%	Hearing Devices	450,123	381,525	(68,598)	(18.0%)
45,612	0	(45,612)	0.0%	Imaging/MRI/CT Global	187,156	141,544	(45,612)	(32.2%)
51,883	0	(51,883)	0.0%	Vision FFS	216,477	164,593	(51,883)	(31.5%)
10	0	(10)	0.0%	Family Planning	40	30	(10)	(33.3%)
555,419	0	(555,419)	0.0%	Laboratory-FFS	2,473,032	1,917,612	(555,419)	(29.0%)
106,023	0	(106,023)	0.0%	ANC Therapist	501,223	395,200	(106,023)	(26.8%)
1,211,100	0	(1,211,100)	0.0%	Transportation (Ambulance)-FFS	4,957,586	3,746,485	(1,211,100)	(32.3%)
1,669,351	0	(1,669,351)	0.0%	Transportation (Other)-FFS	7,598,418	5,929,067	(1,669,351)	(28.2%)
1,565,173	0	(1,565,173)	0.0%	Hospice	7,345,156	5,779,983	(1,565,173)	(27.1%)
1,403,356	0	(1,403,356)	0.0%	Home Health Services	6,397,392	4,994,036	(1,403,356)	(28.1%)
0	9,176,053	9,176,053	100.0%	Other Medical-FFS	3,993	9,180,045	9,176,053	100.0%
(97,107)	0	97,107	0.0%	Medical Refunds through HMS	(407,069)	(309,963)	97,107	(31.3%)
(325,190)	0	325,190	0.0%	Medical Refunds	(890,273)	(565,083)	325,190	(57.5%)
32,009	0	(32,009)	0.0%	DME & Medical Supplies	148,698	116,689	(32,009)	(27.4%)
0	0	0	0.0%	GEMT FFS	(373,988)	(373,988)	0	0.0%
1,437,969	1,443,197	5,229	0.4%	ECM Base/Outreach FFS Anc.	6,568,770	6,573,999	5,229	0.1%
16,861	24,663	7,802	31.6%	CS Housing Deposits FFS Ancillary	103,697	111,499	7,802	7.0%
188,756	208,852	20,096	9.6%	CS Housing Tenancy FFS Ancillary	955,642	975,737	20,096	2.1%

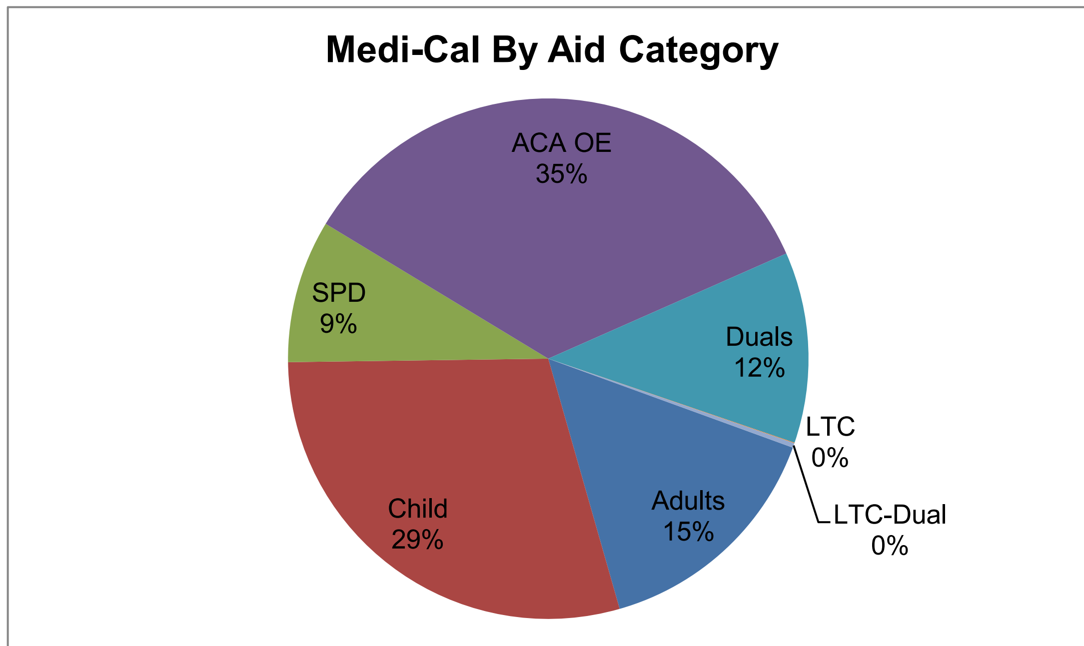
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2023

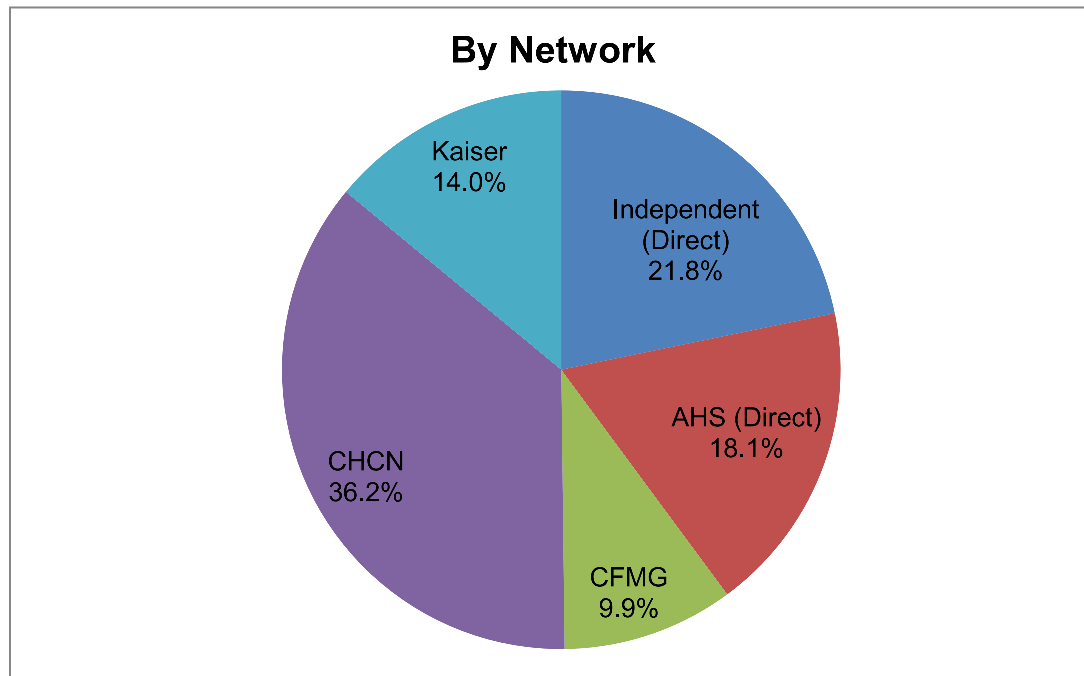
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
47,311	43,161	(4,150)	(9.6%)	CS Housing Navigation Services FFS Ancillary	218,946	214,796	(4,150)	(1.9%)
72,490	56,240	(16,250)	(28.9%)	CS Medical Respite FFS Ancillary	338,306	322,056	(16,250)	(5.0%)
26,994	14,821	(12,173)	(82.1%)	CS Medically Tailored Meals FFS Ancillary	125,904	113,731	(12,173)	(10.7%)
3,677	49	(3,628)	(7,446.8%)	CS Asthma Remediation FFS Ancillary	15,227	11,599	(3,628)	(31.3%)
0	10,000	10,000	100.0%	MOT Wrap Around (Non Medical MOT Cost)	0	10,000	10,000	100.0%
616,458	0	(616,458)	0.0%	Community Based Adult Services (CBAS)	2,041,721	1,425,263	(616,458)	(43.3%)
0	7,646	7,646	100.0%	CS Pilot LTC Diversion Expense	0	7,646	7,646	100.0%
3,058	3,823	765	20.0%	CS Pilot LTC Transition Expense	19,114	19,879	765	3.8%
0	80,556	80,556	100.0%	Justice Involved Pilot	0	80,556	80,556	100.0%
$10,425,866	**$11,069,059**	**$643,193**	**5.8%**	**9 - Ancillary Medical Expense**	**$53,365,030**	**$54,008,223**	**$643,193**	**1.2%**
(1,078,548)	0	1,078,548	0.0%	IBNR Outpatient	(655,922)	422,626	1,078,548	255.2%
(32,357)	0	32,357	0.0%	IBNR Settlement (OP)	(19,680)	12,677	32,357	255.2%
(86,284)	0	86,284	0.0%	IBNR Claims Fluctuation (OP)	(52,473)	33,811	86,284	255.2%
1,866,284	8,144,834	6,278,550	77.1%	Out Patient FFS	8,357,804	14,636,354	6,278,550	42.9%
1,860,339	0	(1,860,339)	0.0%	OP Ambul Surgery FFS	8,797,735	6,937,396	(1,860,339)	(26.8%)
1,601,315	0	(1,601,315)	0.0%	OP Fac Imaging Services FFS	8,271,938	6,670,623	(1,601,315)	(24.0%)
36,169	0	(36,169)	0.0%	Behav Health FFS	14,202	(21,966)	(36,169)	164.7%
605,547	0	(605,547)	0.0%	OP Facility Lab FFS	2,687,411	2,081,864	(605,547)	(29.1%)
163,337	0	(163,337)	0.0%	OP Facility Cardio FFS	771,435	608,098	(163,337)	(26.9%)
542,845	0	(542,845)	0.0%	OP Facility PT/OT/ST FFS	813,076	270,230	(542,845)	(200.9%)
2,183,825	0	(2,183,825)	0.0%	OP Facility Dialysis FFS	10,563,320	8,379,495	(2,183,825)	(26.1%)
$7,662,473	**$8,144,834**	**$482,361**	**5.9%**	**10 - Outpatient Medical Expense Medical Expense**	**$39,548,846**	**$40,031,207**	**$482,361**	**1.2%**
(751,519)	0	751,519	0.0%	IBNR Emergency	(721,259)	30,260	751,519	2,483.5%
(22,545)	0	22,545	0.0%	IBNR Settlement (ER)	(21,635)	910	22,545	2,477.5%
(60,121)	0	60,121	0.0%	IBNR Claims Fluctuation (ER)	(57,698)	2,423	60,121	2,481.3%
905,596	0	(905,596)	0.0%	Special ER Physician FFS	3,962,391	3,056,795	(905,596)	(29.6%)
5,690,671	5,798,104	107,433	1.9%	ER Facility	25,268,018	25,375,451	107,433	0.4%
$5,762,082	**$5,798,104**	**$36,022**	**0.6%**	**11 - Emergency Expense**	**$28,429,817**	**$28,465,840**	**$36,022**	**0.1%**
(240,010)	0	240,010	0.0%	IBNR Pharmacy OP	(444,318)	(204,308)	240,010	(117.5%)
(7,200)	0	7,200	0.0%	IBNR Settlement (RX) OP	(13,333)	(6,133)	7,200	(117.4%)
(19,200)	0	19,200	0.0%	IBNR Claims Fluctuation (RX) OP	(35,545)	(16,345)	19,200	(117.5%)
472,479	371,017	(101,462)	(27.3%)	Pharmacy FFS	2,412,130	2,310,668	(101,462)	(4.4%)
116,903	8,616,517	8,499,614	98.6%	Pharmacy Non-PBM FFS-Other Anc	672,989	9,172,603	8,499,614	92.7%
5,608,292	0	(5,608,292)	0.0%	Pharmacy Non-PBM FFS-OP FAC	27,583,795	21,975,503	(5,608,292)	(25.5%)
252,568	0	(252,568)	0.0%	Pharmacy Non-PBM FFS-PCP	867,930	615,362	(252,568)	(41.0%)
2,290,912	0	(2,290,912)	0.0%	Pharmacy Non-PBM FFS-SCP	11,098,814	8,807,902	(2,290,912)	(26.0%)
5,299	0	(5,299)	0.0%	Pharmacy Non-PBM FFS-FQHC	46,458	41,158	(5,299)	(12.9%)
6,629	0	(6,629)	0.0%	Pharmacy Non-PBM FFS-HH	34,616	27,987	(6,629)	(23.7%)
0	0	0	0.0%	RX Refunds HMS	(63)	(63)	0	0.0%
(35,000)	31,858	66,858	209.9%	Pharmacy Rebate	(195,000)	(128,142)	66,858	(52.2%)
$8,451,672	**$9,019,393**	**$567,720**	**6.3%**	**12 - Pharmacy Expense**	**$42,028,471**	**$42,596,192**	**$567,720**	**1.3%**
1,100,140	0	(1,100,140)	0.0%	IBNR LTC	5,902,679	4,802,539	(1,100,140)	(22.9%)
33,005	0	(33,005)	0.0%	IBNR Settlement (LTC)	177,082	144,077	(33,005)	(22.9%)
88,012	0	(88,012)	0.0%	IBNR Claims Fluctuation (LTC)	472,214	384,202	(88,012)	(22.9%)
17,780,770	0	(17,780,770)	0.0%	LTC Custodial Care	81,172,947	63,392,176	(17,780,770)	(28.0%)
3,435,401	17,349,869	13,914,468	80.2%	LTC SNF	15,376,140	29,290,608	13,914,468	47.5%
$22,437,328	**$17,349,869**	**($5,087,459)**	**(29.3%)**	**13 - Long Term Care FFS Expense**	**$103,101,062**	**$98,013,603**	**($5,087,459)**	**(5.2%)**
$97,360,557	**$96,464,361**	**($896,197)**	**(0.9%)**	**14 - TOTAL FFS MEDICAL EXPENSES**	**$482,250,607**	**$481,354,410**	**($896,197)**	**(0.2%)**
0	9,350	9,350	100.0%	Clinical Vacancy	0	9,350	9,350	100.0%
101,876	486,548	384,672	79.1%	Quality Analytics	434,758	819,430	384,672	46.9%
948,437	902,818	(45,619)	(5.1%)	Health Plan Services Department Total	3,828,353	3,782,734	(45,619)	(1.2%)
711,681	600,855	(110,826)	(18.4%)	Case & Disease Management Department Total	2,815,704	2,704,878	(110,826)	(4.1%)
1,003,787	1,558,022	554,235	35.6%	Medical Services Department Total	9,664,943	10,219,178	554,235	5.4%
688,198	1,395,573	707,375	50.7%	Quality Management Department Total	3,689,726	4,397,101	707,375	16.1%
284,079	281,417	(2,662)	(0.9%)	HCS Behavioral Health Department Total	1,241,618	1,238,957	(2,662)	(0.2%)
173,707	144,009	(29,697)	(20.6%)	Pharmacy Services Department Total	700,077	670,380	(29,697)	(4.4%)
70,346	72,856	2,510	3.4%	Regulatory Readiness Total	319,459	321,970	2,510	0.8%
$3,982,111	**$5,451,450**	**$1,469,339**	**27.0%**	**15 - Other Benefits & Services**	**$22,694,639**	**$24,163,977**	**$1,469,339**	**6.1%**
(850,000)	(774,194)	75,806	(9.8%)	Reinsurance Recoveries	(4,575,001)	(4,499,194)	75,806	(1.7%)
1,228,865	1,032,258	(196,607)	(19.0%)	Reinsurance Premium	5,309,754	5,113,148	(196,607)	(3.8%)
$378,865	**$258,065**	**($120,800)**	**(46.8%)**	**16- Reinsurance Expense**	**$734,754**	**$613,953**	**($120,800)**	**(19.7%)**
1,000,000	1,000,000	0	0.0%	P4P Risk Pool Provider Incenti	3,000,000	3,000,000	0	0.0%
$1,000,000	**$1,000,000**	**$0**	**0.0%**	**17 - Risk Pool Distribution**	**$3,000,000**	**$3,000,000**	**$0**	**0.0%**
$128,295,373	**$129,413,178**	**$1,117,805**	**0.9%**	**18 - TOTAL MEDICAL EXPENSES**	**$637,237,838**	**$638,355,643**	**$1,117,806**	**0.2%**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Nov 2023	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	52,222	15%	10,597	9,958	791	21,859	9,017
Child	101,557	29%	8,412	9,260	31,949	33,755	18,181
SPD	30,887	9%	10,201	4,432	1,130	12,871	2,253
ACA OE	120,666	35%	19,740	36,972	1,253	46,993	15,708
Duals	41,217	12%	24,616	2,513	1	9,746	4,341
LTC	139	0%	139	-	-	-	-
LTC-Dual	980	0%	979	-	-	-	1
Medi-Cal	347,668		74,684	63,135	35,124	125,224	49,501
Group Care	5,586		2,188	835	-	2,563	-
Total	**353,254**	**100%**	**76,872**	**63,970**	**35,124**	**127,787**	**49,501**
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	*21.8%*	*18.1%*	*9.9%*	*36.2%*	*14.0%*
			% Direct:	**40%**		**% Delegated:**	**60%**

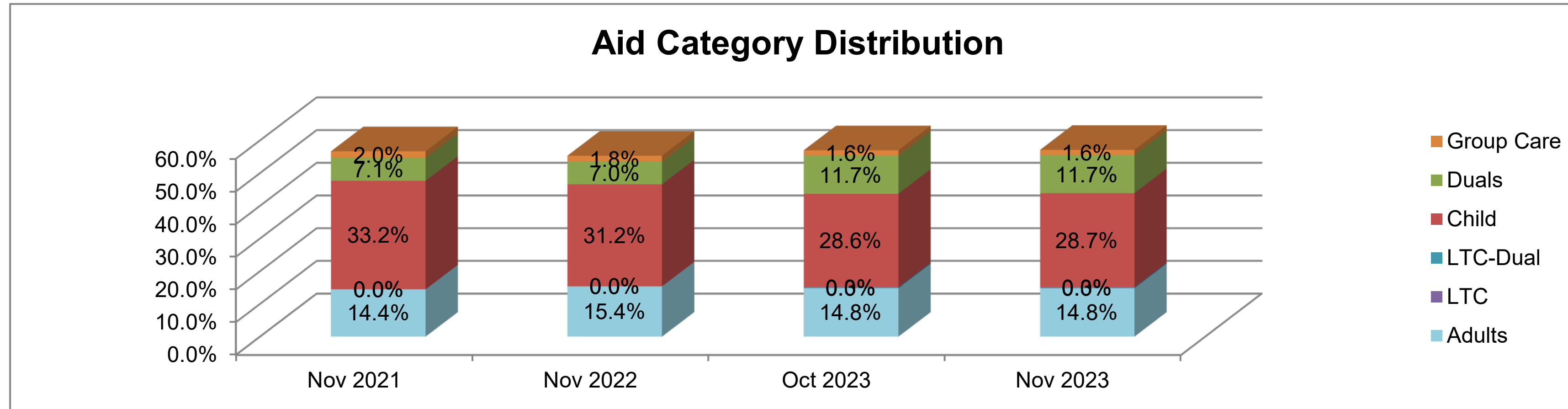




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

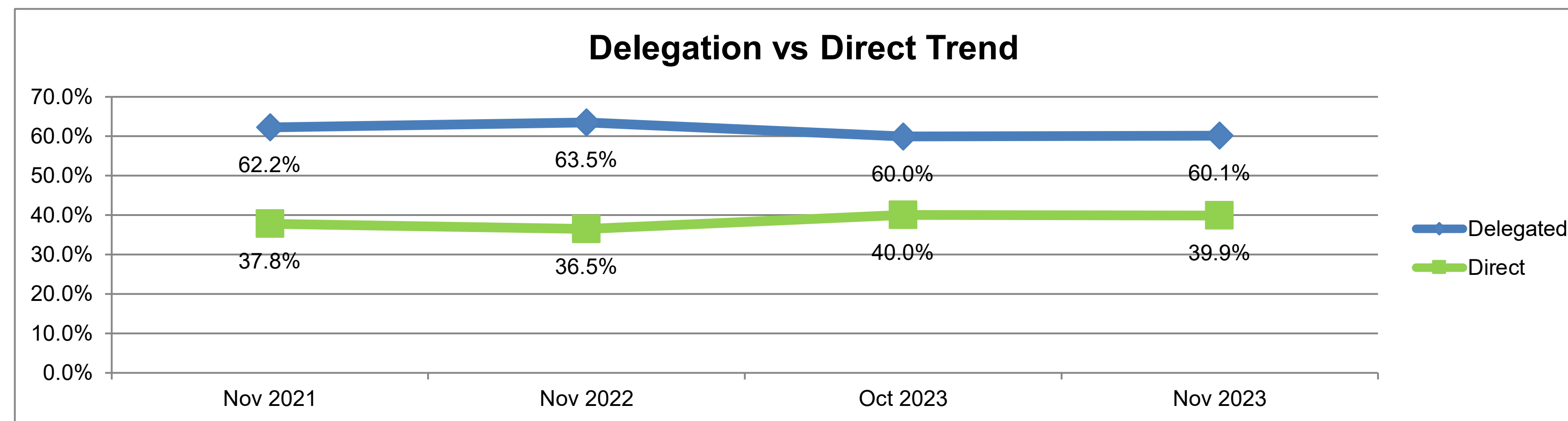
Category of Aid Trend

Category of Aid	Members Nov 2021	Nov 2022	Oct 2023	Nov 2023	% of Total (ie.Distribution) Nov 2021	Nov 2022	Oct 2023	Nov 2023	% Growth (Loss) Nov 2021 to Nov 2022	Nov 2022 to Nov 2023	Oct 2023 to Nov 2023
Adults	42,623	50,069	52,396	52,222	14.4%	15.4%	14.8%	14.8%	17.5%	4.3%	-0.3%
Child	97,935	101,653	101,120	101,557	33.2%	31.2%	28.6%	28.7%	3.8%	-0.1%	0.4%
SPD	26,427	28,365	30,888	30,887	9.0%	8.7%	8.7%	8.7%	7.3%	8.9%	0.0%
ACA OE	101,508	117,328	121,430	120,666	34.4%	36.0%	34.3%	34.2%	15.6%	2.8%	-0.6%
Duals	20,832	22,719	41,496	41,217	7.1%	7.0%	11.7%	11.7%	9.1%	81.4%	-0.7%
LTC	-	-	135	139	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.0%
LTC-Dual	-	-	997	980	0.0%	0.0%	0.3%	0.3%	0.0%	0.0%	-1.7%
Medi-Cal Total	289,325	320,134	348,462	347,668	98.0%	98.2%	98.4%	98.4%	10.6%	8.6%	-0.2%
Group Care	5,826	5,791	5,605	5,586	2.0%	1.8%	1.6%	1.6%	-0.6%	-3.5%	-0.3%
Total	**295,151**	**325,925**	**354,067**	**353,254**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.4%**	**8.4%**	**-0.2%**



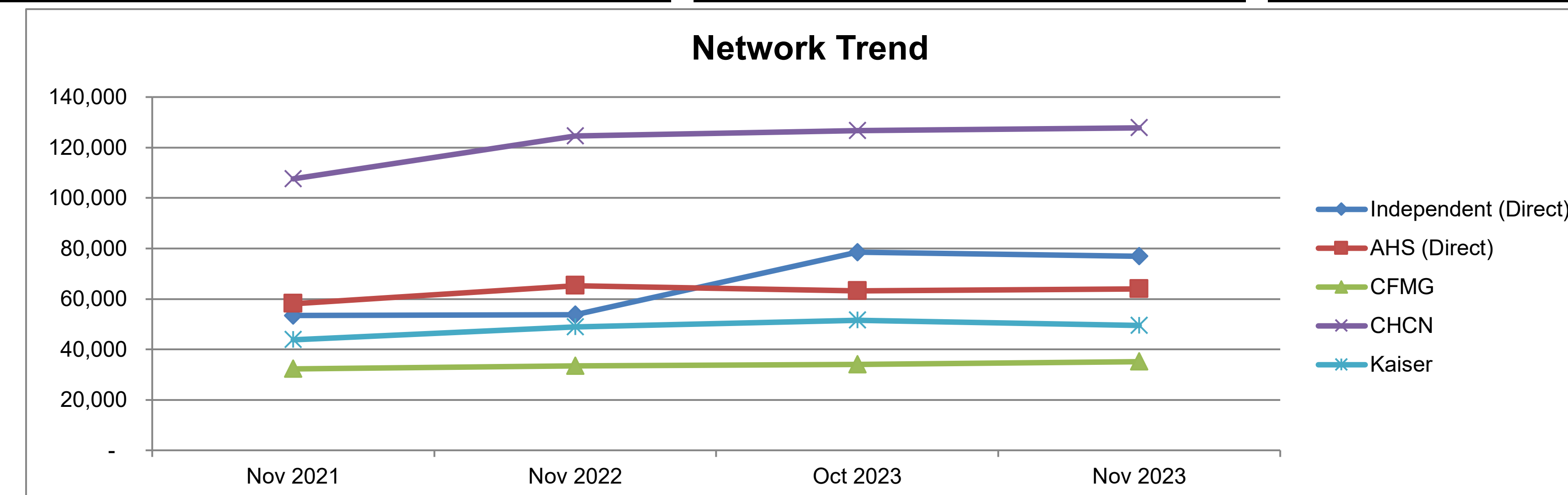
Delegation vs Direct Trend

Members	Members Nov 2021	Nov 2022	Oct 2023	Nov 2023	% of Total (ie.Distribution) Nov 2021	Nov 2022	Oct 2023	Nov 2023	% Growth (Loss) Nov 2021 to Nov 2022	Nov 2022 to Nov 2023	Oct 2023 to Nov 2023
Delegated	183,640	206,973	212,266	212,412	62.2%	63.5%	60.0%	60.1%	12.7%	2.6%	0.1%
Direct	111,511	118,952	141,801	140,842	37.8%	36.5%	40.0%	39.9%	6.7%	18.4%	-0.7%
Total	**295,151**	**325,925**	**354,067**	**353,254**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.4%**	**8.4%**	**-0.2%**



Network Trend

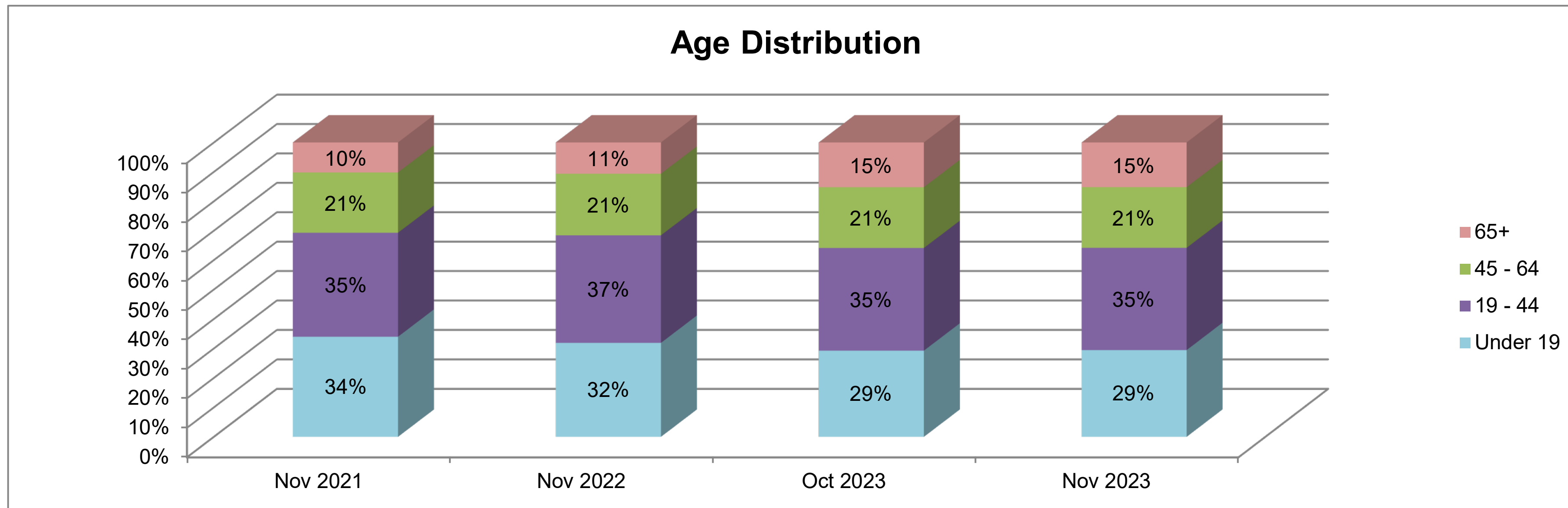
Network	Members Nov 2021	Nov 2022	Oct 2023	Nov 2023	% of Total (ie.Distribution) Nov 2021	Nov 2022	Oct 2023	Nov 2023	% Growth (Loss) Nov 2021 to Nov 2022	Nov 2022 to Nov 2023	Oct 2023 to Nov 2023
Independent (Direct)	53,438	53,736	78,530	76,872	18.1%	16.5%	22.2%	21.8%	0.6%	43.1%	-2.1%
AHS (Direct)	58,073	65,216	63,271	63,970	19.7%	20.0%	17.9%	18.1%	12.3%	-1.9%	1.1%
CFMG	32,266	33,498	34,035	35,124	10.9%	10.3%	9.6%	9.9%	3.8%	4.9%	3.2%
CHCN	107,583	124,637	126,705	127,787	36.5%	38.2%	35.8%	36.2%	15.9%	2.5%	0.9%
Kaiser	43,791	48,838	51,526	49,501	14.8%	15.0%	14.6%	14.0%	11.5%	1.4%	-3.9%
Total	**295,151**	**325,925**	**354,067**	**353,254**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.4%**	**8.4%**	**-0.2%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

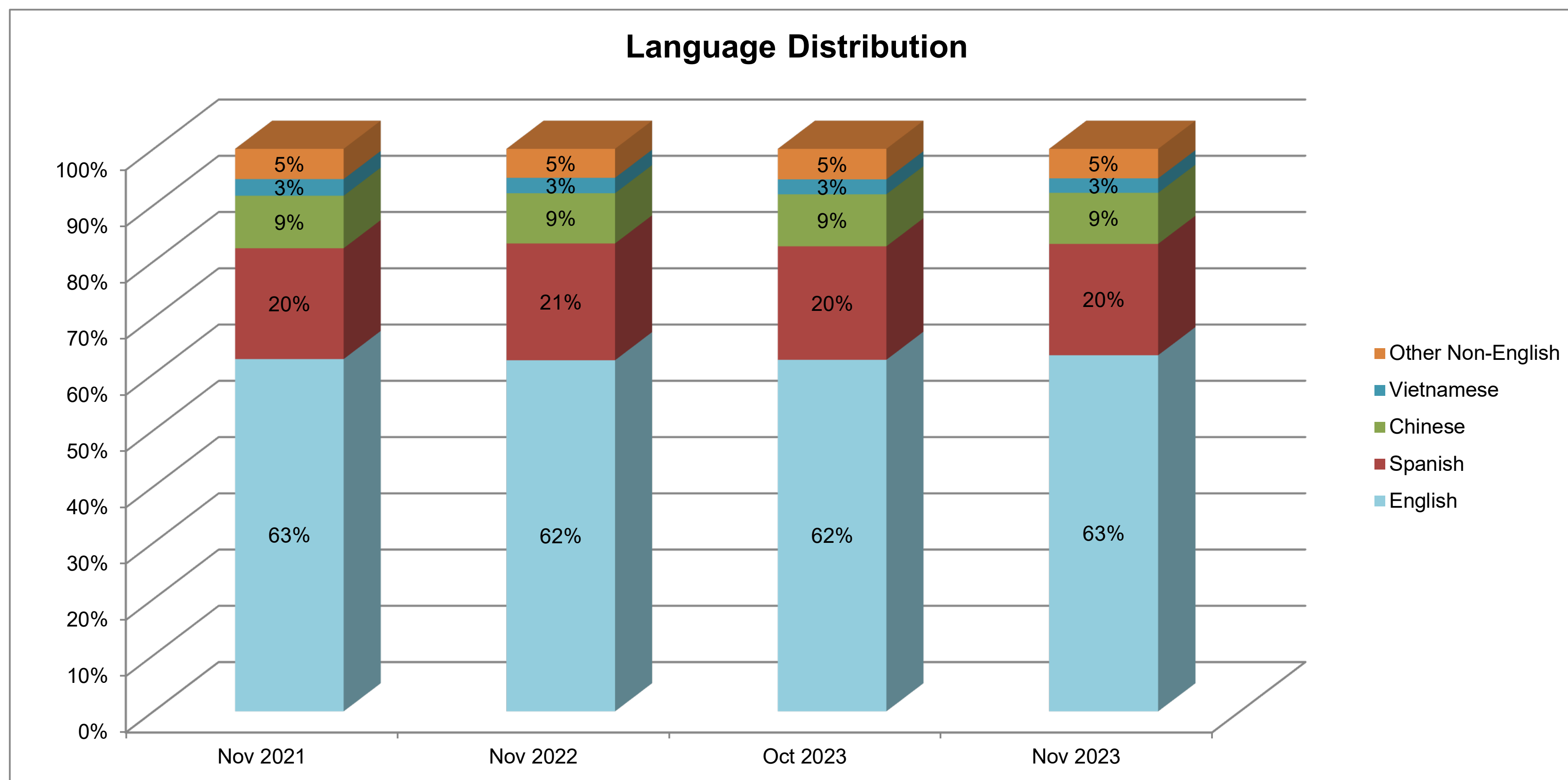
Age Category Trend

Age Category	Members: Nov 2021	Nov 2022	Oct 2023	Nov 2023	% of Total (ie.Distribution): Nov 2021	Nov 2022	Oct 2023	Nov 2023	% Growth (Loss): Nov 2021 to Nov 2022	Nov 2022 to Nov 2023	Oct 2023 to Nov 2023
Under 19	100,206	103,882	103,512	103,912	34%	32%	29%	29%	4%	0%	0%
19 - 44	104,239	119,055	123,390	122,668	35%	37%	35%	35%	14%	3%	-1%
45 - 64	60,571	68,281	73,229	72,865	21%	21%	21%	21%	13%	7%	0%
65+	30,135	34,707	53,936	53,745	10%	11%	15%	15%	15%	55%	0%
Total	**295,151**	**325,925**	**354,067**	**353,190**	**100%**	**100%**	**100%**	**100%**	**10%**	**8%**	**0%**



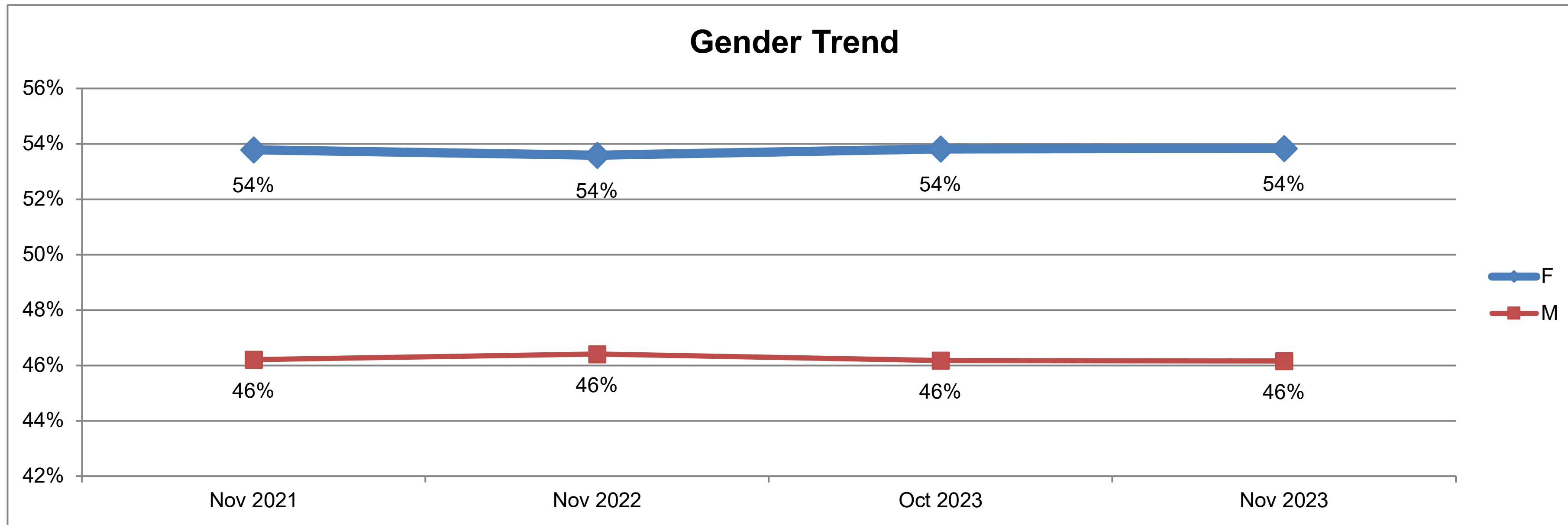
Language Trend

Language	Members: Nov 2021	Nov 2022	Oct 2023	Nov 2023	% of Total (ie.Distribution): Nov 2021	Nov 2022	Oct 2023	Nov 2023	% Growth (Loss): Nov 2021 to Nov 2022	Nov 2022 to Nov 2023	Oct 2023 to Nov 2023
English	184,858	203,441	221,283	223,617	63%	62%	62%	63%	10%	10%	1%
Spanish	58,130	67,653	71,409	69,914	20%	21%	20%	20%	16%	3%	-2%
Chinese	27,553	29,111	32,770	32,047	9%	9%	9%	9%	6%	10%	-2%
Vietnamese	8,737	8,906	9,405	9,104	3%	3%	3%	3%	2%	2%	-3%
Other Non-English	15,873	16,814	19,200	18,508	5%	5%	5%	5%	6%	10%	-4%
Total	**295,151**	**325,925**	**354,067**	**353,190**	**100%**	**100%**	**100%**	**100%**	**10%**	**8%**	**0%**

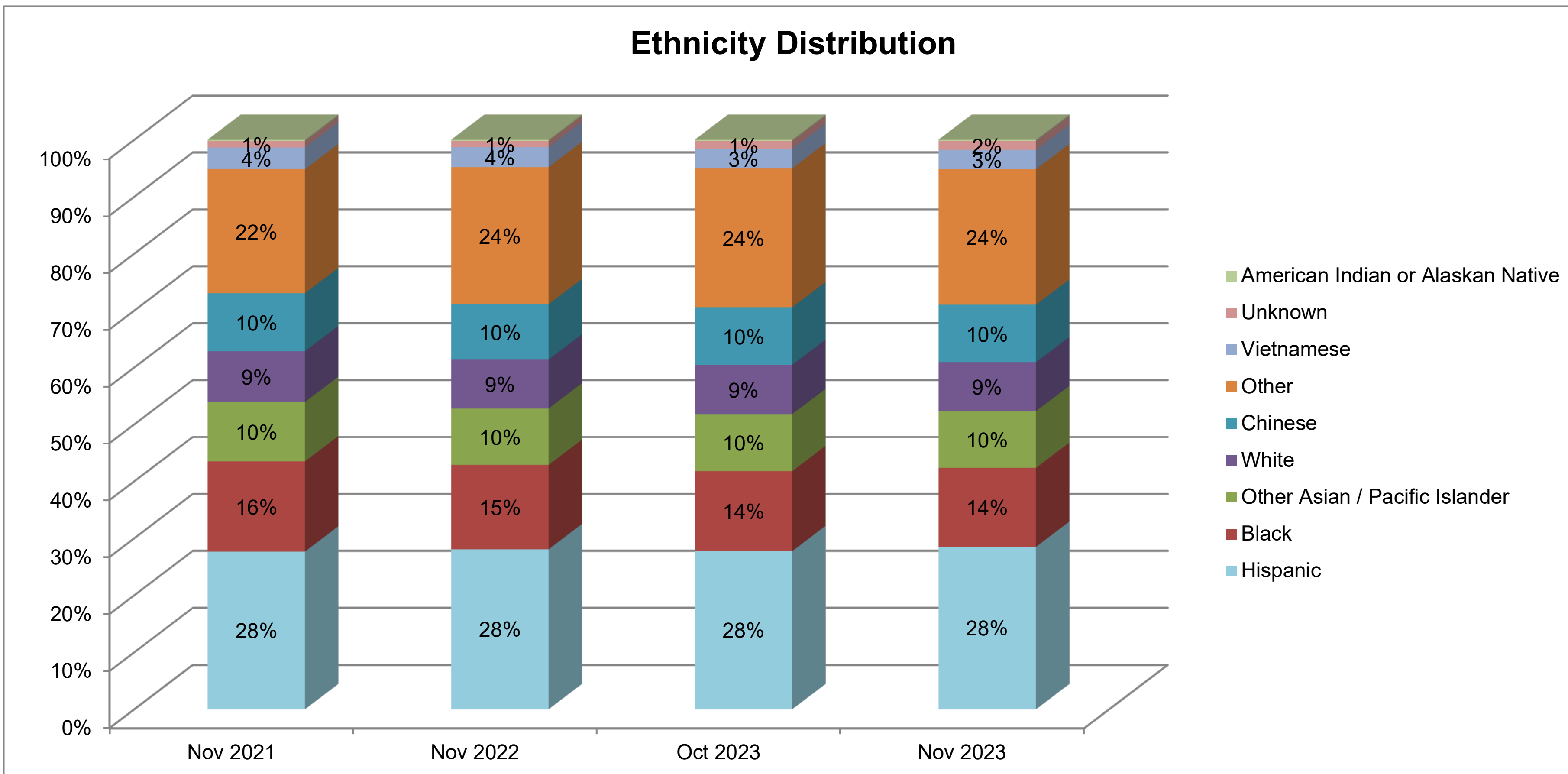


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Gender Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Nov 2021	Nov 2022	Oct 2023	Nov 2023	Nov 2021	Nov 2022	Oct 2023	Nov 2023	Nov 2021 to Nov 2022	Nov 2022 to Nov 2023	Oct 2023 to Nov 2023
F	158,755	174,661	190,566	190,159	54%	54%	54%	54%	10%	9%	0%
M	136,396	151,264	163,501	163,031	46%	46%	46%	46%	11%	8%	0%
Total	**295,151**	**325,925**	**354,067**	**353,190**	**100%**	**100%**	**100%**	**100%**	**10%**	**8%**	**0%**



Ethnicity Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Nov 2021	Nov 2022	Oct 2023	Nov 2023	Nov 2021	Nov 2022	Oct 2023	Nov 2023	Nov 2021 to Nov 2022	Nov 2022 to Nov 2023	Oct 2023 to Nov 2023
Hispanic	81,601	91,418	98,158	100,583	28%	28%	28%	28%	12%	10%	2%
Black	46,720	48,247	49,717	48,956	16%	15%	14%	14%	3%	1%	-2%
Other Asian / Pacific Islander	30,820	32,346	35,487	35,233	10%	10%	10%	10%	5%	9%	-1%
White	26,352	28,029	30,637	30,364	9%	9%	9%	9%	6%	8%	-1%
Chinese	30,070	31,699	35,807	35,686	10%	10%	10%	10%	5%	13%	0%
Other	64,332	78,525	86,487	84,093	22%	24%	24%	24%	22%	7%	-3%
Vietnamese	11,226	11,442	12,050	11,990	4%	4%	3%	3%	2%	5%	0%
Unknown	3,399	3,526	4,980	5,553	1%	1%	1%	2%	4%	57%	12%
American Indian or Alaskan Native	631	693	744	732	0%	0%	0%	0%	10%	6%	-2%
Total	**295,151**	**325,925**	**354,067**	**353,190**	**100%**	**100%**	**100%**	**100%**	**10%**	**8%**	**0%**



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

Medi-Cal By City

City	Nov 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	133,506	38%	20,448	29,525	14,247	55,439	13,847
Hayward	54,529	16%	11,071	11,493	6,028	17,044	8,893
Fremont	32,757	9%	13,029	4,750	1,489	8,504	4,985
San Leandro	31,227	9%	6,714	4,272	3,514	11,241	5,486
Union City	14,516	4%	5,193	2,091	681	3,914	2,637
Alameda	13,482	4%	3,178	1,989	1,728	4,504	2,083
Berkeley	12,882	4%	2,953	1,507	1,332	5,234	1,856
Livermore	10,641	3%	1,652	536	1,794	4,833	1,826
Newark	8,264	2%	2,519	2,528	365	1,485	1,367
Castro Valley	8,805	3%	1,954	1,298	1,132	2,614	1,807
San Lorenzo	7,234	2%	1,328	1,231	672	2,596	1,407
Pleasanton	6,099	2%	1,440	331	541	2,753	1,034
Dublin	6,569	2%	1,560	380	657	2,844	1,128
Emeryville	2,424	1%	578	435	307	710	394
Albany	2,046	1%	386	182	366	709	403
Piedmont	439	0%	94	124	27	87	107
Sunol	73	0%	18	10	6	24	15
Antioch	65	0%	16	16	17	8	8
Other	2,110	1%	553	437	221	681	218
Total	**347,668**	**100%**	**74,684**	**63,135**	**35,124**	**125,224**	**49,501**

Group Care By City

City	Nov 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,764	32%	390	333	-	1,041	-
Hayward	629	11%	302	131	-	196	-
Fremont	598	11%	419	55	-	124	-
San Leandro	593	11%	241	81	-	271	-
Union City	304	5%	197	38	-	69	-
Alameda	284	5%	100	20	-	164	-
Berkeley	163	3%	50	12	-	101	-
Livermore	101	2%	31	3	-	67	-
Newark	133	2%	84	27	-	22	-
Castro Valley	195	3%	83	30	-	82	-
San Lorenzo	130	2%	43	17	-	70	-
Pleasanton	62	1%	21	3	-	38	-
Dublin	100	2%	35	7	-	58	-
Emeryville	34	1%	16	6	-	12	-
Albany	19	0%	8	1	-	10	-
Piedmont	10	0%	2	-	-	8	-
Sunol	-	0%	-	-	-	-	-
Antioch	23	0%	7	5	-	11	-
Other	444	8%	159	66	-	219	-
Total	**5,586**	**100%**	**2,188**	**835**	**-**	**2,563**	**-**

Total By City

City	Nov 2023	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	135,270	38%	20,838	29,858	14,247	56,480	13,847
Hayward	55,158	16%	11,373	11,624	6,028	17,240	8,893
Fremont	33,355	9%	13,448	4,805	1,489	8,628	4,985
San Leandro	31,820	9%	6,955	4,353	3,514	11,512	5,486
Union City	14,820	4%	5,390	2,129	681	3,983	2,637
Alameda	13,766	4%	3,278	2,009	1,728	4,668	2,083
Berkeley	13,045	4%	3,003	1,519	1,332	5,335	1,856
Livermore	10,742	3%	1,683	539	1,794	4,900	1,826
Newark	8,397	2%	2,603	2,555	365	1,507	1,367
Castro Valley	9,000	3%	2,037	1,328	1,132	2,696	1,807
San Lorenzo	7,364	2%	1,371	1,248	672	2,666	1,407
Pleasanton	6,161	2%	1,461	334	541	2,791	1,034
Dublin	6,669	2%	1,595	387	657	2,902	1,128
Emeryville	2,458	1%	594	441	307	722	394
Albany	2,065	1%	394	183	366	719	403
Piedmont	449	0%	96	124	27	95	107
Sunol	73	0%	18	10	6	24	15
Antioch	88	0%	23	21	17	19	8
Other	2,554	1%	712	503	221	900	218
Total	**353,254**	**100%**	**76,872**	**63,970**	**35,124**	**127,787**	**49,501**

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: February 9th, 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.

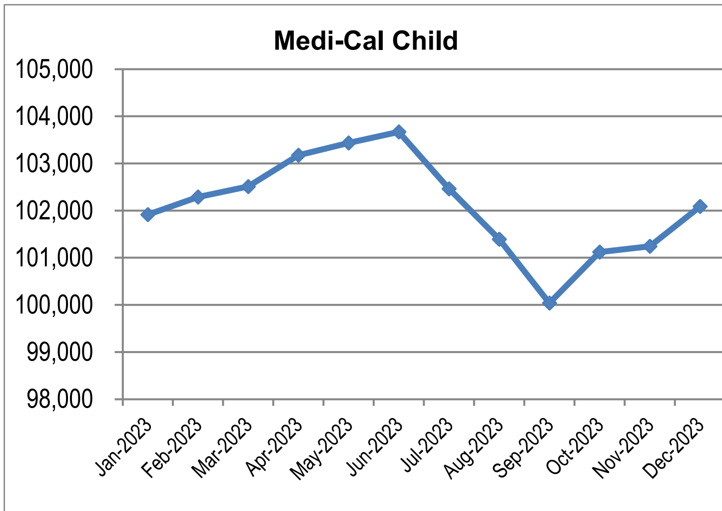
Enrollment

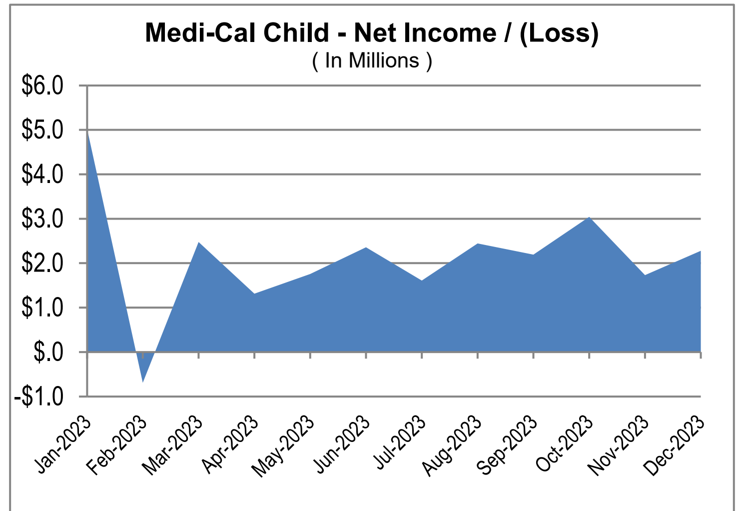
- Total enrollment decreased by 546 members since November 2023.
- Total enrollment decreased by 9,705 members since June 2023.

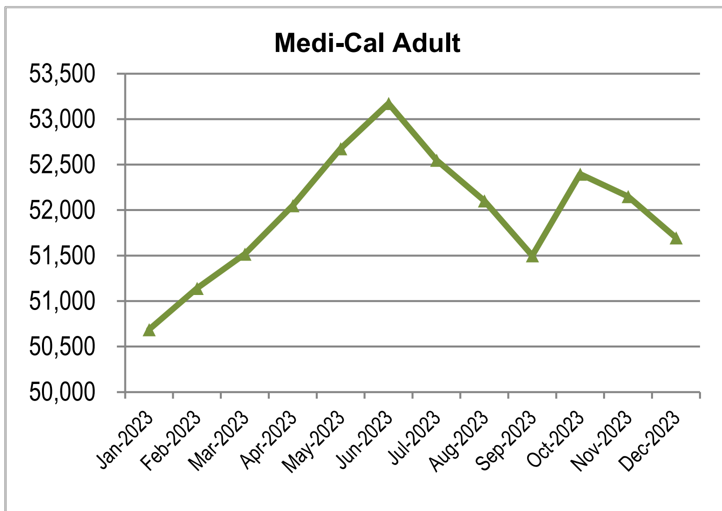
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

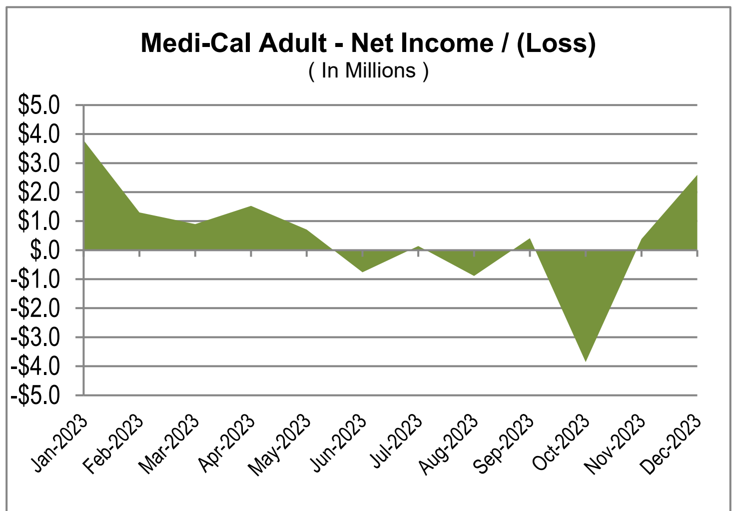
Enrollment					Member Months			
December 2023					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
51,696	51,301	395	0.8%	Adult	312,394	311,720	674	0.2%
102,088	99,008	3,080	3.1%	Child	608,345	604,131	4,214	0.7%
30,846	30,488	358	1.2%	SPD	185,086	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%**

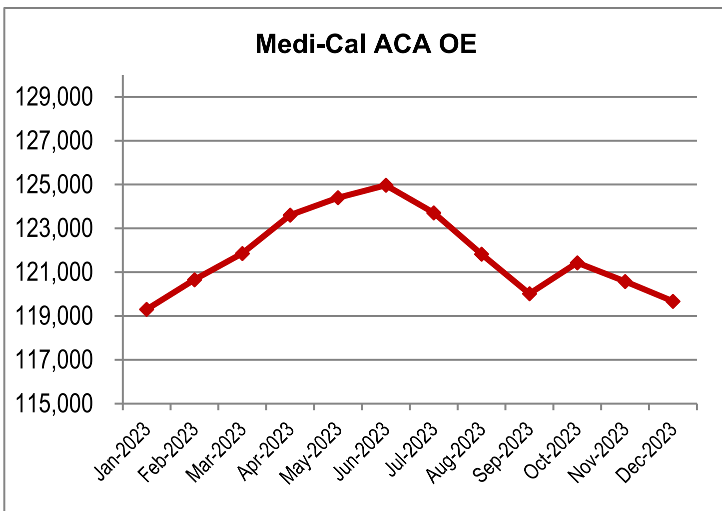
Enrollment and Profitability by Program and Category of Aid

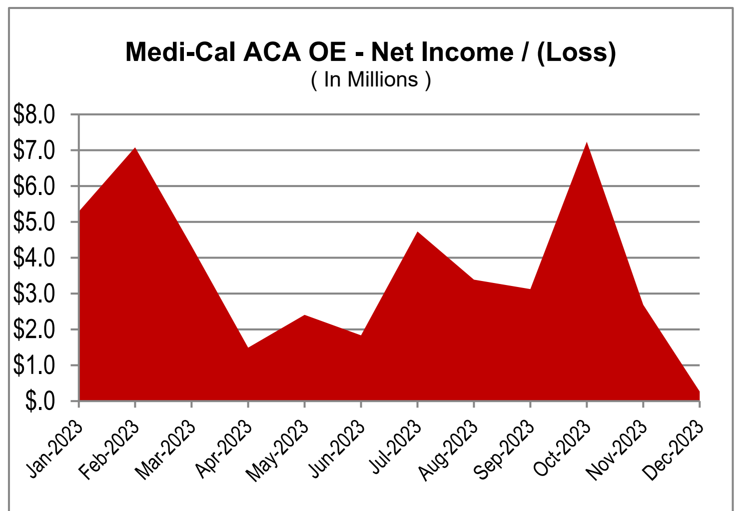




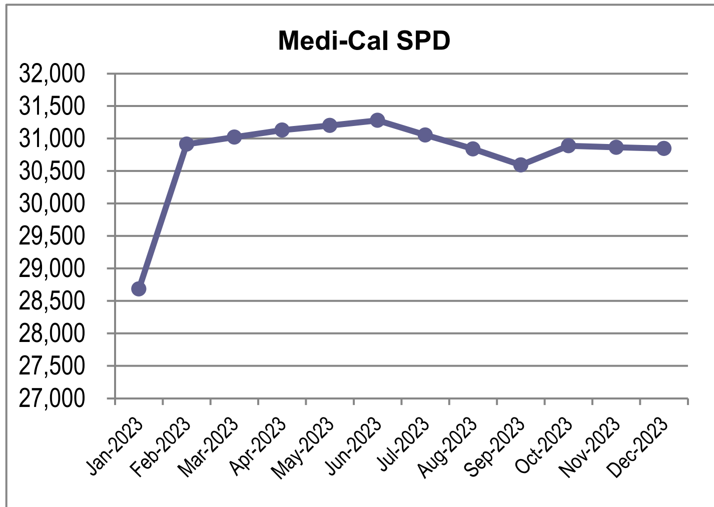


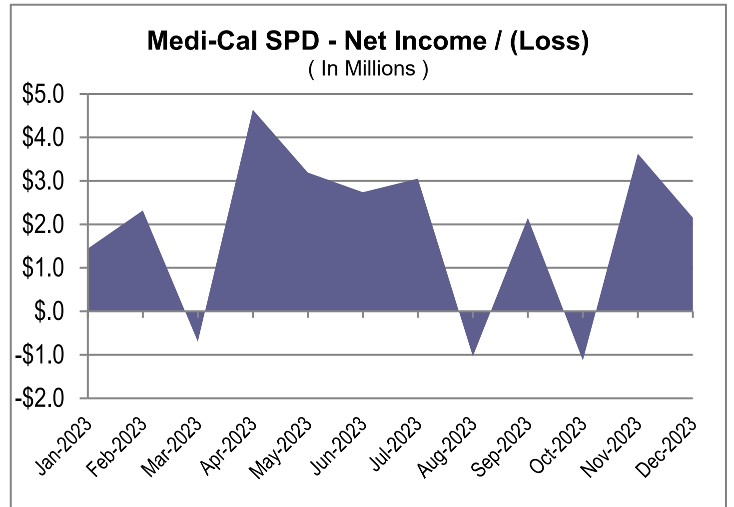


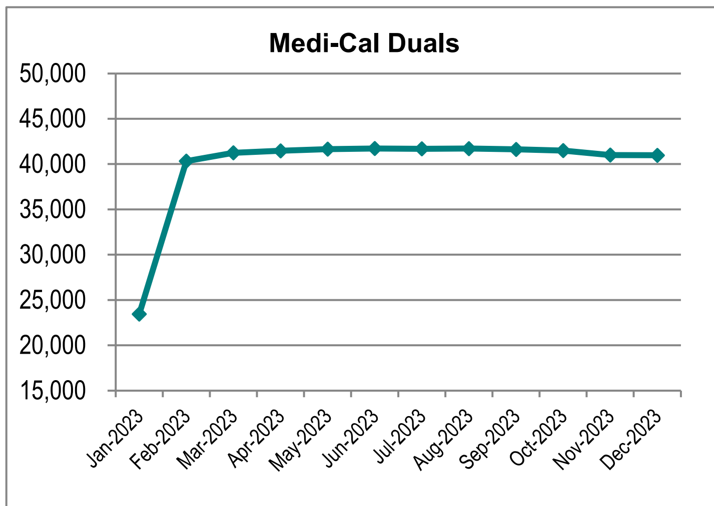


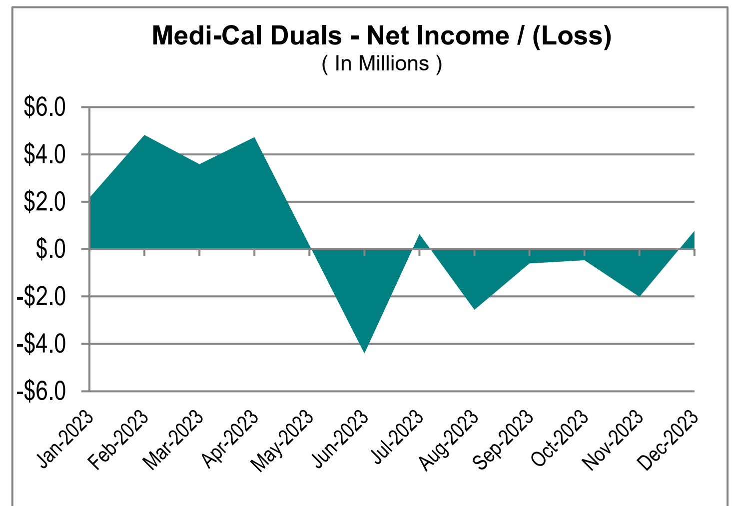


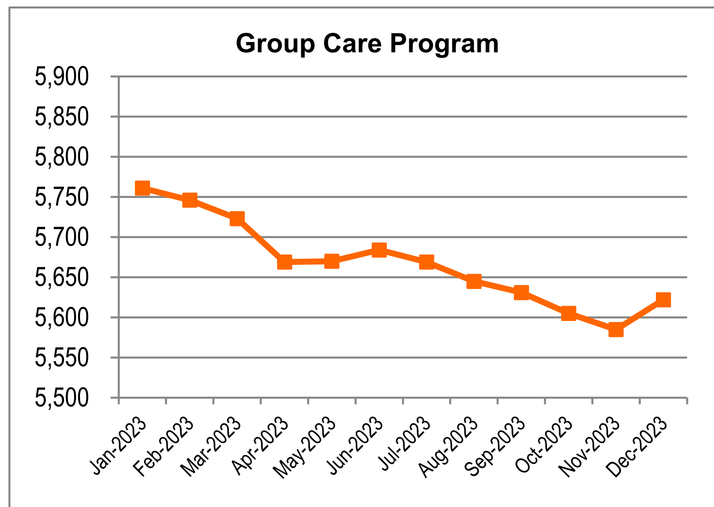
Enrollment and Profitability by Program and Category of Aid

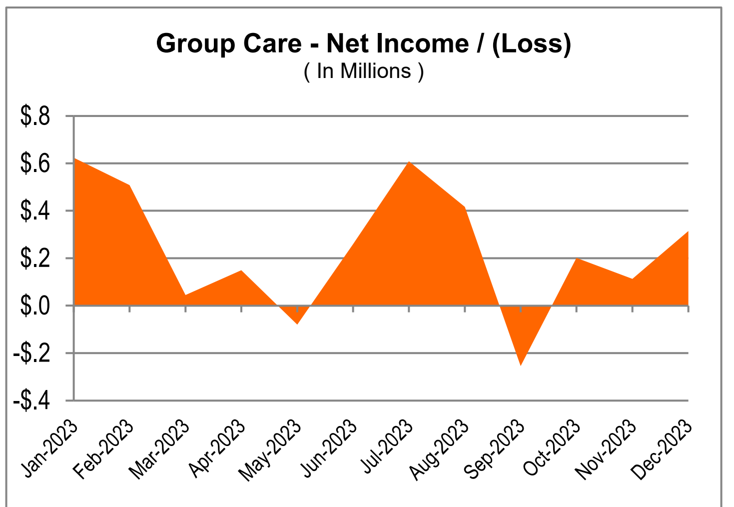




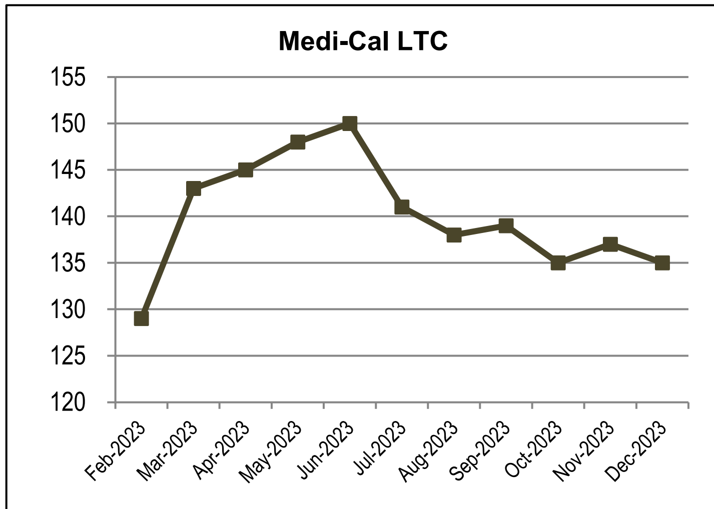


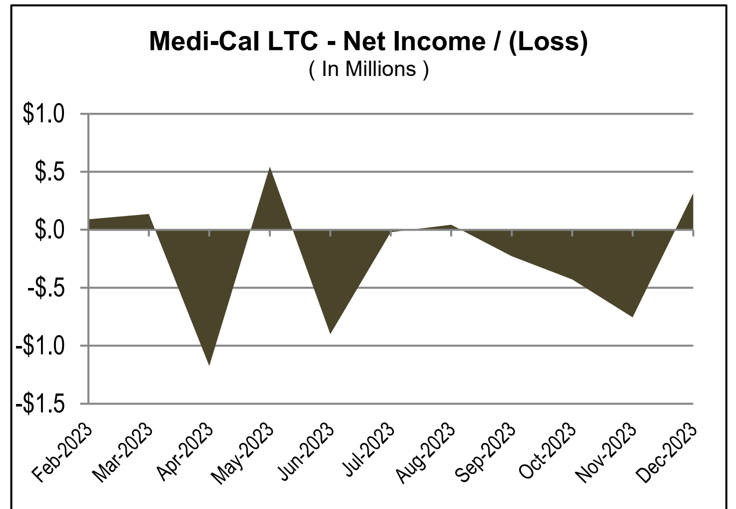


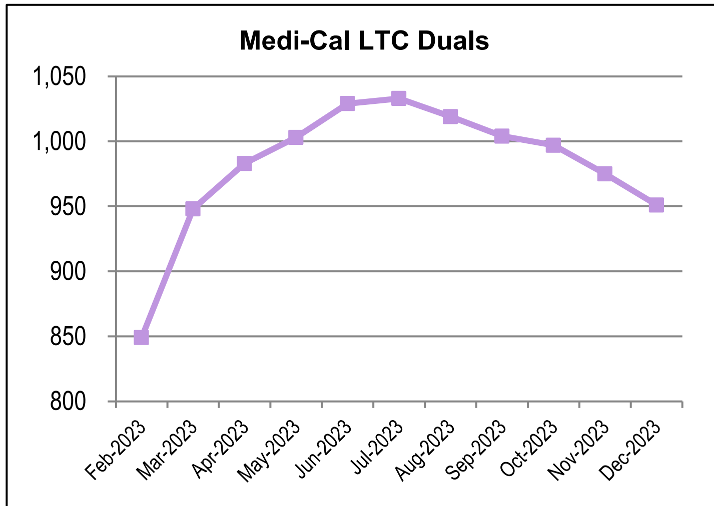


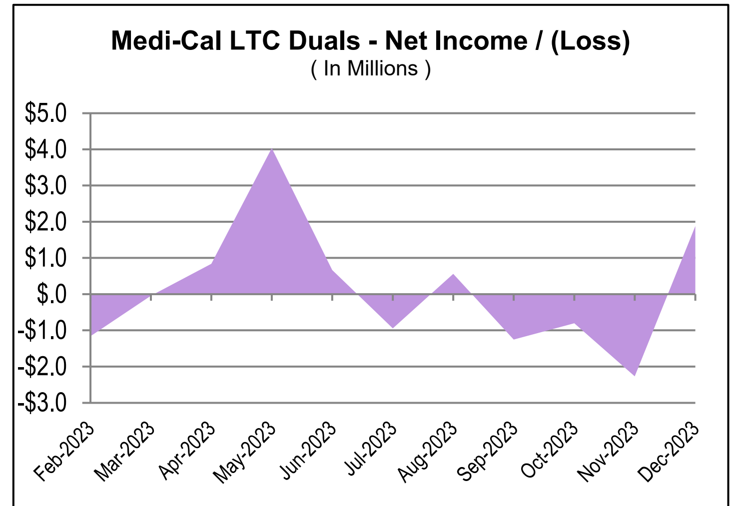


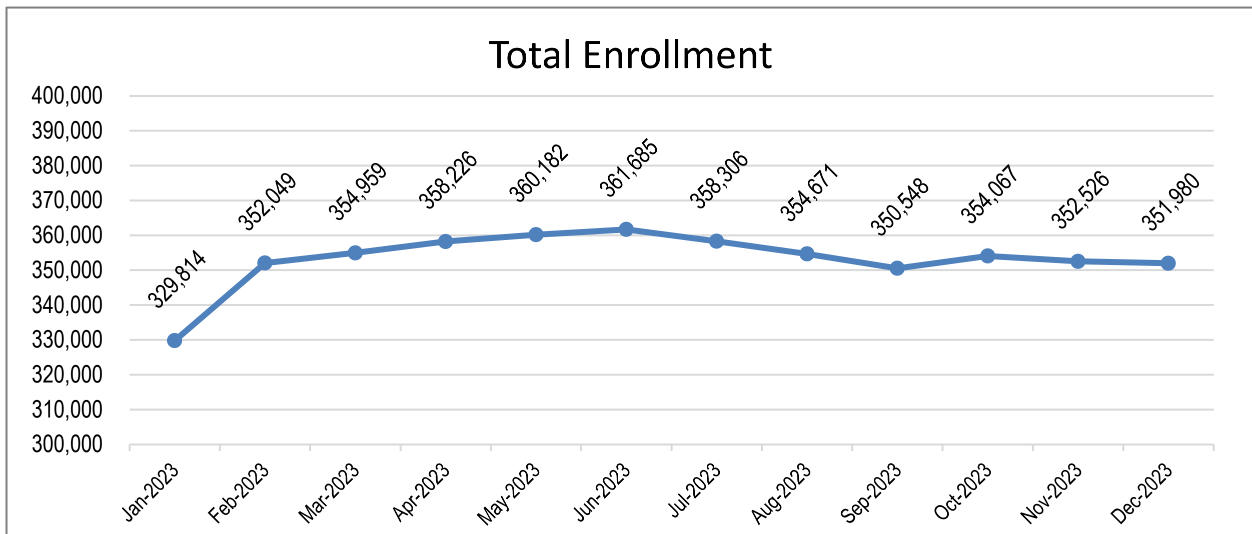
Enrollment and Profitability by Program and Category of Aid

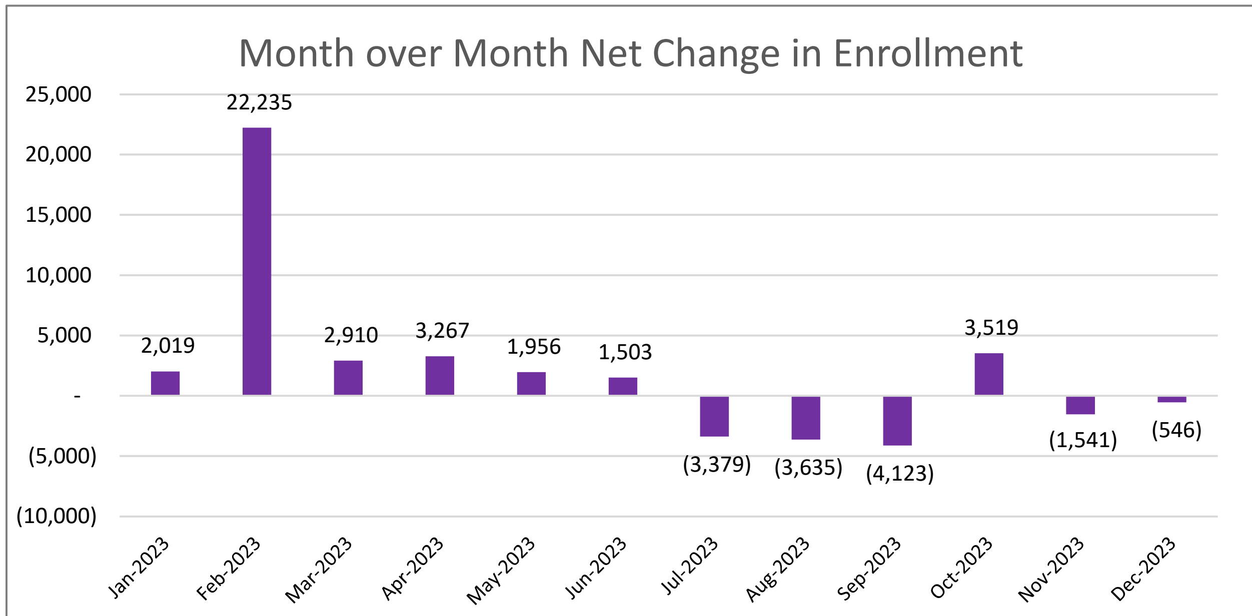










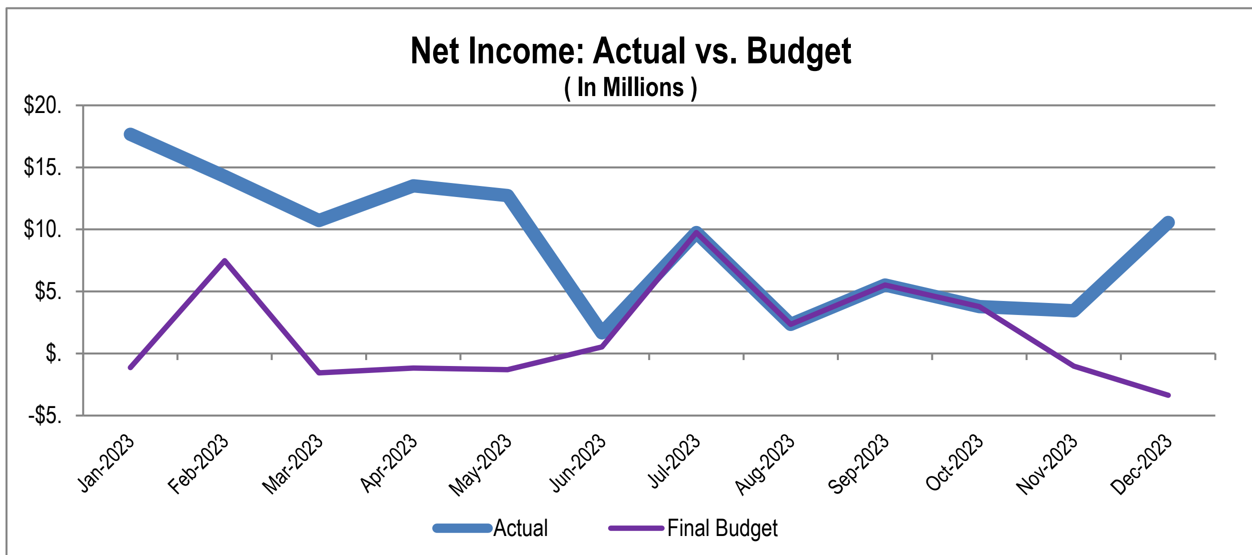


- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started in July 2023. In preparation for the Single Plan Model, DHCS is no longer assigning members to Anthem. New members are now all assigned to the Alliance.

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.

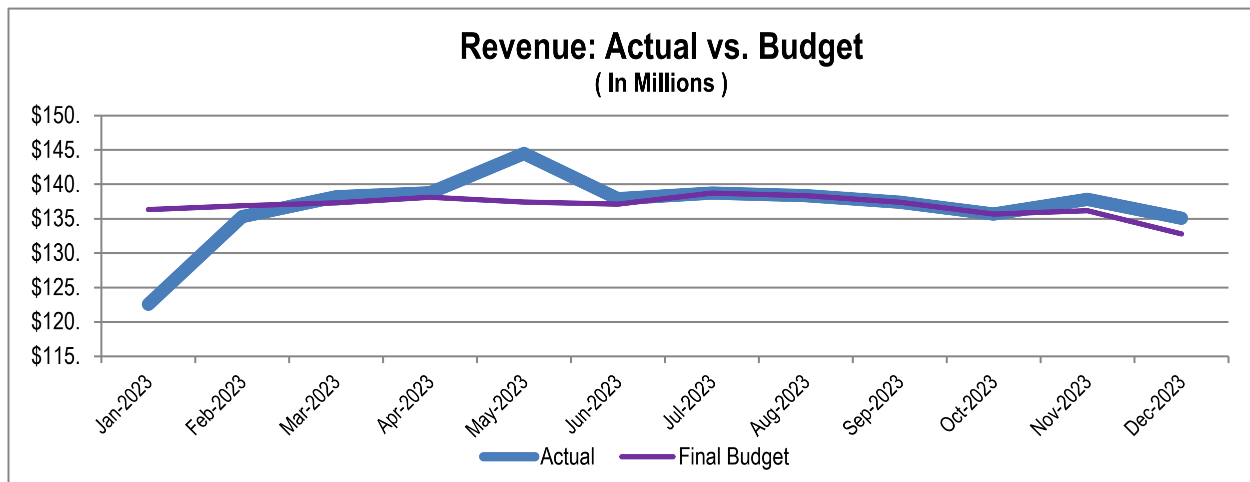


- The favorable variance of $13.9 million in the current month is primarily due to:
  - Favorable $6.4 million lower than anticipated Medical Expense.
  - Favorable $3.0 million lower than anticipated Administrative Expense.
  - Favorable $2.3 million higher than anticipated Revenue.
  - Favorable $2.2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

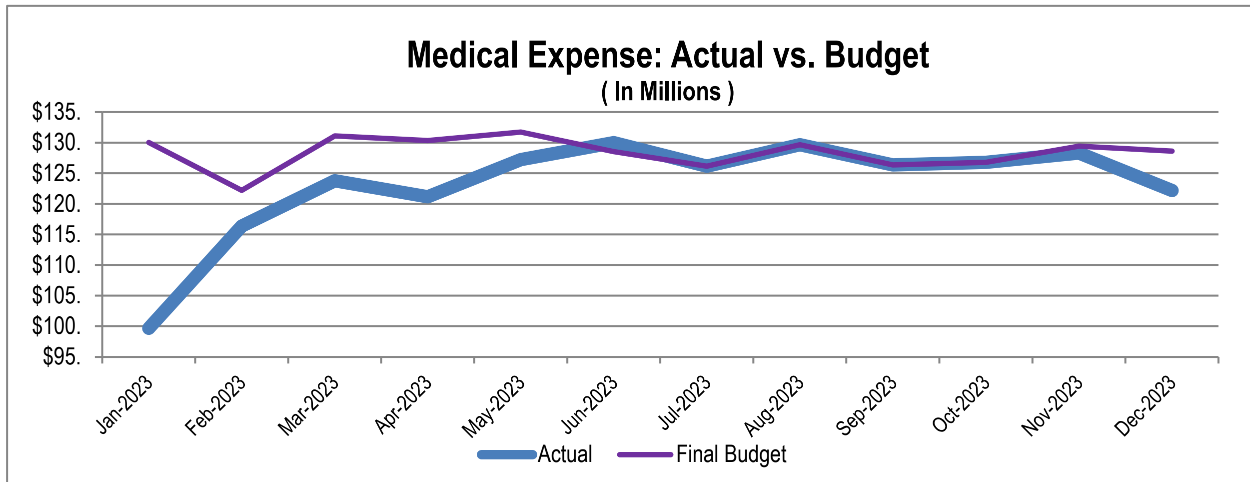


- For the month ended December 31st, 2023, the favorable revenue variance of $2.3 million is primarily due to timing of revenue recognition:
  - Favorable Capitation Rate variance. Higher rates were received primarily due to differences in Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration 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

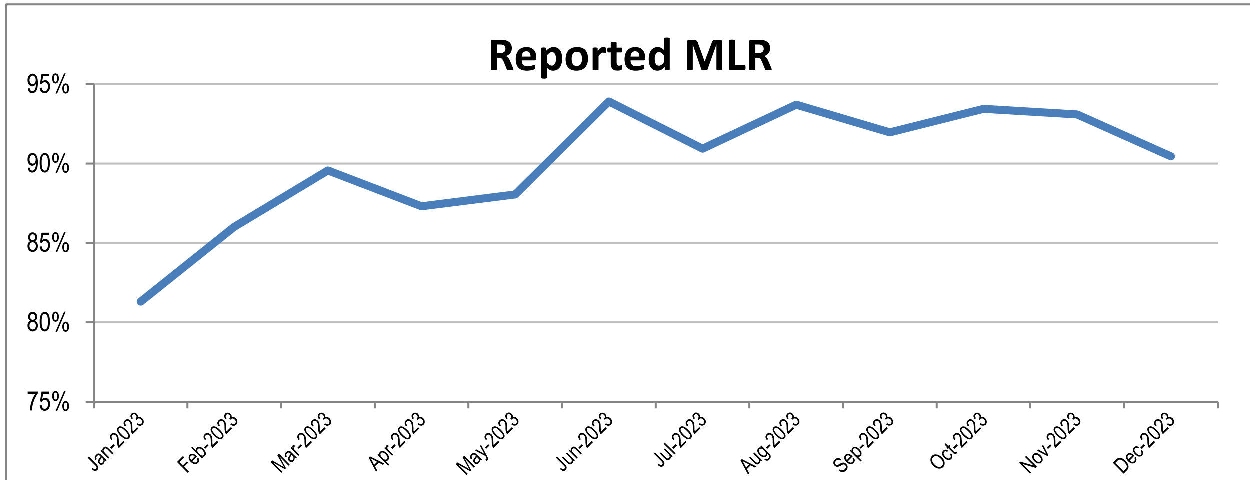
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$72.55	$0.00	$72.55	$73.27	$0.72	1.0%
Primary Care FFS	$15.80	$0.00	$15.80	$15.75	($0.05)	-0.3%
Specialty Care FFS	$14.08	$0.03	$14.11	$14.66	$0.58	3.9%
Outpatient FFS	$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.

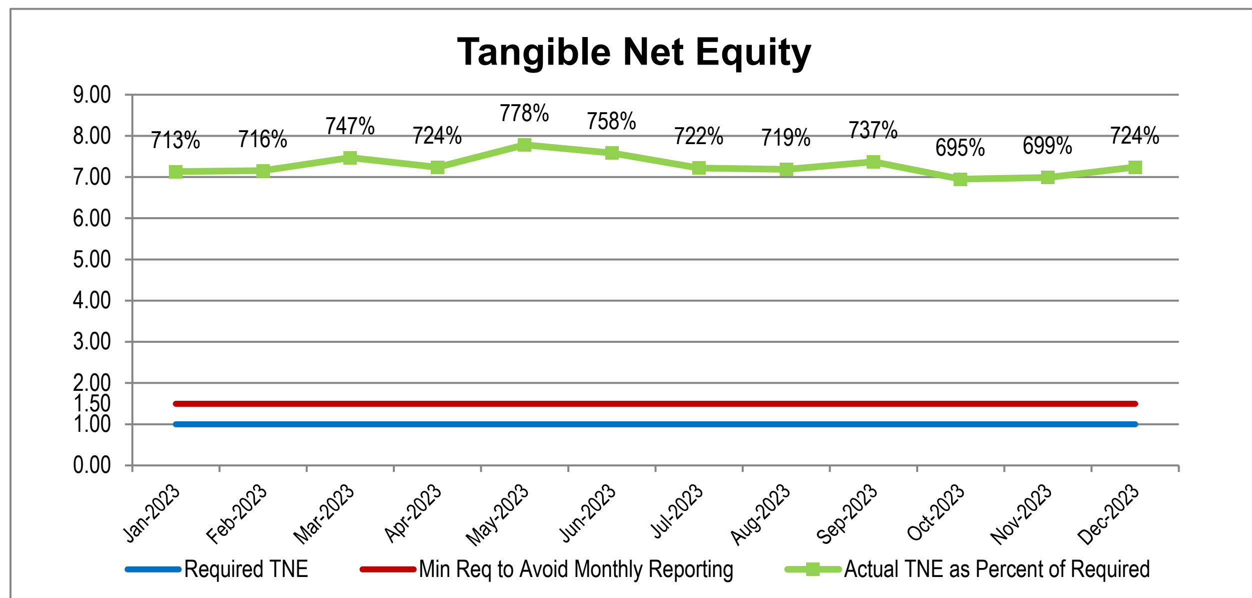
Other Income / (Expense)

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.

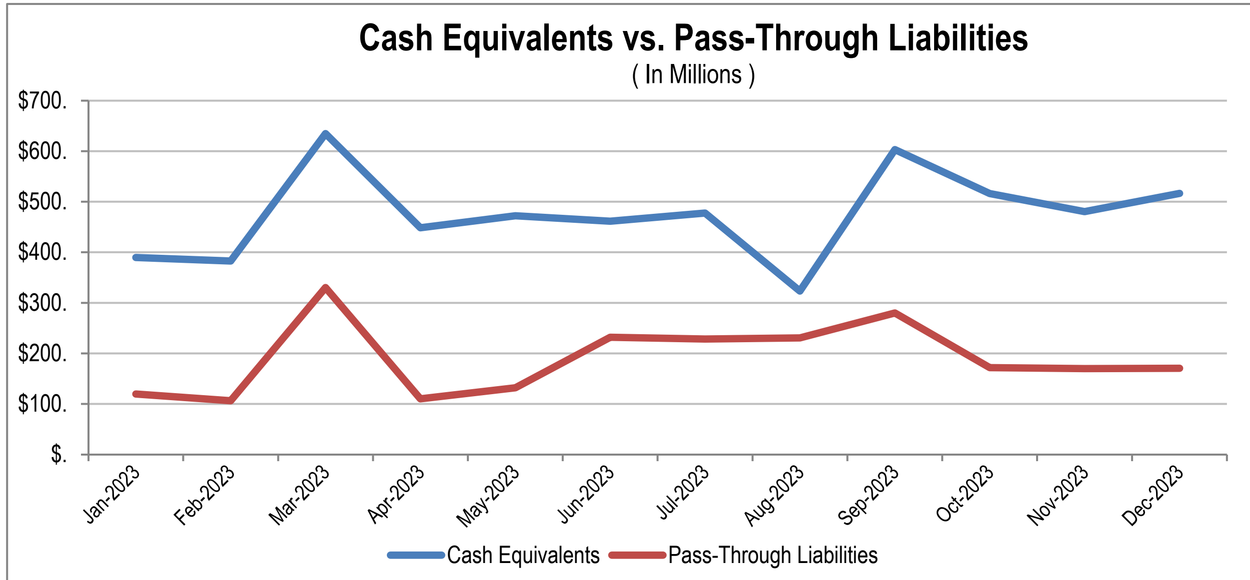
Tangible Net Equity (TNE)

- 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.

Finance

Supporting Documents

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (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

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
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%**

Operations

Ruth Watson

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

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

Date: **February 9th, 2024**

Subject: **Operations Report**

<u>Member Services</u>

- 12-Month Trend Blended Summary:
  - The Member Services Department received forty-four percent (44%) increase in calls in January 2024, totaling 29,606 compared to 16,537 in January 2023. Record number of calls are related to the MCP Transition and Adult Expansion of 110K new members on January 1, 2024.
  - The abandonment rate for January 2024 was eleven percent (11%), compared to twenty-six percent (18%) in January 2023.
  - The Department's service level was seventy-one percent (71%) in January 2024, compared to forty-four percent (44%) in January 2023. The average speed to answer (ASA) was one minute and twenty-six seconds (01:26) compared to four minutes and thirty-two seconds (04:32) 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 fifty-eight seconds (06:58) for January 2024 compared to six minutes and fifty-nine seconds (06:59) for January 2023.
  - Ninety-seven percent (97%) of calls were answered within 10 minutes for January 2024 compared to seventy-five (75%) in January 2023.
  - The top five call reasons for January 2024 were: 1). Eligibility/Enrollment, 2). Change of PCP, 3). ID Card Requests, 4). Benefits, 5). Provider Network. The top five call reasons for January 2023 were: 1). Eligibility/Enrollment, 2). Change of PCP, 3). Kaiser, 4). Benefits, 5). ID Card Requests.
  - January utilization for the member automated eligibility IVR system totaled three thousand eighty-two (3,082) January 2024 compared to nine hundred twenty-nine (929) in January 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 a record twenty-eight hundred thirty-nine (2839) web-based requests in January 2024 compared to nine hundred twenty-nine (929) in January 2023. The top three web reason requests for January 2024 were: 1). ID Card Requests, 2). Change of PCP, 3). Update Contact Information. One hundred-nineteen (119) members were assisted in-person in January 2024.

- Member Services Behavioral Health:

  - The Member Services Behavioral Health Unit received a total of sixteen hundred five (1605) calls in January 2024.
  - The abandonment rate was sixteen percent (16%).
  - The service level was seventy-one percent (71%).
  - Calls answered in 10 minutes were ninety-five percent (95%).
  - The Average Talk Time (ATT) was nine minutes and forty-five seconds (09:45). ATT are impacted by the DHCS requirements to complete a screening for all members initiating MH services for the first time.
  - Eleven hundred sixty-four (1164) outbound calls were completed in January 2024.
  - Two hundred thirteen (213) outreach campaigns were completed in January 2024.
  - Two hundred seventeen (217) screenings were completed in January 2024.
  - Forty-eight (48) referrals were made to the County (ACCESS) in January 2024.
  - Twenty-one (21) members were referred to Center Point for SUD services in January 2024.

Claims

- 12-Month Trend Summary:

  - The Claims Department received 298,465 claims in January 2024 compared to 163,764 in January 2023.
  - The Auto Adjudication was 81.7% in January 2024 compared to 80.3% in January 2023.
  - Claims compliance for the 30-day turn-around time was 88% in January 2024 compared to 99.2% in January 2023. The 45-day turn-around time was 99.9% in January 2024 compared to 99.9% in January 2023.

- Monthly Analysis:

  - In the month of January, we received a total of 298,465 claims in the HEALTHsuite system. This represents an increase of 38.7% from December and is higher, by 134,701 claims, than the number of claims received in January 2023; the higher volume of received claims remains attributed to an increased membership.
    - More than 25,000 claims included in the increase from December to January can be attributed to the new member transition populations from Anthem (21,602 claims) and Adult Expansion (5,404 claims).
  - We received 90.86% of claims via EDI and 9.14% of claims via paper.
  - During the month of January, 99.9% of our claims were processed within 45 working days.
  - The Auto Adjudication rate was 81.7% for the month of January.

Provider Services

- 12-Month Trend Summary:
    - The Provider Services department's call volume in January 2024 was 10,695 calls compared to 5,588 calls in January 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 156 calls/visits during January 2024.
    - The Provider Services department answered 5,889 calls for January 2024 and made 1,140 outbound calls.

Credentialing

- 12-Month Trend Summary:
    - At the Peer Review and Credentialing (PRCC) meeting held on January 16, 2024, there were one hundred and nine (109) initial network providers approved; six (6) primary care providers, fifteen (15) specialists, seven (7) ancillary providers, six (6) midlevel providers, and seventy-five (75) behavioral health providers. Additionally, thirty-three (33) providers were re-credentialed at this meeting; eleven (11) primary care providers, seventeen (17) specialists, one (1) ancillary provider, and four (4) 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 January 2024, the Provider Dispute Resolution (PDR) team received 2,172 PDRs versus 979 in January 2023.
    - The PDR team resolved 1,461 cases in January 2024 compared to 806 cases in January 2023.
    - In January 2024, the PDR team upheld 62% of cases versus 73% in January 2023.
    - The PDR team resolved 99.5% of cases within the compliance standard of 95% within 45 working days in January 2024 compared to 99.8% in January 2023.

- Monthly Analysis:
  - AAH received 2,172 PDRs in January 2024.
  - In the month of January 1,461 PDRs were resolved. Out of the 1,461 PDRs, 912 were upheld and 549 were overturned.
  - The overturn rate for PDRs was 38%, which did not meet our goal of 25% or less.
  - Below is a breakdown of the various causes for the 549 overturned PDRs. Please note that there was one primary area that caused the department to miss their goal of an overturn rate of 25% or less. There was a larger than normal volume of overturns due to Member Other Health Coverage (OHC) corrections, with 132 cases overturned that had been denied incorrectly. This category is the key contributor that prevented the department from achieving the goal of 25% or less.

    - System Related Issues – 16% (91 cases):
      - 67 cases: General configuration issues, e.g., Not Covered, Modifier, Eligibility (12%)
      - 8 cases: Delegated (1%)
      - 16 cases: CES (3%)

    - OHC Related Issues – 25% (132 cases)
      - 132 cases: OHC Member TPL data, incorrect primary EOB not matching, incorrect manual entry (25%)

    - Authorization Related Issues – 24% (133 cases):
      - 69 cases: Processor errors when auth on file (13%)
      - 56 cases: System (10%)
      - 8 cases: UM review (1%)

    - Additional Documentation Provided – 4% (22 cases):
      - 17 cases: Duplicate claim documentation that allowed for claims to be adjusted (3%)
      - 5 cases: Timely Filing (1%)

    - Incorrect Rates – 14% (80 cases)
      - 30 cases: System/LOA (5%)
      - 13 cases: Mental Health (2%)
      - 31 cases: Processor (6%)
      - 6 cases: Incorrect APR-DRG rate (1%)

    - Claim Processing Errors – 17% (91 cases)
      - 37 cases: Duplicate (7%)
      - 54 cases: Various Processor errors. (10%)

  - 1,455 out of 1,461 cases were resolved within 45 working days resulting in a 99.5% compliance rate.
  - The average turnaround time for resolving PDRs in January was 42 days.

- There were 2,695 PDRs pending resolution as of 01/31/2024, with no cases older than 45 working days.

Community Relations and Outreach

- 12-Month Trend Summary:
  - In January 2024, the Alliance completed 654 member orientation outreach calls and 132 member orientations by phone.
  - The C&O Department reached 1,682 people (83% identified as Alliance members) during outreach activities, compared to 602 individuals (57% self-identified as Alliance members) in January 2023.
  - The C&O Department spent a total of $600.00 in donations, fees, and/or sponsorships, compared to $600.00 in January 2023.
  - The C&O Department reached members in 13 cities/unincorporated areas throughout Alameda County, the Bay Area, and the U.S., compared to 11 cities in January 2023.

- Monthly Analysis:
  - In January 2024, the C&O Department completed 654 member orientation outreach calls and 132 member orientations by phone, and 121 Alliance website inquiries.
  - Among the 1,682 people reached, 83% identified as Alliance members.
  - In January 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	January 2024
Incoming Calls (R/V)	29,606
Abandoned Rate (R/V)	11%
Answered Calls (R/V)	26,272
Average Speed to Answer (ASA)	01:26
Calls Answered in 30 Seconds (R/V)	71%
Average Talk Time (ATT)	06:58
Calls Answered in 10 minutes	97%
Outbound Calls	8,404

Top 5 Call Reasons (Medi-Cal and Group Care) January 2024
Eligibility/Enrollment
Change of PCP
ID Card Requests
Benefits
Provider Network Info

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

MSBH	January 2024
Incoming Calls (R/V)	1605
Abandoned Rate (R/V)	16%
Answered Calls (R/V)	1351
Average Speed to Answer (ASA)	01:48
Calls Answered in 30 Seconds (R/V)	71%
Average Talk Time (ATT)	09:45
Calls Answered in 10 minutes	95%
Outbound Calls	1164
Screenings Completed	217
ACBH Referrals	48
SUD referrals to Center Point	21

Claims Department
December 2023 Final and January 2024 Final

METRICS

Claims Compliance	Dec-23	Jan-24
90% of clean claims processed within 30 calendar days	90.0%	88.0%
95% of all claims processed within 45 working days	99.9%	99.9%
Claims Volume (Received)	**Dec-23**	**Jan-24**
Paper claims	26,388	27,273
EDI claims	188,858	271,192
Claim Volume Total	**215,246**	**298,465**
Percentage of Claims Volume by Submission Method	**Dec-23**	**Jan-24**
% Paper	12.26%	9.14%
% EDI	87.74%	90.86%
Claims Processed	**Dec-23**	**Jan-24**
HEALTHsuite Paid (original claims)	156,463	198,846
HEALTHsuite Denied (original claims)	58,648	77,836
HEALTHsuite Original Claims Sub-Total	**215,111**	**276,682**
HEALTHsuite Adjustments	8,773	11,009
HEALTHsuite Total	**223,884**	**287,691**
Claims Expense	**Dec-23**	**Jan-24**
Medical Claims Paid	$83,516,690	$112,276,627
Interest Paid	$40,964	$84,602
Auto Adjudication	**Dec-23**	**Jan-24**
Claims Auto Adjudicated	215,111	276,682
% Auto Adjudicated	83.2%	81.7%
Average Days from Receipt to Payment	**Dec-23**	**Jan-24**
HEALTHsuite	14	15
Pended Claim Age	**Dec-23**	**Jan-24**
0-29 calendar days	31,758	32,848
HEALTHsuite		
30-59 calendar days	7,971	7,036
HEALTHsuite		
Over 60 calendar days	5	4
HEALTHsuite		
Overall Denial Rate	**Dec-23**	**Jan-24**
Claims denied in HEALTHsuite	58,648	77,836
% Denied	26.2%	27.1%

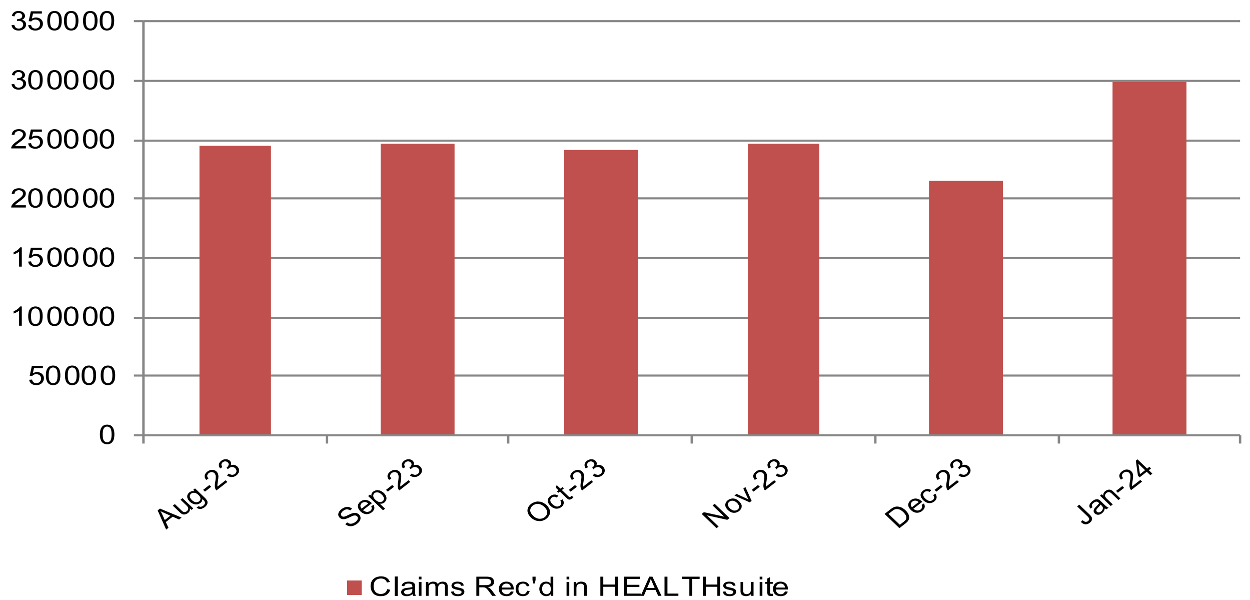
Claims Department
December 2023 Final and January 2024 Final

Jan-24

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	25%
No Benefits Found For Dates of Service	15%
Duplicate Claims	9%
Non-Covered Benefit For This Plan	9%
Must Submit Paper Claim With Copy of Primary Payor EOB	5%
% Total of all denials	**63%**

Claims Received By Month

Run Date	9/1/2023	10/1/2023	11/1/2023	12/1/2023	1/1/2024	2/1/2024
Claims Received Through	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**
Claims Rec'd in HEALTHsuite	244,907	247,423	241,298	247,537	215,246	298,465



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing January 2024 to January 2023 as follows: 30 Days - 88.0% (2024) vs 99.2% (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 298,465 claims in January 2024 vs 163,764 in January 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 276,682 in January 2024 (23 working days) vs 141,633 in January 2023 (20 working days).	N/A	N/A
Medical Claims Expense - the amount of paid claims in January 2024 was $112,276,627 (5 check runs) vs $60,755,515 in January 2023 (4 check runs).	N/A	N/A
Interest Expense - the amount of interest paid in January 2024 was $84,602 vs $27,088 in January 2023.	N/A	< $496,000 per fiscal year or $30,000 per month
Auto Adjudication - the AAH rate in January 2024 was 81.7% vs 80.3% in January 2023.	N/A	70% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in January 2024 was 15 days vs 18 days in January 2023.	N/A	<= 25 days

Claims Year Over Year Summary

Pended Claim Age - comparing January 2023 to January 2023 as follows: 0-30 calendar days - 32,848 (2024) vs 6,631 (2023) 30-59 calendar days - 7,036 (2024) vs 81 (2023) Over 60 calendar days - 4 (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 January 2024 to January 2023.	N/A	N/A

Provider Relations Dashboard January 2024

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10695											
Abandoned Calls	4806											
Answered Calls (PR)	5889											
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	413											
Abandoned Calls (R/V)												
Answered Calls (R/V)	413											
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	1140											
N/A												
Outbound Calls	1140											
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	11835											
Abandoned Calls	4806											
Total Answered Incoming, R/V, Outbound Calls	7442											

Provider Relations Dashboard January 2024

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.5%											
Benefits	4.3%											
Claims Inquiry	38.5%											
Change of PCP	3.3%											
Check Tracer	1.1%											
Complaint/Grievance (includes PDR's)	4.4%											
Contracts/Credentialing	1.1%											
Demographic Change	0.0%											
Eligibility - Call from Provider	23.0%											
Exempt Grievance/ G&A	0.6%											
General Inquiry/Non member	0.0%											
Health Education	0.0%											
Intrepreter Services Request	0.5%											
Provider Portal Assistance	3.7%											
Pharmacy	0.1%											
Prop 56	0.2%											
Provider Network Info	0.0%											
Transportation Services	0.2%											
Transferred Call	0.0%											
All Other Calls	13.4%											
TOTAL	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											
Contracting/Credentialing	9											
Drop-ins	27											
JOM's	3											
New Provider Orientation	104											
Quarterly Visits	0											
UM Issues	0											
Total Field Visits	156	0	0	0	0	0	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS						
Practitioners		BH/ABA 1506	AHP 510	PCP 369	SPEC 700	PCP/SPEC 12
AAH/AHS/CHCN Breakdown			AAH 1902	AHS 266	CHCN 564	COMBINATION OF GROUPS 365
Facilities	**412**					

VENDOR SUMMARY Credentialing Verification Organization, Symply CVO						
	Number		**Average Calendar Days in Process**	**Goal - Business Days**	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	117		42	25	Y	Y
Recred Files in Process	70		60	25	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**						Y
Files currently in process	**187**					

CAQH Applications Processed in January 2024	
Standard Providers and Allied Health	**Invoice not received**

January 2024 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	6
SPEC	15
ANCILLARY	7
MIDLEVEL/AHP	6
BH/ABA	75
	109
Recredentialing	
PCP	11
SPEC	17
ANCILLARY	1
MIDLEVEL/AHP	4
	33
TOTAL	**142**

January 2024 Facility Approvals	
Initial Credentialing	**8**
Recredentialing	**6**
	14
Facility Files in Process	**47**

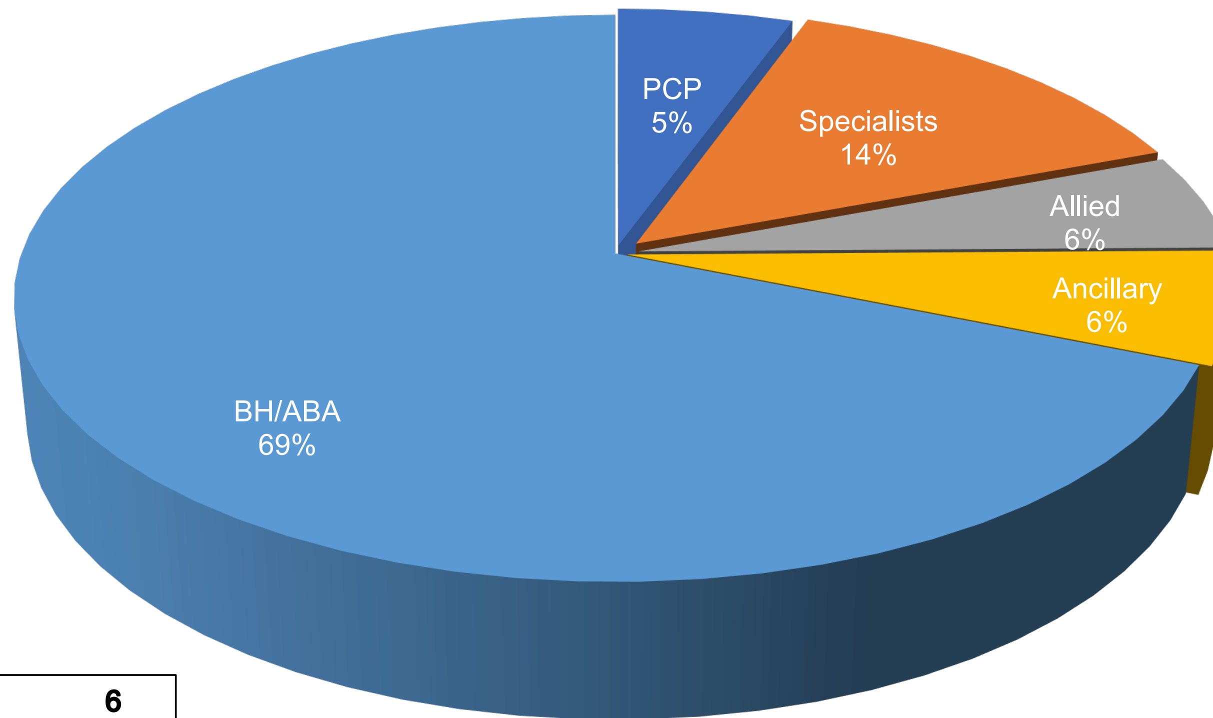
January 2024 Employee Metrics	5		
File Processing	Timely processing within 3 days of receipt		Y
Credentialing Accuracy	<3% error rate		Y
DHCS, DMHC, CMS, NCQA Compliant	98%		Y
MBC Monitoring	Timely processing within 3 days of receipt		Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Allen	Everett	BH-Telehealth	INITIAL	1/16/2024
Amirzadeh	Ali	Specialist	INITIAL	1/16/2024
Anderson	Erik	Specialist	INITIAL	1/16/2024
Araga	Edward Allen	ABA	INITIAL	1/16/2024
Arunachalam	Roselin	BH	INITIAL	1/16/2024
Badduke	Erin	ABA	INITIAL	1/16/2024
Baker	Haley	ABA-Telehealth	INITIAL	1/16/2024
Belcher	Sonni	Allied Health	INITIAL	1/16/2024
Bhat	Joy	Specialist	INITIAL	1/16/2024
Bhat	Jyoti	Primary Care Physician	INITIAL	1/16/2024
Bhat	Kaleyathodi	Specialist	INITIAL	1/16/2024
Brenson	Anna	Ancillary	INITIAL	1/16/2024
Briggs	Vitaline	BH	INITIAL	1/16/2024
Brooks	Sherri	BH	INITIAL	1/16/2024
Burgett	Joshua	BH-Telehealth	INITIAL	1/16/2024
Cabrera	Lizbeth	Allied Health	INITIAL	1/16/2024
Campfield	Suzzie	ABA-Telehealth	INITIAL	1/16/2024
Cao	Tiffany	BH-Telehealth	INITIAL	1/16/2024
Chen	Kyle	BH-Telehealth	INITIAL	1/16/2024
Clark	Jayde	BH-Telehealth	INITIAL	1/16/2024
Cook	Marvin	ABA-Telehealth	INITIAL	1/16/2024
Coutinho	Anastasia	Primary Care Physician	INITIAL	1/16/2024
Curry	Eleanor	BH-Telehealth	INITIAL	1/16/2024
Daniels	Stacy	ABA-Telehealth	INITIAL	1/16/2024
De Vera	Sheryl	ABA	INITIAL	1/16/2024
Desai	Prital	BH-Telehealth	INITIAL	1/16/2024
Donnelly	Elizabeth	Allied Health	INITIAL	1/16/2024
Dunn	Sarah	ABA-Telehealth	INITIAL	1/16/2024
Eastwood	Erin	ABA-Telehealth	INITIAL	1/16/2024
Estrada	Diane	BH-Telehealth	INITIAL	1/16/2024
Farrahi	Farinaz	Specialist	INITIAL	1/16/2024
Fillmore	Melissa	BH-Telehealth	INITIAL	1/16/2024
Fore	David	BH	INITIAL	1/16/2024
Gadson	Charita	Ancillary	INITIAL	1/16/2024
Garay	Brandon	ABA	INITIAL	1/16/2024
Ghanbari	Ramez	BH-Telehealth	INITIAL	1/16/2024
Giri	Aditi	BH-Telehealth	INITIAL	1/16/2024
Green	Domonick	BH-Telehealth	INITIAL	1/16/2024
Gutierrez	Adrian	ABA-Telehealth	INITIAL	1/16/2024
Hernandez	Alma	ABA-Telehealth	INITIAL	1/16/2024
Herring	Andrew	Specialist	INITIAL	1/16/2024
Ho	Joyce	ABA	INITIAL	1/16/2024
James	Molly	Ancillary	INITIAL	1/16/2024
Jewkes	Delaina	BH-Telehealth	INITIAL	1/16/2024
Jimenez	Leila	BH-Telehealth	INITIAL	1/16/2024
Johnson	Robert	ABA-Telehealth	INITIAL	1/16/2024
Junaid	Imran	Specialist	INITIAL	1/16/2024
Kaur	Jasmine	BH-Telehealth	INITIAL	1/16/2024
Kayman	Joshua	BH	INITIAL	1/16/2024
Kearney	Jennifer	BH-Telehealth	INITIAL	1/16/2024
Khor	Fenny	ABA	INITIAL	1/16/2024
Killam	Elissa	Ancillary	INITIAL	1/16/2024
Kirk	Nick	BH-Telehealth	INITIAL	1/16/2024
Kirsch	Nicole	BH	INITIAL	1/16/2024
Kluczinske	Michelle	BH	INITIAL	1/16/2024
Kram	Jerrold	Specialist	INITIAL	1/16/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Krupa	Kasha	BH-Telehealth	INITIAL	1/16/2024
Lee	Mayre	BH-Telehealth	INITIAL	1/16/2024
Lemas	Bryan	BH-Telehealth	INITIAL	1/16/2024
Lind	Karen	Specialist	INITIAL	1/16/2024
Lu	Joyce	Specialist	INITIAL	1/16/2024
Luu	Peter	ABA-Telehealth	INITIAL	1/16/2024
Macatangay	Ashley	ABA-Telehealth	INITIAL	1/16/2024
Macdannald	Harry	Specialist	INITIAL	1/16/2024
Madan	Pavan	BH-Telehealth	INITIAL	1/16/2024
Magavi	Leela	BH-Telehealth	INITIAL	1/16/2024
Mahajan	Rajendra	Primary Care Physician	INITIAL	1/16/2024
Martinez-Salazar	Bianca	BH	INITIAL	1/16/2024
Massion	Ann	BH-Telehealth	INITIAL	1/16/2024
Mathur	Saloni	Specialist	INITIAL	1/16/2024
Matiee	Aesha	ABA	INITIAL	1/16/2024
Mellor-Crummey	Lauren	Primary Care Physician	INITIAL	1/16/2024
Mendelsohn Troy	Kristin	ABA	INITIAL	1/16/2024
Meschede	Kimberly	Ancillary	INITIAL	1/16/2024
Montelongo	Maryam	ABA-Telehealth	INITIAL	1/16/2024
Muoneke	Maureen	Specialist	INITIAL	1/16/2024
Nazar	Lina	Allied Health	INITIAL	1/16/2024
Nickel	Emily	ABA	INITIAL	1/16/2024
Palmer	Mary	Ancillary	INITIAL	1/16/2024
Patel	Savan	ABA	INITIAL	1/16/2024
Patel	Vishal	BH-Telehealth	INITIAL	1/16/2024
Pavon	Jessica	ABA	INITIAL	1/16/2024
Pearce	Beata	BH-Telehealth	INITIAL	1/16/2024
Porter	Jonathon	BH-Telehealth	INITIAL	1/16/2024
Proctor	Vernon	BH-Telehealth	INITIAL	1/16/2024
Provencio	Maria	ABA	INITIAL	1/16/2024
Ramanujam	Abhijit	BH-Telehealth	INITIAL	1/16/2024
Ramos	Nolvia	ABA-Telehealth	INITIAL	1/16/2024
Ranade	Rajdeep	BH-Telehealth	INITIAL	1/16/2024
Romero	Danae	BH	INITIAL	1/16/2024
Sanni	Nikia	ABA	INITIAL	1/16/2024
Shaffer	Shannon	BH-Telehealth	INITIAL	1/16/2024
Shuara	Saoda	BH-Telehealth	INITIAL	1/16/2024
Siddiqui	Reema	ABA	INITIAL	1/16/2024
Stenson	Jon	BH-Telehealth	INITIAL	1/16/2024
Sundberg	Jeffrey	BH	INITIAL	1/16/2024
Tangsombatvisit	Stephanie	BH	INITIAL	1/16/2024
Thorburn	Laura	Ancillary	INITIAL	1/16/2024
Tran	Quang	ABA-Telehealth	INITIAL	1/16/2024
Vora	Ankita	BH-Telehealth	INITIAL	1/16/2024
Wa	Christianne	Specialist	INITIAL	1/16/2024
Wadhwa	Sanya	Specialist	INITIAL	1/16/2024
Wang	Shirley	Primary Care Physician	INITIAL	1/16/2024
Ward	Stephanie	BH-Telehealth	INITIAL	1/16/2024
Woods	Lewis	Primary Care Physician	INITIAL	1/16/2024
Ye	Dianna	ABA	INITIAL	1/16/2024
Young	Kylie	ABA-Telehealth	INITIAL	1/16/2024
Youssef	Rowan	Allied Health	INITIAL	1/16/2024
Zhang	Yifan	Allied Health	INITIAL	1/16/2024
Agbowo	Josephine	Primary Care Physician	RE-CRED	1/16/2024
Barbant	Sophie	Specialist	RE-CRED	1/16/2024
Chandler	Kalaokalani	Specialist	RE-CRED	1/16/2024
Chang	Rona	Ancillary	RE-CRED	1/16/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Clark	Leon	Specialist	RE-CRED	1/16/2024
Dacanay	Leonardo	Specialist	RE-CRED	1/16/2024
D'Harlingue	Katherine	Primary Care Physician	RE-CRED	1/16/2024
Dhawan	Sunil	Specialist	RE-CRED	1/16/2024
Duffy	Jennifer	Specialist	RE-CRED	1/16/2024
Gingery	Robert	Specialist	RE-CRED	1/16/2024
Goldberg	Roger	Specialist	RE-CRED	1/16/2024
Gonzalez	Tara	Primary Care Physician	RE-CRED	1/16/2024
Gwalani	Jaimish	Specialist	RE-CRED	1/16/2024
Jain	Sanjeev	Specialist	RE-CRED	1/16/2024
Kalra	Sumita	Primary Care Physician	RE-CRED	1/16/2024
Lee	Elaine	Specialist	RE-CRED	1/16/2024
Lee	George	Primary Care Physician	RE-CRED	1/16/2024
Liu	Abby	Specialist	RE-CRED	1/16/2024
Loo	Evelyn	Primary Care Physician	RE-CRED	1/16/2024
Martella	Andrew	Specialist	RE-CRED	1/16/2024
Nelson	Nicholas	Primary Care Physician	RE-CRED	1/16/2024
Obeid	Sara	Primary Care Physician	RE-CRED	1/16/2024
Omoregie	Egbebalakhame	Allied Health	RE-CRED	1/16/2024
Ong	Paula	Allied Health	RE-CRED	1/16/2024
Pandya	Chirag	Specialist	RE-CRED	1/16/2024
Peterson	Ralph	Specialist	RE-CRED	1/16/2024
Sawhney	Vinod	Specialist	RE-CRED	1/16/2024
Simms-Mackey	Pamela	Primary Care Physician	RE-CRED	1/16/2024
Tsang	Jennifer	Allied Health	RE-CRED	1/16/2024
Umeh	Christiana	Allied Health	RE-CRED	1/16/2024
Vincent	Deepa	Specialist	RE-CRED	1/16/2024
Wang	Xingyue	Primary Care Physician	RE-CRED	1/16/2024
Woods	Lewis	Primary Care Physician	RE-CRED	1/16/2024

JANUARY PEER REVIEW AND CREDENTIALING
INITIAL APPROALS BY SPECIALTY



PCP	6
SPECIALISTS	15
ALLIED	6
ANCILLARY	7
BH/ABA	75
TOTAL	109

Provider Dispute Resolution
December 2023 and January 2024

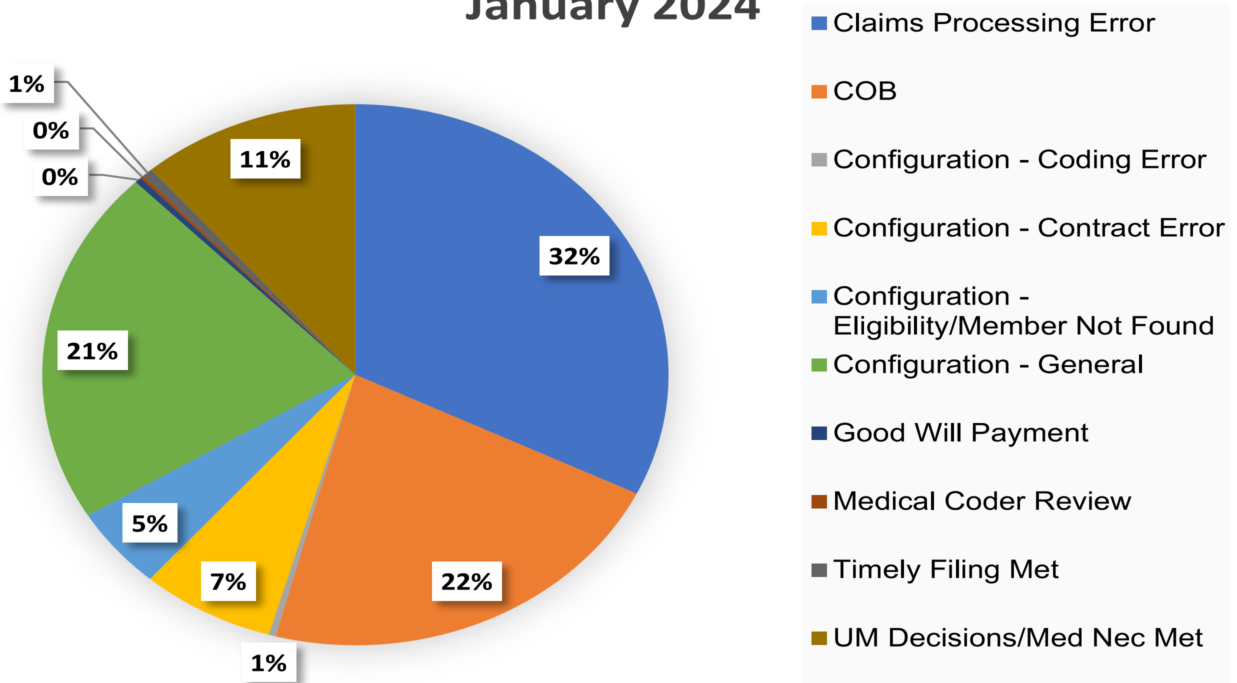
METRICS

PDR Compliance	Dec-23	Jan-24
# of PDRs Resolved	1,040	1,461
# Resolved Within 45 Working Days	1,040	1,455
% of PDRs Resolved Within 45 Working Days	100.0%	99.5%
PDRs Received	**Dec-23**	**Jan-24**
# of PDRs Received	1,642	2,172
PDR Volume Total	**1,642**	**2,172**
PDRs Resolved	**Dec-23**	**Jan-24**
# of PDRs Upheld	709	912
% of PDRs Upheld	68%	62%
# of PDRs Overturned	331	549
% of PDRs Overturned	32%	38%
Total # of PDRs Resolved	**1,040**	**1,461**
Average Turnaround Time	**Dec-23**	**Jan-24**
Average # of Days to Resolve PDRs	41	42
Oldest Resolved PDR in Days	45	77
Unresolved PDR Age	**Dec-23**	**Jan-24**
0-45 Working Days	2,491	2,695
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**2,491**	**2,695**

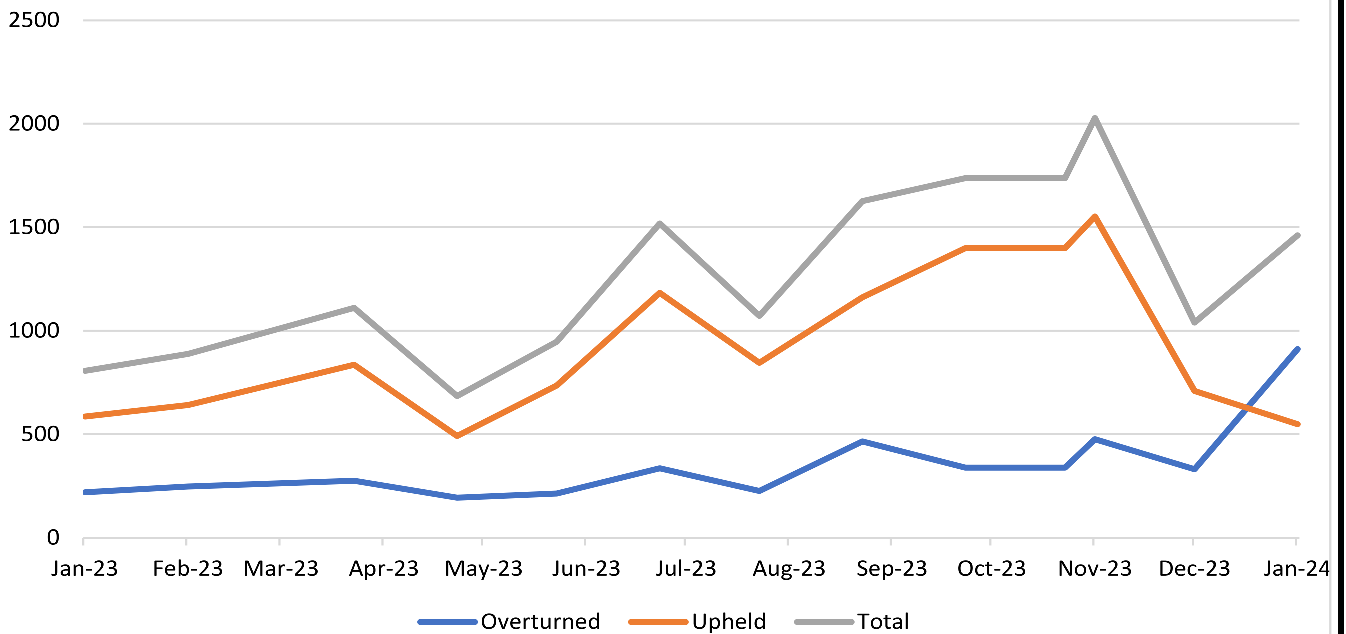
Provider Dispute Resolution
December 2023 and January 2024

Jan-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 - 1,461 in January 2024 vs 806 in January 2023	N/A	N/A
# of PDRs Received - 2,172 in January 2024 vs 979 in January 2023	N/A	N/A
# of PDRs Resolved within 45 working days - 1,455 in January 2024 vs 804 in January 2023	N/A	N/A
% of PDRs Resolved within 45 working days - 99.5% in January 2024 vs 99.8% in January 2023	95%	95%
Average # of Days to Resolve PDRs - 42 days in January 2024 vs 30 days in January 2023	N/A	30
Oldest Resolved PDR in Days - 77 days in January 2024 vs 44 days January 2023	N/A	N/A
# of PDRs Upheld - 912 in January 2024 vs 586 in January 2023	N/A	N/A
% of PDRs Upheld - 62% in January 2024 vs 73% in January 2023	N/A	> 75%
# of PDRs Overturned - 549 in January 2024 vs 220 in January 2023	N/A	N/A

Provider Dispute Resolution Year Over Year Summary		
% of PDRs Overturned - 38% in January 2024 vs 27% in January 2023	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 32% (2024) vs 35% (2023) Configuration errors - 34% (2024) vs 38% (2023) COB -22% (2024) vs 8% (2023) Clinical Review/UM Decisions/Medical Necessity Met - 11% (2024) vs 6% (2023)	N/A	N/A

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 **January 1, 2024**, and **January 31, 2024**:

1. Alliance Website:
   - Received **16,000** unique visits
   - Received **14,000** 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 **628 to 629**
   - Did not receive any reviews in **January 2024**
3. Glassdoor Page:
   - **3** out of a **5-star** overall rating
   - Received 1 review in **January 2024**
4. Instagram Page:
   - Page debuted **June 10, 2021**
   - Slight increase in followers from **483** to **487**
5. Twitter Page:
   - Slight decrease in followers from **357 to 356**
6. LinkedIn Page:
   - Increased followers from **4.7k to 4.9k**
   - Received **209-**page clicks
7. Yelp Page:
   - Page visits **94**
   - Appeared in Yelp searches **142** times
   - Received **2** reviews in **January 2024**
8. Google Page:
   - **3,792** website clicks made from the business profile
   - **2,200** calls made from the business profile
   - Received **1** review in **January 2024**

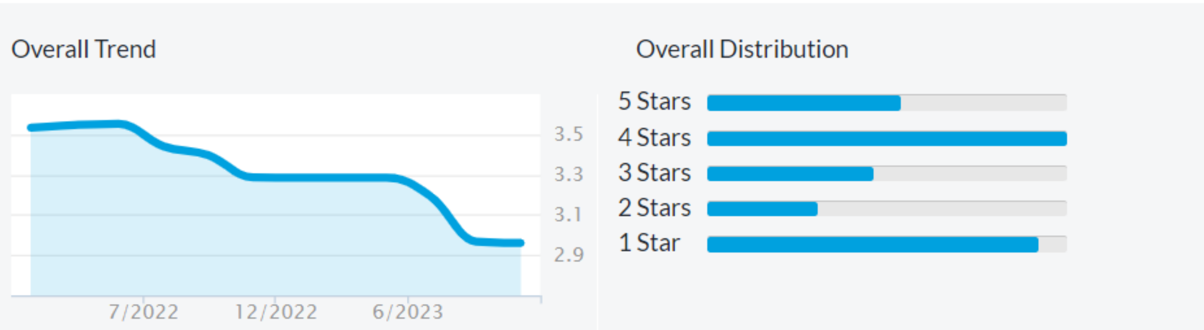
GLASSDOOR OVERVIEW

Alameda Alliance for Health Ratings and Trends

About Glassdoor ratings

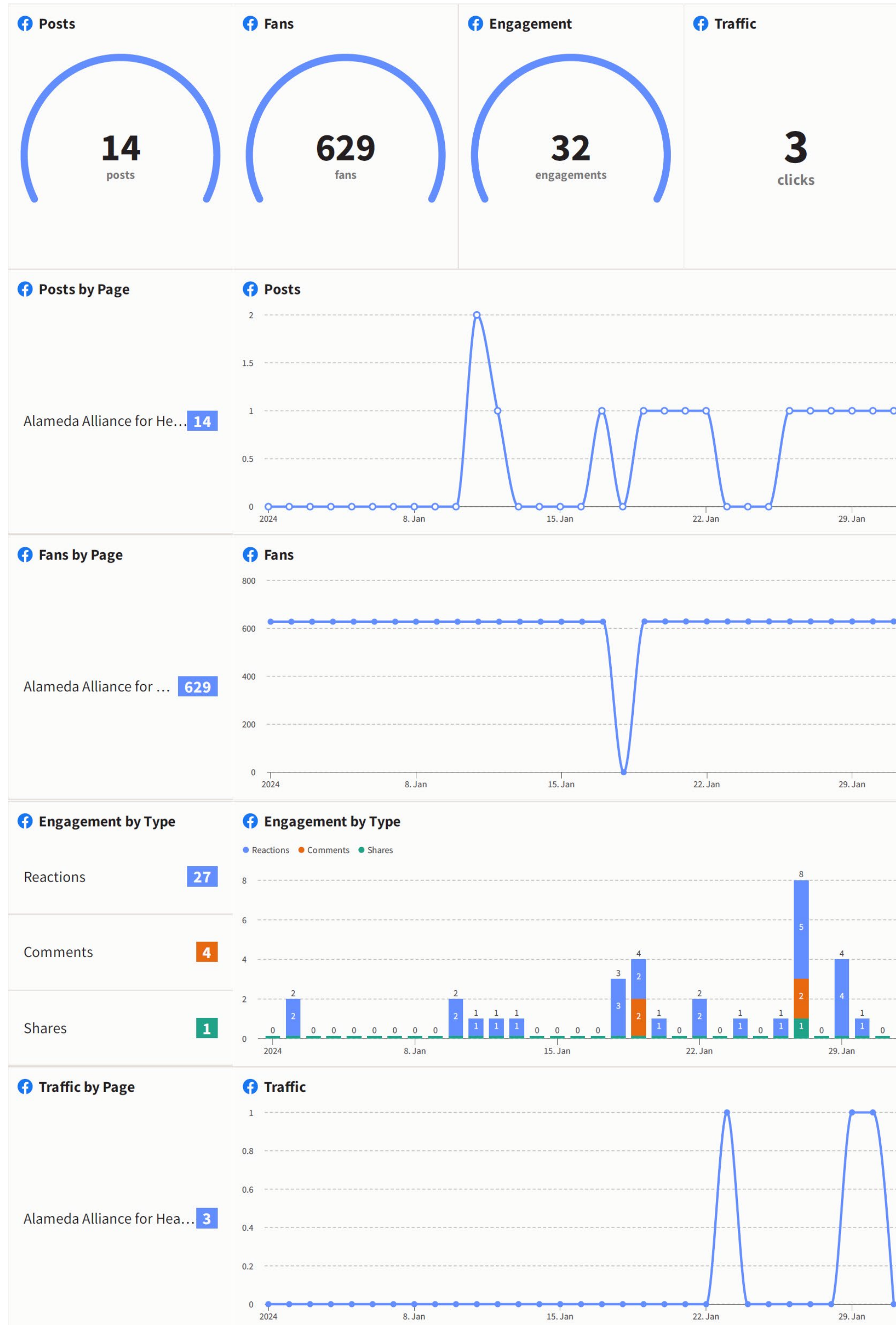
Ratings may vary depending on what filters are applied, but ratings include reviews in all languages. Learn More

Category	Rating
Overall	3
Culture & Values	2.9
Diversity & Inclusion	3.5
Work/Life Balance	3.1
Senior Management	2.5
Compensation and Benefits	3.8
Career Opportunities	2.8



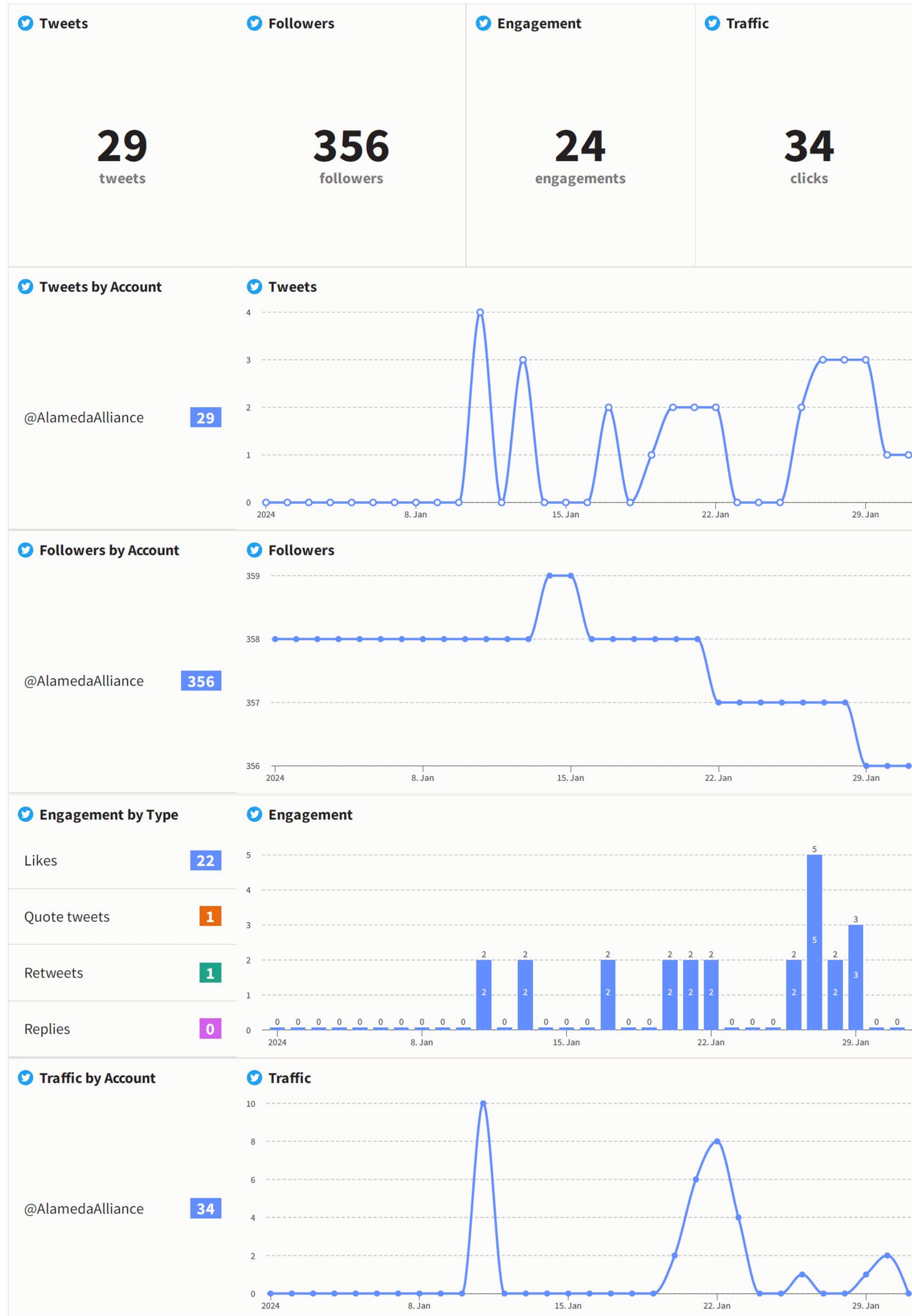
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\1. January 2024

FACEBOOK OVERVIEW



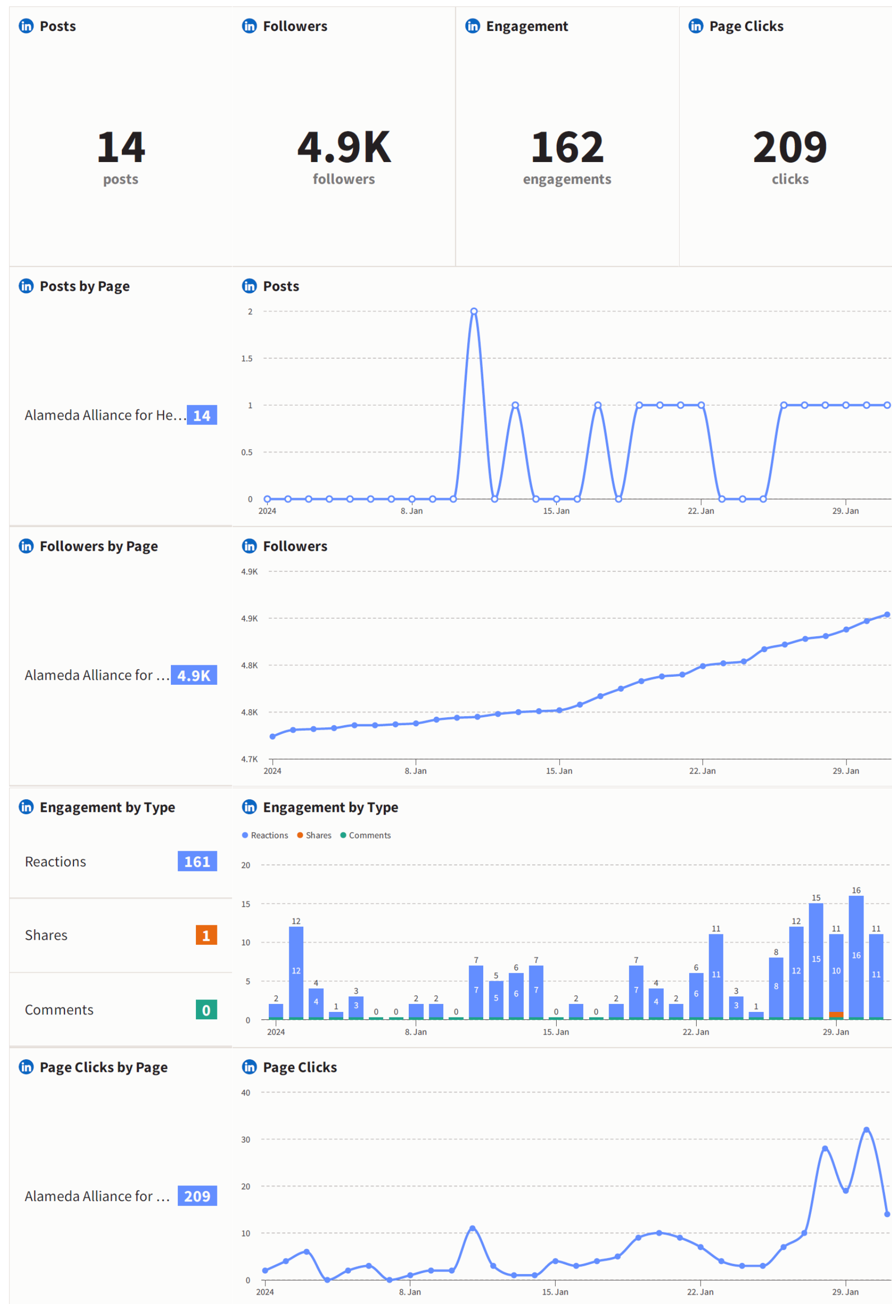
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\1. January 2024

TWITTER OVERVIEW



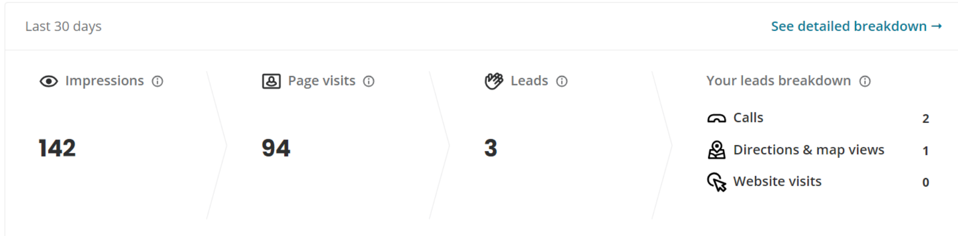
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\1. January 2024

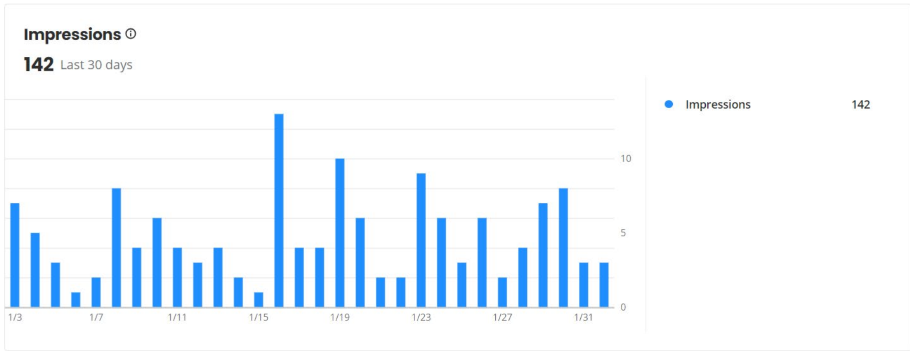
LINKEDIN OVERVIEW

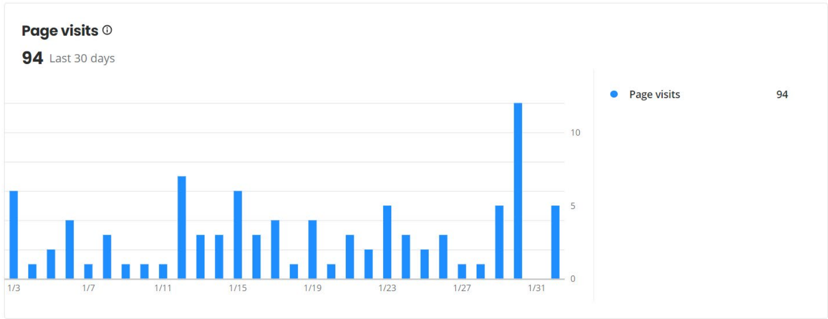


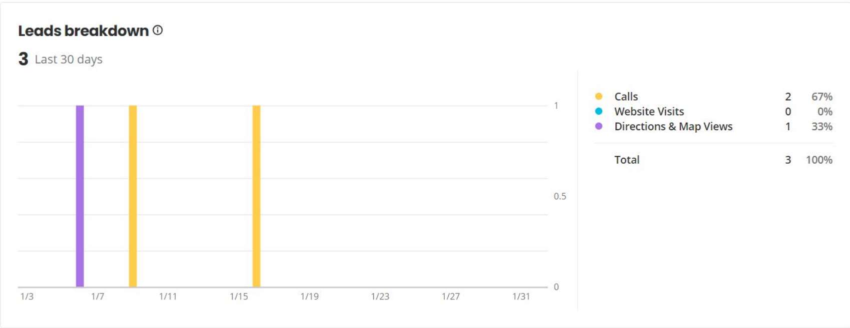
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\1. January 2024

YELP OVERVIEW



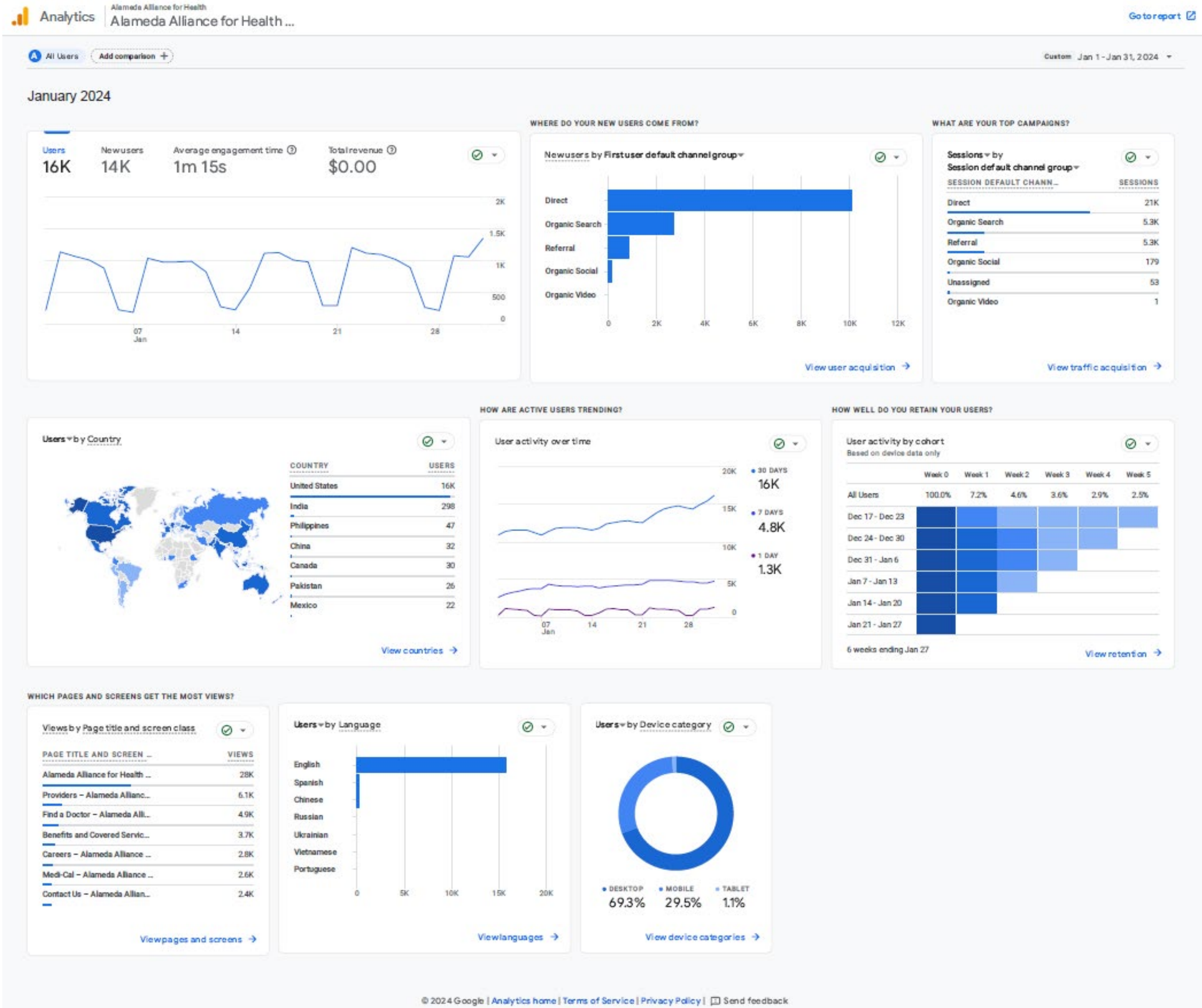






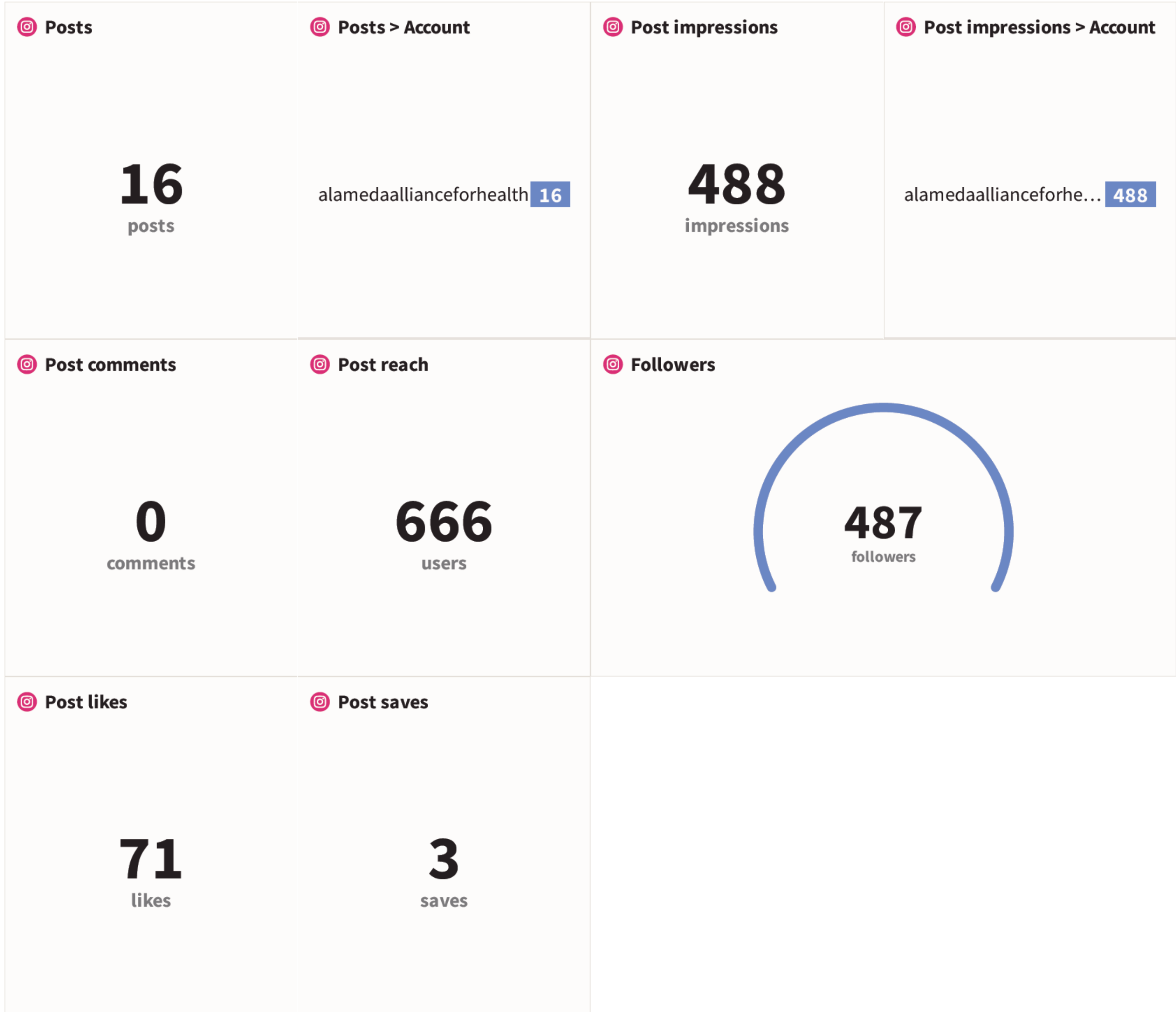
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\1. January 2024

ALLIANCE WEBSITE OVERVIEW:



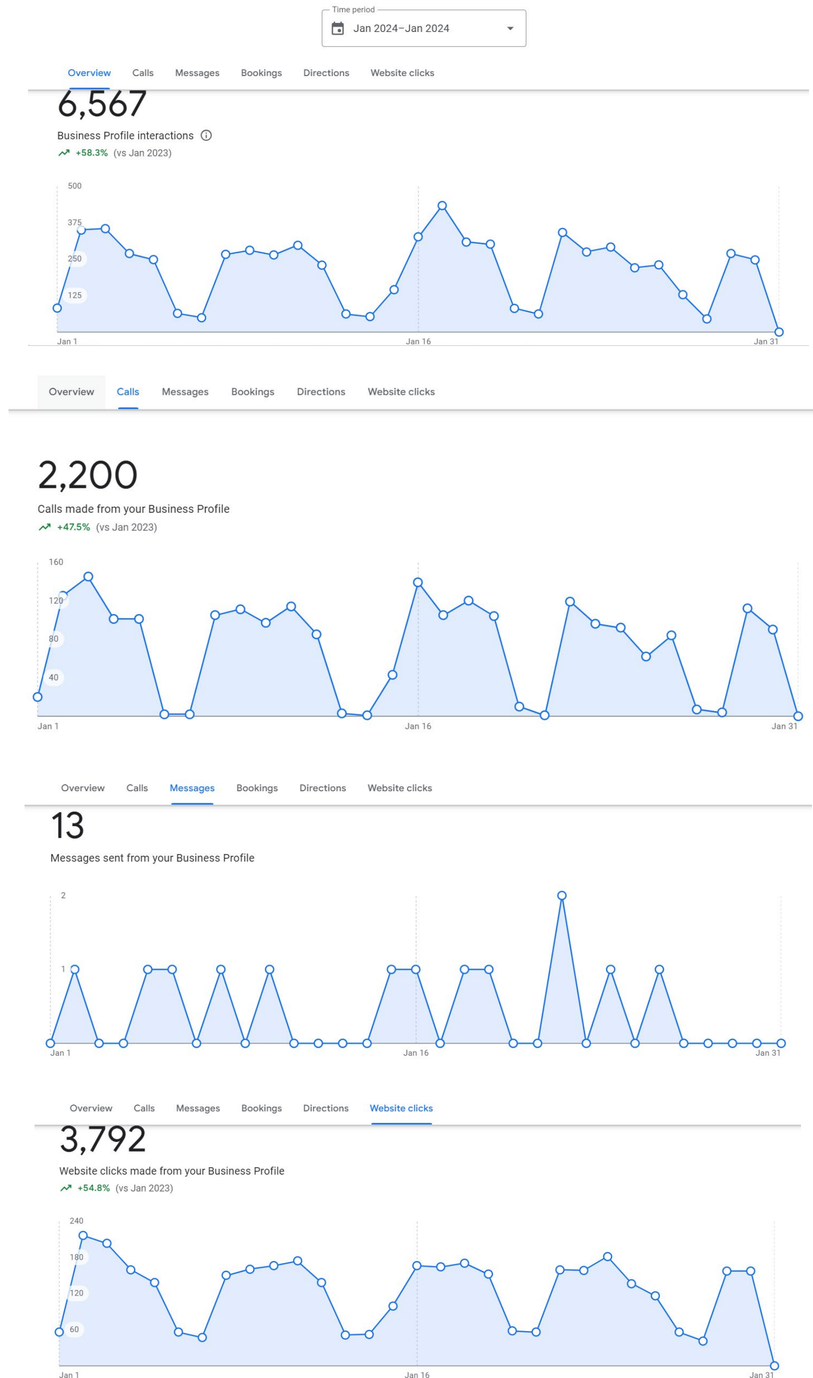
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\1. January 2024

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\1. January 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\1. January 2024

Integrated Planning

Ruth Watson

To: Alameda Alliance for Health Board of Governors

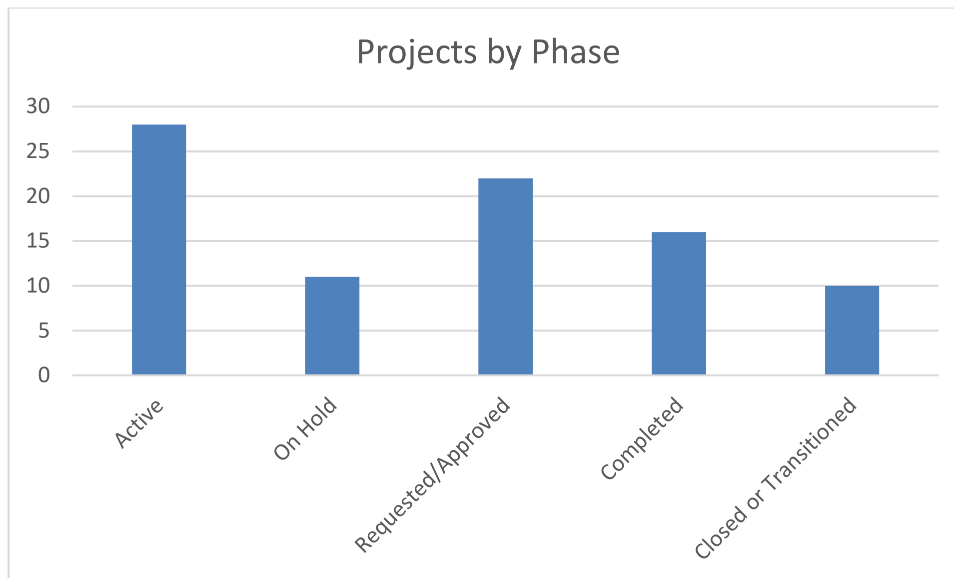
From: Ruth Watson, Chief Operating Officer

Date: February 9th, 2024

Subject: Integrated Planning Division Report – January 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

CalAIM Initiatives

- Enhanced Care Management and Community Supports
    - Enhanced Care Management (ECM)
        - January 2024 ECM Populations of Focus (PoF)
            - Individuals Transitioning from Incarceration
                - ECM MOC Addendum III template was submitted to DHCS on October 12th, 2023

            - Updated Provider Capacity file submitted to DHCS on November 16th
            - AAH is still awaiting approval for this MOC
        - Birth Equity – Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes
            - ECM MOC Addendum template was approved by DHCS on October 20th, 2023
            - Updated Provider Capacity document was approved by DHCS on November 15th, 2023
        - AAH has contracted with additional providers to support these new PoFs
    - 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
        - A follow-up meeting with HCSA was held on January 19th to continue the discussion of data sharing requirements for JI, specifically regarding data from the county's Social Health Information Exchange (SHIE) system
            - 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 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 1st, we have not heard any updates on when this workgroup will initiate

    - JI ECM January 2024 Population of Focus
        - Justice-Involved 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
        - This project is set to close out in March 2024, but JI efforts will continue with regard to re-entry and supporting the expansion of ECM

    - 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
            - Monthly check-ins with Roots will continue into 2024

- Long Term Care (LTC) Carve-In – AAH became responsible for all members residing in LTC facilities as of January 1st, 2023, with the exception of Pediatric and Adult Subacute Facilities and Intermediate Care Facilities-Developmentally Disabled (ICF-DD), which go live January 1st, 2024
    - The following activities took place in January in preparation for this transition:
        - Development work and testing in preparation to load existing authorizations in AAH's Medical Management platform utilizing the data provided by the state
        - Completed staff training on ICF/DD population and internal processes

        - LTSS Liaison continued outreach efforts to connect with ICF/DD homes to establish rapport and answer questions in preparation for the transition
        - Monthly meeting with Regional Center of East Bay to address any provider or Member questions or concerns regarding the transition
        - Contracting and Credentialing efforts continued to onboard providers
        - Finalizing work to load provider contracts into AAH systems in preparation for the transition
        - First Post Transition Monitoring report was submitted to DHCS on 1/17/2024

- 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) and Depression member letters approved by DHCS; goal is to mail to members in February
    - 2023 DHCS PHM Strategy Deliverable
        - Held initial 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
    - DHCS announced it will pause implementation of the certification process based on stakeholder input
    - Developed a strategy to create infrastructure development, including:
        - Developing a funding proposal to boost provider engagement; workgroup plans to present recommendations to Executive Director, Operations
            - IPP funding is specifically for CHWs who work with ECM/CS populations
        - Finalizing workflows, advanced entity interest forms, and reducing potential bottlenecks for CHW operations

          - Awaiting PHM risk stratification gaps in identifying target populations to link CHW services
            - A PHM workgroup was formed 01/23/2024 to target these inquires
              - Exploring the following inquiries with PHM:
                - Application of risk stratification to identify member health disparities for CHW services
                - Pathways to gather member-level data for contracted providers
                - Plans to integrate use of CHW into overall Population Health Strategy
          - Working with Provider Services department to develop communication strategy and documents
          - Developed data collection and quality strategy
          - CHW Workgroup is partnering with the Claims Department to create a new process to pend incorrect claims with misuse of U1 identifier
        - CHW network building continued with potential CHW partners:
          - Youth Alive
          - Family Resource Navigators
          - Inspiring Communities
          - First 5
          - Dr. De La Cruz (Pediatrics)
          - Pear Suite
          - Pair Team (moving into contracting with AAH)
          - Journey Health (under contract)
- 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 by AAH is required by February 6th, 2024, on whether to continue use of the existing Claims (HEALTHsuite) and Medical Management (TruCare) platforms or if new Claims and / or Medical Management systems are needed to support the addition of the D-SNP line of business
  - Development of the project schedule and project status reporting continues

<u>Other Initiatives</u>

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 – 223
      - In Review – 3
      - Additional Information Requests (AIR) – 0
      - On Hold – 0

- MCP Member Transition
  - Anthem Member Transition – Medi-Cal members previously assigned to Anthem transitioned to AAH effective January 1st, 2024
    - PCP Assignment to previous PCP was completed in January
  - IT development for the batch loading of prior authorizations from Anthem completed on January 12th and the previous authorizations from Anthem were pushed to production on February 1st, 2024
    - QA and UAT Testing was conducted in the last two (2) weeks of January
  - IT teams developed the ability to flag all members who were part of the Anthem member transition as well as those that are part of the DHCS-defined Special Populations to support Continuity of Care (CoC) requirements
    - Flags were visible in all systems as of January 11th
  - 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
  - DHCS Bi-weekly monitoring and oversight reporting began on November 22nd
    - Reports have been submitted bi-weekly and will continue through February 2024; reporting will then be monthly for March and quarterly through the end of 2024
    - Next report will be due on February 14th
  - DHCS sent AAH five (5) requests for information to clarify data on the Monitoring and Oversight reporting for the period of 1/1-1/14/2024)
    - All responses were submitted to DHCS by the due dates and AAH is awaiting further feedback
  - 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 January report was completed on January 10th
    - Next report will be due on February 9th
- 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 January 31st, 2024, to March 1st, 2024
- 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
  - First submission to DHCS sent on December 29th, 2023
  - Next submission is due February 15th, 2024

Adult Expansion - Effective January 1st, 2024, DHCS is expanding eligibility for full scope Medi-Cal to individuals who are 26 through 49 years of age and who do not have satisfactory immigration status (SIS) as required by Welfare and Institutions Code section 14011.2, if otherwise eligible. This new coverage is referred to as the Age 26-49 Adult Expansion

- Continued to prepare AAH's systems to ingest the TAR data from the state and create authorizations via a batch authorization process
- PCP assignments to prior PCP was completed in January
- First Post Transition Monitoring report was submitted to DHCS on 1/17/2024

Recruiting and Staffing

Integrated Planning Open position(s):

- All budgeted positions are currently filled
- Recruitment for new positions effective February 2024 are pending

Integrated Planning

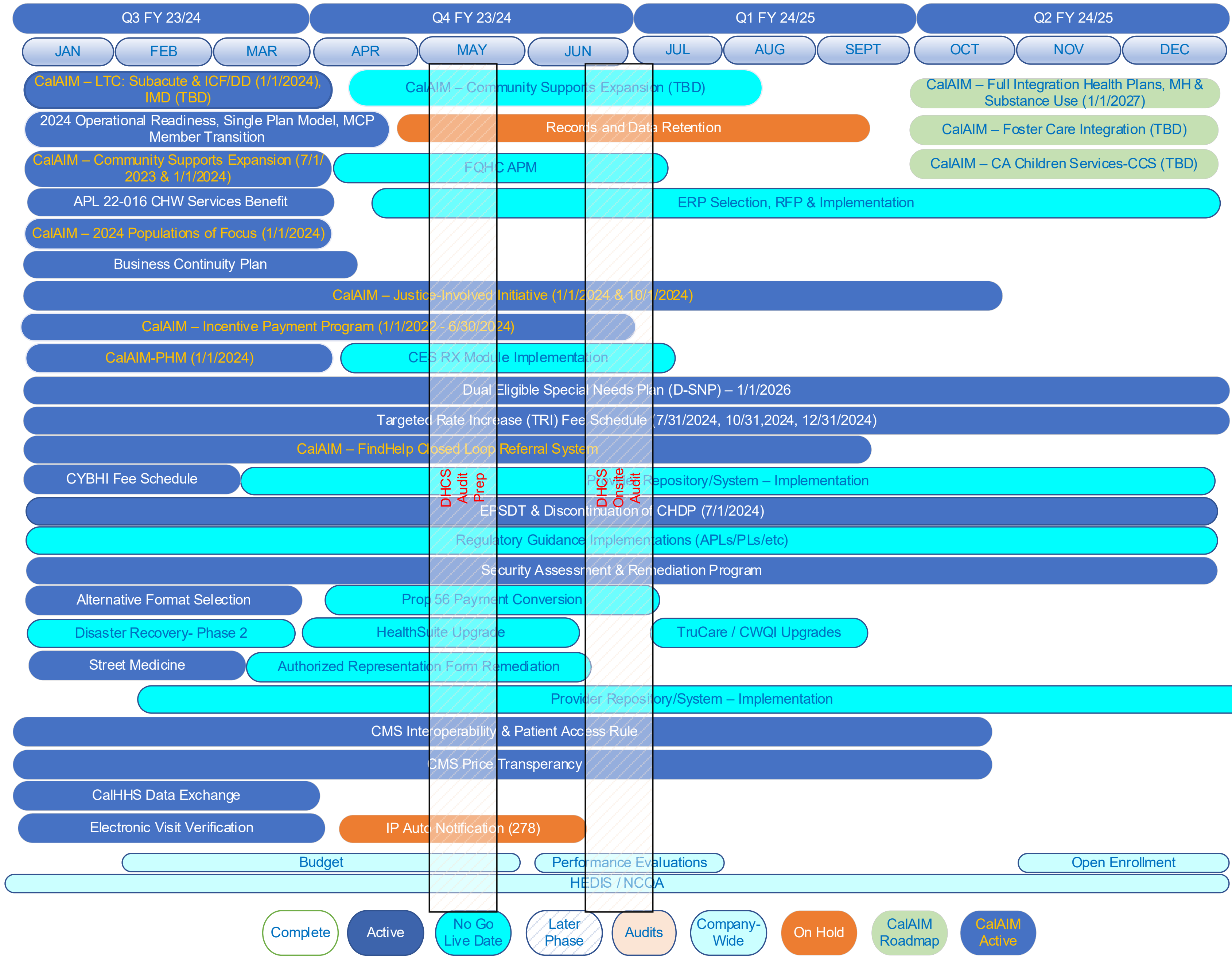
Supporting Documents

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
- Adult Expansion – Senate Bill (SB) 184 (Chapter 47, Statutes of 2022) amended Welfare and Institutions Code section 14007.8 to expand eligibility for full scope Medi-Cal to individuals who are 26 through 49 years of age and who do not have satisfactory immigration status (SIS) as required by Welfare and Institutions Code section 14011.2, if otherwise eligible. This new coverage is referred to as the Age 26-49 Adult Expansion and is effective January 1st, 2024



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 Transparency
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: February 9th, 2024

Subject: Incentives & Reporting Board Report – January 2024 Activities

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
        - DHCS was expected to release funding at the end of December but has yet to do so
    - 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
- Planning for Wave 4 of the IPP Provider Application is underway

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, comprised of Alameda County Office of Education (ACOE), Alameda County Center for Healthy Schools and Communities (CHSC), Alameda Alliance, and Anthem continued to meet to provide strategic program direction to the program
- The Alliance continued to host SBHIP Learning Exchanges; participants include LEAs and Steering Group Partners, with a focus on program updates, LEA project plan sharing, and the current school-based behavioral landscape
- The Center for Healthy Schools and Communities is supporting 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
- To date, $6.3M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $5.4M 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
- To-date, $20.4M has been awarded to the Alliance by DHCS and a total of $17.5M 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 January 31st, $12.7M 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

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

Recruiting and Staffing

Incentives & Reporting Open position(s):

- There are no open positions at this time

Incentives & Reporting

Supporting Documents

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 goals

Compliance

Richard Golfin III

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

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

Date: **February 9th, 2024**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2023 DHCS Routine Medical Survey:
  - The onsite virtual interview took place from April 17th, 2023, through April 28th, 2023. An exit interview took place on September 26th, 2023. There were 15 findings and 4 identified repeat findings. On October 20th, 2023, the Plan received the final report from the DHCS. The Plan submitted its Corrective Action Plan to the Department on November 22nd, 2023. Since November 2023, internal meetings have been held with internal stakeholders to review CAP plans and implementation efforts to eliminate repeat findings and lower the number of overall deficiencies year-over-year. The DHCS is requesting a monthly update of the CAP progress. The December update was submitted on December 20th, 2023. The next CAP update is due to DHCS on January 18th, 2024. As of January 18th , 2023, the DHCS has accepted the response for 4 out of the 15 findings. The Plan is expecting the DHCS response to the January update.

- 2022 DHCS Routine Medical Survey:
  - The 2022 DHCS Routine Medical Survey was held on April 4th, 2022, and completed April 13th, 2022. On September 13th, 2022, the Plan received the Final Audit Report which detailed 15 findings, 9 of which were repeat findings from the previous audit year. On November 3rd, 2023, the Plan received the closing letter from DHCS; DHCS has identified that 4 of 15 findings were repeat findings on the subsequent 2023 Medical Audit; DHCS will assess remediation for the 4 repeat findings in the 2023 Corrective Action Plan (CAP) outlined in the summary above. DHCS accepts and will provisionally close the 2022 CAP with findings 3.8.1, 4.1.1, 4.1.2 and 4.1.3 still needing remediation.

- 2022 DMHC Risk Bearing Organization (RBO) Audits:
  - In 2022, the DMHC examined the claims settlement practices and the provider dispute resolution mechanism of Children First Medical Group, Inc. (CFMG) and Community Health Center Network, Inc. (CHCN). The Plan's oversight of these RBOs includes quarterly audits of claims settlement practices beginning with Q1 2023 dates of service. Case files for both CHCN and CFMG have been reviewed. There are 2 final findings identified in the CHCN review and 4 final

findings in the CFMG review. The Plan issued a corrective action plan to CFMG and CHCN. The Plan is reviewing CAP responses for the Q1 RBO.

- The Plan has requested documents to begin the audits for both the 2nd and 3rd Quarter 2023 dates of service claims for both CFMG and CHCN.2022 DMHC Behavioral Health Investigation:
  The Plan has received audit results for the 2022 DMHC Behavioral Health Investigation. 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 UM and Quality Assurance. The Department also found the Plan to have unaddressed barriers to care in Rx, Cultural Competency, Health Equity and Enrollee Experience. The Plan submitted the correction action plan on February 4th, 2024.

Compliance Activity Updates

- 2024 RFP Contract Update:
  - On November 6th, 2023, the State distributed the Plan's final 2024 Primary and Secondary Contracts for the Single Plan Model, commencing on January 1st, 2024. The Contract was submitted to the State on December 12th, 2023.

- DMHC Material Modification- 2024 RFP Readiness Submission:
  - Policies that were revised or developed for Operational Readiness and financial projections that demonstrate how the increase in membership will affect the Alliance from a financial perspective were submitted to the DMHC.
  - The DMHC provided comments on January 9th, 2024, to which the Alliance must respond by February 8th, 2024. There were no comments related to the financial Exhibits, so the Compliance team anticipates that DMHC may issue additional comments related to financial projections in the next round of comments.

- 2023 Annual Corporate Compliance
  - Annual Corporate Compliance Training was assigned on September 11th, 2023. Staff will have ninety (90) days to complete assigned training, by December 11th, 2023. Currently, 99% of all staff have completed the training. The Annual Training includes:
    - Health Insurance Portability and Accountability Act (HIPAA)
    - Fraud, Waste, and Abuse
    - Cultural Competence and Sensitivity Training

- DHCS 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. The Plan awaits further instruction from DHCS on the Phase two reporting requirements.

- 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 to the Department's satisfaction of eight Undertakings. The Plan completed the comment table and submitted it on January 30th, 2024 we are awaiting a response from DMHC.

Outstanding Undertakings Chart:

Undertaking #	Deliverable	Initial Due Date	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.	By July 12th, 2023	Received extensive comments to which the Plan has responded on January 30th,2024

Compliance

Supporting Documents

COMPLIANCE DASHBOARD SUMMARY										
	Resource	Type	2018	2019	2020	2021	2022	2023	TOTAL	% Completed
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	5	5	
		Total Completed	50	28	7	35	15	12	147	**97%**
		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	5	6	
		Completed	38	33	12	39	26	10	158	**96%**
		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	6	3%
	Total Completed	177	97%
	Total Findings	**183**	
STATE AUDIT FINDINGS	In Progress	6	4%
	Completed	158	96%
	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	5	29%
	Total Completed	12	71%
	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**	

Compliance Internal Audit Validations*	
State Audit Findings	65
Self-Identified	15
Total	80
% (total validated/total completed)	**45%**

* as a result of state Findings

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							**INTERNAL AUDITS**		
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	**Department Responsible**	**State/Self Identified**	**Agency**	**Year**
1	UM	(1.5.1) Notice of Action (NOA) Letters The Plan did not ensure a delegate sent NOA letters to providers and members.	The Plan received 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)	In Progress	Closed 9/25/2023 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) 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 2/28/2024 3/30/2024 Initiated 3/30/2024 12/31/2023	Quality	State	DHCS	2023

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2023 DHCS Audit - *Audit Review Period 4/1/2022 - 3/31/2023* *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	**Department Responsible**	**State/Self Identified**	**Agency**	**Year**
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)	In Progress	11/30/2023 11/30/2023 11/30/2023 11/30/2023 12/29/2023	Claims	State	DHCS	2023

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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							**INTERNAL AUDITS**		
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	**Department Responsible**	**State/Self Identified**	**Agency**	**Year**
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)	In Progress	3/21/2023 12/1/2023	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

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2023 DHCS Audit - *Audit Review Period 4/1/2022 - 3/31/2023* *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	**Department Responsible**	**State/Self Identified**	**Agency**	**Year**
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

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2022 DMHC Behavioral Health Investigation *- Audit Review Period 4/1/2020 - 4/30/2022*
Audit Onsite Dates - September 7, 2022 - September 8, 2022

#	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	UM	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

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2022 DMHC RBO Audit: CHCN - *Audit Review Period* 1/1/2022 - 3/31/2022

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	INTERNAL AUDITS 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

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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

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2022 DMHC FINANCIAL SERVICES : *Audit Review Period 1/1/2022 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Provider Dispute Resolutions	The Department's examination disclosed that the Plan failed to timely acknowledge receipt of 12 out of 71 provider disputes reviewed.	1. Policies and procedures, including internal claims audit procedures, implemented to ensure provider disputes are acknowledged timely. Update 2/13/2023: Policy updated and will be approved at Committee 3/25/2023 2. Staff training completed January 2023 and created a audit workflow effective 01/01/2023. 3. Claims Operations Support Manager and PDR Supervisor. PDR Supervisor will monitor all incoming PDR mail. A daily audit will be conducted before the 15th due date to assure all cases are acknowledged timely.	2/24/2023	Completed	Claims		State	DMHC	2022
2	Claims	The Department's examination disclosed that, due to systemic issues, claims were not reimbursed accurately, including interest and penalties.	CORRECTIVE ACTION TAKEN DURING EXAMINATION The Plan submitted evidence on October 28, 2022, that the Plan reprocessed and paid claims previously paid incorrectly. This correction and remediation resulted in the additional payment of $5,742.29, plus interest of $7,675.43, on 742 claims. In addition, the Plan submitted evidence on October 28, 2022, that the Plan reprocessed and paid claims previously denied incorrectly. This correction and remediation resulted in the additional payment of $64,718.77, plus interest of $6,002.98, on 750 claims. The Plan corrected the deficiencies noted above and completed the required remediation during the course of the examination; therefore, no additional response is required.	10/28/2022	Completed	Claims		State	DMHC	2022
3	Changes in Plan Personnel	**(R)** The Department's examination disclosed that the Plan did not timely file changes in plan personnel.	1. The Plan revised its Desktop Procedure to define the Key Personnel as "Persons holding official positions that are responsible for the conduct of the Plan including but not limited to all Senior Leadership, all members of the BOG and other principal officers." The Desktop Procedure further clarifies the activities that will constitute an official personnel change event for Senior Leadership versus Board of Governors members. Finally, the Desktop Procedure was revised reflect that Key Personnel Change filings must be submitted within five (5) calendar days. 2. We have taken steps to improve the communication with the internal stakeholders to ensure personnel change events are routed to the Regulatory Affairs and Compliance team in a timely manner. The Board Clerk is responsible to immediately notify the Compliance Department of any Board Member changes. To ensure no updates are missed, each month the Compliance Specialist will email the Board Clerk and the Human Resources Department to confirm whether the BOG or SLT has experienced any personnel changes. The Compliance Specialist also maintains a log of Key Personnel Changes. Furthermore, once a personnel change event is anticipated, the Compliance Specialist immediately begins an electronic file and begins preparation of the necessary documents for submission.	**1/13/2023**	Completed	Compliance		State	DMHC	2022
4	Fidelity Bond	The Department's examination disclosed that the Plan's fidelity bond did not have a provision for 30 days' notice to the Department prior to cancellation.	Immediately after receiving the DMHC's audit request, 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
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2022 DHCS AUDIT FINDINGS: ***Audit Review Period 1/1/2021 - 3/31/2022***							**INTERNAL AUDITS**			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
1	G&A	(1.3.1) The Plan did not send acknowledgement letters for standard appeals within the required timeframe of five calendar days.	1. The Daily Clerk Report is received daily by Grievance & Appeals Clerks and Leadership. The report will be reviewed by the Grievance & Appeals Leadership team to ensure acknowledgment letters are mailed timely. 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement letters.	10/1/2022	Completed	G&A		State	DHCS	2022
2	G&A	(1.3.2) The Plan did not comply with existing APLs to notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days in addition to the initial 120 days allowed to request a SFH.	1. Your Rights enclosure was updated to reflect enrollees have 240 days to request a State Fair Hearing 2. Policy & Procedure G&A-007 State Hearings has been updated to reflect the member has 240 calendar days to request a State Hearing. The policy will go to committee for review and approval in December. Update 03/10/2022: Plan submitted draft policy G&A-007 State Fair Hearings that reflects current timeframe to request a SFH (240 calendar days) per the PHE. Policy pending internal committee approval. Plan will need to monitor end of PHE in order to revise policy to reflect normal regulatory requirement of 120 calendar days. PHE was extended through 1/11/23. Update 4/14/2023: The updated policy was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022
3	Provider Relations	**R** (1.5.1) The Plan did not ensure that its subcontractors submitted complete ownership and control disclosure information.	1. The Alliance has made updates to its Provider Services Standard Operating Procedure (SOP) – Ownership and Control Disclosure Reviews for Delegates. This includes an additional layer of review from the Alliance Compliance Department when ownership and control forms are received from delegates. The SOP and tracking sheet has been updated. 2. The findings specifically mentioned two (2) forms: • 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

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#	**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 workflows. Update 3/10/2023: Draft policy QI-124 completed, IVR outreach is pending DHCS approval of script. Upon DHCS approval we will continue to develop the process for IVR outreach and develop desktop procedures. Update 4/15/2023: The updated P&P was approved at Compliance Committee 3/21/2023 5. The plan will create a phone call campaign, create a script, and work with the state for approval. Update 3/10/2023: Awaiting DHCS approval of script. Update 6/9/2023: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreach attempts via providers, by reviewing documentation as part of FSRs.							
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 documentation. Update 03/10/2023: Policy QI-114 has been updated and is awaiting approval at committee Update 4/14/2023: P&P Q1-114 was approved at Compliance Committee 3/21/2023	3/21/2023	Completed	Provider Relations QI		State	DHCS	2022
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

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2022 DHCS AUDIT FINDINGS: ***Audit Review Period 1/1/2021 - 3/31/2022***							**INTERNAL AUDITS**			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
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 changes. Update 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 sheets. Update 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 Committee Update 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

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
12	Member Rights	**R** (4.1.4) The Plan did not thoroughly investigate and resolve grievances prior to sending resolution letters.	1. The Alliance will review resolution letters prior to mailing to the member. 2. The Alliance provided training to the Grievance & Appeals staff to ensure the resolution letter clearly addresses all of the member's concerns 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/2022	Completed	G&A		State	DHCS	2022
13	Member Rights	**R** (4.3.1)The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes.	The Plan has created an interdepartmental team to work in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify HIPAA and FWA incidents and the method for immediate reporting to compliance. Update 03/10/2023: Training created and provided to 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. Update 03/10/2023: Training created and provided to AAH staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022

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

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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*									INTERNAL AUDITS			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
1	UM	(1.2.1) The Plan did not have appropriate processes to ensure that limitations on speech therapy services would not be imposed. In addition to using Medi-Cal guidelines, the Plan used MCG as its evidence-based criteria to make decisions. MCG criteria dictates the amount of visits that can be approved based on a diagnosis and therefore imposes limits.	1. The Plan developed workflow outlining standard review process for speech therapy Prior Authorization (PA) requests, ensuring that no limitations on speech therapy would be imposed on members under age 21. 2. The Plan will conduct a current staff training on standard process, and include it in new staff training. Update 10/8/2021: Training complete 9/29/2021 3. The Plan will revise 10748 Daily Auth Denial report to incorporate service type to capture PA requests for Speech Therapy. Update 11/12/2021: The report request has been submitted, estimated completion is 11/15/2021. Update 12/10/2021: Report has been created and is being completed weekly. 4. The Plan will monitor PA requests for Speech Therapy on a quarterly basis. Update 11/12/2021: The report request has been submitted, estimated completion is 11/15/2021. Update 12/10/2021: Requests for Speech Therapy are being monitored quarterly. 5. The Plan will report results quarterly to UMC. Update 12/10/2021: The first report will be given to the UMC in January 2022. Update 09/09/2022: Speech therapy is now being tracked on a quarterly basis and was reported out at the Q1 2022 UM Committee	Medium	Q1 2022	Completed	UM		State	DHCS	2021
2	UM	(1.2.2) The Plan did not ensure that a qualified health care professional reviewed dental anesthesia prior authorization requests which includes a review of clinical data. The Plan did not ensure the use of appropriate criteria/guidelines when reviewing dental anesthesia requests.	1. The Plan developed workflow outlining standard review process for dental anesthesia Prior Authorization (PA) requests. 2. The Plan will develop mitigation plan until auto auth programming is removed. Update 10/8/2021: Mitigation plan developed and put into place 9/29/2021 3. The Plan will conduct a staff training on the mitigation plan to identify and use standard UM review process for dental anesthesia (DA) and include it in new staff training. Update 10/8/2021 Training complete 9/29/2021 4. The Plan's UM and IT teams will collaborate to remove DA requests from Auto Authorization programming in TruCare (TC). Update 12/10/2021: DA requests have been removed from Auto Authorization programming in TruCare as of 10/1/2021 5. The Plan will develop a Tracking Report to capture and report on PA requests for Dental Anesthesia. Update 12/10/2021: The quarterly report (03127) Dental General Anesthesia Report will be utilized for monitoring 6. The Plan will monitor PA requests for Dental Anesthesia quarterly. Update 10/14/2022: PA requests for Dental Anesthesia are now being monitored quarterly 7. The Plan will report results quarterly to UMC. Update 10/14/2022: PA requests for Dental Anesthesia are now being tracked on a quarterly basis and was reported out at the Q1 2022 UM Committee	High	Q1 2022	Completed	UM		State	DHCS	2021

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2021 DHCS JOINT AUDIT FINDINGS: ***Audit Review Period 6/1/2019 - 3/31/2021***								**INTERNAL AUDITS**			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
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

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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS				
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
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

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

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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

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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

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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

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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

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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

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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**

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2020 DMHC STATE AUDIT FINDINGS - *Audit Review Period: 1/01/2019 - 9/30/2019*								**INTERNAL AUDITS**			
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
1	Grievances & Appeals	The Plan failed to accurately and consistently identify grievances received by telephone. Coverage Dispute issues were processed as an exempt grievance and not a standard grievance as required.	The G&A current procedures appropriately process coverage disputes as a standard grievance. Member Services will provide a refresher staff training of the procedures by 3/31/20 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

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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

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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

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#	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

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2019 DHCS AUDIT FINDINGS - *Audit Review Period: 6/1/2018-5/31/2019*						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
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

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#	**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

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#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
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

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
11	Appeal	1.4.2 The Plan did not translate acknowledgement and resolution appeal letters into the required threshold languages.	The Plan's appeal policies and procedures in place are compliant with the translation requirements. Staff training refresher of translation of letters was conducted on 10/30/2018.	10/30/2018	Completed	Grievance & Appeals	✓	State	DHCS	2018	Completed
12	Appeal	1.4.3 The Plan did not update its provider manual to include the new timeframes for filing a state fair hearing that became effective July 1, 2017.	The Plan updated its provider manual on 12/25/2018 to include the correct new SFH filing timeframes. 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

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23	Emergency & Family Planning Claims	3.5.3 The Plan improperly denied family planning claims for out of network, non-contracted providers. These claims were denied based on edits in the Plan's claims system and subsequent review by claims analysts.	The Plan provided staff training on 6/11/2018 to ensure FP claims edits for out of network claims are reviewed and not inappropriately denied. Monitoring reports have been implemented to review any claims denied incorrectly. Any claims identified as denied incorrectly are adjusted the following week manually.	12/31/2018	Completed	Claims	✓	State	DHCS	2018	Completed
24	Emergency & Family Planning Claims	3.5.4 The Plan did not disclose the specific rationale used in determining why claims are rejected.	Update as of 3/6/19: 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

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#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
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

Health Care Services

Steve O'Brien, MD

To: Alameda Alliance for Health Board of Governors

From: Dr. Steve O'Brien, Chief Medical Officer

Date: February 9th, 2024

Subject: Health Care Services Report

Utilization Management: Outpatient

- Automation process for initial CoC authorization determinations and letter generation for first 6-12 months will take place on 2/1/24. The volume is low at 50 cases total.

- CoC requests from members and/or providers starting 11/1/23 have been cross checked against Anthem PA information. For members where AAH cannot identify a history with Anthem, the members requests are being worked manually by the OP team to ensure member care is not delayed. Total volume of these requests is 73.

- 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.

- OP processed a total of 4,061 authorizations in the month of January. This is a 31% increase in total volume as compared to December 2023. We are attributing this increase to the Adult Expansion and Anthem transitions and the typical volume spike we see in the winter months. We rounded out 2023 total authorizations of 44,238. The top 5 categories of auth type are radiology, OP Rehab, TQ, Home Health and Outpatient facility.

Outpatient Authorization Denial Rates			
Denial Rate Type	**November 2023**	**December**	**January 2024**
Overall Denial Rate	**4.0%**	**3.9%**	**3.5%**
Denial Rate Excluding Partial Denials	**3.8%**	**3.7%**	**3.1%**
Partial Denial Rate	**0.3%**	**0.3%**	**0.4%**

Turn Around Time Compliance			
Line of Business	**November 2023**	**December 2023**	**January 2024**
Overall	**100%**	**99%**	**99%**
Medi-Cal	**100%**	**99%**	**99%**
IHSS	**99%**	**100%**	**100%**
Benchmark	***95%***	***95%***	***95%***

Utilization Management: Inpatient

- The Inpatient UM team processed a total of 3,073 reviews in the month of January. This is a 63% increase in volume since December 2023. We attribute this to 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 (2,427), Skilled (380), Short Term Custodial (189) Skilled Bedholds (32), Acute Rehab/ LTAC (40) and Subacute (4). 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 quarter 4. 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 96% for the months of November and December and in January it rose to 98.6%. This 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**

Turn Around Time Compliance			
Line of Business	**Novemberber2023**	**November 2023**	**January 2024**
Overall	**96%**	**96%**	**98.6%**
Medi-Cal	**96%**	**96%**	**98.6%**
IHSS	**97%**	**100%**	**100%**
Benchmark	***95%***	***95%***	***95%***

Inpatient Authorization Denial Rates			
Denial Rate Type	**October 2023**	**November 2023**	**December 2023**
Full Denials Rate	**0.8%**	**1.6%**	**2.0%**
Partial Denials	**1.1%**	**0.8%**	**1.1 %**
All Types of Denials Rate	**1.9%**	**2.3%**	**3.1%**

Utilization Management: Long Term Care

- LTC census during January 2024 was 2120 members, this does not include the Anthem membership loaded 02/01/24. This is an increase of 16.4% from December 2023.

- During Q3 2023, LTC members had a total of 227 admissions with an average LOS of 6.2 days, which is down from reported trend last quarter.

LTC Summary – IP Utilization Q3 2023	
Admissions	227
Days	1,401
Readmissions	62

***Updated Q3 with additional Claims data

LTC Summary – ER Visits Q3 2023	
Alliance	301
CHCN	3
AHS	2

***Updated Q3 with additional Claims data

- LTC Deliverables all submitted, awaiting DHCS approval.

- Met with Regional Center of East Bay to discuss options for sharing member information Scheduled monthly meetings to have a "rounds" approach to discuss these members.

- 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.

- 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 118 members in ICF/DD and 41 in subacute.

- Anthem transition: Batch load was performed 02/01/24, 245 LTC auths were entered. These numbers are not included in the total counts given as they were done in February 2024.

- Authorization volume has increased by 46% in January 2024 compared to December 2023.

Authorization Count	January 2024
Post Service/ Retrospective	56
Routine (Non-Urgent) Pre-Service	1,315
Urgent Pre-Service	14

- Authorization processing turn-around time (TAT) **meets** benchmark:

	January 2024
Numerator	1321
Denominator	1385
Met %	95%
Benchmark	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- The volume increase in mental health and BHT/ABA services in January of approximately 50% was driven by the Anthem transition. The AAH behavioral health team is responding to members seeking to start services as well as those who are 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).

- 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.

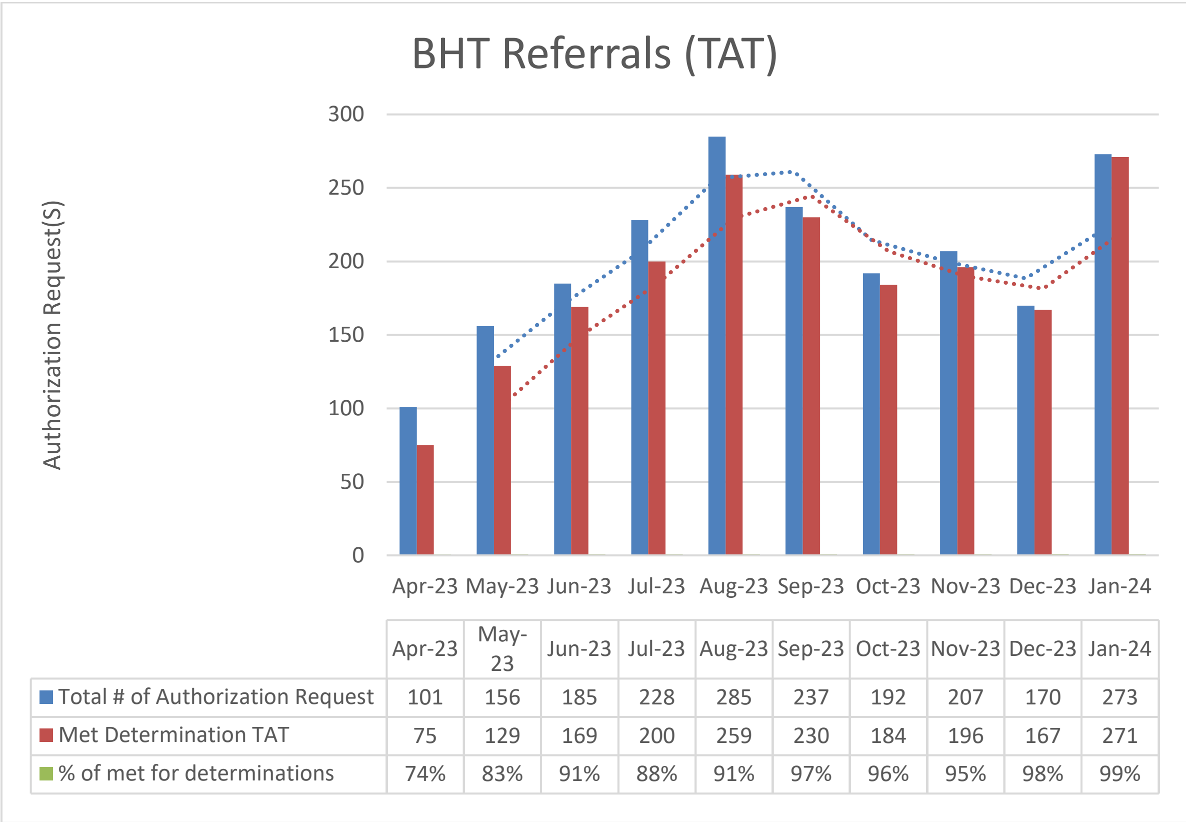
  - We are seeing a steady increase in unique utilizers of BHT/ABA services from the baseline (Ave # of children receiving ABA services in the four months prior to April 1, 2023) of 550 as of Go Live to 673 as of August 2023 and to October 2023 of 806.
  - We are seeing a steady increase in the unique utilizers of mental health services from the baseline (Ave # of children receiving mental health services in the four months prior to April 1, 2023) of 6,157 as of Go Live to 7,424 as of August 2023 and to October 2023 of 10,462.

Behavioral Health Outpatient Overall Denial Rates			
Oct-23	**Nov-23**	**Dec-23**	**Jan-24**
0.01%	0.01%	0.01%	0.01%

MH Overall Turnaround Time Compliance			
Oct-23	**Nov-23**	**Dec-23**	**Jan-24**
100.00%	95.00%	99.00%	98.00%

BHT Overall Turnaround Time Compliance			
Oct-23	**Nov-23**	**Dec-23**	**Jan-24**
96.00%	95.00%	98.00%	99.00%

Detailed TAT with graphs (optional)



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Total # of Authorization Request	101	156	185	228	285	237	192	207	170	273
Met Determination TAT	75	129	169	200	259	230	184	196	167	271
% of met for determinations	74%	83%	91%	88%	91%	97%	96%	95%	98%	99%

BH Case Management

- 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.
  - Undated 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 of 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 in order 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 has completed the project potential underutilizers for hepatitis C and chronic hepatitis B. We will continue with interventions in April after we get through the Anthem transition.

- Pharmacy is collaborating with population health, QI, and disease management on creating clinical programs for HEDIS measures for high blood pressure, asthma, and diabetes.

- Pharmacy continues to monitor members on use of opioids:

MME	IHSS	MCAL	Total
October 2023			**248**
50-89	2	203	205
90-119	1	12	13
120-199	0	16	16
200-299	1	8	9
300-399	0	2	2
>400	0	3	3
November 2023			**231**
50-89	3	183	186
90-119	0	10	10
120-199	0	17	17
200-299	1	12	13
300-399	0	2	2
>400	0	3	3
December 2023			**237**
50-89	0	189	189
90-119	0	14	14
120-199	0	18	18
200-299	1	10	11
300-399	0	2	2
>400	0	3	3

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 530 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 December 2023	Total Open Cases as of December 2023	Cases Opened in January 2024	Total Open Cases as of January 2024
Care Coordination	544	1009	775	1261
Complex Case Management	38	139	13	114
Transitions of Care (TCS)	220	331	1227	1398

<u>CalAIM</u>

Enhanced Case Management

- January 1, 2024, was the launch of the final Populations of Focus (Justice Involved & Birth Equity).

- ECM anticipates 168 authorization requests for Continuity of Care for members previously assigned to Anthem. The ECM team is working closely with each provider to confirm all 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.

- In January, meetings wrapped with Anthem and Kaiser to discuss cases for continuity of care for the ECM/CS transition. Contacts remain up to date, in case outreach becomes necessary.

- 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 anticipates referrals to begin shortly.

ECM Outreach in October 2023	Total Open Cases as of October 2023	ECM Outreach in November 2023	Total Open Cases as of November 2023	ECM Outreach in December 2023	Total Open Cases as of December 2023
760	1521	441	1702	356	1842

Community Supports

- Community Supports is expecting 541 authorizations for Continuity of Care for members previously assigned to Anthem. The CS team is working 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.

- The following CS network expansion went live 1/1/24:
  - Asthma Remediation for adults
    - Through HCSA and Roots Community Health Clinic
  - Further network expansion for Nursing Facility Transition/Diversion
    - Omatochi
  - Further network expansion for Community Transition Services
    - Omatochi
  - Sobering Centers (contract is being finalized)
    - Cherry Hill – operated by Horizon
  - Medically Tailored Meals/Medically Supportive Food
    - Alameda County Community Food Bank

Community Supports	Services Authorized in Octoboer 2023	Services Authorized in November 2023	Services Authorized in December 2023
Housing Navigation	637	655	694
Housing Deposits	121	113	97
Housing Tenancy	842	838	801
Asthma Remediation	59	51	53
Meals	1262	1276	1122
Medical Respite	84	78	69
Transition to Home	3	3	3
Nursing Facility Diversion	8	11	11
Home Modifications	3	5	4
Homemaker Services	49	80	130
Caregiver Respite	1	2	2

Grievances & Appeals

- All cases were resolved within the goal of 95% of regulatory timeframes.
- Total grievances resolved in December were 5.48 complaints per 1,000 members.
- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of December 2023; we met our goal at 13.6% overturn rate.

December 2023 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	989	30 Calendar Days	95% compliance within standard	989	100.0%	2.60
Expedited Grievance	0	72 Hours	95% compliance within standard	N/A	N/A	0.00
Exempt Grievance	1,186	Next Business Day	95% compliance within standard	1,183	99.7%	2.88
Standard Appeal	22	30 Calendar Days	95% compliance within standard	22	100.0%	0.06
Expedited Appeal	0	72 Hours	95% compliance within standard	N/A	N/A	0.00
Total Cases:	2,197		95% compliance within standard	2,194	99.8%	5.48

*Calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1000.

Grievances:

- 331 of 989 (33%) cases were related to Access to Care, the top 3 grievance categories are:
  - (183) Timely Access
  - (57) Provider Availability
  - (41) Technology/Telephone

- 303 of 989 (30.6%) cases were related to Coverage Dispute, the top 3 categories are:
  - (114) Provider Balance Billing
  - (113) Provider Direct Member Billing
  - (41) Reimbursement

- 229 of 989 (23%) cases were related to Quality of Service, the top 3 categories are:
  - (50) Plan Customer Service
  - (44) Provider/Staff Attitude
  - (36) Transportation

Appeals:

- 3 out of 22 (13.6%) cases were overturned for the month of December 2023:
  - (3) Disputes Involving Medical Necessity

Quality

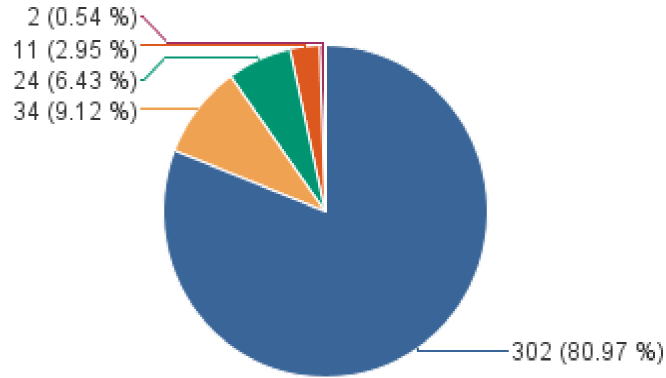
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

- 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.

- 97.35% of cases in December and 99.46% of cases in January 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.

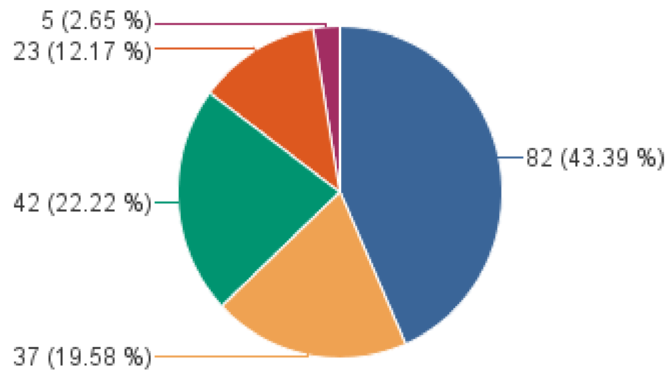
PQI Aging Report as of 01/31/2024 N= 373



TAT_Bracket

1. <=30 | 2. >30<=60 | 3. >60<=90 | 4. >90<=120 | 5. >120

PQI Aging Report as of 12/31/2023 N= 189



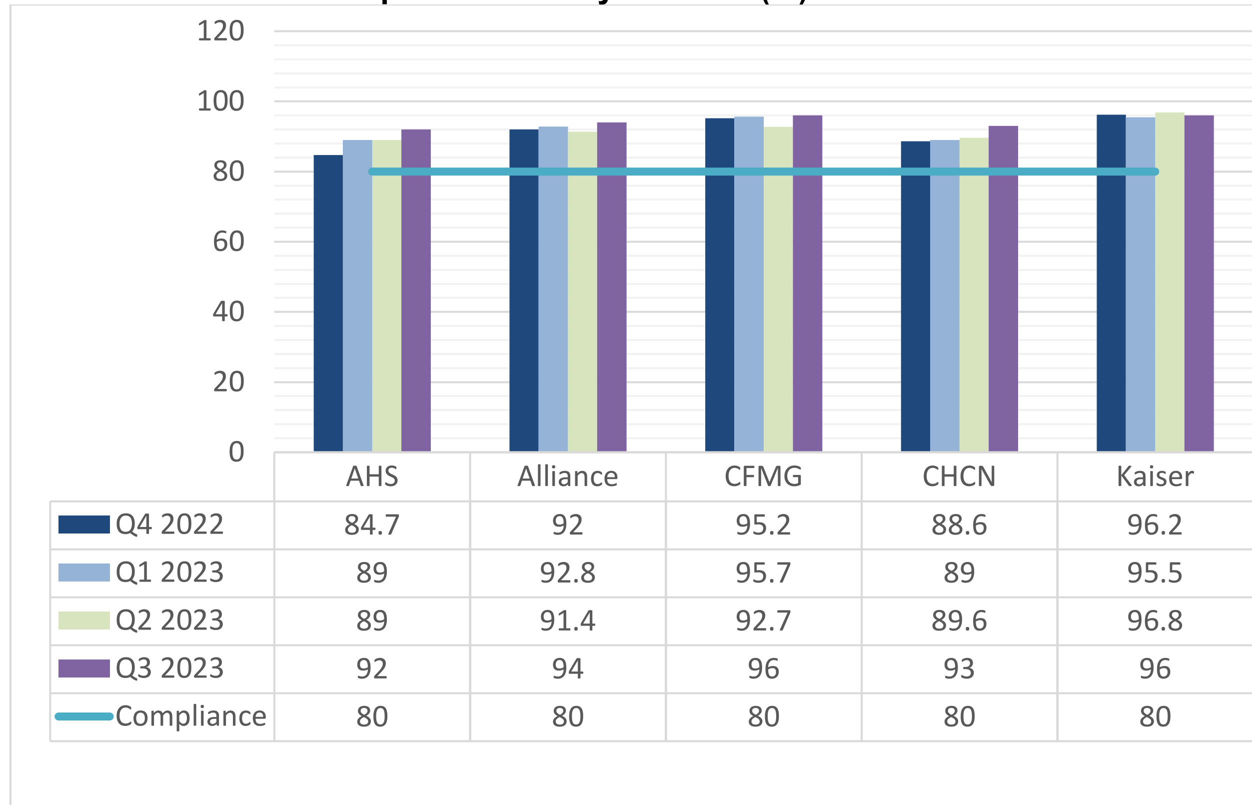
TAT_Bracket

1. <=30 | 2. >30<=60 | 3. >60<=90 | 4. >90<=120 | 5. >120

CG-CAHPS Survey

- Survey Objective: The Clinician and Group Consumer Assessment Provider and Systems (CG-CAHPS) measures member experience with health care providers and staff, as well as with in-office wait time, provider time to answer calls during business hours, and provider call return time during business hours.

In-Office Wait Time Compliance Rate by Network (%)

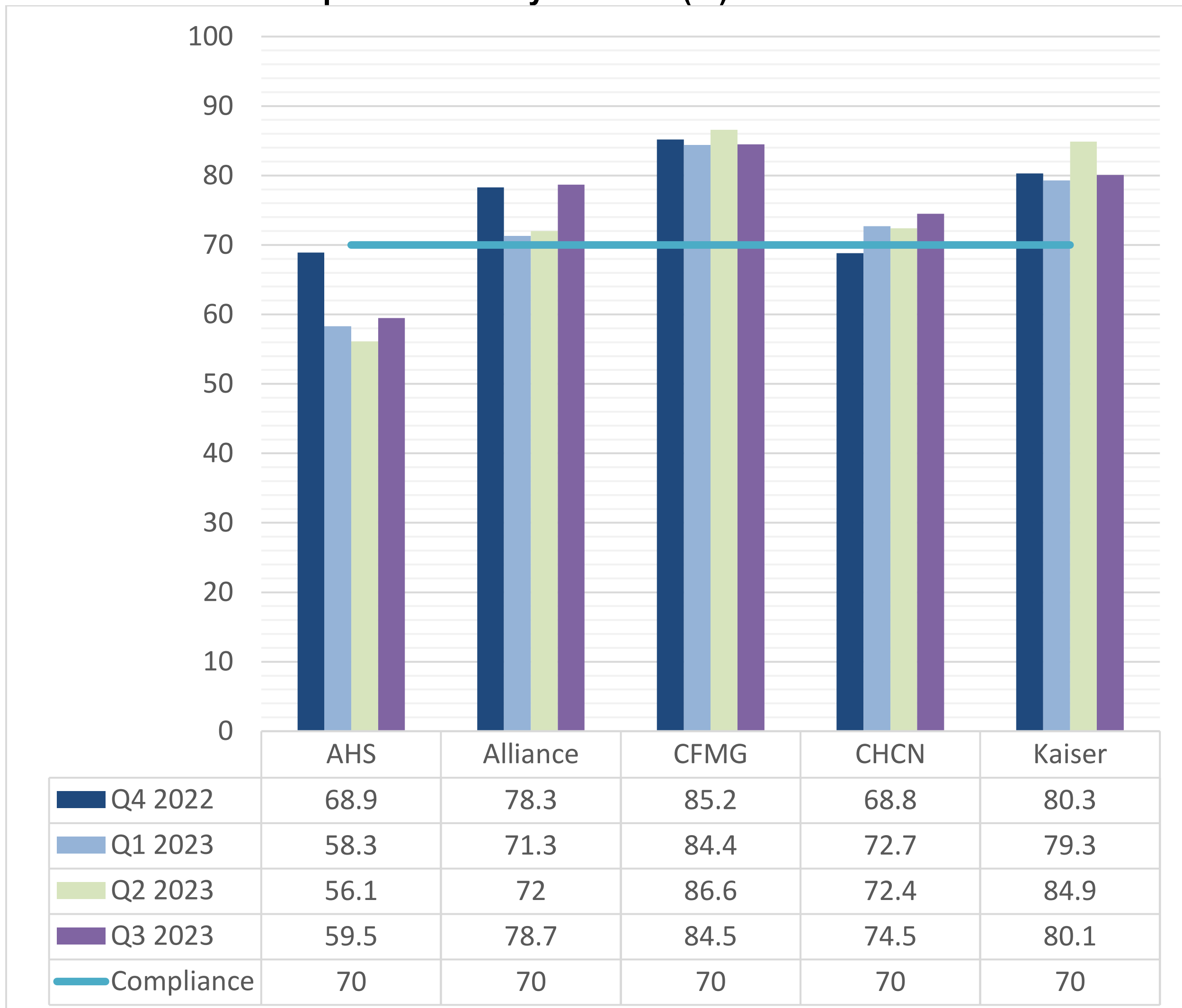


	AHS	Alliance	CFMG	CHCN	Kaiser
Q4 2022	84.7	92	95.2	88.6	96.2
Q1 2023	89	92.8	95.7	89	95.5
Q2 2023	89	91.4	92.7	89.6	96.8
Q3 2023	92	94	96	93	96
Compliance	80	80	80	80	80

- Office wait time includes both times spent in the waiting room and the exam room before seen by the doctor:
    - Compliance rate: Less than 60 minutes

- All delegate providers continue to score above the 80% compliance threshold from Q4 2022 to Q3 2023.

Call Return Time Compliance Rate by Network (%)

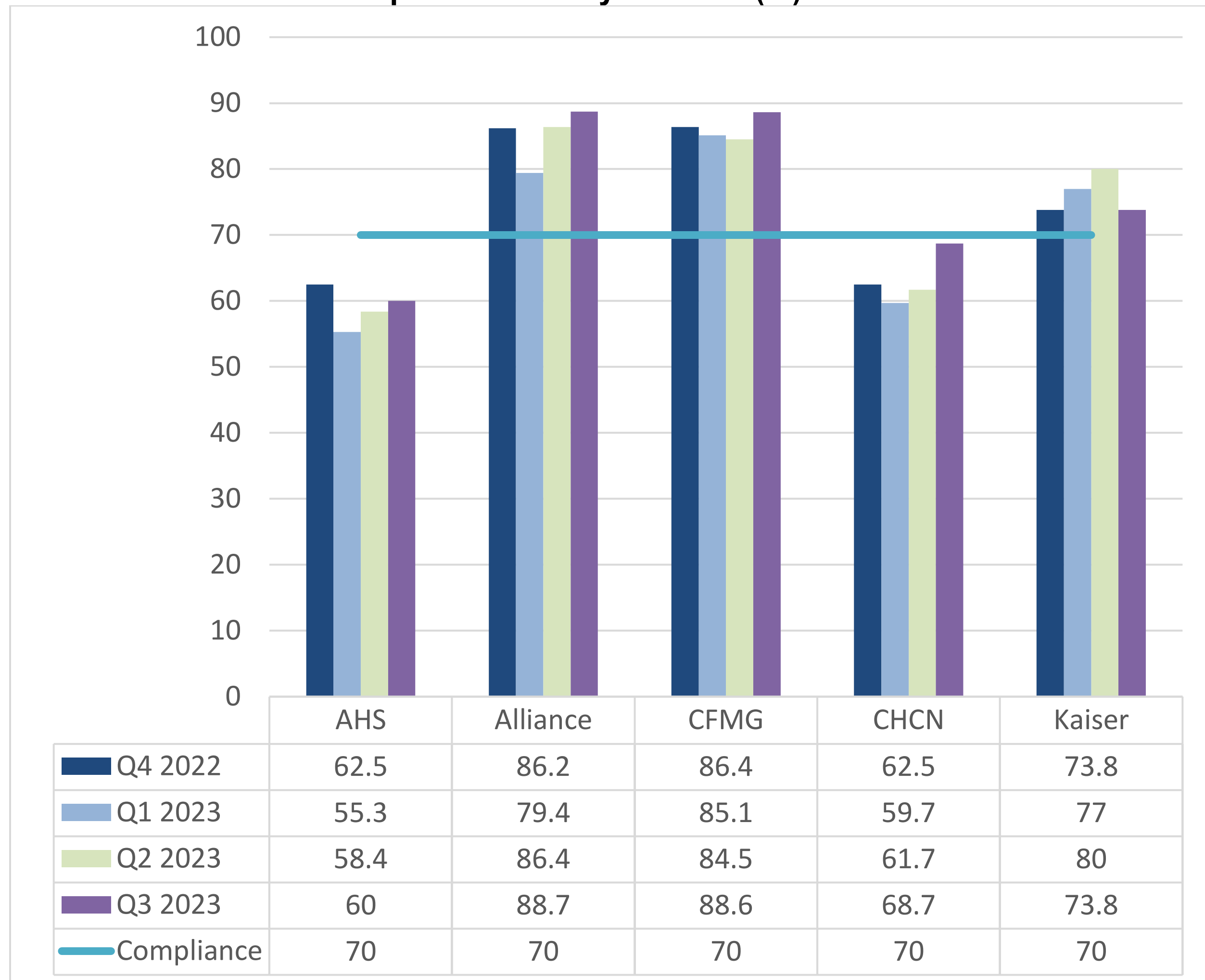


	AHS	Alliance	CFMG	CHCN	Kaiser
Q4 2022	68.9	78.3	85.2	68.8	80.3
Q1 2023	58.3	71.3	84.4	72.7	79.3
Q2 2023	56.1	72	86.6	72.4	84.9
Q3 2023	59.5	78.7	84.5	74.5	80.1
Compliance	70	70	70	70	70

- Call return time – when a member called provider's office during regular office hour, when did a member get a call back:
  - Compliance rate: Within 1 business day

- Only AHS continues to not meet the threshold goal. All other network providers met the 70% threshold goal from Q1 2023 to Q3 2023.

Time To Answer Call Compliance Rate by Network (%)



	AHS	Alliance	CFMG	CHCN	Kaiser
Q4 2022	62.5	86.2	86.4	62.5	73.8
Q1 2023	55.3	79.4	85.1	59.7	77
Q2 2023	58.4	86.4	84.5	61.7	80
Q3 2023	60	88.7	88.6	68.7	73.8
Compliance	70	70	70	70	70

- Time to answer call – when a member called provider's office during regular office hours, how long did a member wait to speak to a staff member:
    - Compliance rate: 0 – 10 minutes

- AHS and CHCN continue to score below the 70% threshold goal. However, percentage increases were seen for both delegates. With a 1.6% increase for AHS and a 7% increase for CHCN in Q3 2023.

- Next Action Steps:
    - Track and Trend Compliance rates.
    - Share results with Delegate and Direct entities.
    - Share results with Provider Services and FSR staff to incorporate as part of provider and office education for identification of barriers and improvement opportunities.
    - CAPs to be sent to non-compliant provider.

Health Equity

Lao Paul Vang

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

From: **Lao Paul Vang, Chief Health Equity Officer**

Date: **February 9th, 2024**

Subject: **Health Equity Report**

Internal Collaboration

- **Meetings and check-ins with Division Chiefs Update**
  - The CHEO met with the Chief Cultural Officer of the Native American Health Center of Oakland to discuss partnerships and collaborations on health equity.

- **Population Health Management (PHM), Quality Improvement (QI), and Utilization Management (UM) Update**
  - Discussed and shared thoughts on the CLS Program Description and the HE Role.
  - Discussed the consultant work for the Advancing Health Equity Initiative (AHEI).
  - The Quality Improvement Department, in collaboration with the Health Equity Department, announced a guest speaker, Dr. Pooja Mittal, Vice President and Chief Health Equity Officer of Health Net, who will present on Health Net's health equity strategy and examples of how health equity has been incorporated into their programs.

- **Vendor Management (VM) Update**
  - **Supplier Diversity Project:**
    - High level recommendations prepared and presented to Vendor Management.
    - Committee work is underway to develop strategy development and implementation.

External Collaboration

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update** – The following items were discussed at the January meeting
  - Discussed internal survey results and the alignment of our work on

health equity and DEI.

- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**

    - Discussed with DHCS CHEO how we can support her on her health equity roadmap initiative.

- **Webinar**

    - Attended the DMHC Health Equity and Quality All Plan Letter 23-029 and NCQA Accreditation Review Webinar.

- **DEI Training Program – All Health Plan Meeting**

    - Attended LA Care's All Health Plans Equity DEI Training program meeting.
    - Open discussion with other regional health plans across California on progress with the DEI Training Program and any barriers health plans are facing.

Advancing Health Equity Initiative (AHEI)

- **Assessments**
    - Completed 88% of 1:1 and group listening sessions; the remaining sessions are scheduled to be completed by 2/15.
    - "All-Staff" employee engagement results (9/2023) were received, reviewed, and will be incorporated into the findings report.

- **Key Findings Report**

    - Preparation of the findings report is underway and will be finalized at the conclusion of the assessments.
    - The report will be presented in February 2024 and will inform and guide the strategic roadmap development process.

- **The Data Committee Team (QI, UM, PHM, Analytics) Update**

    - The final recommendation report was delivered and presented to the Data Committee Team and the Health Equity Officer.

- **Alliance Strategic Roadmap Update**

    - Meetings are scheduled to begin in February 2024, along with proposed leadership development sessions.
    - The Strategic Planning Workbook and Mission & Vision Planning Workbook will be reviewed in the upcoming week by the Health

Equity Office in preparation for the strategic planning work ahead.

- **DEI Training Curriculum (APL 23–025) Update**
  - The APL DEI Training Curriculum strategy was completed and scheduled for review in mid-February.
  - The project is on track to meet the initial APL deadline (mid-September).

- **Communications Update**
  - Recommendations were made on various communication strategies and approaches.
  - The HE Department is creating an intranet page for the staff. We have met with IT regarding the next steps. We are in development.

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

- **DEIB Committee Update**
  - In January, the DEIB Committee discussed the DEI vendor updates (see above) and finalizing the DEI Calendar.

- **VIA Committee Update**
  - In January, the VIA Committee discussed the upcoming 2024 Alliance Staff Socials. The members decided that there would be a spring, summer, and fall social. The months for these socials were discussed and the final decision will be made by the administration.

Information Technology

Sasikumar Karaiyan

To: Alameda Alliance for Health Board of Governors

From: Sasi Karaiyan, Chief Information & Security Officer

Date: February 9th, 2024

Subject: Information Technology Report

Call Center System Availability

- AAH phone systems and call center applications performed at 100% availability during the month of January 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.
    - Final testing and system validation will be scheduled.

Encounter Data

- In the month of January 2024, the Alliance submitted 312 encounter files to the Department of Health Care Services (DHCS) with a total of 532,008 encounters.

- Receipts and Submissions were higher than average due to:
    - Resubmissions of encounters by LogistiCare to correct records based on a contract change.
    - Growth from the Single Plan Model Migration and Adult Expansion, which resulted in more claims in HealthSuite.

- Lag Time Performance was lower than average due to the LogistiCare encounter resubmissions.

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.

- The next phase of this program will kick-off in January 2024 and will include multiple phases and remediation efforts are now in progress.

    - **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 been presented to the Project Governance Committee in January and has been approved for kick-off.

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 and will begin January 2024 and provide larger capacity and improved performance in preparation for anticipated growth and new environments.

- The application migration activities will begin in March 2024.

- New IBM server hardware has been successfully installed, configured, and deployed at the DR site.

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.

- Business case and review is currently in progress.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of January 2024”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of January 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 January 2024

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
January	400,356	110,006	62,296	5,603	121	140

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 January 2024

Auto-Assignments	Member Count
Auto-assignments MC	2,471
Auto-assignments Expansion	1,869
Auto-assignments GC	64
PCP Changes (PCP Change Tool) Total	5,921

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of January 2024”.
- There were 25,493 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 January 2024*

Transaction Type	Inbound automated Auths	Errored	Total Auths Loaded in TruCare
Paper Fax to Scan (UM, BH)	2,864	2,344	1,569
Provider Portal Requests (UM, BH)	5,827	1,379	5,676
EDI (CHCN historical)	5,401	1,540	5,271
Provider Portal to AAH Online (Long Term Care)	256	85	243
IP Auth from ADT	1,247	625	759
Provider Portal to AAH Online (Behavioral Health)	107	72	94 *(Manual + Automated)*
Manual Entry (all other not automated or faxed vs portal use)	N/A	N/A	2,911
AAH Online (AE)	16	6	16
Total			16,539

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 December 2023

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	6,283	4,467	514,656	532
MCAL	102,258	2,783	6,817	984
IHSS	3,573	68	62	29
Total	**112,114**	**7,318**	**521,535**	**1,545**

Table 3-2 Top Pages Viewed for the Month of December 2023

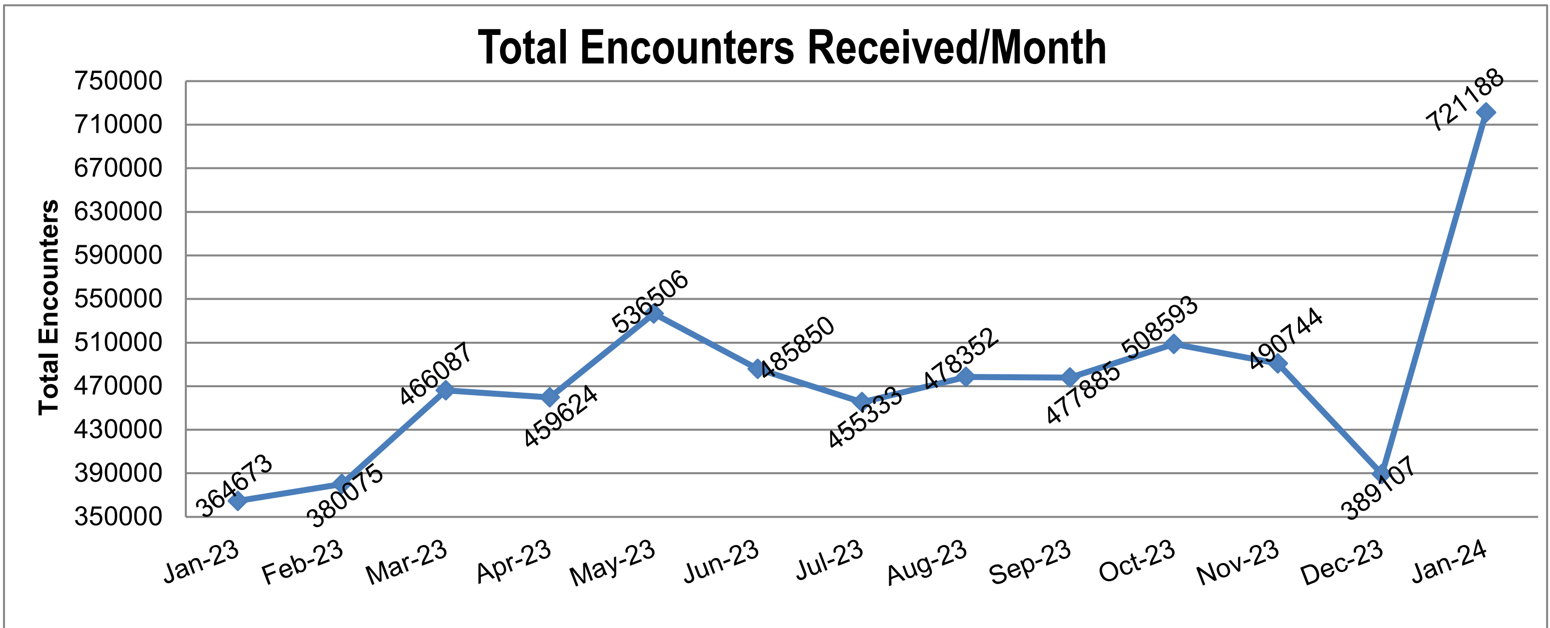
Category	Page Name	Page Views
Provider	Member Eligibility	1517144
Provider	Claim Status	185898
Provider - authorizations	Auth Submit	12123
Member	Provider Directory	5808
Provider - authorizations	Auth Search	5272
Member My Care	Member Eligibility	3728
Provider - Claims	Submit professional claims	3554
Directory Config	Provider Directory	3316
Provider	Member Roster	2466
Member Help Resources	ID Card	2046
Member Help Resources	Find a Doctor or Hospital	2017
Member Help Resources	Select or Change Your PCP	1362
Member Home	MC ID Card	1165
Member My Care	My Claims Services	973
Provider - reports	Reports	699
Member My Care	Authorization	625
Provider - Provider Directory	Provider Directory	610
Provider	Behavior Health Forms SSO	571
Member My Care	My Pharmacy Medication Benefits	308
Member Help Resources	Forms Resources	269
Member My Care	Member Benefits Materials	262
Provider - Provider Directory	Manual	218
Provider	Long Term Care Forms SSO	216
Member Help Resources	Contact Us	206
Member Help Resources	Authorizations Referrals	200
Provider - Provider Directory	Instruction Guide	181
Member My Care	Protected Health Information	110

Encounter Data From Trading Partners January 2024

- **ACBH**: January monthly files (0 records)
  - No longer receiving encounter files but through HCSA.
- **AHS**: January weekly files (4,570 records) were received on time.
- **BAC**: January monthly files (59 records) were received on time.
- **Beacon**: January weekly files (0 records)
  - No longer receiving encounter files.
- **CHCN**: January weekly files (96,124 records) were received on time.
- **CHME**: January monthly files (5,843 records) were received on time.
- **CFMG**: January weekly files (12,043 records) were received on time.
- **Docustream**: January monthly files (930 records) were received on time.
- **EBI**: January monthly files (1,047 records) were received on time.
- **FULLCIR**: January monthly files (828 records) were received on time.
- **HCSA**: January monthly files (2,223 records) were received on time.
- **IOA**: January monthly files (1,453 records) were received on time.
- **Kaiser**: January bi-weekly files (77,407 records) were received on time.
- **LAFAM**: January monthly files (0 records) were NOT received on time.
- **LogistiCare**: January weekly files (182,822 records) were received on time.
- **March Vision**: January monthly files (9,693 records) were received on time.
- **MED**: January monthly files (535 records) were received on time.
- **Quest Diagnostics**: January weekly files (27,022 records) were received on time.
- **SENECA**: January monthly files (124 records) were received on time.
- **TITANIUM**: January monthly files (0 records) were NOT received on time.
- **Magellan**: January monthly files (386,769 records) were received on time.

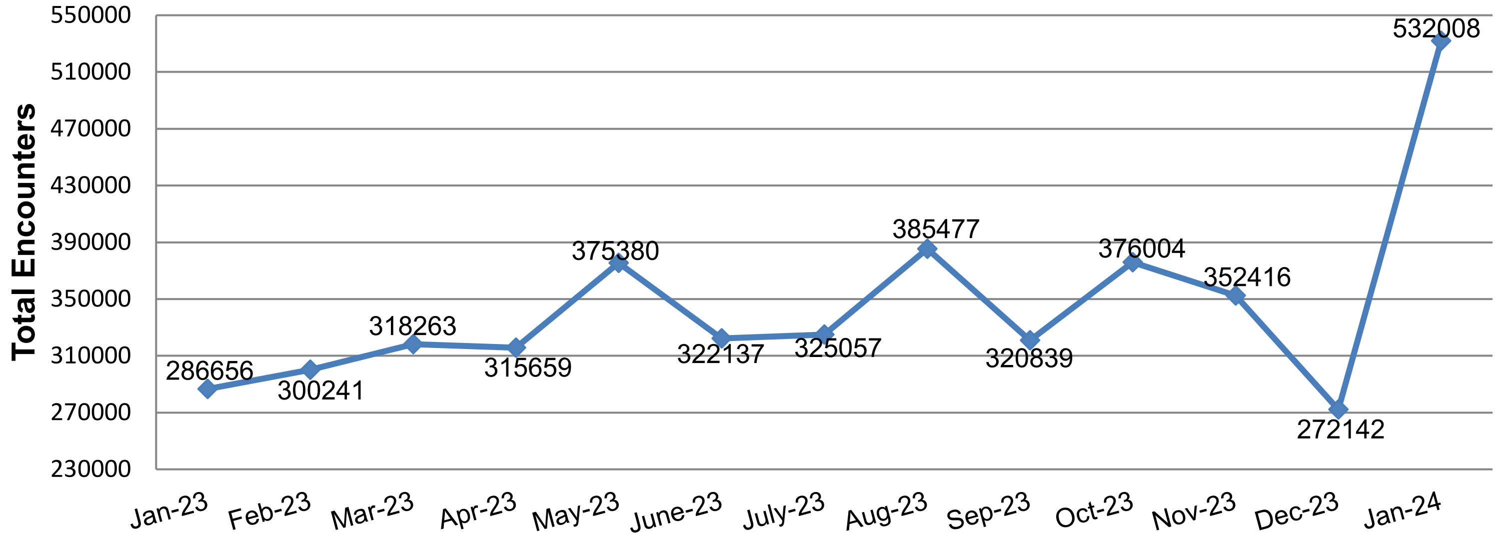
Trading Partner Encounter Inbound Submission History

Trading Partners	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	July-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Health Suite	163764	167475	23828 3	218296	251858	267437	224540	244907	247423	241298	247537	215246	298465
ACBH	86	39	95										
AHS	4568	5377	5088	6353	5380	6250	4363	4380	5479	5371	5243	6284	4570
BAC	199	34	32	38	40	37	39	38	38	57	73	55	59
Beacon	13824	11036	12159	15799	5822	4559	620						
CHCN	87182	83191	82394	84654	117764	90418	102081	85836	77060	111275	87839	58566	96124
CHME	4574	5303	4729	5277	4987	5692	5706	5704	6212	7609	6445	5694	5843
Claimsnet	9679	11694	8851	16155	12526	9986	12379	8946	12302	12167	11670	18995	12043
Docustream	1327	1794	1361	865	575	607	567	744	562	400	705	476	930
EBI				976	15	910	1664	814	867	718	823	811	1047
FULLCIR										888	598	177	828
HCSA	1825	1976	590	78	72	5573	3824	3466	2490	1913	2403	2087	2223
IOA		172	156	201	325	974	424	673	1086	967	1073	1250	1453
Kaiser	35798	56965	73095	68883	91196	53820	56673	76278	79751	81985	87005	26208	77407
LAFAM										24			
Logisticare	24456	18034	21647	20558	28628	20859	22235	27129	22456	25509	20781	32181	182822
March Vision	3598	3434	3281	4275	3647	5101	4468	4563	4933	4427	4428	4562	9693
MED							9	11	144	194	523	532	535
Quest	13793	13551	14326	17216	13671	13627	15741	14859	17008	13712	13077	15834	27022
SENECA								4	74	79	56	52	124
TITANIUM											465	97	
Total	364673	380075	46608 7	459624	536506	485850	455333	478352	477885	508593	490744	389107	721188



Outbound Encounter Submission

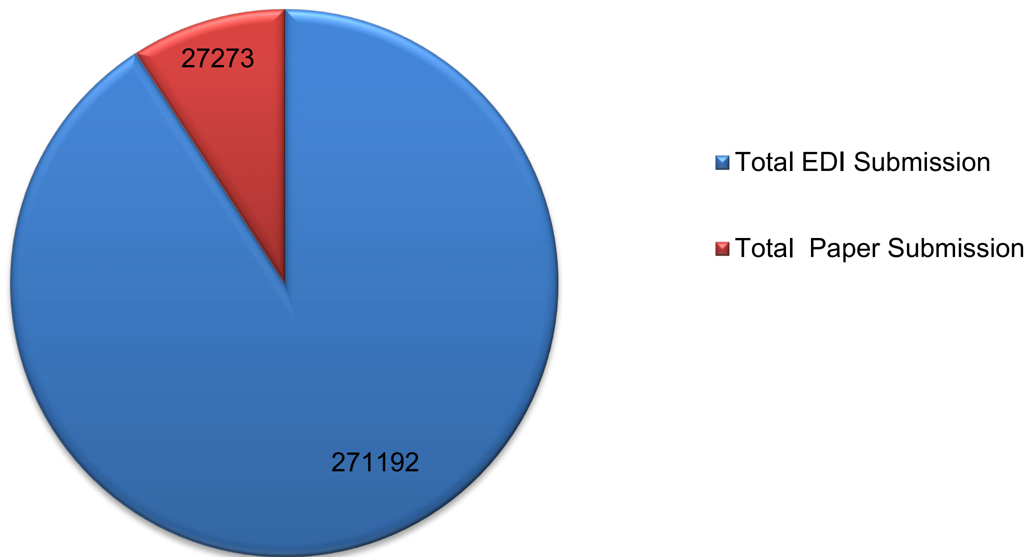
Trading Partners	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Health Suite	114224	128102	117672	117823	151866	126674	147199	170751	127465	163149	134823	136233	172386
ACBH	56	21	73										
AHS	5439	5260	3845	7300	5236	5070	5318	4251	4253	6355	5147	4936	5667
BAC	196	33	32	38	40	37	39	37	38	52	67	53	55
Beacon	11282	8910	9674	11927	2879	2233	318						
CHCN	58881	58279	59074	60373	79256	65595	56593	74313	55365	62962	73866	39846	67063
CHME	4470	5181	4606	5159	4864	5577	5595	5546	6063	7475	6321	5588	5703
Claimsnet	8241	8334	6361	9834	10891	7445	8849	6386	7075	7452	8031	11581	10145
Docustream	1117	1521	1232	481	411	378	347	529	441	270	573	404	387
EBI				906	15	872	1574	804	855	710	794	802	987
FULLCIR										806	516	124	653
HCSA	1777	1304	287	52	55	1781	3778	3405	2349	1876	2342	1991	2142
IOA		168	152	45	276	751	410	654	984	65	934	1228	1378
Kaiser	35360	55930	72409	65652	72893	68887	55988	75591	78162	81165	85807	26113	76335
LAFAM										2			
LogistiCare	24291	12223	27071	20411	28455	20787	21686	26670	22142	24497	25951	31546	157548
March Vision	2454	2308	2400	3006	2366	3408	2720	2737	2992	2863	2661	2752	2700
MED							9	11	126	145	438	428	446
Quest	18868	12667	13375	12652	15877	12642	14634	13788	12456	16082	3655	8394	28299
SENECA								4	73	78	52	48	114
TITANIUM											438	75	
Total	286656	300241	318263	315659	375380	322137	325057	385477	320839	376004	352416	272142	532008



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
24-Jan	271192	27273	298465

Key: EDI – Electronic Data Interchange

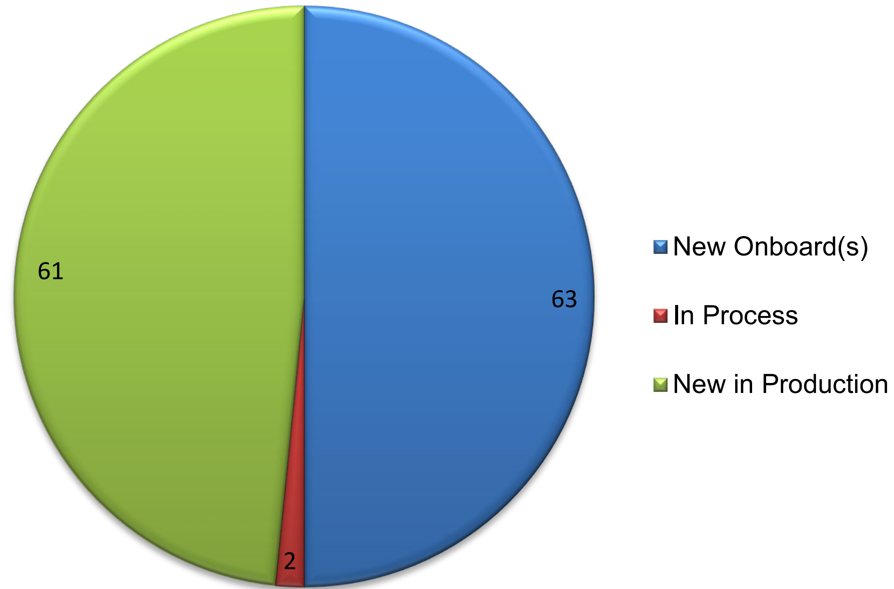


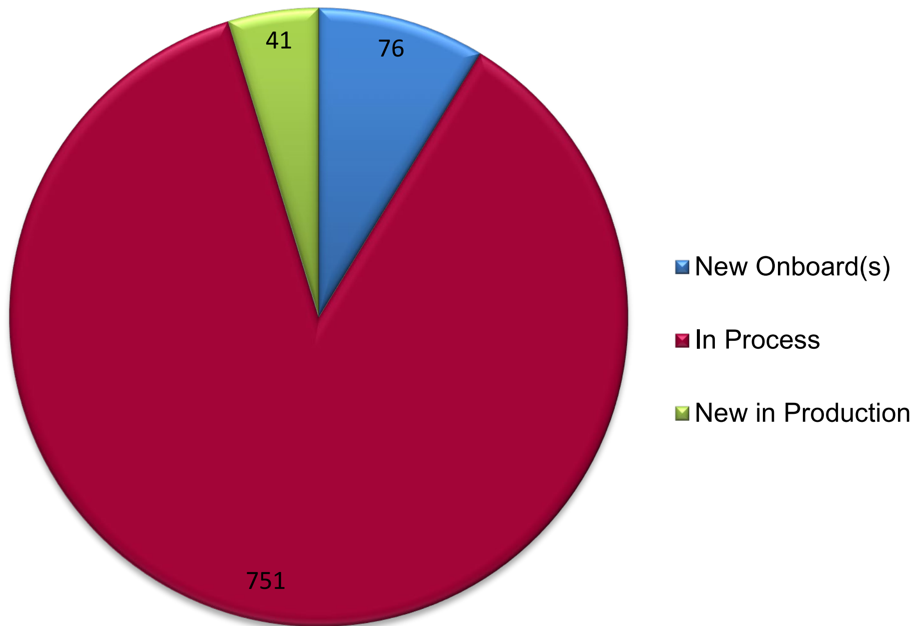
Onboarding EDI Providers – Updates

- January 2024 EDI Claims:
    - A total of 2054 new EDI submitters have been added since October 2015, with 61 added in January 2024.
    - The total number of EDI submitters is 2794 providers.

- January 2024 EDI Remittances (ERA):
    - A total of 894 new ERA receivers have been added since October 2015, with 41 added in January 2024.
    - The total number of ERA receivers is 910 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
Feb-23	24	0	24	2268	37	457	3	646
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


837 EDI Submitters - January 2024
61
63
2
New Onboard(s)
In Process
New in Production


835 EDI Receivers - January 2024
41
76
751
New Onboard(s)
In Process
New in Production

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 **January** 2024.

File Type	JAN-24
837 I Files	48
837 P Files	264
Total Files	312

Lag-time Metrics/Key Performance Indicators (KPI)

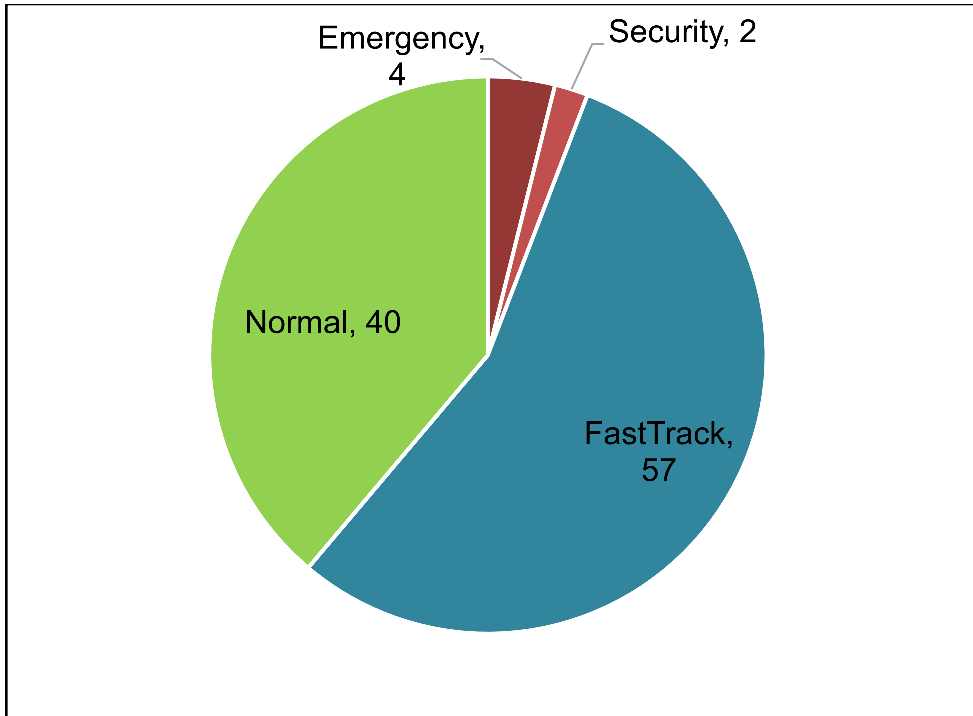
AAH Encounters: Outbound 837	Jan-24	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	79%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	92%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	69%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	79%	80%

- Timeliness submission of the professional encounters is lower than expected due large volume of historical encounters clean-up activities by LogistiCare.
- LogistiCare submitted additional 153K historical encounters with the Date of Service greater than 90 days. In early 2023, our delegate LogistiCare made error in their system while doing contract changes. Now corrections have been made and resubmit the historical encounters.

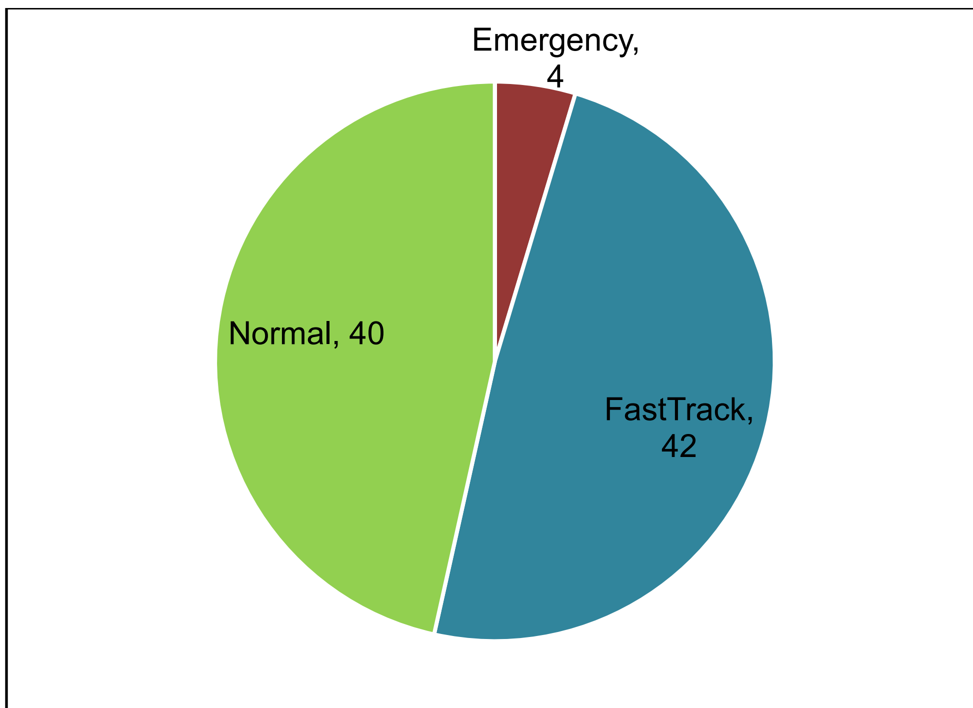
Change Management Key Performance Indicator (KPI)

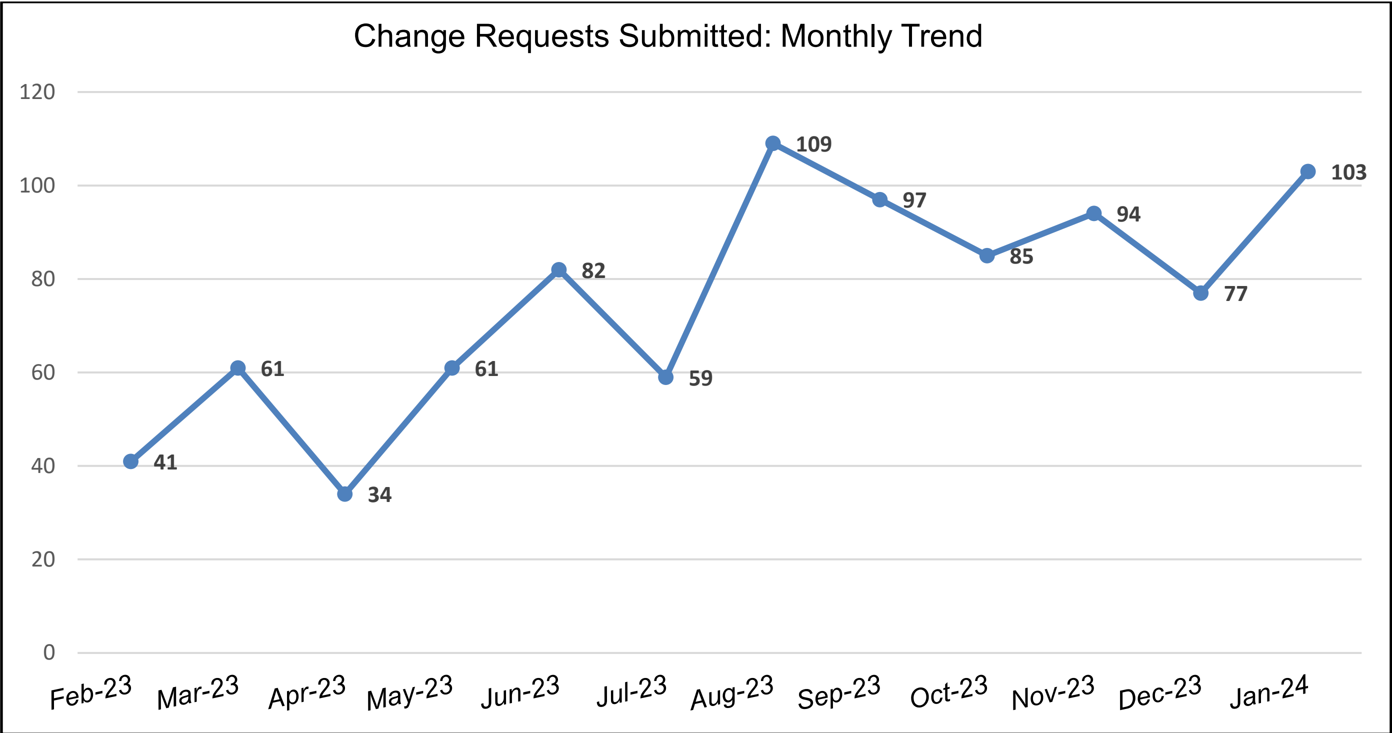
- Change Request Overall Summary in the month of January 2024 KPI:
  - 103 Changes Submitted.
  - 86 Changes Completed and Closed.
  - 168 Active Change Requests in pipeline.
  - 31 Change Requests Cancelled or Rejected.

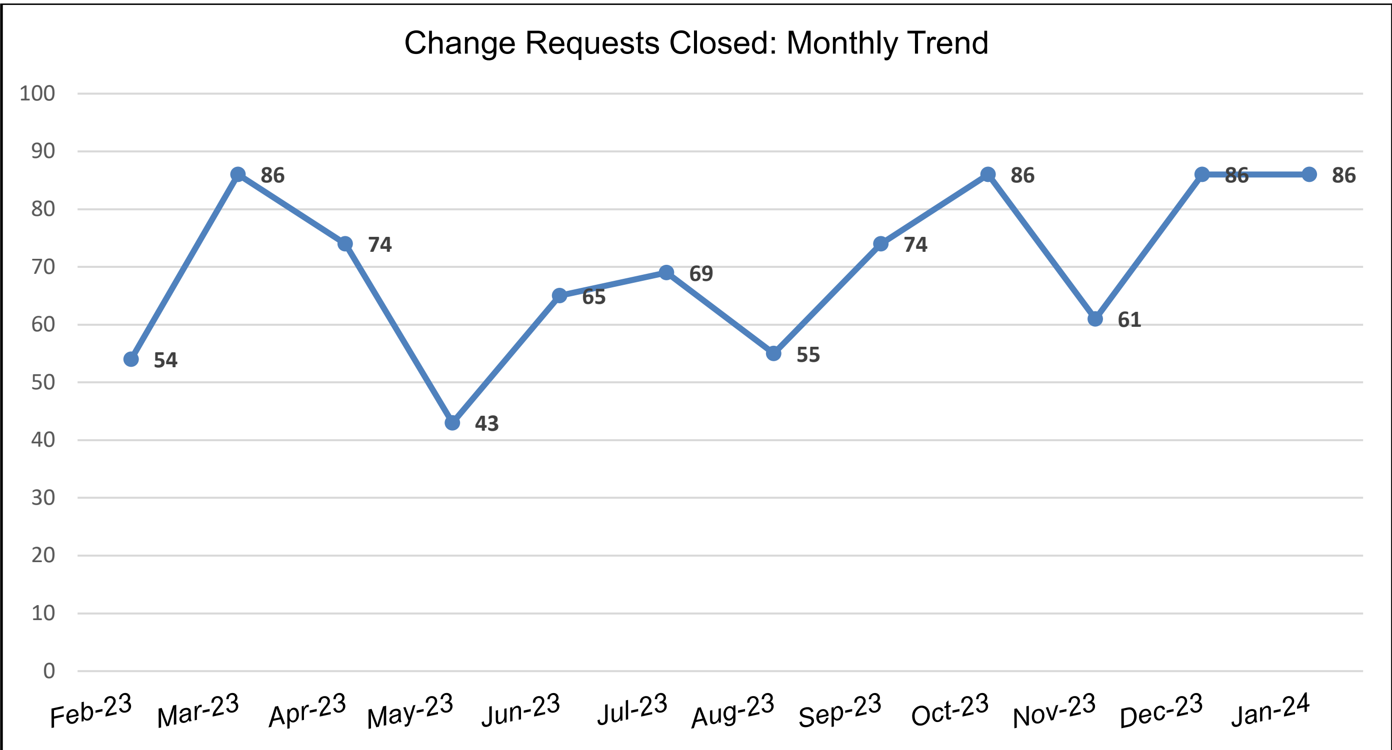
- 103 Change Requests Submitted/Logged in the month of January 2024



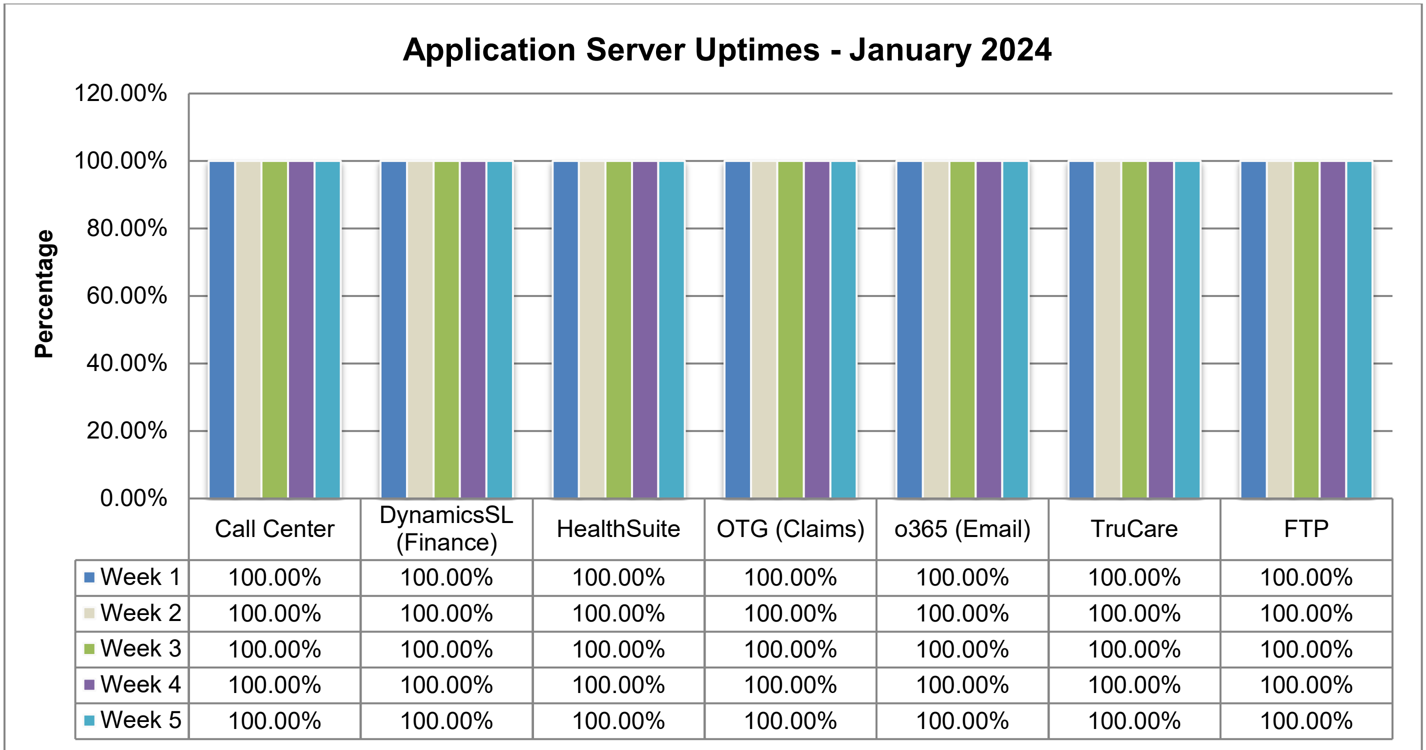
- 86 Change Requests Closed in the month of January 2024




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

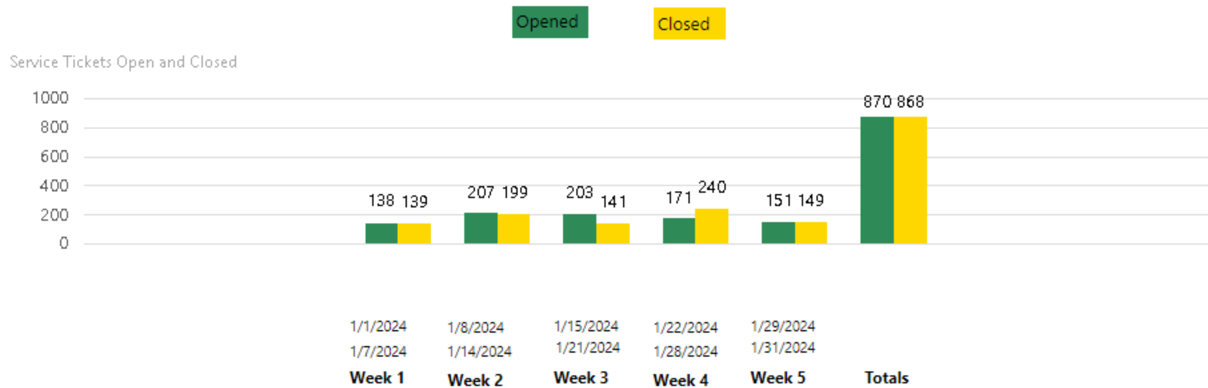
IT Stats: Infrastructure



	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.

Microsoft Teams experienced a global issue that affected the messaging platform on Friday, January 26th, 2024. Services were restored the following day.



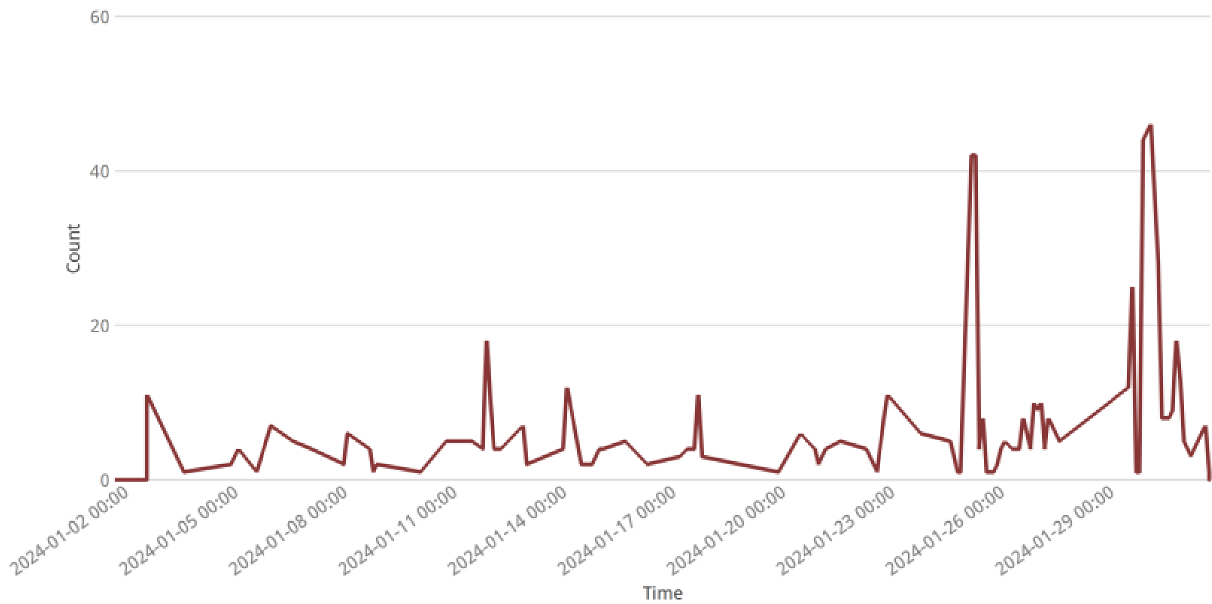
- 870 Service Desk tickets were opened in the month of January 2024, which is 11.37% higher than the previous month (771) and 10% higher than the previous 3-month average of 783.

- 868 Service Desk tickets were closed in January 2024, which is 6.91% higher than the previous month (808) and 8.06% higher than the previous 3-month average of 798.

January 2024

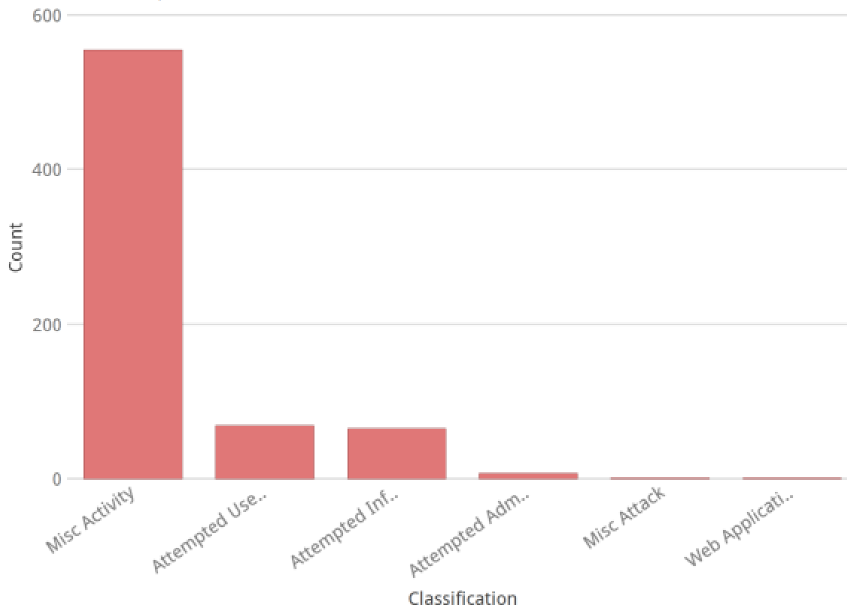
All Intrusion Events

Time Window: *2024-01-01 09:29:00 - 2024-01-31 09:29:00*



Dropped Intrusion Events

Time Window: *2024-01-01 09:30:00 - 2024-01-31 09:30:00*
Constraints: *Inline Result = !Alert,!Would **



Classification	Count
Misc Activity	555
Attempted User Privilege Gain	69
Attempted Information Leak	65
Attempted Administrator Privilege Gain	7
Misc Attack	1
Web Application Attack	1

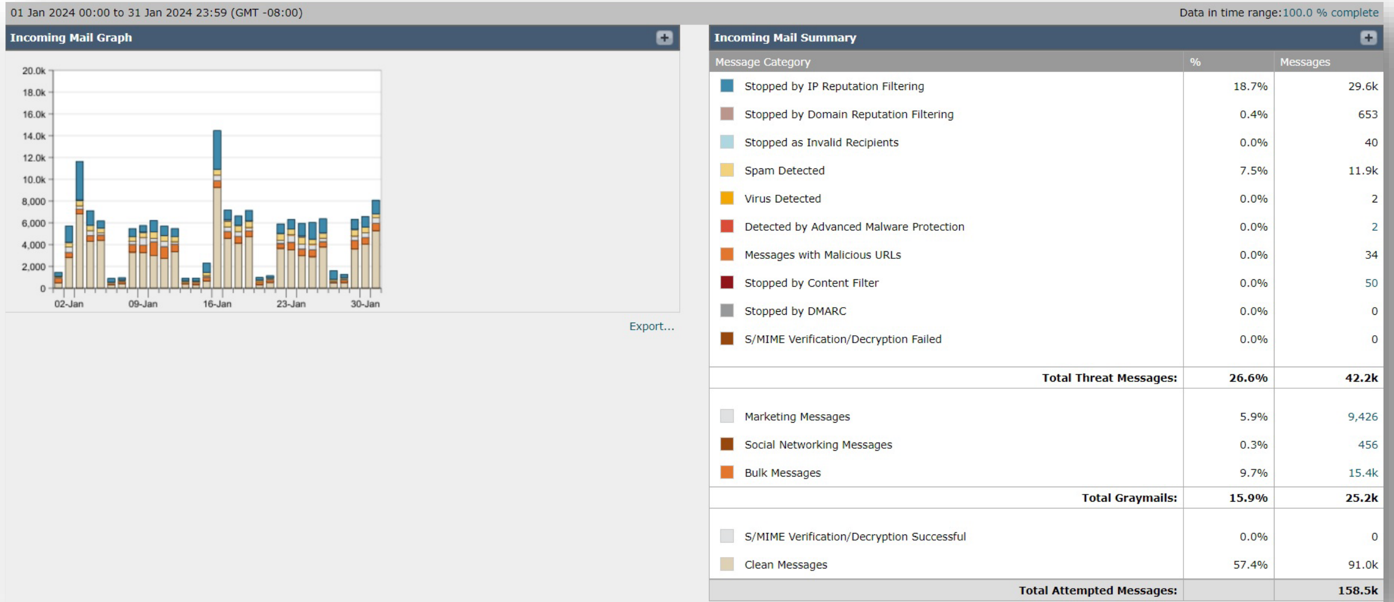
IronPort Email Security Gateways

Email Filters

January 2024

MX4

Inbound Mail



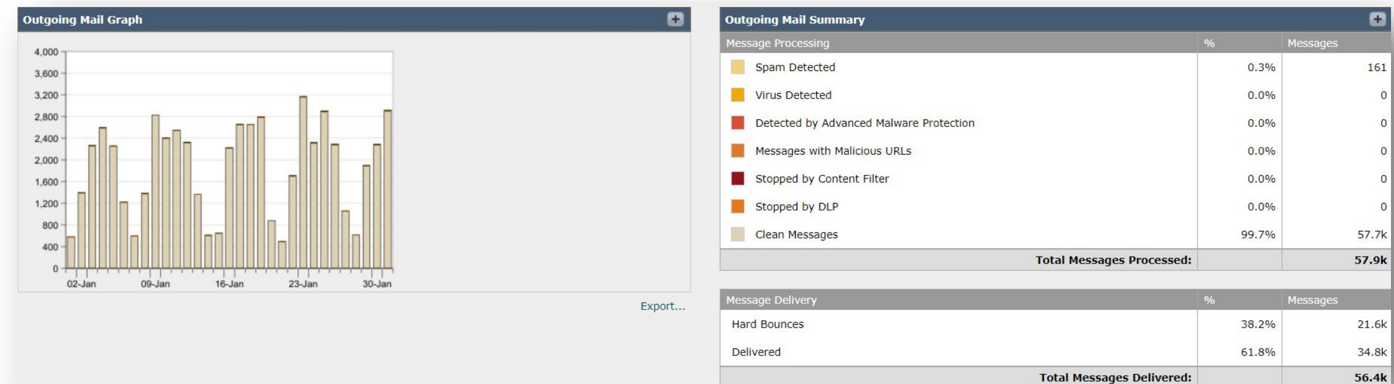
01 Jan 2024 00:00 to 31 Jan 2024 23:59 (GMT -08:00) — Data in time range: 100.0 % complete

Incoming Mail Graph

Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	18.7%	29.6k
Stopped by Domain Reputation Filtering	0.4%	653
Stopped as Invalid Recipients	0.0%	40
Spam Detected	7.5%	11.9k
Virus Detected	0.0%	2
Detected by Advanced Malware Protection	0.0%	2
Messages with Malicious URLs	0.0%	34
Stopped by Content Filter	0.0%	50
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**26.6%**	**42.2k**
Marketing Messages	5.9%	9,426
Social Networking Messages	0.3%	456
Bulk Messages	9.7%	15.4k
Total Graymails:	**15.9%**	**25.2k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	57.4%	91.0k
Total Attempted Messages:		**158.5k**

Outbound Mail



Outgoing Mail Graph

Outgoing Mail Summary

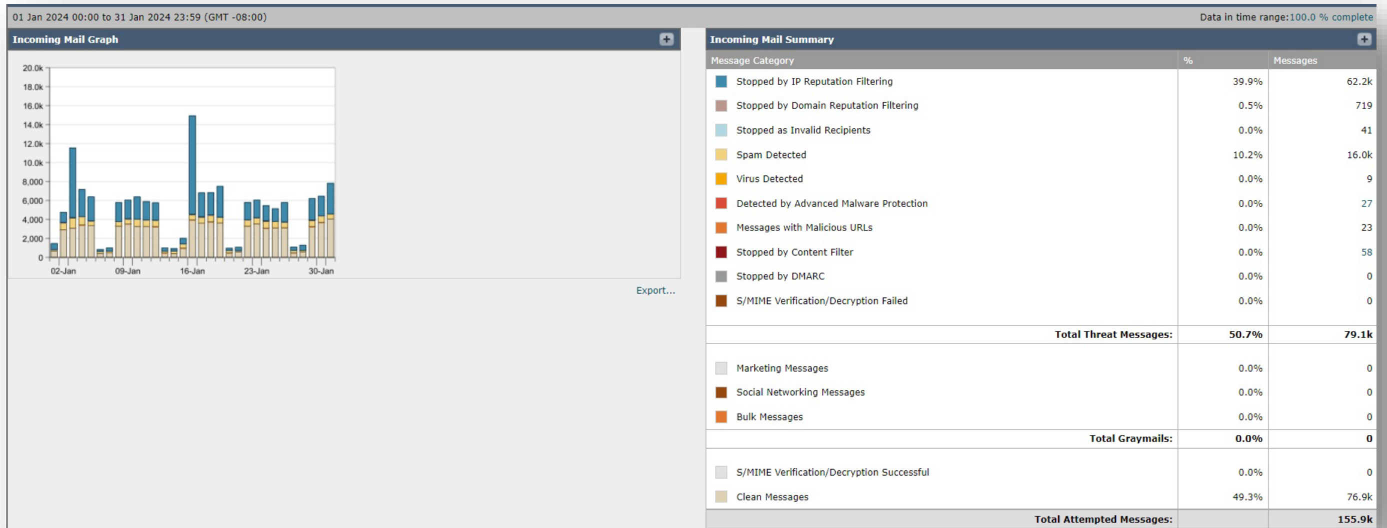
Message Processing	%	Messages
Spam Detected	0.3%	161
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	0
Stopped by Content Filter	0.0%	0
Stopped by DLP	0.0%	0
Clean Messages	99.7%	57.7k
Total Messages Processed:		**57.9k**

Message Delivery	%	Messages
Hard Bounces	38.2%	21.6k
Delivered	61.8%	34.8k
Total Messages Delivered:		**56.4k**

January 2024

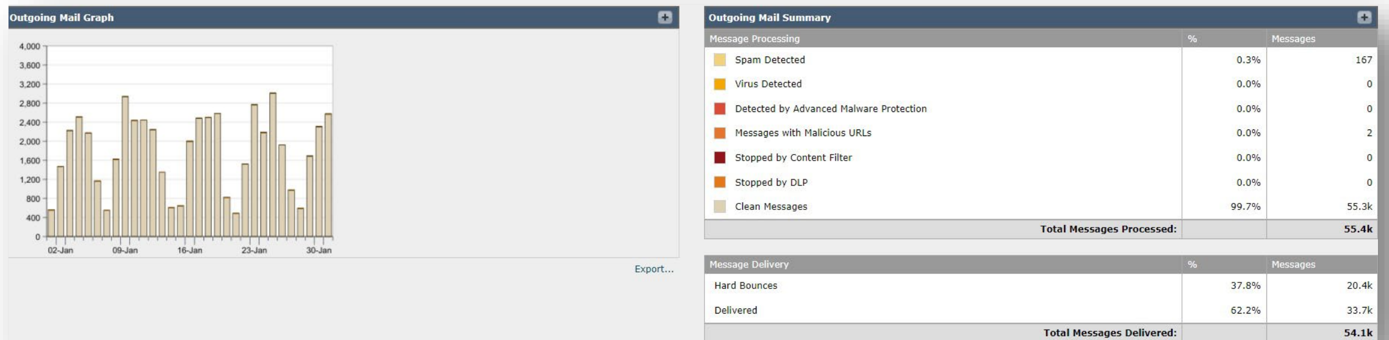
MX9

Inbound Mail



Message Category	%	Messages
Stopped by IP Reputation Filtering	39.9%	62.2k
Stopped by Domain Reputation Filtering	0.5%	719
Stopped as Invalid Recipients	0.0%	41
Spam Detected	10.2%	16.0k
Virus Detected	0.0%	9
Detected by Advanced Malware Protection	0.0%	27
Messages with Malicious URLs	0.0%	23
Stopped by Content Filter	0.0%	58
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**50.7%**	**79.1k**
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	49.3%	76.9k
Total Attempted Messages:		**155.9k**

Outbound Mail



Message Processing	%	Messages
Spam Detected	0.3%	167
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	2
Stopped by Content Filter	0.0%	0
Stopped by DLP	0.0%	0
Clean Messages	99.7%	55.3k
Total Messages Processed:		**55.4k**

Message Delivery	%	Messages
Hard Bounces	37.8%	20.4k
Delivered	62.2%	33.7k
Total Messages Delivered:		**54.1k**

Item / Date	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	*Sep-23*	Oct-23	Nov-23	Dec-23	***Jan-24***
Stopped By Reputation	41.9k	65.3k	60.9k	31.7k	33.2k	27.1k	30.4k	59.1k	*99.7k*	74k	74.1k	58k	***91.9k***
Invalid Recipients	204	68	75	97	113	92	82	79	*98*	86	88	73	***81***
Spam Detected	10.1k	12.5k	15.4k	14.5k	13.7k	14.1k	12.5k	27.9k	*33.1*	28.7k	25.8k	20.6k	***26.9k***
Virus Detected	1	3	0	2	9	1	5	3	*22*	10	29	6	***11***
Advanced Malware	1	1	0	0	3	1	0	1	*55*	37	78	24	***29***
Malicious URLs	35	34	27	6	478	233	170	6	*50*	97	11	57	***57***
Content Filter	37	33	40	115	127	162	56	39	*110*	114	333	66	***108***
Marketing Messages	13.7k	13.9k	15.5k	15.5k	18.5k	16.1k	15.7k	16.2k	*8.4k*	9.5k	8.9k	8.1k	***9.4k***
Attempted Admin Privilege Gain	61	61	115	170	4	50	173	51	*250*	6	0	1	***7***
Attempted User Privilege Gain	107	307	87	428	42	66	162	47	*329*	146	48	48	***69***
Attempted Information Leak	17.8k	17.1k	12.5k	24.4k	5	1	18	53	*118*	71	51	50	***65***
Potential Corp Policy Violation	0	0	0	0	4	2	0	0	*0*	0	0	0	***0***
Network Scans Detected	0	0	0	0	0	0	0	0	*0*	0	0	0	***0***
Web Application Attack	19	1	2	2	7	1	8	0	*15*	7	4	4	***1***
Attempted Denial of Service	0	0	2.9k	109	0	0	1	0	*4*	0	0	0	***0***
Misc. Attack	240	1,288	2	521	2	3	1,862	151	*2,901*	1,023	347	2,146	***1***

- 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 57k.

- Attempted information leaks detected and blocked at the firewall is at 65 for the month of **January 2024.**

- Network scans returned a value of 0, which is in line with previous month's data.

- Attempted User Privilege Gain slightly increased at 69 from a previous six-month average of 114.

Analytics

Tiffany Cheang

To: Alameda Alliance for Health Board of Governors

From: Tiffany Cheang, Chief Analytics Officer

Date: February 9th, 2024

Subject: Performance & Analytics Report

Member Cost Analysis

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

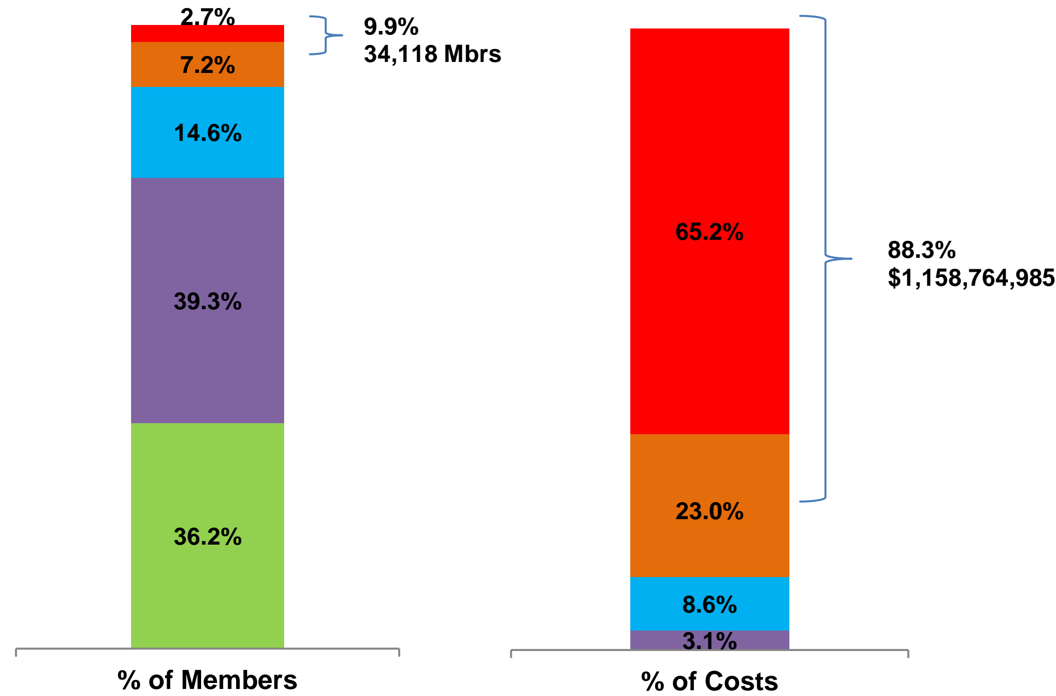
Current reporting period: Nov 2022 – Oct 2023 dates of service
Prior reporting period: Nov 2021 – Oct 2022 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 9.9% of members account for 88.3% of total costs.
- In comparison, the Prior reporting period was lower at 9.5% 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 56.4% of the members, with SPDs accounting for 24.1% and ACA OE's at 32.3%.
    - The percent of members with costs >= $30K increased from 2.1% 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, decreasing to 39.9%.
    - 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 9.9% is more concentrated in the 45-66 year old category (38.2%) compared to the overall population (20.6%).

Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Nov 2022 - Oct 2023
Note: Data incomplete due to claims lag
Run Date: 01/28/2024



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	9,252	2.7%	$ 856,494,040	65.2%
$5K - $30K	24,866	7.2%	$ 302,270,944	23.0%
$1K - $5K	50,618	14.6%	$ 112,750,580	8.6%
< $1K	136,160	39.3%	$ 41,332,017	3.1%
$0	125,413	36.2%	$ -	0.0%
Totals	**346,309**	**100.0%**	**$ 1,312,847,582**	**100.0%**

Top 9.9% of Members = 88.3% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	2,137	0.6%	$ 464,049,006	35.3%
$75K to $100K	1,410	0.4%	$ 120,492,386	9.2%
$50K to $75K	2,232	0.6%	$ 137,916,482	10.5%
$40K to $50K	1,374	0.4%	$ 61,302,240	4.7%
$30K to $40K	2,099	0.6%	$ 72,733,927	5.5%
SubTotal	***9,252***	***2.7%***	***$ 856,494,040***	***65.2%***
$20K to $30K	3,510	1.0%	$ 85,683,314	6.5%
$10K to $20K	9,363	2.7%	$ 131,056,645	10.0%
$5K to $10K	11,993	3.5%	$ 85,530,985	6.5%
SubTotal	***24,866***	***7.2%***	***$ 302,270,944***	***23.0%***
Total	**34,118**	***9.9%***	**$ 1,158,764,985**	***88.3%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Oct 2023	303,463	$ 1,182,378,362
Dis-Enrolled During Year	42,846	$ 130,469,220
Totals	**346,309**	**$ 1,312,847,582**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
9.9% of Members = 88.3% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Nov 2022 - Oct 2023
Note: Data incomplete due to claims lag
Run Date: 01/28/2024

9.9% of Members = 88.3% of Costs
24.1% of members are SPDs and account for 28.7% of costs.
32.3% of members are ACA OE and account for 31.7% of costs.
8.0% of members disenrolled as of Oct 2023 and account for 10.3% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	147	612	759	2.2%
MCAL	MCAL - ADULT	831	4,530	5,361	15.7%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	386	1,901	2,287	6.7%
	MCAL - ACA OE	2,706	8,304	11,010	32.3%
	MCAL - SPD	2,735	5,495	8,230	24.1%
	MCAL - DUALS	641	2,113	2,754	8.1%
	MCAL - LTC	116	9	125	0.4%
	MCAL - LTC-DUAL	795	80	875	2.6%
Not Eligible	Not Eligible	895	1,822	2,717	8.0%
Total		**9,252**	**24,866**	**34,118**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 11,197,975	$ 7,035,682	$ 18,233,657	1.6%
MCAL	MCAL - ADULT	$ 73,220,601	$ 52,473,769	$ 125,694,369	10.8%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 25,523,495	$ 21,896,509	$ 47,420,004	4.1%
	MCAL - ACA OE	$ 265,487,404	$ 101,425,901	$ 366,913,305	31.7%
	MCAL - SPD	$ 262,492,347	$ 70,596,587	$ 333,088,934	28.7%
	MCAL - DUALS	$ 48,393,892	$ 24,941,824	$ 73,335,716	6.3%
	MCAL - LTC	$ 13,137,036	$ 150,159	$ 13,287,195	1.1%
	MCAL - LTC-DUAL	$ 60,050,971	$ 1,290,038	$ 61,341,009	5.3%
Not Eligible	Not Eligible	$ 96,990,320	$ 22,460,475	$ 119,450,795	10.3%
Total		**$ 856,494,040**	**$ 302,270,944**	**$ 1,158,764,985**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
34.0% of members are SPDs and account for 33.2% of costs.
33.0% of members are ACA OE and account for 34.9% of costs.
12.1% of members disenrolled as of Oct 2023 and account for 13.6% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	29	1.4%
MCAL	MCAL - ADULT	181	8.5%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	43	2.0%
	MCAL - ACA OE	706	33.0%
	MCAL - SPD	727	34.0%
	MCAL - DUALS	67	3.1%
	MCAL - LTC	44	2.1%
	MCAL - LTC-DUAL	82	3.8%
Not Eligible	Not Eligible	258	12.1%
Total		**2,137**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 4,969,886	1.1%
MCAL	MCAL - ADULT	$ 40,312,384	8.7%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 10,036,268	2.2%
	MCAL - ACA OE	$ 162,159,616	34.9%
	MCAL - SPD	$ 154,211,443	33.2%
	MCAL - DUALS	$ 11,982,337	2.6%
	MCAL - LTC	$ 7,307,802	1.6%
	MCAL - LTC-DUAL	$ 10,171,150	2.2%
Not Eligible	Not Eligible	$ 62,898,118	13.6%
Total		**$ 464,049,006**	**100.0%**

% of Total Costs By Service Type

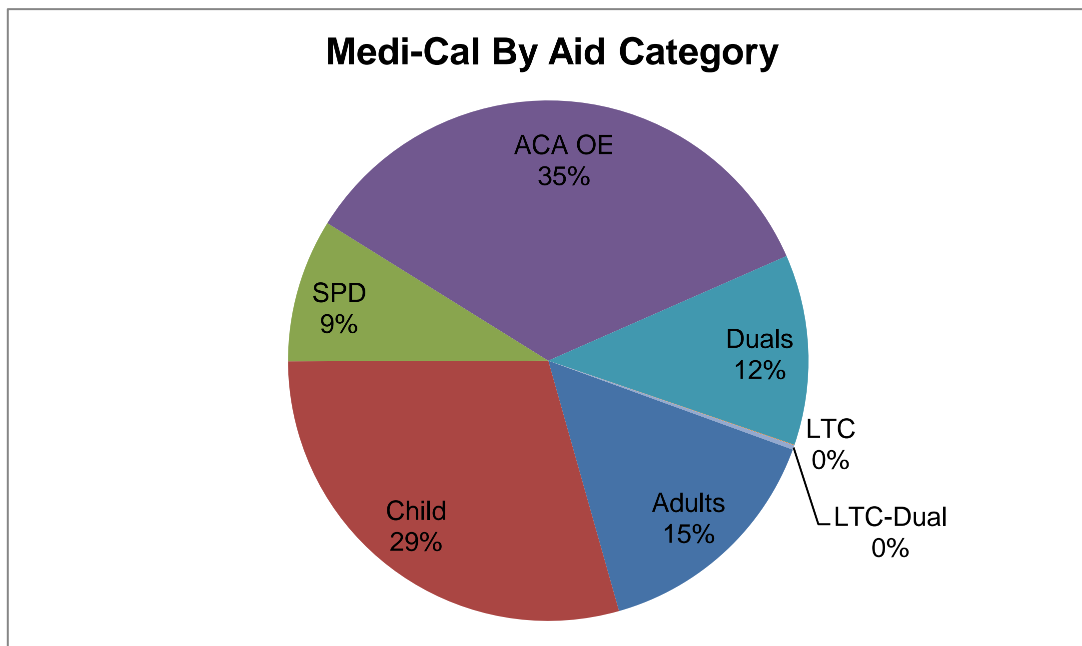
				Breakout by Service Type/Location						
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	8%	0%	1%	0%	48%	1%	13%	4%	2%	14%
$75K to $100K	3%	0%	1%	0%	22%	2%	5%	3%	4%	49%
$50K to $75K	3%	0%	2%	0%	26%	2%	5%	4%	5%	38%
$40K to $50K	5%	0%	1%	1%	31%	5%	5%	5%	2%	19%
$30K to $40K	10%	0%	2%	0%	25%	12%	6%	6%	1%	18%
$20K to $30K	3%	1%	4%	0%	24%	6%	7%	7%	1%	17%
$10K to $20K	0%	0%	9%	1%	26%	5%	10%	7%	2%	15%
$5K to $10K	0%	0%	12%	1%	22%	7%	11%	11%	1%	17%
Total	**5%**	**0%**	**3%**	**0%**	**35%**	**3%**	**10%**	**5%**	**2%**	**22%**

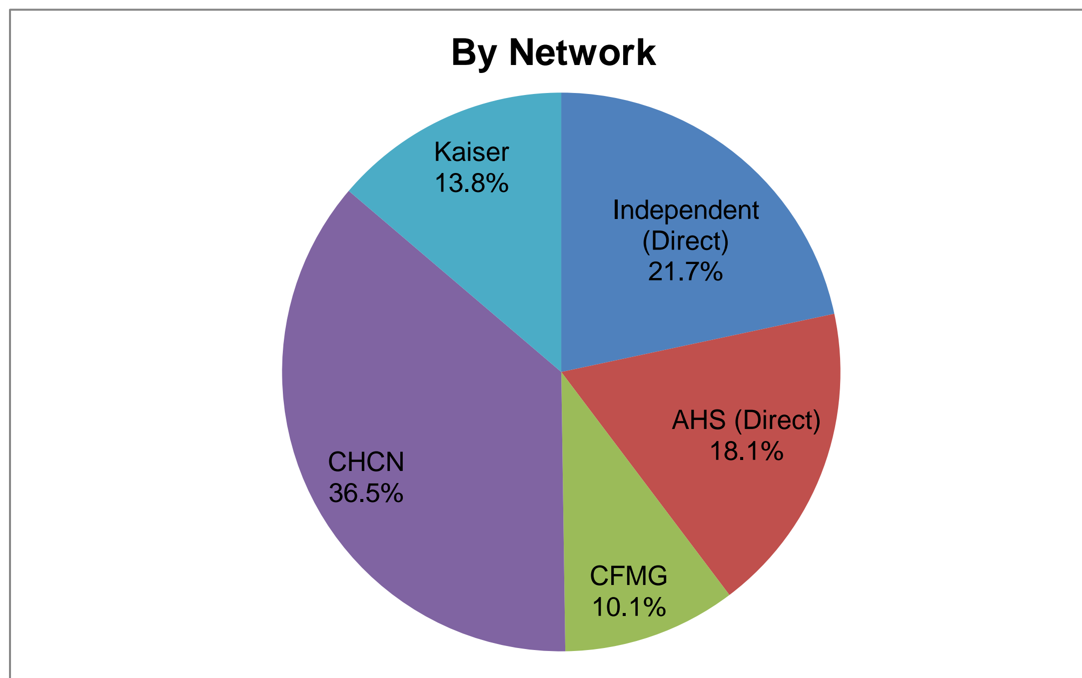
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	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%**

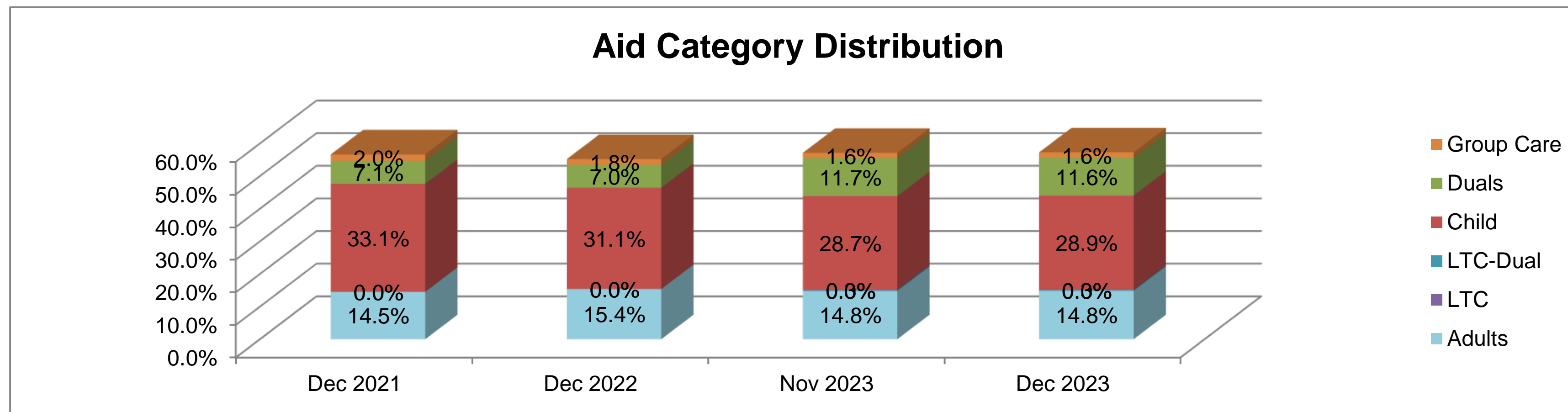




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

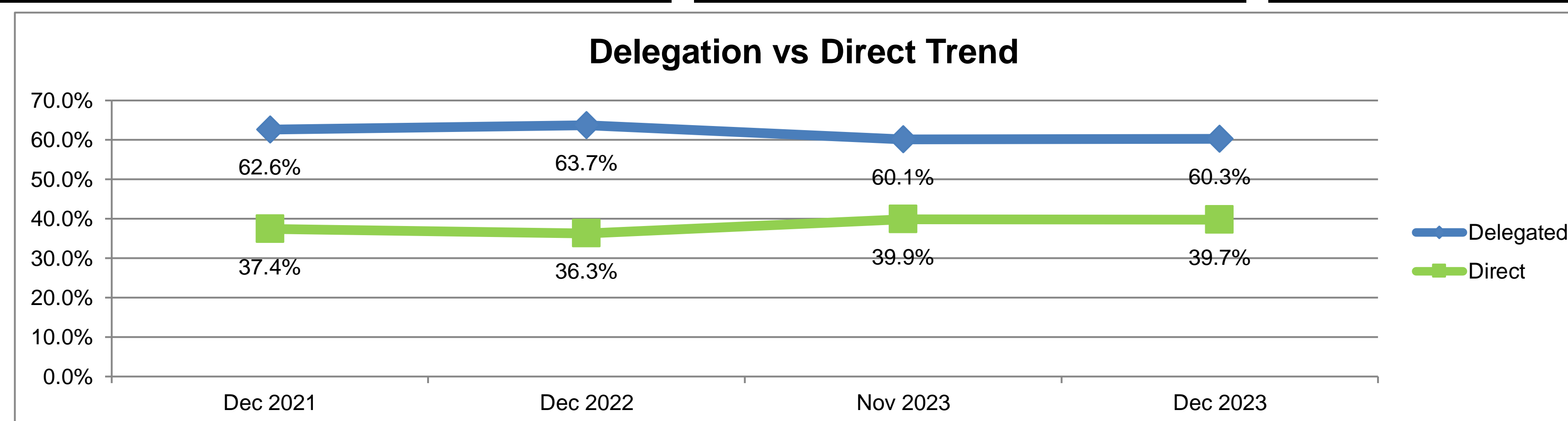
Category of Aid Trend

Category of Aid	Members Dec 2021	Dec 2022	Nov 2023	Dec 2023	% of Total (ie.Distribution) Dec 2021	Dec 2022	Nov 2023	Dec 2023	% Growth (Loss) 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%**



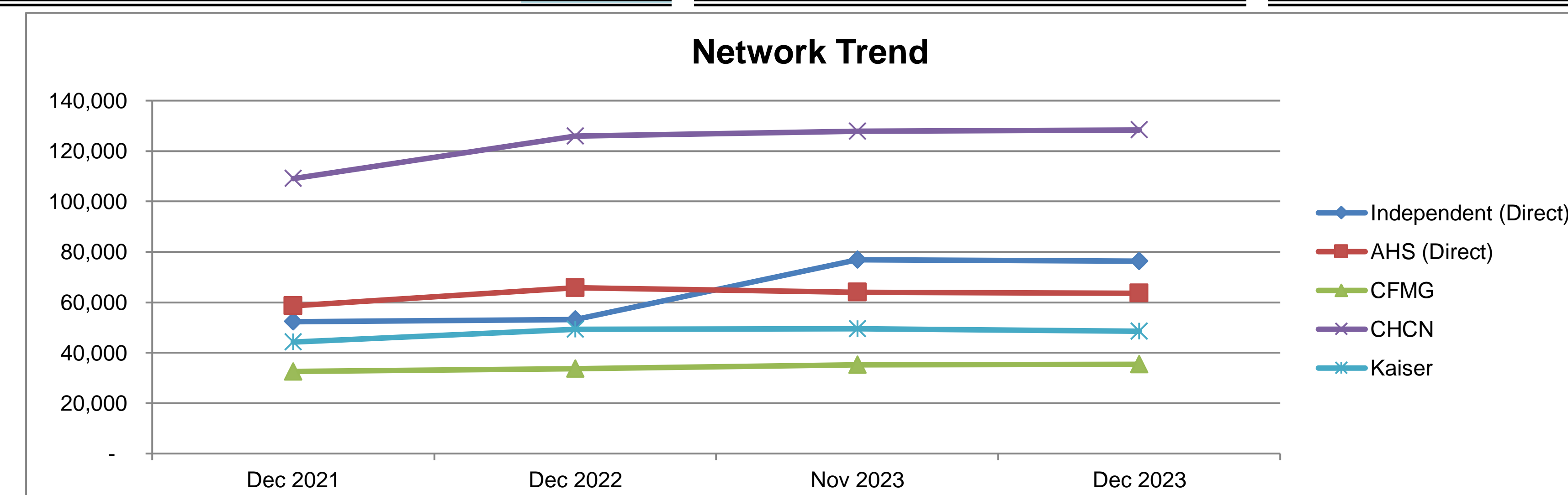
Delegation vs Direct Trend

Members	Members Dec 2021	Dec 2022	Nov 2023	Dec 2023	% of Total (ie.Distribution) Dec 2021	Dec 2022	Nov 2023	Dec 2023	% Growth (Loss) 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

Network	Members Dec 2021	Dec 2022	Nov 2023	Dec 2023	% of Total (ie.Distribution) Dec 2021	Dec 2022	Nov 2023	Dec 2023	% Growth (Loss) 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%**



Human Resources

Anastacia Swift

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

From: **Anastacia Swift, Chief Human Resources Officer**

Date: **February 9th, 2024**

Subject: **Human Resources Report**

Staffing

- As of February 1st, 2024, the Alliance had 556 full time employees and 1-part time employee.
- On February 1st, 2024, the Alliance had 87 open positions in which 14 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 73 positions open to date. The Alliance is actively recruiting for the remaining 73 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by department:

Department	Open Position February 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	31	5	26
Operations	36	6	30
Healthcare Analytics	2	0	2
Information Technology	13	3	10
Finance	2	0	2
Compliance & Legal	1	0	1
Human Resources	2	0	2
Health Equity	0	0	0
Executive	0	0	0
Total	87	14	73

- Our current recruitment rate is 14%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in January 2024 included:

  - 5 years:
    - Yan Xiao (Utilization Management)
    - Chidananda Mahalingaiah (Apps Management, IT Quality & Process Improvement)
    - Jeffrey Bencini (Pharmacy Services)
  - 6 years:
    - Dr. Sanjay Bhatt (Behavioral Health)
    - Alice Mak (Utilization Management)
    - Dr. Stephen O'Brien (Medical Services)
    - Anastacia Swift (Human Resources)
  - 8 years:
    - Deborah Ames (Finance)
    - Shruti Gupta (Healthcare Analytics)
    - Jennifer Karmelich (Regulatory Readiness)
  - 9 years:
    - John Settle (IT Development)
  - 11 years:
    - Lena Lee (Quality Management)
    - Catherine Chang (Finance)
  - 12 years:
    - Raul Cornejo (Information Technology)
  - 16 years:
    - Beza Tesfaye (IT – Ops & Quality Applications Management)
  - 22 years:
    - Rachel Cooper (Claims)

Legislative Tracking

2024 Legislative Tracking List

The 2024 California State Legislative Session is in full swing. The deadline to pass two-year bills out of their respective chambers was January 31st and the legislature has until February 16th to introduce new bills. 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
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

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

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
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: 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
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 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
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
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
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
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
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
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
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
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
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
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
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
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 1313 **(Ortega D) Older individuals: case management services.**
Current Text: Amended: 4/27/2023
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
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 1450 **(Jackson D) Behavioral health: behavioral health and wellness screenings: notice.**
Current Text: Amended: 1/3/2024
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
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
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
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
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
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
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
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 1943 (Weber D) **Health information.**
Current Text: Introduced: 1/29/2024
Status: 1/30/2024-From printer. May be heard in committee February 29.
Location: 1/29/2024-A. PRINT

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

Summary: Current law requires the 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 1975 (Bonta D) **Medi-Cal: medically supportive food and nutrition interventions.**
Current Text: Introduced: 1/30/2024
Status: 1/31/2024-From printer. May be heard in committee March 1.
Location: 1/30/2024-A. PRINT

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
Status: 1/31/2024-From printer. May be heard in committee March 1.
Location: 1/30/2024-A. PRINT

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 2043 **(Boerner D) Medi-Cal: nonmedical and nonemergency medical transportation.**
Current Text: Introduced: 2/1/2024
Status: 2/1/2024-Read first time. To print.
Location: 2/1/2024-A. PRINT

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

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.

SB 70 **(Wiener D) Prescription drug coverage.**
Current Text: Amended: 6/29/2023
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
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
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
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. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

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: Enrollment: 1/29/2024
Status: 1/29/2024-Enrolled and presented to the Governor at 11 a.m.
Location: 1/29/2024-S. ENROLLED

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

Summary: 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 424 **(Durazo D) Medi-Cal: Whole Child Model program.**
Current Text: Amended: 5/25/2023
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 516 **(Skinner D) Health care coverage: prior authorization.**
Current Text: Amended: 9/13/2023
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: 1/29/2024
Status: 1/29/2024-Read third time and amended. Ordered to third reading. Re-referred to Com. on RLS. pursuant to Assembly Rule 77.2.
Location: 1/29/2024-A. RLS.

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 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 comply with the postconsumer recycled plastic content requirements and the virgin plastic and postconsumer recycled plastic reporting requirements by submitting a consolidated report with aggregated information that covers one or more beverage manufacturers, as specified. The bill would authorize the department to adopt regulations to implement the bill's provisions, as specified.

SB 729 (**Menjivar** D) **Health care coverage: treatment for infertility and fertility services.**
Current Text: Amended: 8/14/2023
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 contract holders 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 980 **(Wahab D) Medi-Cal: dental crowns and implants.**
Current Text: Introduced: 1/29/2024
Status: 1/30/2024-From printer. May be acted upon on or after February 29.
Location: 1/29/2024-S. RLS.

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
Status: 2/1/2024-Introduced. Read first time. To Com. on RLS. for assignment. To print.
Location: 2/1/2024-S. RLS.

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
Status: 2/1/2024-Introduced. Read first time. To Com. on RLS. for assignment. To print.
Location: 2/1/2024-S. RLS.

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.