ALAMEDA ALLIANCE FOR HEALTH
QUALITY IMPROVEMENT – PROGRAM EVALUATION 2020

ALAMEDA Alliance FOR HEALTH

2020
Quality Improvement Program Evaluation Signature Page

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ALAMEDA Alliance FOR HEALTH

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Introduction

Alameda Alliance for Health (Alliance) is a local, public, not-for-profit managed care health plan committed to making high-quality health care services accessible and affordable to County. The Alliance staff and provider network reflect the county's cultural and linguistic diversity. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for county residents. The Alliance currently provider health care coverage to over 275,589 children and adults through its programs.

Under the leadership and strategic direction established by the Board of Governors (BOG), senior management and the Health Care Quality Committee (HCQC), the Health Services 2020 Quality Improvement (QI) Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2020 through December 31, 2020.

Mission, Vision, and Values

Mission

The Alliance strives to improve the quality of life of our members and people throughout our diverse community by collaborating with our provider partners in delivering high quality, accessible and affordable health care services. As participants of the safety-net system, we recognize and seek to collaboratively address social determinants of health as we proudly serve Alameda County.

Vision

The Alliance Vision is to be the most valued and respected managed care health plan in California.

Values

Teamwork – We participate actively, remove barriers to effective collaboration and interact as a winning team.

Respect – We are courteous to others, embrace diversity and strive to create a positive work environment.

Accountability – We take ownership of tasks and responsibilities and maintain a high level of work quality.

Commitment & Compassion – We collaborate with our providers and community partners to improve the wellbeing of our members, focus on quality in all we do and act as good stewards of resources.

Knowledge & Innovation – We seek to understand and find better ways to help our members, providers, and community partners.

Purpose

The purpose of the Alliance 2020 Annual QI Program Evaluation is to access and evaluate the overall quality and effectiveness of the QI Program in meeting the goals and objectives of the QI Program and Work Plan. The QI Department leads the evaluation assessment in collaboration with cross function departments utilizing data and reports from committees, content experts, data analysts, work plans outcomes, Plan-Do-Study-Act studies, Performance Improvement and QI Projects to perform qualitative and quantitative analysis of initiatives and activities outcomes, identify barriers to established goals and objectives, best practices, next steps and other improvement opportunities. The Alliance uses the annual evaluation to identify new and ongoing goals, objectives, and activities for the QI Program in the coming year.

This evaluation assesses the following elements:

Completed and ongoing QI activities that address the quality and safety of clinical care and quality of service.

Performance measure trends to assess performance in the quality and safety of clinical care and quality of service.

Analysis and evaluation of the overall effectiveness of the QI Program and of its progress toward influencing network wide safe clinical practices.

The annual QI Program Evaluation is reviewed and approved by the Health Care Quality Committee (HCQC) before being submitted for review and approval by the Alliance BOG. The HCQC and the BOG also review and approve the QI Program Description and Work Plan for the upcoming year.

Membership and Provider Network

The Alliance product lines include Medi-Cal managed care and Group Care commercial insurance. Medi-Cal managed care beneficiaries, eligible through one of several Medi-Cal programs, e.g. Temporary Assistance Needy Families (TANF), Seniors and Persons with Disabilities (SPD), Medi-Cal Expansion and Dually Eligible Medi-Cal members who do not participate in California's Coordinated Care Initiative (CCI). For dually eligible Medi-Cal and Medicare beneficiaries,

Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan offered by the Alliance. The Group Care product line provides comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Table 1: 2020 Trended Enrollment by Network and Aid Category

Current Membership by Network By Category of Aid							
Category of Aid	**Dec 2020**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	38,150	14%	8,844	8,501	374	13,958	6,473
Child	94,969	35%	9,292	8,661	28,902	31,790	16,324
SPD	26,339	10%	8,535	4,009	1,122	10,723	1,950
ACA OE	91,050	34%	15,063	31,096	1,129	32,984	10,778
Duals	19,127	7%	7,635	2,054	2	6,998	2,438
Medi-Cal	269,635		49,369	54,321	31,529	96,453	37,963
Group Care	5,954		2,568	919	-	2,467	-
Total	**275,589**	**100%**	**51,937**	**55,240**	**31,529**	**98,920**	**37,963**
Medi-Cal %	97.8%		95.1%	98.3%	100.0%	97.5%	100.0%
Group Care %	2.2%		4.9%	1.7%	0.0%	2.5%	0.0%
			18.8%	*20.0%*	*11.4%*	*35.9%*	*13.8%*
Network Distribution			**% Direct:**	**39%**		**% Delegated:**	**61%**

Table 2: 2020 Trended Categories of Aid, Distribution and Growth/Loss

Category of Aid Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Dec 2018	Dec 2019	Nov 2020	Dec 2020	Dec 2018	Dec 2019	Nov 2020	Dec 2020	Dec 2018 to Dec 2019	Dec 2019 to Dec 2020	Nov 2020 to Dec 2020
Adults	35,559	32,066	37,638	38,150	13.5%	12.9%	13.8%	13.8%	-9.8%	19.0%	1.4%
Child	95,322	89,056	94,620	94,969	36.1%	35.8%	34.6%	34.5%	-6.6%	6.6%	0.4%
SPD	26,006	25,687	26,314	26,339	9.8%	10.3%	9.6%	9.6%	-1.2%	2.5%	0.1%
ACA OE	85,345	78,154	89,752	91,050	32.3%	31.4%	32.8%	33.0%	-8.4%	16.5%	1.4%
Duals	16,072	17,776	18,990	19,127	6.1%	7.1%	6.9%	6.9%	10.6%	7.6%	0.7%
Medi-Cal Total	258,304	242,739	267,314	269,635	97.8%	97.6%	97.8%	97.8%	-6.0%	11.1%	0.9%
Group Care	5,886	6,092	5,982	5,954	2.2%	2.4%	2.2%	2.2%	3.5%	-2.3%	-0.5%
Total	264,190	248,831	273,296	275,589	100.0%	100.0%	100.0%	100.0%	-5.8%	10.8%	0.8%

Table 3: 2020 Trend Enrollment by Age Category

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Dec 2018	Dec 2019	Nov 2020	Dec 2020	Dec 2018	Dec 2019	Nov 2020	Dec 2020	Dec 2018 to Dec 2019	Dec 2019 to Dec 2020	Nov 2020 to Dec 2020
Under 19	98,122	91,641	97,068	97,399	37%	37%	36%	35%	-7%	6%	0%
19 - 44	84,866	78,271	91,897	93,280	32%	31%	34%	34%	-8%	19%	2%
45 - 64	57,340	54,210	57,413	57,679	22%	22%	21%	21%	-5%	6%	0%
65+	23,862	24,709	26,918	27,231	9%	10%	10%	10%	4%	10%	1%
Total	**264,190**	**248,831**	**273,296**	**275,589**	**100%**	**100%**	**100%**	**100%**	**-6%**	**11%**	**1%**

In December of 2020, the Alliance membership increased by 11% from December 2019 compared to a decrease in enrollment of 6% from December of 2018 to December of 2019. Total membership numbers increased by 11,399 from December 2018 to December 2020. The Alliance experienced membership growth in all age categories from 2019 to 2020. **6.0%** membership growth for ages under 19, **19%** growth (largest growth category) in the 19-44 age category, **6.0 %** growth for 45-64 age category and **10%** growth noted for 65+ age category. Percent of total distribution by age category decrease by **2%** for age category under age 19 (37% in 2018 down to 35% in 2020). Additionally, there was a **2%** increase in age category 19 – 44 (32% in 2018 to 34% in 2020). There was a 16.5% growth trend noted in ACA-OE aid category from December

2019 to December 2020. A likely driver of the noted increases in membership was the economic downturn related to the 2020 pandemic.

Medical services are provided to beneficiaries through one of the contracted provider networks. Currently, The Alliance provider network includes:

Table 4: 2020 Provider Network by Type, Enrollment and Percentage

PROVIDER NETWORK	PROVIDER TYPE	MEMBERS (ENROLLMENT)	% OF ENROLLMENT IN NETWORK
Direct-Contracted Network	Independent	51,937	19%
Alameda Health System (AHS)	Managed Care Organization	55,240	20%
Children First Medical Group (CFMG)	Medical Group	31,529	11%
Community Health Clinic Network (CHCN)	Medical Group	98,920	36%
Kaiser Permanente	HMO	37,963	14%
	TOTAL	**275,589**	**100%**

From 2018 to 2020, the percentage of members within each provider network has remained relatively steady.

The Alliance offers a comprehensive health care delivery system, including the following scope of services:

- Ambulatory care
- Hospital care
- Emergency services
- Behavioral health (mental health and addiction medicine)
- Home health care
- Hospice
- Palliative Care
- Rehabilitation services
- Skilled nursing services - Skilled

- Managed long term services and support (MLTSS)
  - Community based adult services
  - Long Term SNF Care (limited)
- Transportation
- Pharmacy

Care coordination along the continuum of care including arrangements for linked and carved out services, programs, and agencies.

These services are provided through a network of contracted providers inclusive of hospitals, nursing facilities, ancillary providers and service vendors. The providers/vendors are responsible for specifically identified services through contractual arrangements and delegation agreements.

The Alliance provider network includes:

Table 5: Alliance Ancillary Network

ANCILLARY TYPE	COUNT
Behavioral Health Network	1
DME Vendor	1 (Capitated)
Health Centers (FQHCs and non-FQHCs)	67
Hospitals	17
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200
Skilled Nursing Facilities	64
Transportation Vendor	1 individual vendor with 380 individual transportation providers

Alliance members may choose from a network of over 590 primary care practitioners (PCPs), nearly 7000 specialists, 17 hospitals, 67 health centers, 64 nursing facilities and more than 200 pharmacies throughout Alameda County. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our first priority.

The Alliance Quality Improvement (QI) Program strives to ensure that members have access to quality health care services.

ALAMEDA Alliance FOR HEALTH

QI Structure and Resources

A. QI Structure

The structure of the Alliance QI Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of the Alliance health care delivery network for medical and behavioral health care services. Additionally, the structure is designed to enhance communication and collaboration on QI program goals and objectives, activities, and initiatives, that impact member care and safety both internal and external to the organization, inclusive of delegates. The QI Program is evaluated on an on-going basis for efficacy and appropriateness of content by Alliance staff and oversight committees.

B. Governing Committee

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 15-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of the Alliance QI Programs and is responsible for approving the annual QI Program Description, Work Plan, and Program Evaluation. The BOG delegates oversight of Quality functions to the Alliance Chief Medical Officer (CMO) and the Health Care Quality Committee (HCQC) and provides the authority, direction, guidance and resources to enable Alliance staff to carry out responsibilities, functions and activities of the QI Program. QI oversight is the responsibility of the HCQC.

The HCQC develops and implements the QI program and oversees the QI functions within the Alliance.

The HCQC:

- Recommends policies or revisions to policies for the operational effectiveness of the QI Program and the achievement of QI program objectives.
- Oversees the analysis and evaluation of the QI, Utilization Management (UM) and Case Management (CM) programs and Work Plan activities and assesses the results.
- Ensures practitioner participation in the QI program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings.
- Identifies needed actions, and ensures follow-up to improve quality, prioritizing actions based on their significance and provides guidance on which to choose and pursue as appropriate. The HCQC also assesses the overall effectiveness of the QI, UM, CM and Pharmacy & Therapeutics (P&T) Programs.

The HCQC met a total of 6 times in 2020:

- January 16, 2020
- March 19, 2020
- May 21, 2020
- July 16, 2020
- September 17, 2020
- November 19, 2020

The 2019 QI Program Evaluation, the 2020 QI Program Description and the 2020 QI Work Plan were presented to the HCQC during the May 21, 2020 meeting and unanimously approved.

C. Committee Structure

The BOG appoints and oversees the HCQC which, in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QI Programs. The BOG also oversees the Peer Review and Credentialing Committee (PRCC) which provides a peer review platform and also a platform to review provider credentialing and re-credentialing. Committee membership is made up of provider representatives from the Alliance contracted networks and the Alliance community including, those who provide health care services to Behavioral Health, Seniors and Persons with Disabilities (SPD) and chronic conditions.

The HCQC provides oversight, direction, recommendations, and final approval of the QI Program documents. Committee meeting minutes are maintained summarizing committee activities and decisions and are signed and dated.

HCQC charters a sub-committee, the Internal Quality Improvement Sub-Committee (IQIC) which serves as a forum for the Alliance to evaluate current QI activities, processes, and metrics. The IQIC also evaluates the impact of QI programs on other key stakeholders within various departments and when needed, assesses and plans for the implementation of any needed changes. HCQC assumes responsibility for oversight of the IQIC activities and monitoring its areas of accountability as needed. The structure of the committee meetings is designed to increase engagement from all participants.

The major committees that support the quality and utilization of care and service include:

- Healthcare Quality Committee (HCQC)
- Peer Review and Credentialing Committee (PRCC)
- Member Advisory Committee (MAC)
- Pharmacy and Therapeutics (P&T) Sub-committee
- Utilization Management (UM) Sub-committee
- Access and Availability Sub-committee

- Internal Quality Improvement Sub-committee (IQIC)
- Cultural and Linguistic Services Sub-committee

Additionally, joint operations meetings (JOMs) support the quality improvement work of the Alliance. Each committee meets at least quarterly, some monthly, and all committees / sub-committees, except the PRC and MAC committees, report directly to the HCQC. The PRC and MAC report directly to the BOG. The PRCC supports the quality and utilization of safe care and service for the Alliance membership and reports directly to the BOG. Each committee continues to meet the goals outlined in their charters, as applicable. The HCQC membership includes practitioners representing a broad range of specialties, as well as Alliance leadership and staff.

D. Evaluation of Senior- Level Physician and Behavioral Health Practitioners

The BOG delegates oversight of QI and UM functions to the HCQC which is chaired by the Alliance Chief Medical Officer (CMO) and vice-chaired by the Medical Director of Quality. The CMO and Medical Director provides the authority, direction, guidance and resources to enable Alliance staff to carry out the QI Program. The CMO delegates senior level physician involvement in appropriate committees to provide clinical expertise and guidance to program development.

During 2020, Dr. Aaron Chapman, a psychiatrist and CMO of Alameda County Behavioral Health Care (ACBH), actively participated in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications.

The active involvement of senior-level physicians including the psychiatrist from Alameda County Behavioral Health (ACBH) has provided consistent input into the quality program. Their participation helped ensure that the Alliance is meeting accreditation and regulatory requirements.

E. Program Structure and Operations

The Alliance QI Program encompasses quality of care across the Alliance enterprise and across the health care continuum.

2020 QI Program activities included, but were not limited to the following:

- Evaluation of the effectiveness of the QI program structure and oversight
- Implementation and completion of ongoing QI activities that addressed quality and safety or clinical care and quality of service
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service
- Analysis of QI initiatives and barriers to improvement

- Monitoring, auditing, and evaluation of delegated entities QI activities for compliance to contractual requirements with the implementation of corrective action plans as appropriate
- Internal monitoring and auditing of QI activities for regulatory compliance, and assurance of quality and safety of clinical care and quality of service
- Development and revision of department policies, procedures and processes as applicable
- Development and implementation of direct and delegate network corrective action plans as a result of non-compliance and identified opportunities for improvement, as applicable.

F. QI Resources

The Alliance QI Department key staff included licensed physicians and registered nurses, qualified non-clinical management staff, as well as non-clinical specialist staff and non-clinical administrative support coordinators. The assignment and performance of work within the team, whether working on site or remotely, for both clinical and non-clinical activities, is seamless to the Alliance operations processes. Job description expectations with assigned tasks and responsibilities remain unchanged regardless of the geographical location of staff member.

In 2020, as the result of onboarding of new senior and management level leadership, and qualified support staff the Health Care Services in 2019, the QI Department team was able to further mitigate gaps in both leadership and oversight of the QI program integrity. The QI program moved forward in providing quality improvement guidance enterprise-wide meeting regulatory and accreditation standards and promoting positive health outcomes for the Alliance membership. In late October 2020 the QI Department experienced a vacancy for the Access to Care Manager due to employee resignation. Health Care Services continues to evaluate staff turn-over and strives to provide a positive work environment while creating a stable work force.

Through 2020, vendor partnerships were a part of the QI resource strategy. The Alliance discontinued its contractual relationship with Health Data Decisions (HDD). However, the department continued to augmented QI resources via consultants and analytic expertise for the HEDIS program.

Additionally, the Alliance maintained its strong relationship with healthcare services support and survey vendor, SPH Analytics (SPH).

In 2020 SPH support the QI Department work with implementation, analysis, and reporting on the following surveys:

- Afterhours and Emergency Instruction Survey
- Health Information Form/Member Evaluation Tool (HIF-MET) Survey

- Health Risk Assessment (HRA) Survey
- Member Satisfaction Survey
- Provider Satisfaction Survey

Overall Program Effectiveness

The Alliance's quality improvement efforts strive to impact the safety and quality of care and service provided to our members and providers. Review of the Alliance's 2020 QI activities as described herein demonstrates the Alliance's QI department ability (in collaboration with internal and external entities) to successfully assess, design, implement, and evaluate an effective QI Program inlcuding but, not limited to, the following:

Improved focus on the importance of chronic condition management, and accessing appropriate care through initiatives to educate and connect with members, direct and delegated providers, communitiy based organizations, state and county entities and enhance our improvements to our internal operations.

1. Maintained a targeted focus on the analysis of key drivers, barriers and best practices to improve access to care.
2. Expanded staff knowledge of health disparities within the Alliance membership through population data collection, analysis and segmentation.
3. Promoted the awareness and concepts of inter-departmental QI initiatives and activities, including Plan-Do-Study-Act (PDSA), and Inter-Rater Reliability (IRR), to create greater operational efficiencies.
4. Invested in quality measurement analysis expertise.
5. Identified Potential Quality Issues (PQIs) operations gaps and root cause analysis to identify and overcome barriers, as well as, best practices resulting in internal workflow improvements and staff retraining.
6. Exhibited improvement in HEDIS measures' performance including CIS-Combo 10, IMA-Combo 2, PPC, AMR, and AMM.
7. Ensured timely Facilty Site Review (FSR/Medical Record Review (MRR) audits and Physical Accessibility Review Surveys (PARS).
8. Targeted QI initiatives to improve direct and delegate provider engagement in access to care efforts to improve rates of preventive care and services, screenings and referrals for members
9. Targeted partnerships with community based, county agencies and delegate providers to improve referral and resources triage and management through technology collaboration and support.

10. Promoted healthcare access and safety education for members and providers through targeted pharmacy substance use programs.
11. Improved engagement with intereprter services vendors and Alliance network providers to ensure quality interpreter services at all points of healthcare service contact.
12. Enhanced engagement with Behavioral Health delegate for improved and timely access to care.
13. Collaborated with delegated providers around the implementation of a revised Delegate Corrective Action Plan (CAP) Process creating increased efficiencies for compliance from both direct and delegated providers.

The Alliance is invested in a multi-year strategy to ensure that the organization adapts to health plan industry changes now and within 3 - 5 years. An effective QI program with adequate resources is essential to the Alliance's successful adaptation to expected changes and challenges.

Serving Members with Complex Conditions

The Alliance continues to identify members with complex health conditions in need of supportive services based on data collection and analysis. The Alliance links members to Asthma and Diabetes Disease Management, Complex Case Management (CCM), Transition of Care (TOC), Whole Person and Health Homes Management Programns and services based on healthcare needs.

Members identified as potential candidates for Asthma Disease Management are mailed outreach materials explaining their condition and the process to enroll in Disease Management. Disease Management is optional. Members who do not pursue Disease Management programs are also provided information related to community resources available to support their health concers.

Additionally, some of the Alliance members were identified as "high risk" for complex health conditions through claims, encounter and referral data. Identified members are forwarded to case management and health homes management for follow up. Complex Case Management (CCM) and Health Homes Management staff outreach to high risk members by telephone and communicate with Community-Based Care Management (CB-CMEs). When outreach attempts are successful, initial assessments are performed and care plans are developed. Members who agree to care are provided assistance with provision of services and recommendations to support managing their conditions. When outreach is attempted but unsuccessful, the case is closed.

Members were also identified for TOC" assistance. TOC assistance is designed to ensure that the coordination and continuity of health care occurs for members who are discharged from Medical or Surgical inpatient care settings to a different level of care. Tracking and trending of outcomes through CM and DM processes is a key component of the Case Management and Disease

Management program activities. Serving all members inclusive of those with complex needs and conditions for tracking and trending of more targeted improvement in health outcomes through population health and needs assessments data collection will continue to be a part of the Health Care Services fabric in 2021.

Provider Outreach and Engagement

During 2020, the Provider Services department provided continued outreach to all PCP, Specialists and Ancillary provider offices via the use of fax blasts. In-person visits were conducted until Shelter-in-Place orders went into effect in March 2020 and subsequently resumed through alternative modalities of email, telephone, and mail.

Topics covered in the visits and fax blasts included but, were not limited to: use of the provider portal, the announcement of the Member Satisfaction update and reminders, Provider Satisfaction updates, Population Needs Assessment, Rx Safety Guidelines and updates, Gap-in Care report updates, Lactation Program Changes, DHCS Medi-Cal Rx updates, Immunizations, Stanford Cancer Network Program Partnership, Provider Appointment Availability Survey (PAAS) Update, Cultural Sensitivity Training for 2020, Initial Health Assessment (IHA) Update, Electronic submission of Prior Authorization notification, Timely Access Standards Reminders, Young Adult Expansion update, Provider Portal updates, Case Management Referral form distribution, Diabetes Prevention Program Benefit update, New Maternal Mental Health Program information, U.S. Preventative Services Task Force (USPSTF) A and B Recommendations Update, and several COVID-19 updates.

In addition to ongoing quarterly visits, every newly credentialed provider received a new provider orientation within 10 days of becoming effective with the Alliance. This orientation includes a very detailed summary which includes but not limited to:

- Plan review and summary of Alliance programs
- Review of network and contract information
- How to verify eligibility
- Referrals and how to submit prior authorizations
- Timely Access Standards
- Member benefits and services that require PCP referral
- How to submit claims
- Filing of complaints and the appeal process
- Interpreter Services process
- Initial Health and Staying Healthy Assessment
- Coordination of Care, CCS, Regional Center, WIC program

- Child Health and Disability Program
- Members Rights and Responsibilities
- Member Grievances
- Potential Quality Issues (PQIs)
- Health Education
- HEDIS Education

Overall, there were approximately 500 quarterly packets mailed to providers with updates as mentioned above. Additionally, 1,700 outreach occurrences conducted during the 2020 calendar year. The Provider Services department plans to continue our robust provider outreach and engagement strategies in 2021.

Member Outreach and Member Services

In 2020, the Alliance Member Services (MS) Department continued to have a strong focus on providing high-quality service. The Alliance received certification as a Center of Excellence for superior performance in the Alliance Member Services Call Center. The Center of Excellence recognition, awarded by BenchmarkPortal, is a high honor in the customer service and support industry.

The Alliance Member Services Team is committed to providing the highest levels of exceptional service to our members and providers. This award of excellence shows our dedication to deliver first-rate customer service and ensure that our members have access to the care and services they need to stay healthy.

As a committed safety-net partner, the Center of Excellence award is an example of our commitment to centering the needs of members and the larger Alameda County community. To become a Center of Excellence, the Alliance had to pass a thorough assessment that measures ongoing performance on key operating metrics. The key metrics were rated against the international BenchmarkPortal database – the largest in the world of contact center metrics. The outcome demonstrates the superior service the Alliance provides to members every day.

Our Alliance Team is greatly honored to receive the Certified Center of Excellence award during these challenging times. Our mission at the Alliance is to help our members live a healthy life by providing access to high-quality care and services that they need. Providing excellent customer service is just one of the many ways that we serve our community. This honor could not be achieved without the hard work of our dedicated staff.

Quarterly call center metrics are presented below in the Member Services blended (Ansafone and AAH call center) dashboard. The dashboard represents blended (Medi-Cal and Group Care) customer service results.

Table 6: 2020 Quarterly Call Center Metrics

ALLIANCE MEMBER SERVICES STAFF	Q1	Q2	Q3	Q4
Incoming Calls (MS)	30783	24743	29647	26869
Answered Calls (MS)	29112	24203	28236	25372
Abandoned Rate (MS)	5%	2%	5%	6%
Average Speed to Answer (ASA)	00:40	00:25	01:08	01:24
Calls Answered in 30 Seconds (All)	77%	88%	67%	61%
Average Talk Time	06:55	07:00	07:24	07:45
Calls Answered in 10 Minutes (goal: 100%)	100.0%	100.0%	100.0%	100.0%
Ansafone Call Center	**Q1**	**Q2**	**Q3**	**Q4**
Incoming Calls (AF)	9315	2903	7175	8759
Answered Calls (AF)	8358	2810	6589	8095
Abandoned Rate (AF)	10%	3%	8%	8%
Average Speed to Answer (ASA)	02:02	00:32	01:05	01:41
Calls Answered in 30 Seconds (AF)	48%	69%	64%	57%
Average Talk Time (ATT)	07:27	07:17	07:09	05:57
Recordings/Voicemails	**Q1**	**Q2**	**Q3**	**Q4**
Incoming Calls (R/V)	2837	1570	2172	2185
Answered Calls (R/V)	2837	1570	2172	2185
Abandoned Rate (R/V)	0.00%	0.00%	0.00%	0.00%
Calls Answered in 30 Seconds (R/V)	100%	100%	100%	100%
Blended Results	**Q1**	**Q2**	**Q3**	**Q4**
Incoming Calls (R/V)	42935	29216	38994	37813
Answered Calls (R/V)	40307	28583	36997	35652
Abandoned Rate (R/V)	6%	2%	5%	6%
Average Speed to Answer (ASA)	0:55	0:24	01:04	01:22
Calls Answered in 30 Seconds (R/V)	72%	86%	69%	63%

ALLIANCE MEMBER SERVICES STAFF	Q1	Q2	Q3	Q4
Average Talk Time (ATT)	6:32	6:39	6:55	6:53

Table 7: Member Services Call Volume 2020 Member Services Call Center Report

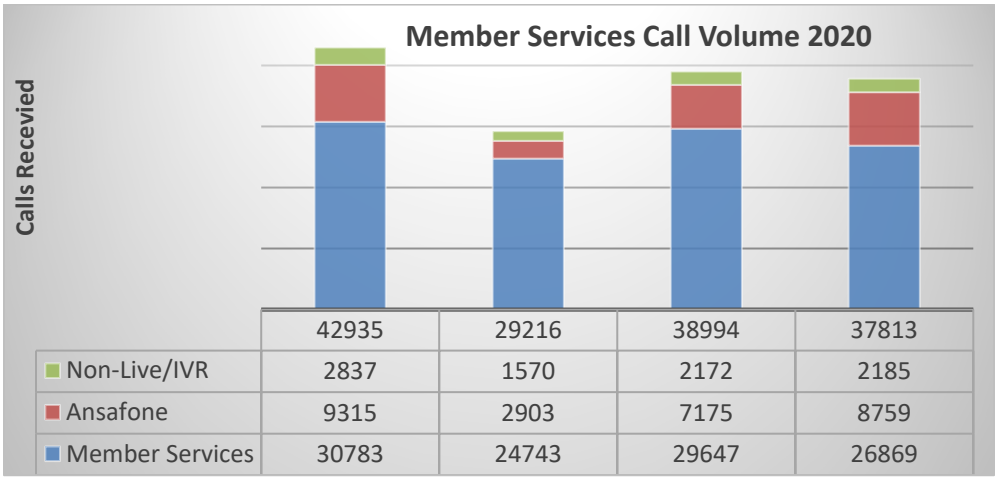
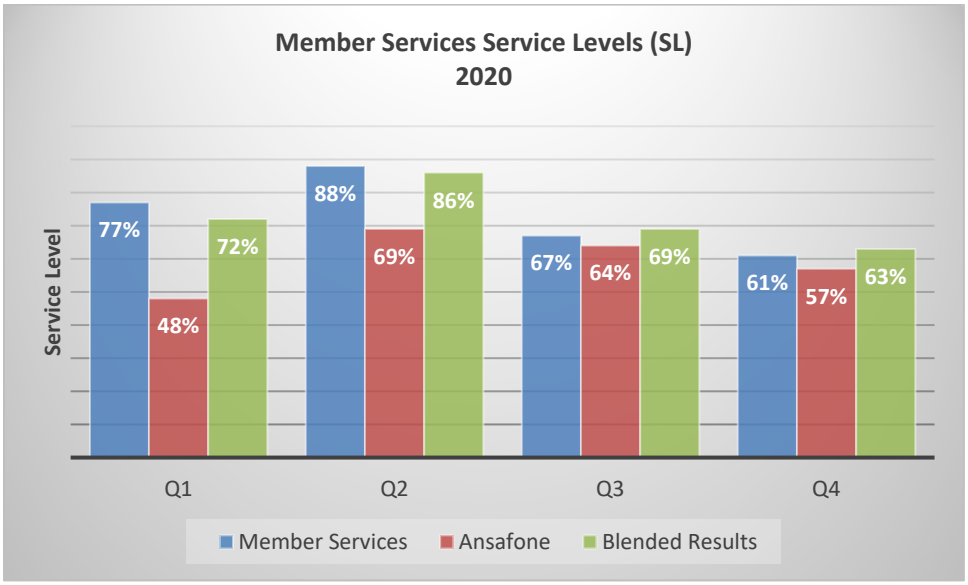


Table 8: Member Services Levels (SL) 2020 Member Services Call Center Report



In 2020, Member Services blended call center targeted metrics were not met for Q1 and Q4 for the abandonment rate of 5% or less. Staffing challenges due to unexpected/unplanned leave of absences (LOAs) and the pandemic impacted the team's ability to meet its service metrics. The MS Department reviewed and implemented various changes to improve service levels and meet metrics. The Member Services phone tree was redesigned to increase member satisfaction and decrease abandonment rates by allowing members to reach the right people, with the right skills

(bilingual in particular), at the right time. An automated edibility verification system implementation for January 2021 is planned that will allow members the self-serve option to check eligibility – real time without speaking to a live agent 24/7. In 2020 Member Services Leadership collaborated with HR to review the bilingual language assessment to increase the level of proficiency required to meet the quality standards to better service our members in this important area. Member Services is currently and will continue working with Compliance to review contractual performance guarantees to ensure quality measures have been met by our call overflow vendor. Through quality assurance process when service measures are not met by the vendor, Compliance will continue to issue corrective action plans. The Department continues to monitor and track call center operations to ensure compliance and quality standards are met. The plan will consolidate the external and internal call centers in 2021 to better service our membership.

Table 9: Abandonment Rate

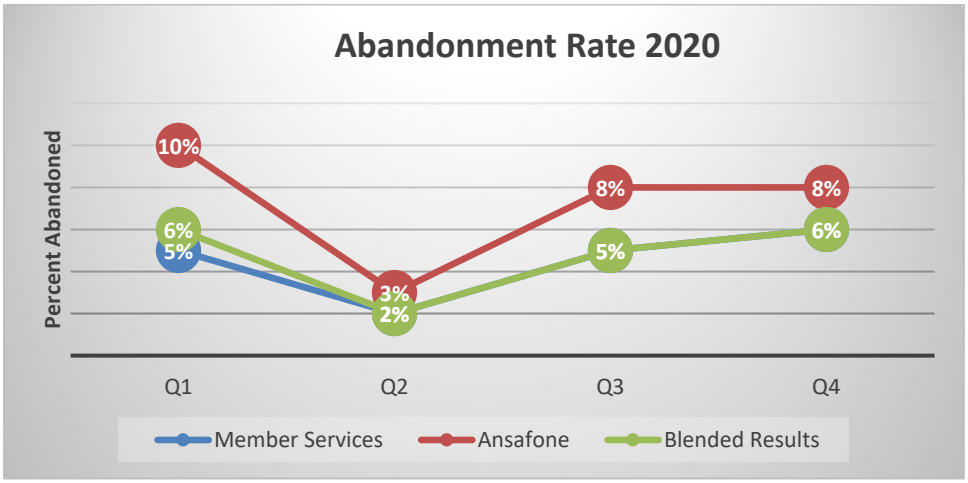
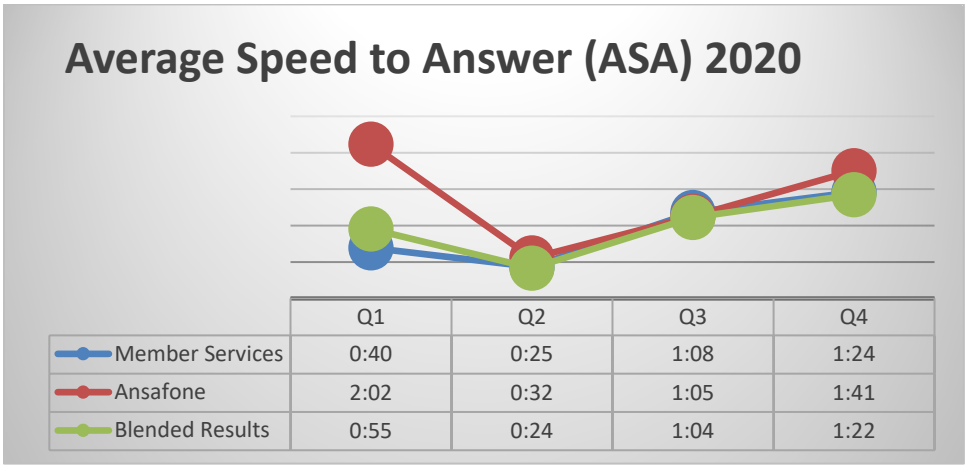


Table 10: Average Speed to Answer (ASA) 2020



	Q1	Q2	Q3	Q4
Member Services	0:40	0:25	1:08	1:24
Ansafone	2:02	0:32	1:05	1:41
Blended Results	0:55	0:24	1:04	1:22

Member Advisory Committee (MAC)

In 2020, the Member Advisory Committee (MAC) functioned to provide information, advice, and recommendations to the Alliance on member educational and operational issues in respect to the administration of the Alliance's cultural and linguistic services. These advisory functions include but, are not limited to, providing input on the following:

- Culturally appropriate service or program design
- Priorities for the health education and outreach programs
- Member satisfaction survey results
- Findings of the population needs assessment
- The Alliance's outreach materials and campaigns
- Communication of needs for provider network development and assessment
- Community resources and information

The Member Advisory Committee received information from the Alliance on public policy issues, including financial information, and data on the nature and volume of member grievances and the grievance disposition.

The MAC met four times in 2020:

- March 19, 2020
- June 18, 2020
- September 17, 2020
- December 17, 2020

Some of the key topics discussed in 2020 included:

- Cultural and Linguistics Work Plan and Report
- Grievances & Appeals
- Communications & Outreach collateral, events and activities
- Health Education Report
- Timely Access Report
- Population Needs Assessment
- Pharmacy Updates
- COVID-19
- Questions & Answers for member concerns

Member Newsletter

The Alliance 2020 Spring/Summer and Fall/Winter *Member Connect* newsletters were published and shared with more than 150,000 member households and provider offices. The newsletter contained a variety of disease self-management and preventive care topics and education on:

- COVID-19
- Childhood injury prevention
- Heart health
- Autoimmune diseases
- Alliance response to racism
- Cancer care
- Smoking Cessation
- Asthma care
- Well-child and well-care visits
- Preventive care for children
- COVID-19 safety at doctor visits
- Tips for successful telehealth visits
- Immunizations
- Language Services
- Cancer care program

Safety of Clinical Care

In 2020, the Alliance continued its organizational focus on maintaining safety of clinical care for its membership.

A. Substance Use Disorder

In 2020 the Alliance partnered with our network providers and other local leaders to develop a Substance Use Disorder Program.

Alameda Alliance has continued to use multiple strategies involving Member *and Provider Educational Outreach and Pharmacy Safeguards*. The Alliance has worked together with our internal analytics team to create an accurate and comprehensive monthly report opioid overutilization, grandfathered members, hospice/palliative, cancer, and sickle cell members on opioids, and monitoring the changes in MME (morphine milliequivalence)

The Alliance has identified a list of members in Q4 2020 who were considered chronic users and potential chronic opioid users. Chronic users are defined as members with prescriptions of greater than 300 MME consecutively for the last three months, and potential chronic opioid users are defined as members with prescriptions between 50 to 89 MME consecutively for the last three months. The Alliance will continue to address members with another MME tier after successful member and provider educational outreach are completed through mailings and potential phone outreach in coordination with case management. The Alliance also has compiled a list of members who presented to the ED with opioid and benzodiazepine overdose and a separate list of members on concurrent use of opioids and benzodiazepines.

In 2021, the Alliance plans to send out educational mailings that is pertinent to members and providers. Mailing campaign may include:

1. Lists of identified members who are chronic users, high risk members on becoming chronic users, concurrent chronic opioid/benzodiazepine usage and members presenting to ED for opioid/benzodiazepine overdose
2. Provider Opioid and Benzodiazepine Tapering Tools
3. Opioid Safety guide for members and caregivers
4. Non-opioid formulary alternatives
5. Treatment for opioid dependence
6. Local alternative health services contracted with the Alliance (e.g. physical therapy, acupuncture, chiropractor, massage)

B. Opioids Stewardship Report

Alameda Alliance Ongoing Activities

Purpose of Report: To provide periodic updates regarding steps that AAH is taking to help combat the opioid epidemic.

Opioid and Benzodiazepine ER Reporting

- Reports based on claims data and reflects each unique claim with opioids/benzodiazepine related ICD code.
- Reports are shared with assigned PCPs of members on these reports on a quarterly basis.
- There was almost a 2-fold increase on average on opioid/benzodiazepine related ER visits between 2019 and 2020.

Table 11: 2019 Opioid/Benzodiazepine related ER Visits

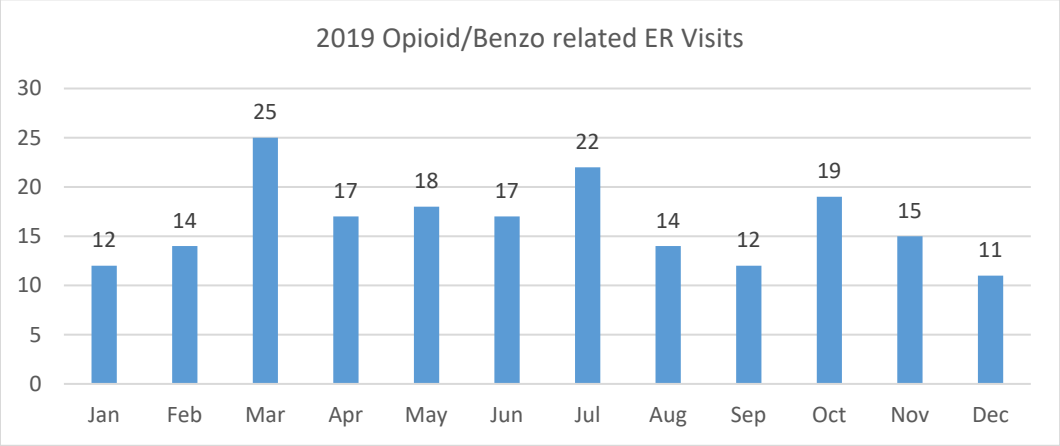
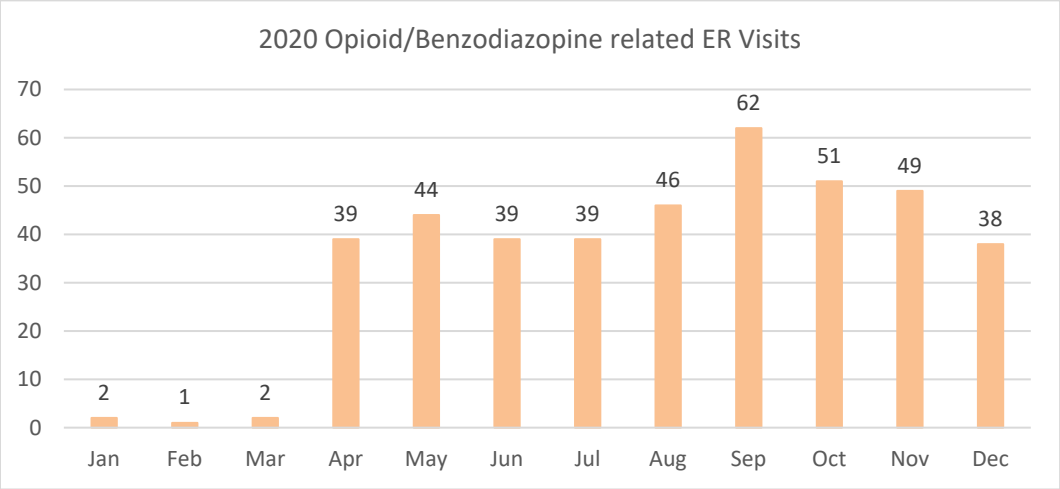


Table 12: 2020 Opioid/Benzodiazepine related ER Visits



Academic Detailing

- **Overview:** QI and Pharmacy Services to identify chronic users defined as greater than 3 months of use and prescribed **≥ 300 MME.** AAH will provide provider education for the providers of these chronic users which includes the following components:
- **Health education materials:** Three documents related to safety, alternative methods, and medications for pain management have been created and designed.
- **Network access maps for alternative resources:** Work with data analytics and C&O to create maps for providers and **members** we are focusing on for under academic detailing.
- **Members ≥ 300 MME data:** Pharmacy services working with PBM to collect most accurate data to identify members receiving ≥ 300 MME. QI gathering CURES reports and the most recent EMR notes per member.
- **Rising risk members:** members taking 50-89 MME for three consecutive months.
- **High risk members:** members taking ≥ 300 MME for three consecutive months.
    - Based on Quarter 4 (Sept – Dec 2020) MME data, we identified 78 risking risk members and 13 high risk members.

Risking risk members will receive:

- Rising risk cover letter
- Health education: Safety guide for patients and caregivers
- Health education: Treating pain without opioids

High risk members will receive:

- High risk cover letter

- Health education: Safety guide for patients and caregivers
- Health education: Treating pain without opioids
- Health education: Medicines for opioid dependence
- Map of providers in your area

The Alliance will continue to improve our opioid stewardship program. Below are some changes the Alliance has implemented.

Pharmacy Safeguards – As of January 2020, AAH implemented additional safeguards to ensure appropriate opioid use.

Key Points include:

- SAOs have a 14-day limit on their initial start for opioid naïve patients
- Grandfathering chronic users 6 months prior to when program were started; chronic users defined as a cumulative day supply of greater or equal to 90 days' supply.
- All SAOs formulation will be limited for to maximum of 3 times daily dosing
- All cancer diagnosis, hospice/palliative care, and sickle cell anemia diagnosis will be exempted from quantity and fill restrictions for opioids
- Monthly reporting and tracking of >120, 200, 300, 400 MME members, providers
- Quarterly reporting of chronic users

Table 13: Pharmacy Safeguard Implementations

Pharmacy Safeguards

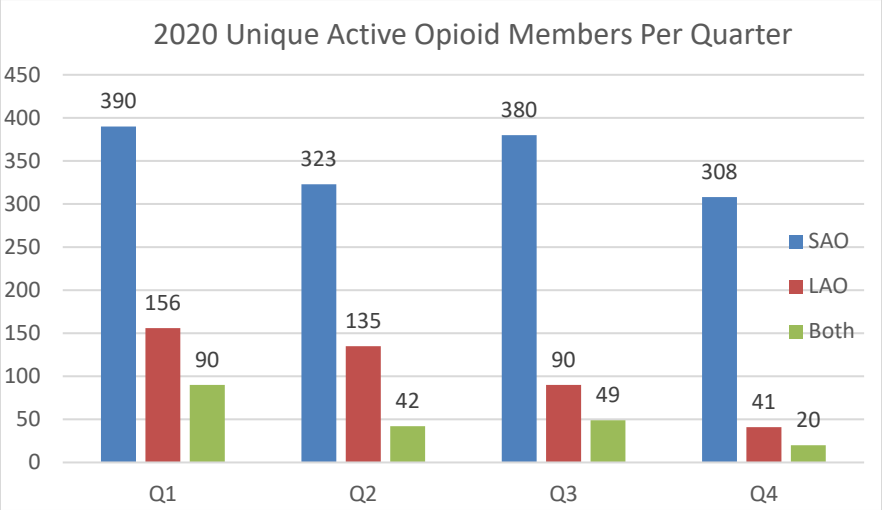
- PA: Prior Authorization
- LAO: Long Acting Opioid
- SAO: Short Acting Opioid

ACTION	ALLIANCE IMPLEMENTATION DATE				
Opioid Program Start		12/2017	06/2018	10/2019	01/2020
"New Start" SAO Limit	None	None	None	None	14
SAO QL per month	180	#180/30	#180/30	#90/30	#90/30
SAO Limited by	Drug	Drug	Drug	Total	Total
PA for all LAOs	No	Yes	Yes	Yes	Yes
LAO Increase limit	No	Yes	Yes	Yes	Yes
Cover Alprazolam	Yes	Yes	No	No	No
Cover Carisoprodol	Yes	Yes	No	No	No
Diazepam Limits	3/day	3/day	3/day	3/day	3/day
Lorazepam Limits	No	4/day	4/day	4/day	4/day
Clonazepam Limits	No	3/day	3/day	3/day	3/day

Below is a table that lists the number of members on short acting opioids (SAO) only, long acting opioids (LAO) only, and both short and long acting opioids in 2020. Short and long acting opioids had a general decrease in utilization and increase SAO utilization from Q2 to Q3 with a 17.6% (323 to 380 members).

Table 14: Members on SAO, LAO, and Both SAO and LAO for 2020

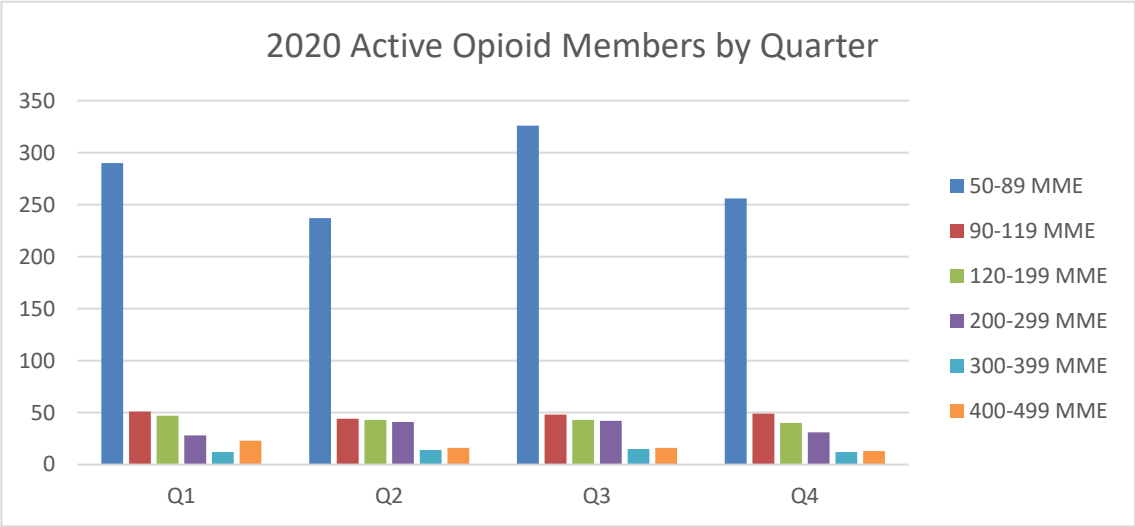
YEAR	SAO	LAO	BOTH
Q1	390	156	90
Q2	323	135	42
Q3	380	90	49
Q4	308	41	20



Below is a table that lists the number of members on greater than 50 MME opioids. Within 2020, this table shows a 13.2% (290 to 256 members from Q1 to Q4) decrease in members utilizing 50-89 MME, 4.1% (51 to 49 members) decrease in members utilizing 90-119 MME, 17.5% (47 to 40 members) decrease in members utilizing 120-199 MME, 133% (28 to 12 members) decrease in members utilizing 200-299 MME, no change for member utilizing 300-399 MME, and a 76.9% (23 to 13 members) decrease in members utilizing greater than 400 MME. There was also an increase in utilization from Q2 to Q3 for 50-89 MME and 90-119 MME.

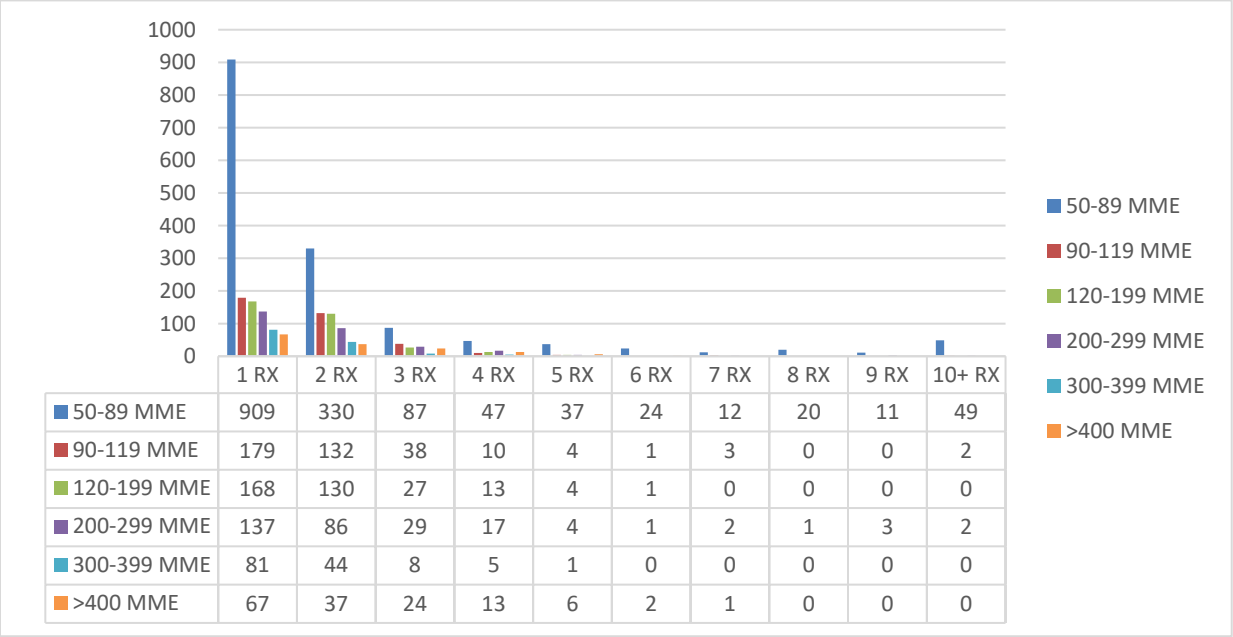
Table 15: Members per quarter on >50MME

MME (MORPHINE MILLIGRAM EQUIVALENTS)						
Month	**50-89**	**90-119**	**120-199**	**200-299**	**300-399**	**>400**
Q1	290	51	47	28	12	23
Q2	237	44	43	14	14	16
Q3	326	48	43	15	15	16
Q4	256	49	40	12	12	13



Below is a graph depicting how many unique providers prescribing opioids categorized by ascending MME. There is a general decrease in prescribing trend as the MME go up. In 2020, 81 providers each wrote 1 prescription for 300-399 MME and 67 providers each wrote 1 prescription greater than 400 MME. In addition, 1 provider wrote 7 prescriptions greater than 400 MME.

Table 16: Frequency of provider opioid prescription count by MME



	1 RX	2 RX	3 RX	4 RX	5 RX	6 RX	7 RX	8 RX	9 RX	10+ RX
50-89 MME	909	330	87	47	37	24	12	20	11	49
90-119 MME	179	132	38	10	4	1	3	0	0	2
120-199 MME	168	130	27	13	4	1	0	0	0	0
200-299 MME	137	86	29	17	4	1	2	1	3	2
300-399 MME	81	44	8	5	1	0	0	0	0	0
>400 MME	67	37	24	13	6	2	1	0	0	0

Drug Recalls

The Pharmacy Department monitors all drug recalls. In 2020, pharmacy recall information is as below:

Table 17: 2020 Pharmacy Recalls

RECALL TYPE	QUANTITY
Total number of safety notices/recalls	**78**
Total number of withdrawals	0
The number of notifications where PBM completed a claims data review	21

In 2020, there were 78 recalls. Recalls were monitored for adversely affected members. The number of notifications where the PBM completed a claims data review were 21.

The Alliance website has a continuous flow of safety resources for members and providers and includes FDA recalls, Risk Evaluation and Mitigation Strategies, a Patient Safety Resource Center, and Drug Safety Bulletins.

Potential Quality Issues (PQIs)

Potential Quality Issues (PQIs) are defined as: A individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issues exists. PQI cases are classified as, **Quality of Access (QOA)**, **Quality of Care (QOC),** or **Quality of Service (QOS) Issues**. The Alliance QI Department investigates all PQIs referred as outlined in policy QI-104, Potential Quality Issues. PQIs may be submitted by members, practitioners, or internal staff. PQIs are referred to the Quality Improvement (QI) Department through a secure electronic feed or entered manually into the PQI application, for evaluation, investigation, resolution, and tracking.

Quality Review Nurses investigate PQIs and summarize their findings. QOA and QOS cases that do not contain a clinical component are closed by the review nurse. The QI Medical Director reviews all QOC cases, in addition to, any QOA or QOS case where the Quality Review Nurse requests Medical Director case review. The QI Medical Director will refer cases to the Peer Review and Credentialing Committee (PRC) for resolution, on clinical discretion or if a case is found to be a significant quality of care issue (Clinical Severity 3, 4).

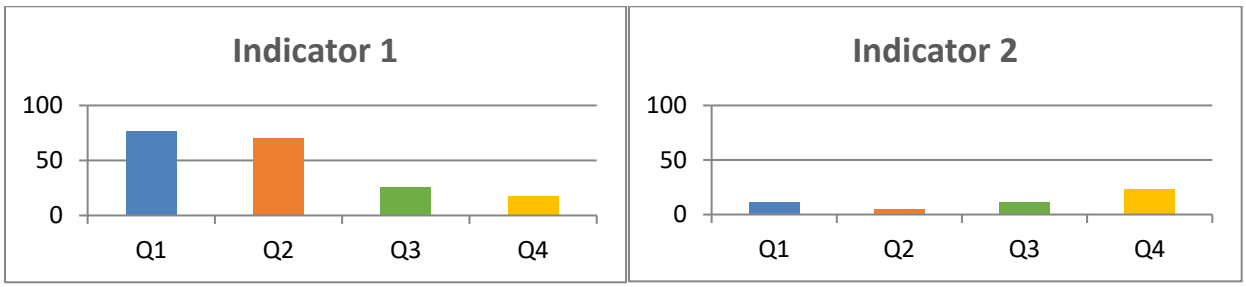
Table 18: Quality of Care (QOC) Issue Severity Level

SEVERITY LEVEL	DESCRIPTION
C0	No QOC Issue
C1	Appropriate QOC May include medical / surgical complication in the *absence of negligence* Examples: Medication or procedure side effect
C2	Borderline QOC With potential for adverse effect or outcome Examples: Delay in test with *potential* for adverse outcome
C3	Moderate QOC Actual adverse effect or outcome (non-life or limb threatening) Examples: Delay in / unnecessary test *resulting in* poor outcome
C4	Serious QOC With significant adverse effect or outcome (life or limb threatening) Examples: Life or limb threatening

Alameda Alliance for Health's Quality Department received 1,343 Potential Quality Issues (PQIs), during measurement year 2020, which is a 17.42% increase from 2019. Of the 1,343 PQIs received in 2020, 31.79%, or 427, of the PQIs were classified as a QOC. The quarterly frequencies are listed below:

Table 19: 2020 PQI Quarterly Frequencies

INDICATOR	Q1	Q2	Q3	Q4
Indicator 1: QOC PQIs	Denominator: **166** Numerator: **127** Rate: **76.51%**	Denominator: **137** Num: **97** Rate: **70.80%**	Denominator: **333** Numerator: **86** Rate: **25.82%**	Denominator: **707** Numerator: **117** Rate: 17.65%
Indicator 2: QOC PQIs leveled at severity C2-4	Denominator: **127** Numerator: **14** Rate: **11.02%**	Denominator: **97** Num: **5** Rate: **5.15%**	Denominator: **86** Numerator: **10** Rate: **11.63%**	Denominator: **117** Numerator: **28** Rate: **23.93%**



In 2020, the QI team continued its PQI PDSA (Plan-Do-Study-Act) improvement process.

In PDSA cycle 1, the QI Review Nurse Supervisor continued to conduct Exempt Grievances case audits via random sampling, to ensure that PQIs are not missed. QI Department management continues to provide oversight of exempt and standard grievances, reviews and investigates *clinical* referrals internal and external to the organization, and ensures that services and access related PQIs are addressed through vendor management and compliance oversight, and other existing channels.

PDSA cycle 2, addressed the technological support and improvement of the PQI application for the QI team. From 2017 through 2019, the team heavily relied on Microsoft Excel for tracking PQIs. In 2019, the QI Department began to collaborate with the IT department to develop a PQI application. In January of 2020, Quality Suite, an internally built PQI application was launched. The new PQI application is a more robust and responsive system allowing for improved reporting, documentation, tracking, and adjudication of PQIs.

PDSA cycle 3 began in August of 2020 the QI Department saw a dramatic increase of QOA referrals from Member Services and Grievance and Appeals due to a change in process to capture the depth and breadth of Access to Care complaints for PDSA performance improvement.

A full description of the PQI process is available in policy QI-104.

A. Consistency in Application of Criteria in (IRR)

The Alliance QI Department assesses the consistency with which physicians, pharmacist, UM nurses, Retrospective Review nurses and non-physician reviewers apply criteria to evaluate inter-rater reliability (IRR). A full description of the testing methodology is available in policy QI-133. The QI has set the IRR passing threshold as noted below.

Table 20: Inter-rater Reliability (IRR) Thresholds

SCORE	ACTION
High – 90%-100%	No action required.
Medium – 61%-89%	Increased training and focus by supervisors/managers.
Low – Below 60%	• Additional training provided on clinical decision-making. • If staff fails the IRR test for the second time, a Corrective Action Plan is required with reports to the Director of Health Services and the Chief Medical Officer. • If staff fails to pass the IRR test a third time, the case will be escalated to Human Resources which may result in possible further disciplinary action.

The IRR process for PQIs uses actual PQI cases. IRRs included a combination of acute and/or behavioral health IRRs. Results will be tallied as they complete the process and corrective actions implemented as needed. When opportunities for improving the consistency in applying criteria, QI staff addresses corrective actions through requiring global or individualized training or completing additional IRR case reviews.

For 2020, IRR testing was performed with QI clinical staff to evaluate consistency in classification, investigation and leveling of PQIs. All QI Review Nurse and Medical Director Reviewers passed the IRR testing with scores of 100%.

Facility Site Review (FSR)

Facility Site Review (FSR) and Medical Record Review (MRR) audits are mandated for each Health Plan under DHCS Plan Letter 14-004 to occur every three (3) years. FSRs are another way the Alliance ensures member quality of care and safety within the provider office environment. Mid-cycle, interim monitoring, and follow-up of FSR and MRR occurs between each regularly

scheduled full scope reviews. Corrective Action Plans (CAPs) for non-compliance are required depending on the site FSR and MRR scores and critical element failures.

In March 3, 2020, DHCS issued All Plan Letter (APL) 20-006 Site Reviews: Facility Site Review and Medical Record Review. This outlines the revised FSR and MRR tools and standards which take effect on July 1,2020.

In April 24,2020, DHCS issued APL 20-011 Governor's Executive Order N-55-20 in Response to COVID-19 allowing Alliance to temporarily suspend contractual requirement for in-person site reviews. DHCS encourages plans to explore alternatives to in-person site review and consider extensions to outstanding CAPs if alternatives to onsite verification are not feasible. In June 12, 2020, APL 20-011 was revised suspending requirements in APL 20-006 during COVID-19 pandemic and for an additional six months following the end of public health emergency.

In 2020, there were 74 site reviews. The total number and types of audits are detailed in the table below.

Table 21: 2020 Facility Site Reviews

TYPE	Q1	Q2	Q3	Q4	TOTAL
FSR/MRR: Full Scope	7	0	0	0	**7**
Initial FSR	1	0	2	3	**6**
Initial MRR	1	0	0	0	**1**
Initial FSR/MRR	0	0	0	0	**0**
MRR: Follow Up	1	0	0	0	**1**
FSR/MRR: Mid-cycle	3	0	0	0	**3**
FSR: Mid-cycle	1	0	0	0	**1**
Interim Monitoring	0	29	21	5	**55**
Periodic Annual	0	0	0	0	**0**
Periodic FSR	0	0	0	0	**0**
Periodic MRR	0	0	0	0	**0**
Total Reviews	14	29	23	8	74

In Q2, no onsite reviews were conducted due to COVID-10 pandemic. Interim Monitoring (IM), a provider self-assessment fax back form with required documented evidence that serves as an alternate to onsite review, includes, at a minimum, review of DHCS FSR critical elements. In 2020, a total of 55 IMs were issued. Two IM from 2020 remain open. In Q3 and Q4, five (5) initial site reviews were conducted for new providers and network provider site relocation. The virtual reviews were conducted via Webex.

DHCS regulation requires that Critical Element (CE) CAPs be received by the Alliance within 10 business days and FSR/MRR CAPs within 45 days of the site review.

Additionally, a critical element CAP is issued for deficiencies in any of the 9 critical elements in the FSR that identify the potential for adverse effects on patient health or safety and must be corrected within 10 business days of the site review. All CAPs were compliant in Q1 and Q2. There were 2 CAPs in Q3 and 3 CAPs in Q4. Alliance allowed extension on CAP submission due to reduce office hours and staffing during public health emergency according to APL 20-011. CAP timeliness was not reported for Q3 and Q4. FSR staff continued to work with providers in getting CAP submission.

Table 22: Compliant and non-compliant FSR/MRR CAPs received in 2020

TYPE	Q1	Q2	Q3	Q4	TOTAL
Compliant CAPs (received within 45 calendar days)	9	1	not reported	not reported	**10**
Non-Compliant CAPs	9	0	not reported	not reported	**0**
Total CAPs Issued	**9**	**1**	**N/A**	**N/A**	**10**

In 2020, all CAPs were closed within 120 days of site review.

CAPs closed within 120 days of FSR in 2020

TYPE	Q1	Q2	Q3	Q4	TOTAL
CAPs closed within 120 days	9	1	2	3	**15**
CAPs not closed within 120 days	0	0	0	0	**0**
Total CAPs Issued	**9**	**1**	**2**	**3**	**15**

Per DHCS regulation, failed periodic reviews are reported to bi-annually. In 2020, the Alliance had no provider with non-passing scores below 80%.

Table 23: 2020 Audits with Non-Passing Scores

QUARTER	AUDIT DATE	FSR SCORE	MRR SCORE
Q1	N/A	N/A	N/A
Q2	N/A	N/A	N/A
Q3	N/A	N/A	N/A
Q4	N/A	N/A	N/A

A. Audit of Initial Health Assessments (IHAs) via FSR/MRR

IHA includes history and physical (H&P) and Individual Health Education Behavioral Assessment (IHEBA). An IHA must be completed within 120 days of member assignment.

In 2020, medical records at 11 sites were reviewed for the presence of an IHA. Table lists the results of these reviews. In April 24,2020, DHCS issued APL 20-011 Governor's Executive Order N-55-20 in response to COVID-19 allowing Alliance to temporarily suspend contractual requirement for in-person site reviews. DHCS encouraged plans to explore alternatives to in-person site review. There were no MRR conducted in Q2 to Q4 due to public health emergency. The compliance rate goal of 30% was exceeded in all Q1 audits. The 4 total non-compliant providers received re-education/training on IHA and IHEBA compliance.

Table 24: 2020 MRR Results

TYPE	Q1	Q2	Q3	Q4	TOTAL
# of MRRs with Compliant* IHAs	7 (64%)	N/A	N/A	N/A	7
# of MRRs with Non-Compliant IHAs (CAPs)	4	N/A	N/A	N/A	4
Total IHAs Audited via FSR	11	0	0	0	11

*Compliant = Per DHCS CAP guidelines, no CAP issued if MRR score is 90% or greater and 80% or greater on Pediatric/Adult Preventive section.

Peer Review and Credentialing Committee (PRCC)

In 2020, 33 practitioners were reviewed for lack of board certification. If there were complaints about a practitioner's office, facility site reviews were conducted and the outcome was reviewed by the PRCC. There was no site reviews conducted based on complaints in 2020. All grievances, complaints, and PQIs that required investigation were forwarded to this committee for review. In 2020, 54 practitioner grievances, complaints, or PQIs were investigated by the committee. There were no practitioners that required reporting to National Practitioner Data Bank (NPDB) by the Alliance.

In 2020, the PRCC granted one year reappointment for two practitioners for grievances filed regarding office procedures. The table below shows evidence of practitioner review by the PRCC prior to credentialing and re-credentialing decisions.

Table 25: Count of Practitioners Reviewed for Quality Issues at PRCC in 2020

PRCC DATE	PRC	NPDB	ATTESTATION	MALPRACTICE (PENDING/DISMISSED)	FSR	GRIEVANCE, COMPLIANTS, PQI	LICENSE ACTION	BOARD CERTIFICATION CAP	CAP	TOTAL
Jan		2				3		3	2	10
Feb		1		4		8			5	18
Mar						6		2	3	11
Apr		2		1		4	1		3	11
May						6		2	1	9
Jun						2		1	5	8
Jul	1		1			4		2	2	10
Aug No Committee Meeting										0
Sep		2				6		1	3	12
Oct		2		2				8		12
Nov	1					3		11		15
Dec				1		10		3	4	18
Total	**2**	**9**	**1**	**8**	**0**	**52**	**1**	**33**	**28**	**134**

Delegation Oversight

The Alliance conducts quarterly and annual delegation oversight in compliance with California Department of Health Care Services (DHCS), the California Department of Managed Health Care

(DMHC), and the National Committee for Quality Assurance (NCQA) regulations. Annual delegation oversight reviews were conducted in 2020.

Results from the 2020 reviews were reported to the Compliance Committee and/or Delegation Oversight Committee. The QI delegation audit results were also reported to the HCQC.

In addition to the annual oversight audits, the Alliance held quarterly Joint Operations Meetings with delegates. Additionally, the Alliance held regular Executive Team meetings with Community Health Center Network (CHCN) and Alameda Health Systems Leadership. The Alliance, as well as, the delegate contribute to the meeting agenda. The standard Leadership meeting agenda includes but, is not limited to, the following topics with updates: claims adjudication, information technology, provider relations, member services, quality activities concerns and progress, in addition to new and/or revised legislation, or DMHC, DHCS regulations. Weekly or biweekly Alliance and delegate calls were held to improve communication and information flow, provide bi-directional updates, and resolve any immediate mutual concerns. The Alliance places a high degree of importance on problem solving and communicating with delegates.

In 2020, the Alliance conducted Joint Operations Meetings (JOM) with the delegated groups to review their individual Access and Timely of Care survey results, in addition to, HEDIS rate performance specific to their group to identify opportunities for improvement, strategies for improvement of scores, and HEDIS timelines for reporting year 2020.

The following delegated groups were audited in 2020:

Table 26: Alameda Alliance Delegated Entities

Delegate	Quality Improvement		Utilization Management		Credentialing		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
Beacon Health Strategies LLC	X	X	X	X	X	X			X	X	X	X	X		X	X	X	
Community Health Center Network (CHCN)			X	X					X	X			X	X			X	
March Vision Care Group, Inc.					X				X									
Children's First Medical Group (CFMG)			X		X				X									
PerformRx			X	X	X	X			X	X	X	X			X	X		
California Home Medical Equipment (CHME)			X	X														
Kaiser	X		X		X		X		X		X		X		X		X	
UCSF					X	X												

Delegate	Quality Improvement		Utilization Management		Credentialing		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
Physical Therapy PN					X	X												
Lucille Packard					X	X												

The Alliance will continue to conduct oversight of the delegated groups, review thresholds to ensure they are aligned with industry standards and will issue corrective actions when warranted. After review of the QI delegates, no actions were specifically identified or taken. The QI Delegates Program Evaluation will be reviewed by the HCQC in Q1 of 2021.

Population Health Strategy

In accordance with NCQA 2020 Standards and Guidelines for the Accreditation of the Health Plans, Alameda Alliance for Health has developed a basic framework to support a cohesive plan of action for addressing member needs across the continuum of care. This continuum includes the community setting, through participation, engagements, and targeted interventions for a defined population.

The Population Health Program aims to influence the health outcomes of the Alameda Alliance membership. The program oversees the health management system by ensuing that the system caters to the health needs of the enrolled member population. A key priority is to ensure that the new and ongoing programs target and close the gaps between identified disparities and the social determinants of health (SDOH) that cause those disparities.

The Population Health Program will be used to:

- Enhance Case Management Department and program
- Inform Quality Improvement Performance Projects
- Guide Health Education Materials and Programs
- Guide the Population Needs Assessment (PNA)

Additionally, the program may be used to better understand the patterns of cost, utilization and identify high-risk members with high-risk disease processes.

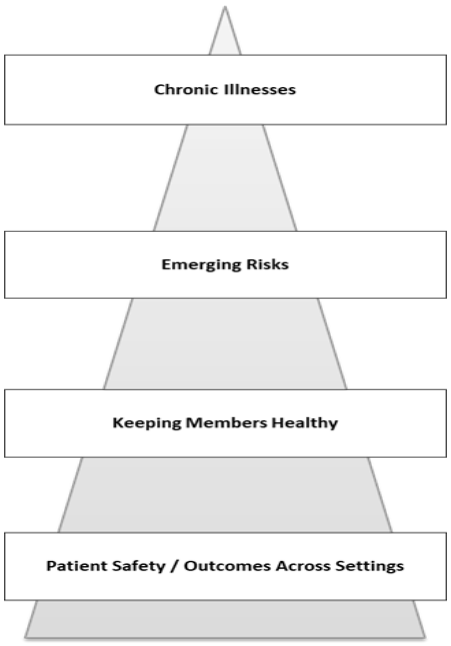
The framework of this strategy is designed to address the four focus areas of population health, as outlined by NCQA, while using Department of Health Care Services (DHCS) / Department of Managed Health Care (DMHC) required methods.

The following four areas of this strategy focus on a whole-person approach to identify members at risk, and to provide strategies, programs, and services to mitigate or reduce that risk.

The Alliance also aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored solutions.

The 4 areas of focus are:

1. Members with Chronic Illness
2. Members with Emerging Risk
3. Keeping Members Healthy
4. Patient Safety



At least annually, the Alliance conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: Quantitative results for relevant clinical/cost, utilization, and experience measures. Quantitative and qualitative analysis is conducted on the results. Comparison of results with established benchmarks are evaluated for evidence of program effectiveness and room for improvement. This analysis will be conducted by the Health Services Department in conjunction with Analytics, Member Services, Provider Services, Pharmacy, Quality, and Grievance & Appeals to support the Alliance's members and promote an effective Population Health Management Strategy. Additional information regarding the Plan's Population Health Strategy can be found in the Population Health Management Strategy Document.

Quality Improvement Projects

HEDIS Measure CDC: Improve the rate of HbA1c Testing in African American Men.

The Plan intended to adapt its pervious Quality Improvement Project and partner with additional providers during 2020. However, due to the pandemic providers were not willing to partner with the Plan on this initiative. In 2021, the Plan intends to revisit this initiative to improve the HbA1c testing in its African American diabetic male population.

HEDIS Measure AWC: Increase the Alameda Alliance overall rate of Adolescent Access to Primary Care

The Plan adapted its previous Quality Improvement Project and partnered with nine providers during 2020, to increase utilization of preventive care services for members 12-21 years of age

by offering a member incentive. A total of 441 gift cards were given to members between the ages of 12-21 at the completion of their well-child exam. The Plan recognizes that this is a challenging age group to engage to obtain preventive care services. The Plan intends to continue to adapt this strategy in 2021 to continue to improve the compliance rate for this age group.

Increasing rates of Tdap vaccines in pregnant women in the third trimester

The intent during 2020 was to expand the project to additional provider locations however, on February 20,2020, the Plan was notified that Alameda County Public Health Department had to shift its focus to COVID-19 activities. Additionally, on September 8, 2020, the principle project manager that the Plan worked with on the Tdap project accepted a temporary assignment with California's COVID-19 vaccine implementation project. As a result, the Plan is in the process of reevaluating this project and intends to revisit it in 2021.

Improve Compliance Rate for the African American Pediatric Population for W15 – DHCS Equity PIP

In California, it has been identified that children are not accessing comprehensive pediatric services consistently. The California State Auditor Report identified that, "an annual average of 2.4 million children enrolled in Medi-Cal do not receive all required preventive services." Additionally, this report confirms utilization rates for children in Medi-Cal have remained below 50 percent. As a result, Alameda Alliance for Health (Alliance), has decided to focus on increasing pediatric access through its Pediatric Care Coordination Pilot. The goal of the pilot is to engage the Alliance's pediatric members to seek regular check-ups at age-appropriate intervals that follows the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule and anticipatory guidance with increased screenings and referrals to improve member health functional status and/or satisfaction. This includes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for Medical, Dental, Vision, Hearing, and Mental Health, Substance Use Disorders, Developmental and Specialty Services.

During the development of the Pediatric Care Coordination Pilot, the Alliance identified that during 2018, only 45.92% of children who turned 15 months old received 6 or more well-child visits (W15). The Plan's performance rate for the W15 HEDIS measure is 20.31% below the 50th percentile.

During further analysis, the Alliance identified a disparity in access for Well-Child visits for the Plan's African American infant population compared to other ethnicities. For example, in 2018, 55.66% of the Plan's Chinese infant population received 6 or more Well-Child visits during the measurement year compared to 33.33% of the African American infant population. As a result, the Plan developed the following goal that by June 30, 2021, the percentage rate of 6 Well-Child visits within the first 15 months of life among African American infants, increase from 33.33% to 42.10%. However, on June 22, 2020, the Plan was notified by DHCS that due to COVID-19 public health crisis that the current PIP topic ended on June 30, 2020.

Improve Compliance Rate for Members Assigned to 5 Direct Providers for W34 – DHCS Priority PIP

The intervention will be focused on the HEDIS measure: W34 -- the percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year. Well-child visits provide a critical opportunity for screening, referrals, and counseling as children develop physical activity, social, nutritional, and behavioral habits that often continue into adulthood. With these visits, providers conduct comprehensive physicals, connect patients to important EPSDT services, important vaccinations and medications, as well as help answer any health-related questions patients and their families may have.

In the past two measurement years, MY2017 and MY2018, Alameda Alliance for Health (AAH)'s W34 hybrid rate was 79.27% and 73.84% respectively. In an effort to improve this rate and at the request of DHCS, AAH will conduct a W34 PIP.

W34 admin rates for direct providers within the AAH network will be the narrowed focus of this PIP. The MY2018 admin rate for AAH was 75.55% and for directs, it was 61.02%.

After looking at AAH MY2018 W34 admin data, we established a threshold to identify providers with patient panels greater than 60 and a compliance rate less than 70% to incorporate into this PIP. Based on this threshold, we identified the five providers. These five providers have the largest patient panels and the top five largest non-compliant populations in comparison to the rest of the AAH direct providers.

Specifically, the target population for this initiative will be members ages 3-6 assigned to five direct AAH providers:

1. Rhodora De La Cruz MD,
2. Susana Nolasco MD,
3. Merlin Tungol Venzon MD,
4. Washington Township Medical Foundation,
5. Ebrahim Ahmadi MD

As an initiative starting in 2019, AAH along with its providers are dedicated to access to care for children. The W34 measure specifically promotes the use of well-child visits for members between 3-6 years old. It has the potential to improve member health status and satisfaction by promoting preventative care including physical exams and vaccines. The W34 MY2018 admin rates for direct AAH providers demonstrate there is underutilization of preventative care among members 3-6 years old, and AAH will work to improve the rate for this measure.

Table 27: W34 Admin Rate per Direct AAH Provider for MY2018

Direct AAH Provider Name	False (Non-compliant)		True (Compliant)		Grand Total
	Number of Members	Percentage	Number of Members	Percentage	
Alameda Family Physician Medical Group, Inc.	2	50.00%	2	50.00%	4
California Cardiovascular Consultants	2	33.33%	4	66.67%	6
Castro Valley Pediatrics		0.00%	1	100.00%	1
Cuong Tat Vu, MD, Inc.	1	100.00%		0.00%	1
Davis Street Primary Care Clinic	15	34.09%	29	65.91%	44
De Hieu Le, MD	1	100.00%		0.00%	1
De La Cruz, Rhodora Cruz., MD	**79**	**32.64%**	**163**	**67.36%**	**242**
East Bay Pediatric Primary Care, Inc.	10	15.15%	56	84.85%	66
Ebrahim Ahmadi, M.D.	**30**	**48.39%**	**32**	**51.61%**	**62**
Express Medicine Urgent Care	1	100.00%		0.00%	1
Family Medicine Oakland	11	36.67%	19	63.33%	30
Ho Chao MD		0.00%	1	100.00%	1
Integrated Medical Associates	3	100.00%		0.00%	3
John Muir Health - Berkeley Center		0.00%	2	100.00%	2
La Loma Medical Group, Inc.	7	58.33%	5	41.67%	12
Lim, Mabel A., MD	5	83.33%	1	16.67%	6
Massen Medical, Inc.	5	100.00%		0.00%	5
Mintz Medical Corporation	1	100.00%		0.00%	1
Mission Primary Care	9	75.00%	3	25.00%	12
MOWRY MEDICAL GROUP, Inc.	1	100.00%		0.00%	1
Nolasco-Alonzo, Susana S., MD	**71**	**30.87%**	**159**	**69.13%**	**230**
Pacific Cardiology Associates	10	55.56%	8	44.44%	18

Direct AAH Provider Name	False (Non-compliant)		True (Compliant)		Grand Total
	Number of Members	Percentage	Number of Members	Percentage	
Phuong Duc Dang, MD	1	100.00%		0.00%	1
Piedmont Primary Care		0.00%	2	100.00%	2
Reen, Ranjit K., MD	1	100.00%		0.00%	1
Roots Community Health Center	22	73.33%	8	26.67%	30
Venzon, Merlin Tungol., MD	**70**	**43.75%**	**90**	**56.25%**	**160**
Washington Township Medical Foundation	**122**	**42.07%**	**168**	**57.93%**	**290**
West Coast Medicine and Cardiology, Inc.	1	100.00%		0.00%	1
Grand Total	481	38.98%	753	61.02%	1234

Table 28: W34 Admin Rate per Identified Direct AAH Provider for MY2018

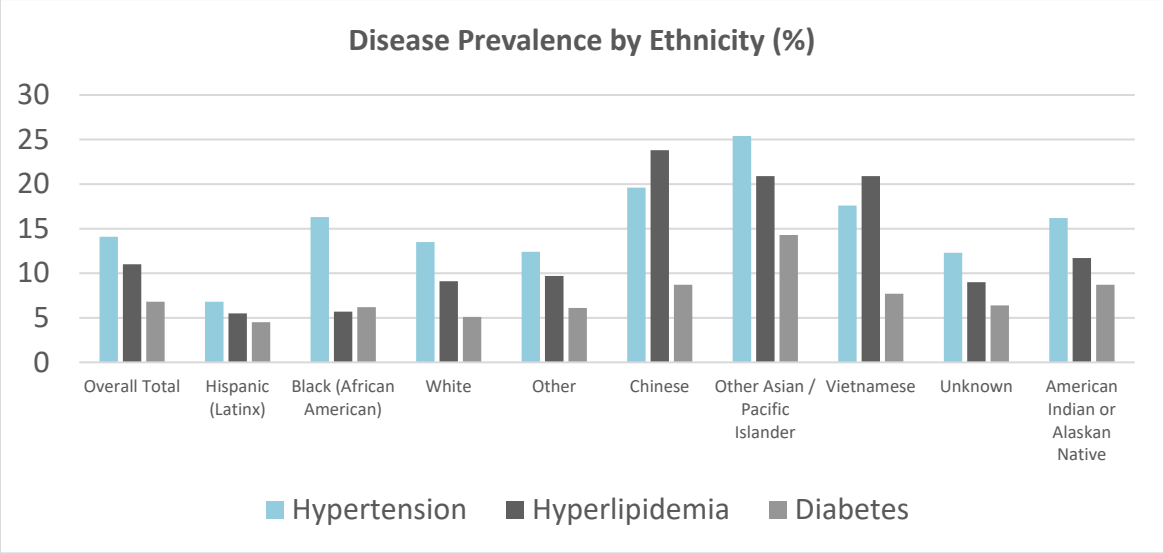
PCP Clinic	False (Non-compliant)		True (Compliant)		Grand Total
	Number of Members	Percentage	Number of Members	Percentage	
De La Cruz, Rhodora Cruz., MD	79	32.64%	163	67.36%	242
Ebrahim Ahmadi, M.D.	30	48.39%	32	51.61%	62
Nolasco-Alonzo, Susana S., MD	71	30.87%	159	69.13%	230
Venzon, Merlin Tungol., MD	70	43.75%	90	56.25%	160
Washington Township Medical Foundation	122	42.07%	168	57.93%	290
Total	**372**	**37.80%**	**612**	**62.20%**	**984**

As a result, the Plan developed the following goal that by June 30, 2021, increase the overall W34 admin rate from 62.20% to 66.46% for the group of five identified providers: (1) Rhodora De La Cruz MD, (2) Susana Nolasco MD, (3) Merlin Tungol Venzon MD, (4) Washington Township Medical Foundation, and (5) Ebrahim Ahmadi MD. However, on June 22, 2020, the Plan was notified by DHCS that due to COVID-19 public health crisis that the current PIP topic ended on June 30, 2020

Asian Health Services – BP Cuff Pilot

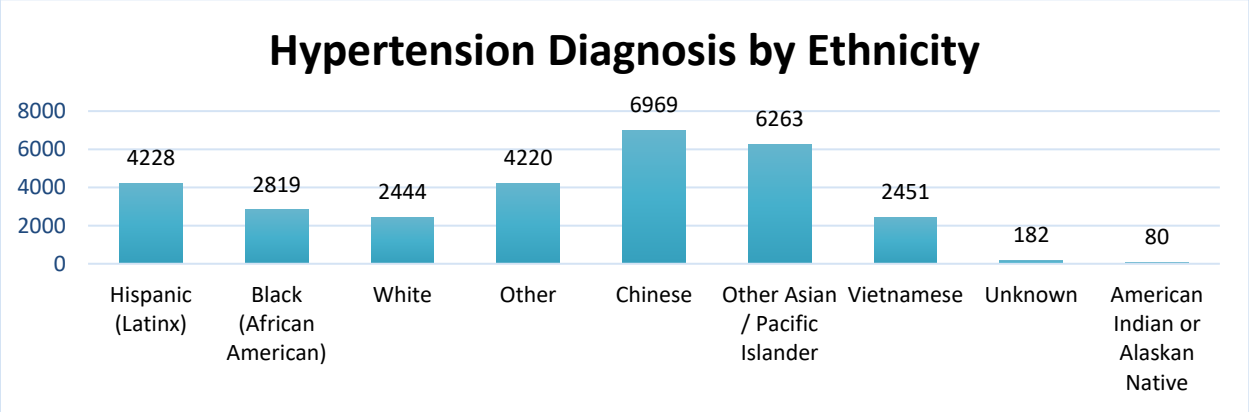
Through review of the Plan's Population Health data, it identified that Asian and Pacific Islander members were disproportionately affected by hypertension. Other Asian/Pacific Islander ethnic group had 80% greater prevalence of hypertension, 90% of hyperlipidemia, and 109% of diabetes than the total population. Chinese and Vietnamese ethnicities also had greater prevalence of these diseases. The Chinese ethnic group had the highest prevalence for hyperlipidemia (116% greater). This is a disparity focused initiative.]

Table 29:Disease Prevalence by Ethnicity (%)



The Alliance identified that hypertension has the highest prevalence in its Asian population. Through the review of the data, 15,683 Asian members were identified as being hypertensive. As a result, the Quality Improvement Department developed a quality improvement project to help improve at home BP monitoring of 150 Asian members assigned to Asian Health Services by offering a blood pressure cuff.

Table 30: Hypertension Diagnosis by Ethnicity



As a result, the Plan developed a pilot strategy to reach 150 Asian members with hypertension assigned to Asian Health Services was developed. The initial goal was to have the 150 members selected to participate in this project to have a controlled BP of <140/90 by December 31, 2020

In September, the pilot was initiated to improve BP control of 100 Asian members diagnosed with hypertension by providing digital BP cuffs for at home monitoring. The Plan partnered with Asian Health Services, which developed a scalable and sustainable workflow that allows the clinical team to identified Asian members who are hypertensive and have uncontrolled blood pressure and do not have an at home monitor. 54% of the members who participated in the pilot had their BP controlled by the last 2020 reading compared to 46% who had no change in compliance.

Improving Initial Health Assessment (IHA) Rates

The past 1 year of IHA rates is outlined below.

Table 31: 2019 IHA Rates

Q1 2019	Q2 2019	Q3 2019	Q4 2019
Denominator: 13,501 Numerator: 5,438 Rate: 40.28% Goal: 30% Gap to goal: Goal Met	Denominator: 13,714 Numerator: 5,444 Rate: 39.70% Goal:30% Gap to goal: Goal Met	Denominator:13,688 Numerator: 5,437 Rate: 30.72% Goal: 30% Gap to goal: Goal Met	Denominator: 12,647 Numerator: 4,626 Rate: 36.58% Goal: 30% Gap to goal: Goal Met

On average, an IHA is completed for 39.2% of new members (1/1/19 – 12/31/19); the table below identifies IHA completion rates by network.

Table 32: IHA Completion Rates among New Enrollees

Network	New Enrollees	With IHA Completed	IHA Compliant Rate
AHS	15,139	5,660	**37.4%**
ALLIANCE Excl. AHS	9,042	4,728	**52.3%**
CFMG	8,234	4,727	**57.4%**
CHCN	15,020	8,570	**57.1%**
KAISER	6,679	3,639	**54.4%**
ALL NETWORK	**54,114**	**27,324**	**50.5%**

In an effort to improve IHA compliance rates, the Alliance is working to:

- Ensure member education – through mailings and member orientation
- Improve provider education – through faxes, the PR team, provider handbook, and P4P program
- Improve data sharing – by sharing gaps in care lists with our delegates and providers
- Incentivize IHA completion rates – by including IHA completion rates as an incentivized program
- Update claims codes – to ensure proper capture of IHA completion
- Monitor records to ensure compliance with all components of the IHA
- Given the 6 month claims lag, data will be reviewed and analyzed in Q3 – Q4 of 2021.

Pediatric Care Coordination Pilot

In 2018 CA State Auditor Report cited the following:

- "90% of children in MCL receive services through managed care plans
- "An annual average of 2.4 million children who were enrolled in MCL over the past five (5) years have not received all of the preventive health services that the State has committed to provider them."
- "Under-utilization of children's preventive health in CA MCL has been consistently below 50% and is ranked 40th in the country, 10% below the national average."
- Alameda Alliance for Health Direct and Delegate Network providers are performing below 50% on several pediatric HEDIS measures

The Pediatric Care Coordination Pilot launched October of 2019.

Goal of effective partnerships will result in value-add outcomes for the Alliance and its pediatric members that include:

- A shared vision
- Improved access to care (quality initiatives with delegates)
- Increased utilization rates for preventive health services (quality initiatives)
- Improved data sharing
- Improved care coordination (clinical initiatives with delegates)
- Improved health outcomes, (clinical initiatives with delegates)
- Improved HEDIS rates to MCAS 50% MPL (quality initiatives with delegates)
- Enriched member and provider experience/satisfaction (quality initiatives)

In 2020, the Alliance continued to address the important issue of under-utilization and improve pediatric access to care for preventive health services. Health Care Services (HCS) QI department developed deployed strategies for enhanced integration of pediatric health care services for the children and adolescent population enrolled in the Alameda Alliance (AA) for Heath Medi-Cal program. The Alliance sought to constructively influence and impact care delivery for this identified population in three (3) ways:

- Quality Initiatives
- Clinical Initiatives
- Pilot Program

The HCS strategy proposed leveraging “whole child wellness” integration through:

- Improved screening and referrals as part of Medi-Cal Early and Periodic Screening, and Diagnostic and Treatment (EPSDT) supplement benefit
- Reporting via data segmentation and visualization
- Member and provider incentives
- Community based program funding
- Provider P4P
- Health Education engagement
- QI Initiatives
- DHCS Performance Improvement Initiatives
- The Alliance collaborated with external stakeholder’s key to the success of this pediatric pilot
- Direct Providers
- Delegates

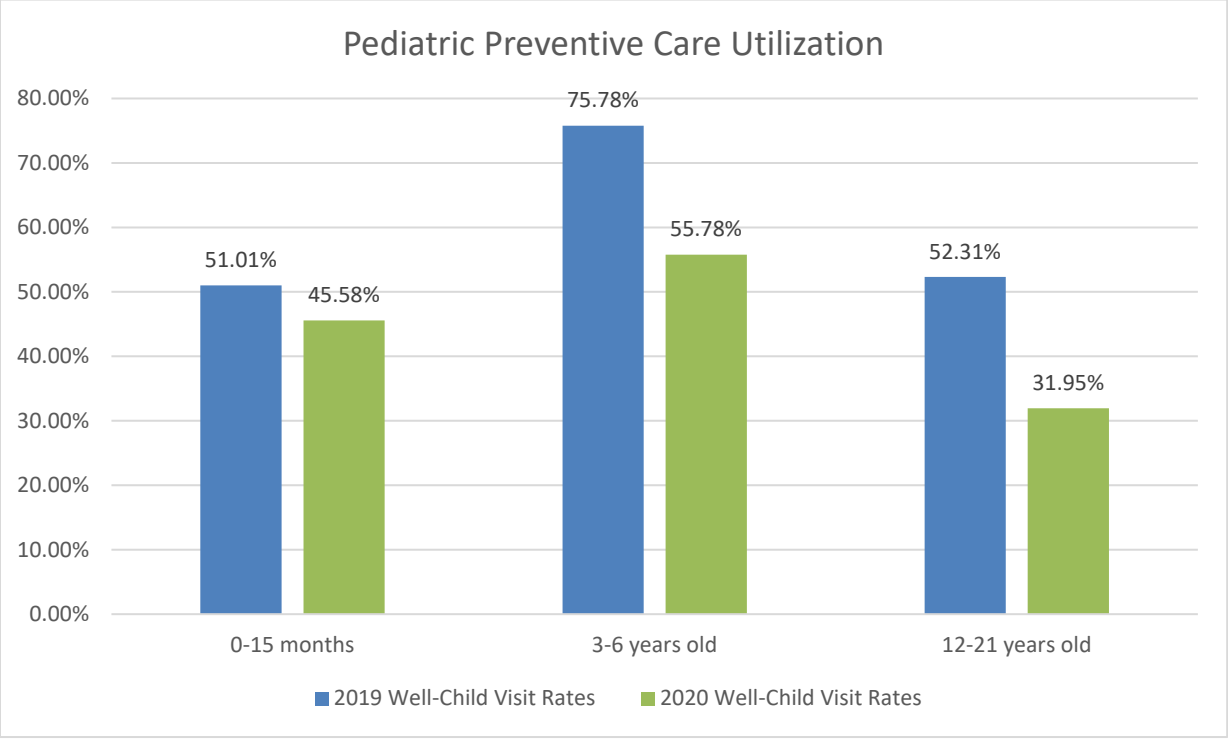
- Alameda Health Services (8K Pediatric Members)
- Children's First Medical Group (29K Pediatric Members)
- Community Health Care Network (31K Pediatric Members)

- Community Based Organizations (CBOs)
  - Alameda County Public Health Asthma Start
  - Alameda County Healthy Homes Lead Poisoning Prevention
  - First 5 Alameda County
  - Benioff Children's Hospital Oakland (FINDconnect Resource and Referral Platform)

Pediatric HEDIS Performance Measures selected for improvement:

In MY2020, there were changes made to the HEDIS Pediatric Measures by combining two existing measures (W34 and AWC) to form WCV and the expansion of W15 to W30. As a result, the Plan was able to evaluate pediatric utilization of preventive care services by examining utilization in the following age bands, 0-15 months, 3-6 years old, and 12-21 years of age.

Table 33: Pediatric Preventive Care Utilization



Based on the underutilization of preventive care service es, the Plan has identified the following two HEDIS measures need to be a focus of the Pediatric Care Coordination Program:

- WCV – Well Child-Visits for Children 3 – 21 years of age

- W30 – Well-Child Visits in the first 30 months of life

Clinical Improvement Trends: HEDIS

The Alliance is committed to ensuring the level of care provided to all enrollees meets professionally recognized standards of care and is not withheld or delayed for any reason. The Alliance adopts, re-adopts, and evaluates recognized standards of care for preventive, chronic and behavioral health care conditions. The Alliance also approves the guidelines used by delegated entities. Guidelines are approved through the HCQC. Adherence to practice guidelines and clinical performance is evaluated primarily using standard HEDIS measures. HEDIS is a set of national standardized performance measures used to report on health plan performance in preventive health, chronic condition care, access and utilization measures. DHCS requires all Medicaid plans to report a subset of the HEDIS measures. Two years of Medicaid administrative rates are noted below. Reporting year is noted and reflects prior calendar year. Minimum Performance Level and High Performance Level are determined by the Medi-Cal Managed Care Division.

Table 34:: Medicaid Administrative HEDIS Rates

NCQA Acronym	Current Rate Method	Accred - MCAS - Both	Measure	Admin Final 2019	Admin Final 2020	Current Hybrid
CCS	H	Both	Cervical Cancer Screening	62.86%	58.32%	60.68%
CIS	H	Both	Combo 10	41.81%	46.81%	57.91%
CDC	H	MCAS	HbA1c Poor Control (>9.0%)	42.83%	42.87%	41.46%
CBP	H	Both	Controlling High Blood Pressure	22.49%	25.57%	51.34%
IMA	H	Both	Combination 2	50.51%	50.04%	51.09%
PPC	H	Both	Timeliness of Prenatal Care	76.47%	86.91%	92.01%
PPC	H	Both	Postpartum Care	77.75%	78.95%	83.68%
WCC	H	Both	BMI Percentile	37.66%	34.89%	70.83%
WCC	H	MCAS	Counseling for Nutrition	32.97%	35.09%	70.83%
WCC	H	MCAS	Counseling for Physical Activity	33.98%	33.23%	67.50%
AMM	A	Both	Effective Acute Phase Treatment	69.74%	72.83%	
AMM	A	MCAS	Effective Continuation Phase Treatment	54.94%	56.40%	
AMR	A	Both	Asthma Medication Ratio	59.93%	68.24%	
APM	A	Both	Metabolic Monitoring for Children and Adolescents on Antipsychotics Blood Glucose	67.86%	57.59%	
APM	A	Both	Metabolic Monitoring for Children and Adolescents on Antipsychotics Cholesterol	52.98%	36.65%	
APM	A	Both	Metabolic Monitoring for Children and Adolescents on Antipsychotics Blood Glocose and Cholesterol	52.38%	36.65%	
BCS	A	Both	Breast Cancer Screening	62.82%	56.19%	
CHL	A	Both	Chlamydia Screening in Women - Total	59.34%	59.09%	
SSD	A	Both	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.10%	76.29%	
WCV	A	MCAS	Child and Adolescent Well-Care Visit	0.00%	39.47%	
W30	A	MCAS	Well Child Visits in the First 15 Months	0.00%	45.64%	
W30	A	MCAS	Well Child Visits for age 15 Months- 30 Months	0.00%	69.34%	

Analysis Of HEDIS MEDICAID Managed Care Accountability Set (MCAS)

The above tables represent the Medicaid HEDIS measures for the DHCS' Managed Care Accountability Set. Of the trended measures (including individual sub measures), 12/19 measures met the Minimum Performance Level (MPL). The decline in HEDIS performance can be attributed to the decrease in members seeking services and the Plan's ability to obtain medical records during the pandemic.

The Aggregated Quality Factor Score (AQFS) is a single score that accounts for plan performance on all DHCS-selected Health Effectiveness Data and Information Set (HEDIS) indicators. It is a composite rate calculated as a percent of the National High Performance Level (HPL). The Alliance goal is to increase Aggregated Quality Factor Score rates by 5% each year. If a minimum performance level is not met, an in depth analysis occurs to identify barriers to access and care.

Based on the HEDIS data presented, potential focus areas for 2021 may include the following:

- BCS – Breast Cancer Screening
- CCS – Cervical Cancer Screening
- CDC – Comprehensive Diabetic Care
- CBP – Controlling High Blood Pressure
- WCC – BMI Percentile
- WCC – Counseling for Nutrition
- WCV – Well-Child Visits

Health Plan Accreditation

In September 2019, Alameda Alliance participated in the triennial reaccreditation survey for Health Plan Accreditation (HPA) sponsored by NCQA. NCQA HPA is a voluntary recognition program consisting of a triennial desktop review of program materials, policies and procedures and on-site file review. The standards evaluate Quality Improvement, Population Health Management, Network Management, Utilization Management, Credentialing, Rights and Responsibilities, and Member Connections. Annually, the score and award are reevaluated based on the fixed survey standards score and an annual reevaluation of audited HEDIS and CAHPS scores. NCQA grants the following decisions: Excellent (90-100 points), Commendable (80-89.99 points), Accredited (65-79.99 points), Provisional (55-64.99 points), and Denied (less than 54.99 points).

Table 35: Medicaid NCQA Accreditation Status Award

With a combined score of 86.14, Medicaid earned "Commendable" status, 48.99 Standards score, and 37.14 HEDIS + CAHPS score. Received CAP 2020 resurveyed 2/2021 on element UM 7B and passed with 100%.

Table 36: Group Care NCQA Accreditation Status Award

With a combined score of 41.66 for Standards, GroupCare earned "Accredited" status for the next year. The Alliance will have a resurvey in June 2020 to review elements that did not pass 80%, we will need a score of 42.5 for Standards to obtain our accredited status for 3 years. For GroupCare we also did not receive a passing score for the must pass element UM 7B. Resurvey of this element will also be conducted in June 2020. Received CAP 2020 resurveyed 2/2021 on element UM 7B and passed with 100%.

Quality of Service

Analyses of member experience information helps managed care organizations identify aspects of performance that do not meet member and provider expectations and initiate actions to improve performance. Alameda Alliance for Health (AAH) monitors multiple aspects of member and provider experience, including:

- Member Experience Survey
- Member Complaints (Grievances)
- Member Appeals

Member Experience Survey

The Medi-Cal and Commercial Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by the National Committee for Quality Assurance (NCQA) a certified Health Effectives Data and Information Set (HEDIS) survey vendor. SPH Analytics was selected by the Alliance to conduct the 2020 CAHPS 5.0 survey. The survey method includes mail and phone responses. Members in each Alliance line of business (LOB) are surveyed separately. The table below shows the survey response rates. As of 12/31/2020, the Alliance had a total of 275,589 members.

The breakdown of member enrollment by network is as follows:

- Alameda Health Systems (AHS) 20%
- Alliance 19%
- Community Health Center Network (CHCN) 36%
- Children First Medical Group (CFMG) 11%, Kaiser 14%

Table 37: Survey Response Rates by Line of Business

	Medi-Cal Adult	Medi-Cal Child	Commercial Adult
2020	14.7%	16.5%	23.5%
2019	21.3%	21.3%	28.3%
2018	20.9%	24.3%	27.9%

The Medi-Cal Child, Adult Medi-Cal and Adult Commercial Trended Survey Results in the tables below, contains trended survey results for the Medi-Cal Child, Medi-Cal Adult, and Commercial Adult populations across composites. Quality Compass All Plans (QCAP) benchmark noted within the tables is a collection of CAHPS 5.0 mean summary ratings for the Medicaid and Commercial samples that were submitted to NCQA in 2019 that provides for an aggregate or national summary. In respect to the QCAP scores, Red signifies that the current year 2020 score is significantly lower than the 2019 score, the 2018 score or benchmark score. Green indicates that the current year 2020 score is significantly higher than the2019 score, the 2018 score, or benchmark score.

Table 38:Medi-Cal Child Trended Survey Results

Summary Rate Scores: Medi-Cal Child				
Composite	**2020**	**Previous Year Comparison**	**2019**	**2018**
Getting Needed Care	81.0%	↓	83.5%	81.9%

Summary Rate Scores: Medi-Cal Child				
Composite	2020	Previous Year Comparison	2019	2018
Getting Care Quickly	82.0%	↓	85.4%	82.8%
How Well Doctors Communicate	92.7%	↓	93.7%	91.6%
Customer Service	84.0%	↓	86.1%	84.6%
Shared Decision Making	Removed from survey	N/A	78.4%	75.3%
Rating of Health Care (8-10)	87.3%	↓	89.8%	85.9%
Rating of Personal Doctor (8-10)	91.2%	↓	93.6%	89.6%
Rating of Specialist (8-10)	90.6%	↑	85.5%	86.3%
Rating of Health Plan (8-10)	87.5%	↓	88.9%	88.3%

Table 39:Medi-Cal Adult Trended Survey Results

Summary Rate Scores: Medi-Cal Adult				
Composite	2020	Previous Year Comparison	2019	2018
Getting Needed Care	82.6%	↑	76.0%	76.1%
Getting Care Quickly	71.7%	↓	74.5%	73.2%
How Well Doctors Communicate	95.7%	↑	88.4%	90.5%
Customer Service	88.8%	↑	80.7%	86.7%
Shared Decision Making	Removed from survey	N/A	78.7%	70.8%
Rating of Health Care (8-10)	75.4%	↑	73.6%	73.5%
Rating of Personal Doctor (8-10)	84.7%	↑	77.1%	80.3%
Rating of Specialist (8-10)	91.7%	↑	74.5%	77.8%
Rating of Health Plan (8-10)	78.4%	↑	73.4%	73.0%

Table 40:Commercial Adult Trended Survey Results

Summary Rate Scores: Commercial Adult				
Composite	**2020**	**Previous Year Comparison**	**2019**	**2018**
Getting Needed Care	65.6%	↓	72.8%	72.3%
Getting Care Quickly	68.7%	↓	70.9%	69.5%
How Well Doctors Communicate	90.0%	↑	87.6%	85.8%
Customer Service	80.3%	↓	82.8%	86.5%
Shared Decision Making	Removed from survey	N/A	84.3%	84.3%
Rating of Health Care (8-10)	66.1%	↓	68.2%	66.8%
Rating of Personal Doctor (8-10)	77.6%	↓	80.4%	73.3%
Rating of Specialist (8-10)	80.2%	↑	75.5%	75.9%
Rating of Health Plan (8-10)	68.5%	↑	64.5%	66.5%

Tables below contain trended survey results for the three (3) member populations and their delegate network compared to the Alliance.

Table 41:Medi-Cal Child Trended Survey Results – Delegates

		AHS			Alliance			CFMG			CHCN			Kaiser 2019		
	2020 Plan Total	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend
Total Respondents	**338**	**36**			**23**			**98**			**122**			**59**		
Getting Needed Care	**81.0%**	84.%	79.2%	↑	59.4	77.5%	↓	91.7%	82.6%	↑	73.7%	83.8%	↓	89.6	90.1%	↓
Getting Care Quickly	**82.0%**	77.1%	55.7%	↑	75.0	93.3%	↓	87.4%	89.3%	↓	74.4%	79.8%	↓	90.2	98.6%	↓
How Well Doctors Communicate	**92.7%**	90.1%	94.7%	↓	83.3	86.1%	↓	95.9%	93.8%	↑	90.3%	92.8%	↓	96.3	98.5%	↓
Rating of Health Care (8-10)	**87.3%**	94.1%	87.5%	↑	75.0%	100.0%	↓	95.0%	91.1%	↑	80.8%	87.0%	↓	89.5	93.9%	↓
Rating of Personal Doctor (8-10)	**91.2%**	100%	97.0%	↑	85.0%	100.0%	↓	96.2%	97.9%	↓	85.2%	88.1%	↓	90.7	94.7%	↓
Rating of Specialist (8-10)	**90.6%**	100%	75.0%	↑	80.0%	100.0%	↓	100%	91.3%	↑	84.2%	77.8%	↑	91.7	90.9%	↑
Rating of Health Plan (8-10)	**87.5%**	90.9%	97.2%	↓	76.2%	96.2%	↑	93.8%	88.8%	↑	79.7%	84.1%	↓	94.9	95.1%	↓

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Table 42:: Medi-Cal Adult Trended Survey Results – Delegates

		AHS			Alliance			CHCN				KAISER		
	2020 Total Plan	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend	KAISER	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend
Total Respondents	**193**	38			37				93			25		
Getting Needed Care	**82.6%**	88.3%	74.5%	↑	78.6%	81.9%	↓		82.7%	70.1%	↑	79.5%	90.0%	↓
Getting Care Quickly	**71.7%**	72.2%	69.5%	↑	79%	75.0%	↑		69.1%	75.2%	↓	70.3%	82.4%	↓
How Well Doctors Communicate	**95.7%**	98.1%	88.8%	↑	96.4%	82.9%	↑		95.3%	91.8%	↑	94.2%	93.2%	↑
Rating of Health Care (8-10)	**75.4%**	81.0%	67.6%	↑	95.8%	71.7%	↑		73.0%	75.6%	↓	80.0%	81.3%	↓
Rating of Personal Doctor (8-10)	**84.7%**	84.2%	70.6%	↑	73.9%	65.5%	↑		89.3%	85.9%	↑	79.2%	85.7%	↓

		AHS			Alliance			CHCN				KAISER		
	2020 Total Plan	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend	KAISER	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend
Rating of Specialist (8-10)	**91.7%**	90.9%	62.5%	↑	76.9%	67.9%	↑		93.8%	86.0%	↑	100%	63.6%	↑
Rating of Health Plan (8-10)	**78.4%**	80.0%	67.7%	↑	80.0%	71.0%	↑		78.0%	74.8%	↑	84.0%	91.6%	↓

Table 43: Commercial Adult Trended Survey Results – Delegated Network

		Alliance			CHCN			AHS		
	2020 Plan Total	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend	2020	2019	Year Over Year Trend
Total Respondents	**241**	**90**			**121**			**30**		
Getting Needed Care	**65.6%**	59.8%	72.4%	↓	72.5%	71.8%	↑	52.8%	77.7%	↓
Getting Care Quickly	**68.7%**	63.5%	73.5%	↓	73.3%	71.2%	↑	68.9%	61.4%	↑
How Well Doctors Communicate	**90.0%**	86.9%	83.7%	↑	91.7%	90.8%	↑	93.5%	91.3%	↑
Rating of Health Care (8-10)	**66.1%**	62.5%	68.0%	↓	67.4%	65.6%	↑	75.0%	79.2%	↓
Rating of Personal Doctor (8-10)	**77.6%**	72.1%	73.2%	↓	81.9%	85.6%	↓	76.2%	88.9%	↓
Rating of Specialist (8-10)	**80.2%**	74.2%	70.0%	↑	89.4%	82.9%	↑	50%	81.8%	↓
Rating of Health Plan (8-10)	**68.5%**	66.3%	61.8%	↑	70.8%	67.5%	↑	65.5%	64.1%	↑

CAHPS Survey Analysis

The 2020 CAHPS survey results year-over-year trends show variation within the **Alliance** business lines. Across LOBs, the Medi-Cal Child population had the highest decrease 6 of seven measures, in composite summary rate scores in 2020. The Medi-Cal Adult population had the highest overall increase composite summary rate scores 6 of seven measures. Commercial Adult for the Alliance shows decrease in four (4) of seven measures.

Five (5) of the seven composite summary rate scores increased for **CFMG** for their Medi-Cal Child population in 2020. Six (6) of seven composite summary rate scores decrease for CHCN for their Medi-Cal Child population; however, five (5) of CHCN scores for their Medi-Cal Adult population increased and six (6) of seven composite scores increased for Commercial Adult .

Six out of seven composite summary rate scores decreased for **Kaiser** for their Medi-Cal Child population; five of seven composite rate scores for Adult Medi-Cal decreased, and four of the seven composite summary rate scores decreased for Commercial Adult.

AHS composite summary rate scores for their Medi-Cal Child population increased in five (5) of seven measures, while seven (7) of seven composite summary rate scores increased for their Medi-Cal Adult population and three (3) of seven measures increased for Commercial Adult.

Four of the seven composite summary rate scores decreased for their Commercial Adult population. Six out of seven composite summary rate scores increased for the Alliance network for their Medi-Cal Child population; however, six out of seven composite summary rate scores decreased for their Medi-Cal Adult population. Five of the seven composite summary rate scores increased for their Commercial Adult population.

Table 44: Composite Measures

Population	Top Measures	Bottom Measures
Medi-Cal Child	Rating of Specialist	Getting Needed Care
	Coordination of Care	Getting Care Quickly
	Rating of Health Plan	Customer Service
Medi-Cal Adult	How Well Doctors Communicate	Rating of Health Plan
	Rating of Health Care	Coordination of Care
	Rating of Specialist	Getting Care Quickly
Commercial Adult	Rating of Health Plan	How well Doctors Communicate
	Coordination of Care	Getting Care Quickly
	Rating of Personal Doctor	Rating of Specialist

Lastly, three composites - Rating of Health Plan, Rating of Health Care, and Rating of Personal Doctor – have been identified for all LOBs as key drivers of member satisfaction, as shown in the table below thus, providing opportunities for improvement.

Table 45: Composites and Key Drivers

Composite	Key Driver
Rating of Health Plan	Getting Quickly
	Getting Needed Care
Rating of Health Care	How Well Doctors Communicate
	Getting Needed Care
Rating of Personal Doctor	How Well Doctors Communicate
	Coordination of Care

Next Steps

The Alliance will continue to collaborate interdepartmentally, focusing on maintaining power in top rating measures and improving member perception of care and services ranked at the bottom of composite scores. Additionally, the Alliance will continue to partner with providers on initiatives designed to improve the member experience and survey scores in 2021-2022 using the Plan-Do-Study-Act cycle to improve or maintain Member Satisfaction scores.

Quality Of Access

A. Standards and Provider Education

The Alliance has continued to educate providers on, monitor, and enforce the following standards**:**

Table 46:Primary Care Physician (PCP) Appointment

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment	10 Business Days of Request
First OB/GYN Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

Table 47:Specialty/Other Appointment

SPECIALTY/OTHER APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of Request
Non-Urgent Appointment with an **Ancillary Service** Provider	15 Business Days of Request
First OB/GYN Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

Table 48: All Provider Wait Time/Telephone/Language Practices

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Appointment Within:**
In-Office Wait Time	60 Minutes
Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
Telephone Access – Provide coverage 24 hours a day, 7 days a week.	
Telephone Triage and Screening – Wait time not to exceed 30 minutes.	
Emergency Instructions – Ensure proper emergency instructions.	
Language Services – Provide interpreter services 24 hours a day, 7 days a week.	

*** Per DMHC and DHCS Regulations, and NCQA HP Standards and Guidelines**

PA = Prior Authorization

Urgent Care refers to services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Non-urgent Care refers to routine appointments for non-urgent conditions.

Triage or Screening refers to the assessment of a member's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice. This individual must be trained to screen or triage, and determine the urgency of the member's need for care.

Each of these standards are monitored as described in the table below. In 2019, the Alliance made changes to the CG-CAHPS instrument to ensure that the collected data was consistent with the Alliance standards which remained in place during the 2020 measurement year.

Table 49: Primary Care Physician (PCP) Appointment

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Measured By:**
Non-Urgent Appointment	PAAS, CG-CAHPS
First OB/GYN Pre-natal Appointment	First Prenatal, Confirmatory Survey
Urgent Appointment that *requires* PA	PAAS, CG-CAHPS
Urgent Appointment that *does not* require PA	PAAS, CG-CAHPS

Table 50: Specialty/Other Appointment

SPECIALTY/OTHER APPOINTMENT	
Appointment Type:	**Measured By:**
Non-Urgent Appointment with a **Specialist** Physician	PAAS
Non-Urgent Appointment with a **Behavioral Health** Provider	PAAS
Non-Urgent Appointment with an **Ancillary Service** Provider	PAAS
First OB/GYN Pre-natal Appointment	First Prenatal, Confirmatory Survey
Urgent Appointment that *requires* PA	PAAS
Urgent Appointment that *does not* require PA	PAAS

Table 51:All Provider Wait Time/Telephone/Language Practices

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Measured By:**
In-Office Wait Time	CG-CAHPS
Call Return Time	CG-CAHPS
Time to Answer Call	CG-CAHPS
Telephone Access – Provide coverage 24 hours a day, 7 days a week	Confirmatory Survey
Telephone Triage and Screening – Wait time not to exceed 30 minutes	Confirmatory Survey
Emergency Instructions – Ensure proper emergency instructions	After Hours: Emergency Instructions Survey, Confirmatory Survey

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Measured By:**
Language Services – Provide interpreter services 24 hours a day, 7 days a week	CG-CAHPS

The Alliance and the QI team adopted a PDSA approach to the access standards.

- Plan: The standards were discussed and adopted, and surveys have been aligned with our adopted standards.
- Do: The surveys are administered, per our policies and procedures (P&Ps); survey methodologies, vendors, and processes are outlined in P&Ps.
- Study: Survey results along with QI recommendations are brought forward to the A&A Committee; the Committee formalizes recommendations which are forwarded to the HCQC and Board of Governors
- Act: Dependent on non-compliant providers and study / decision of the A&A Committee, actions may include, but are not limited to, provider education/re-education and outreach, focused discussions with providers and delegates, resurveying providers to assess/reassess provider compliance with timely access standard(s), issuing of corrective action plans (CAPs), and referral to the Peer Review and Credentialing Committee.

B. Provider Capacity

The Alliance reviews network capacity reports monthly to determine whether primary care providers are reaching network capacity standards of 1:2000. In 2020, no providers exceeded the 2,000 member threshold. The Network Validation department flags the provider at 1900 and above to ensure member assignment does not reach the 2,000 capacity standard. If a provider is close to the threshold, the plan reaches out to confirm if the provider intends to recruit other providers. If not, the panel is closed to new assignment. During this time, the plan and the provider are in communication of such changes.

C. Geo Access

The geographic access reports are reviewed quarterly to ensure that the plan is meeting the geographic access standards for provided services in Alameda County. For PCPs, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. For specialists, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. During 2020, the Alliance continued its cross functional quarterly meeting to review access issues and concerns.

In 2020, the rural areas near Livermore were the only areas in which the plan faced geographic access issues for Primary Care Provider (PCP) services. Although, there were some deficiencies in the Livermore area for PCP services for distance, the Alliance was able to demonstrate

compliance in meeting "time" regulatory standards. The Alliance has received DHCS approval to their request for alternative access for certain Pediatric specialist.

D. Provider Appointment Availability

The Alliance's annual Provider Appointment Availability Survey (PAAS) for MY2020 was used to review appointment wait times for the following provider types:

- Primary Care Physicians (PCPs)
- Specialist Physicians (SPCs):
  - Cardiovascular Disease
  - Endocrinology
  - Gastroenterology
- Non-Physician Mental Health (NPMH) Providers (PhD-level and Masters-level)
- Ancillary Services Providers offering Mammogram and/or Physical Therapy
- Psychiatrists

The Alliance reviewed the results of its annual PAAS for MY2020 in order to identify areas of deficiency and areas for potential improvement. The Alliance defines *deficiency* as a provider group scoring less than a seventy-five percent (75%) compliance rate on any survey question related to appointment wait times.

The Alliance analyzed results for Alameda County, as the vast majority of members live and receive care in Alameda County, the Alliance's service area. Additionally, per the MY2019 DMHC PAAS Methodology, the Alliance reported compliance rates for all counties in which its contracted providers were located, regardless of whether the providers were located outside the Alliance's service area. This included provider groups in the following counties – Contra Costa, Sacramento, San Francisco, Santa Clara, Solano, Marin, Madera, Monterey, San Mateo, Santa Cruz, and Sonoma.

Table 52:Compliance Rates by Appointment Type across All Provider Types

LOB	2019 Urgent Appt	2020 Urgent Appt	Routine Appt	Routine Appt
IHSS	65%	70%	72%	87%
MCL	68%	72%	75%	88%

Across all provider types, there was greater compliance with the routine appointment standard than with the urgent appointment standard, and this was evidenced for both LOBs – MCL and

IHSS for 2019 and 2020. When engaging in provider/delegate re-education around the timely access standards, the Alliance will increase its efforts around compliance with the urgent appointment standard through the following ways:

- Dissemination of provider communications (written and posted) emphasizing the urgent appointment standards;
- Reinforcement of the urgent appointment standards by Provider Services within their interactions with providers; and
- Targeted discussions with leadership staff during Joint Operations Meetings between the Alliance and its delegate leadership.

Table 53:Overall Appointment Compliance Rates by Provider Type

LOB	Ancillary	PCPs	NPMH	Psychiatrists	Specialists
IHSS	94%	81%	85%	82%	63%
MCL	94%	87%	85%	84%	63%

In 2020 Ancillary Providers had the highest level of compliance for both LOBs across both appointment types (urgent appointment standard excluded for this provider type), followed by MCL PCPs, NPMH providers, and Psychiatrists, with Specialists having the lowest level of compliance for both LOBs. Results of the MY2019 PAAS also show Ancillary providers with the highest level of compliance, followed by PCPs, Psychiatrists, and NPMH providers, with Specialists again having the lowest level of compliance for both LOBs. When engaging in provider/delegate re-education around the timely access standards, the Alliance will increase its efforts on Specialists, given they had the lowest level of compliance across all provider types. This will be accomplished through targeted discussions with leadership staff during Joint Operations Meetings between the Alliance and its delegate leadership.

Table 54:Appointment Type by Provider Survey Type

Ancillary		
LOB	Urgent Appt	Routine Appt
IHSS	Not applicable	94%
MCL	Not applicable	94%

PCPs		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	74%	88%
MCL	80%	93%
NPMH		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	86%	84%
MCL	85%	84%
Psychiatrists		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	67%	97%
MCL	71%	97%
Specialists		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	54%	72%
MCL	53%	73%

All provider types had higher levels of compliance with the routine appointment standard than with the urgent appointment standard.

Table 55:Percentage of Ineligible Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2020	41%	17%	29%	36%	18%
2019	36%	31%	30%	29%	27%

Across all provider types, Psychiatrists had the highest percentage of ineligible providers, followed by Ancillary providers, Specialists, and NPMH, with PCPs providers having the lowest percentage of ineligible providers. Results of the MY2019 PAAS also show Psychiatrists as having the highest percentage of ineligible providers. Psychiatrists, PCPs, Specialists and NPMH providers showed a decrease in percentage of ineligible providers from MY2019 to MY2020. The Alliance will ensure continued collaboration with its Analytics and Provider Services Teams, as

well as with its delegate networks, to enhance accuracy of provider contact information, provider specialty, provider network status, and/or provider appointment availability, with the goal of decreasing the overall percentage of ineligible providers.

Table 56:Percentage of Non-Responsive Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2020	30%	6%	33%	12%	28%
2019	17%	8%	41%	15%	37%

Across all provider types, Specialists had the highest percentage of non-responsive providers, followed by Psychiatrists, NPMH providers, and Ancillary providers, with PCPs having the lowest percentages of non-responsive providers (see table above). The Alliance will increase its level of provider/delegate education around survey completion and purpose, including a focus on the development of provider/delegate improvement plans, with the overall goal of lessening and/or removing barriers for non-responsiveness. These efforts will include a focus on Specialists, given they had the highest level of survey non-responsiveness across provider types year-on-year.

E. Year-Over-Year Analysis

All provider types, showed improvement in compliance rates in either appointment types for both LOBs. NPMH providers had the biggest increase in compliance rates for the urgent appointment standard for both LOBs, followed by Psychiatrists. Psychiatrists had the biggest increase in compliance rates for the routine appointment standard for both LOBs.

Alameda Health System

For the PCP provider type, Alameda Health System still fell short of the compliance threshold for both appointment standards for both LOBs, although they made substantial progress in their rate of compliance with routine appointments from the previous year.

CFMG

For the PCP provider type, CFMG providers increased their rate of compliance with both appointment standards for LOBs. For the Specialist provider types, CFMG providers demonstrated best practice by maintaining 100% compliance with both appointment standards for cardiology appointments. CFMG also showed significant improvements with endocrinology and gastroenterology routine appointments. However, CFMG providers lacked improvement with endocrinology and gastroenterology urgent appointments, providing opportunity for improvements.

CHCN

For the PCP and Ancillary provider types, CHCN providers demonstrated best practice with 100% compliance with both appointment standards for both LOBs. For Specialist provider types, CHCN providers demonstrated a slight increase and decrease in their rates of compliance with urgent and routine cardiology appointments respectively, for both LOBs. For endocrinology appointments, CHCN providers showed a significant decrease in their rates of compliance for both appointment standards for both LOBs. For gastroenterology appointments, CHCN providers demonstrated a significant improvement with routine appointments, however, they showed a significant decrease in compliance with urgent appointments, providing opportunity for improvements.

ICP

For the PCP provider type, ICPs demonstrated a significant improvement with both appointment standards for both LOBs. For cardiology, ICPs demonstrated best practice by maintaining 100% compliance with the routine appointment standard for both LOBs. Additionally, for cardiology, ICPs increased their rate of compliance with the urgent appointment standard to 100% compliance for LOBs. For gastroenterology, ICPs demonstrated best practice by maintaining 100% compliance for both appointment standards for both LOBs. ICPs demonstrated 100% compliance with both Psychiatry appointment standards for both LOBs; a significant improvement from MY 2019 compliance rates. For the Adult NPMH provider type, ICPs demonstrated a significant improvement for both appointment standards for both LOBs for the Adult NPMH provider category but they did not participate in the Child NPMH provider category survey.

F. Provider-Focused Improvement Activities

As part of the Quality Improvement strategy for 2020, the Alliance will continue its ongoing re-education of providers/delegates regarding timely access standards via various methods (e.g., quarterly provider packets, fax blasts, postings on the Alliance website, targeted outreach to providers/delegates, in-office provider visits, and others as appropriate), with the goal of increasing the overall percentage of survey participation and compliance. Additionally, the Alliance will continue to conduct regularly scheduled and ad-hoc surveys/audits that assess provider compliance with timely access standards, issuing time-sensitive corrective action plans (CAPs) to all non-responsive and non-compliant providers. The Alliance will continue to discuss the importance of completion of the PAAS and other timely access surveys. Results and corrective actions needed for improvement are discussed with leadership staff during Joint Operations Meetings between the Alliance and its delegate leadership. The Alliance will also consider engaging in similar discussions with the larger provider groups in its network, especially those with low compliance rates and/or high rates of non-responsiveness. Lastly, the Alliance will continue to review other indicators of access and availability throughout the year and will engage in Plan-Do-Study-Act cycles, as appropriate.

All non-compliant PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their survey results and the timely access standards in which they were deficient, along with time-sensitive CAPs. All non-responsive PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their non-responsiveness reminding them of the requirement to respond to timely access surveys, along with the timely access standards and time-sensitive CAPs.

G. Best Practices

As part of the Quality Improvement strategy for 2021, during Joint Operations Meetings the Alliance will engage in discussions with delegate leadership whose providers have higher compliance rates, in an effort to learn about best practices that can be shared with other providers. The Alliance will share findings from the MY2020 PAAS within its Health Care Quality Committee (HCQC), which is comprised of leadership staff from several delegated networks, offering additional opportunities for discussion of best practices.

H. After Hours Survey

The Alliance contracted with SPH Analytics (SPH) to conduct the annual Provider After-Hours Survey for MY2020, which measures providers' compliance with the after-hours emergency instructions standard. The MY2020 After-Hours Survey was conducted from August to November 2020. SPH followed a phone-only protocol to administer the survey to the eligible provider population during closed office hours. A total of 350 Alliance providers and/or their staff were surveyed, and included 95 primary care physicians (PCPs), 211 specialists, and 44 behavioral health (BH) providers. The survey assesses for the presence of instructions for a caller with an emergency situation, either via a recording or auto-attendant, or a live person.

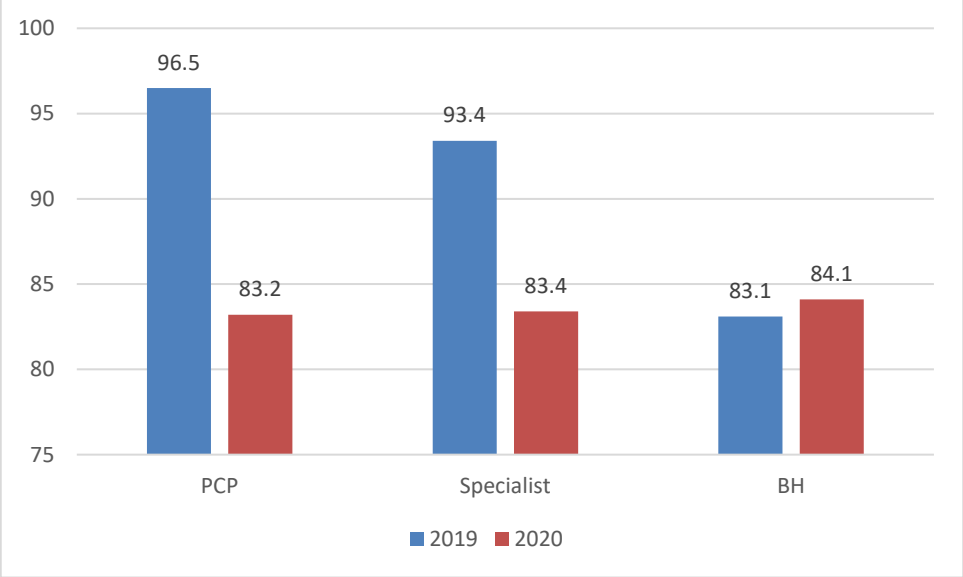
The table below presents the compliance rates for the providers surveyed in the After-Hours Survey:

Table 57:Compliance Rates for After Hours Survey

	Emergency Instructions		
Provider Type	**Total Compliant**	**Total Non-Compliant**	**Compliance Rate**
PCP	79	16	83.2%
Specialist	176	35	83.4%
BH	37	7	84.1%
Total	**292**	**58**	

A total of 58 providers (16 PCPs, 35 Specialists, 7 BH) were found to be non-compliant with the emergency instructions standard as a result of the After-Hours Survey. BH providers had the highest compliance rate, followed by Specialists, then PCP providers.

Table 58:After Hours Emergency Instruction and Access to Physician Compliance Rate Comparison (2019 v 2020)



The figure below presents the response rate across provider types:

Table 59: Response Rate by Provider Type

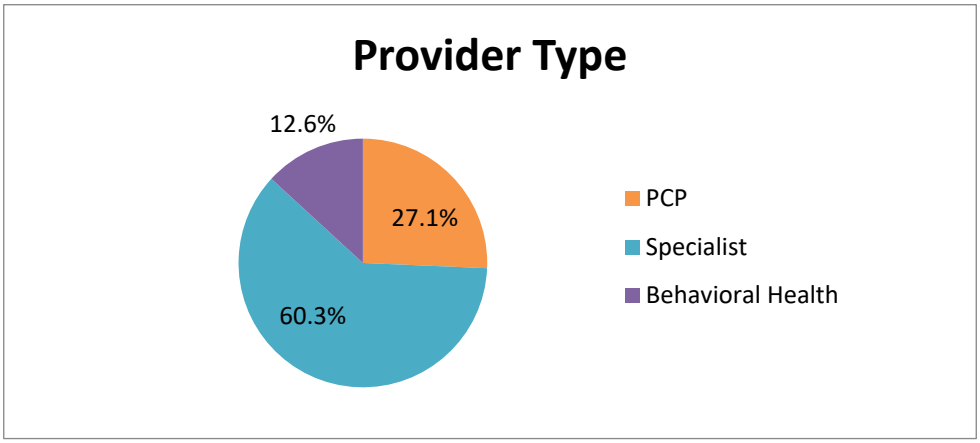
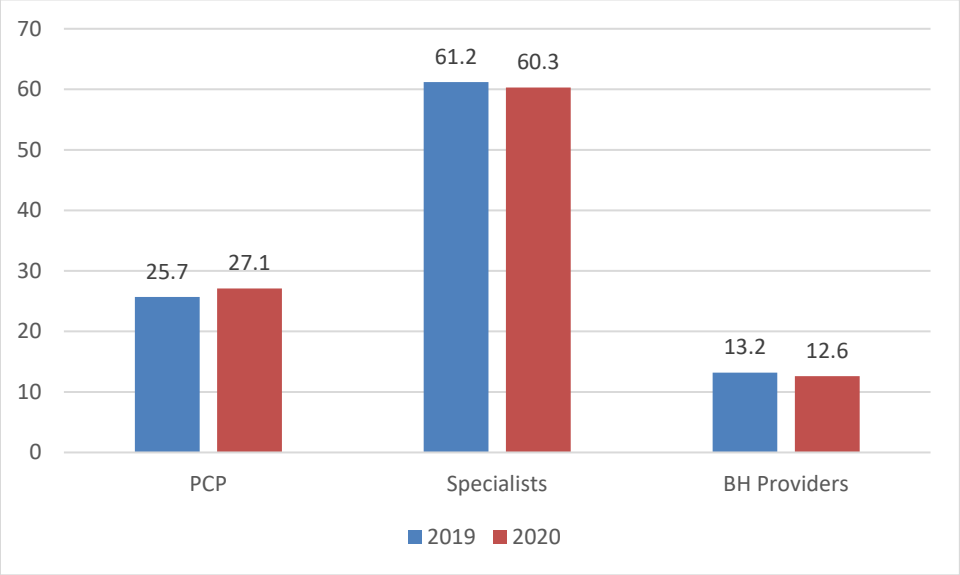


Table 60:After Hours Emergency Instruction and Access to Provider Survey Response Rate Comparison (2019 v 2020)



2020 results are not comparable to previous year's (2019) results due to a change in call script methodology. 2020 After Hours Emergency Response Rates for 2020 when compared to 2019 vary less than 1% year over year. However, Compliance Rates with After Hours Emergency Instruction year over year show significant decrease for PCPs at 13.3% and 10% decrease for Specialists in 2020 when compared to 2019. Additionally, the impact of the COVID PHE on After Hours Emergency Instruction compliance remains uncertain. Results of survey will be presented at Q2 Access and Availability Committee. Corrective Action Plans will be issued to all non-compliant and non-responsive providers.

I. First Prenatal Visit Survey

The Alliance conducted the annual First Prenatal Visit Survey for MY2020, which measures providers' compliance with the first prenatal visit standard. The survey was conducted in September - December of 2020 and was administered to a random sample of eligible Alliance Obstetrics and Gynecology (OB/GYN) providers. The table below shows results of the survey.

Table 61: First Prenatal Visit Survey

Appointment Within 2 Weeks	75% Target Goal Met	Percent of Ineligibles	Precent of Non-Responsive
68.9%	No	51%	11.1%

The First Prenatal Visit 2020 survey results shows a compliance rate is 10 percentage points higher than the 2019 compliance rate, although the goal of 75% was not met. Corrective Action

Plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2021. Additionally, the Alliance's QI Department will continue: 1) between survey monitoring of First Prenatal Visit compliance via Quality of Access PQIs 2) ongoing provider education and discussions at delegate Joint Operations Meetings (JOMs) regarding timely access standards; 3) collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.

J. Oncology Survey

The Alliance conducted the annual Oncology Survey for MY2019, which measures providers' compliance with the urgent and non-urgent appointment standards for specialists. The survey was conducted in June and July of 2019 and was administered to a random sample of eligible Alliance oncology providers. The table below shows results of the survey.

Table 62:Oncology Survey

Urgent Appt	75% Target Goal Met	Non-Urgent Appt	75% Target Goal Met	Percent of Ineligibles	Percent of Non-Responsive
86.7%	Yes	90%	Yes	3%	16%

The 2020 the compliance rate for non-urgent appointments decreased from 100% , as did the compliance rate for urgent appointments by 5 percentage points. Time-sensitive corrective action plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2021. Additionally, the Alliance's QI Department will: continue: 1) its ongoing provider education and discussions at delegate Joint Operations Meetings (JOMs) regarding timely access standards; 2) collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.

K. CG-CAHPS SURVEY

The Alliance contracted with SPH Analytics (SPH) to conduct its quarterly Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey within 2020, which measures member perception of and experience with three timely access standards: in-office wait time; call return time; and time to answer call. The CG-CAHPS survey was fielded in Q1, Q2,Q3 Q4 of 2020. In 2019 the Alliance was given approval by DHCS to modified the CG-CAHPS survey . Per approval from DHCS, the in-office wait time standard changed from within 30 minutes to within 60 minutes. Also, the call return time standard changed from within 30 minutes to within one business day. The time to answer call standard remained the same (within 10 minutes). SPH followed a mixed methodology of mail and phone to administer the survey to a

randomized selection of eligible members who had accessed care with their PCP within the previous six months.

The table below presents the compliance rates across the three metrics for the CG-CAHPS surveys that were conducted in 2020 within each quarter.

Table 63:CG-CAHPS Survey Results 2020

Metric	Compliance Goal	Q1 2020	Q2 2020	Q3 2020	Q4 2020
In-Office Wait Time (Within 60 minutes)	80%	90.1%	91.1%	91.2%	92.4%
Call Return Time (Within 1 Business Day)	80%	79.0%	79.2%	77.6%	76.3%
Time To Answer Call (Within 10 minutes)	80%	79.0%	78.6%	79.4%	81.1%

The target compliance goal for each of the three metrics is 80%. In-office Wait Time compliance goals were met throughout 2020. Call Return Time and Time to Answer Call compliance rates trended slightly below the compliance goal of 80% ranging from 76.3% - 79.4%

The Alliance continues to follow its Escalation Process for Providers Non-Compliant with CG-CAHPS which involves: tracking and trending in the first quarter of non-compliance; sending a provider letter and discussions at Joint Operations Meetings with delegates for two consecutive quarters of non-compliance; and issuing corrective action plans (CAPs) and discussions with COOs/CFOs during three consecutive quarters of non-compliance.

Provider Satisfaction Survey Overview

The Alliance contracted with its NCQA certified vendor, SPH, to conduct a Provider Satisfaction Survey for measurement year 2020. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Alliance provided SPH with a database of Primary Care Physicians (PCPs), Specialists (SPCs) and Behavioral Health (BH) providers who were part of the Alliance network. Duplicate provider names or NPIs were removed from the databased prior to submitting to survey vendor. From the database of unique providers, a sample of 815 records was drawn. A total of 147 surveys were completed between October - December 2020 (87 mail, 34 internet, 26 phone).

The table below contains the survey response rates, survey respondents, and role of survey respondents for 2020 compared to 2019.

Table 64:Survey Response Rates: 2020 vs. 2019

	Mail/Internet	Phone
2020	15%	8%
2019	14.3%	28.6%

Table 65: Survey Respondents 2019 vs. 2018

	PCPs	BH Providers	SPCs
2019	58.0%	29.0%	27.8%
2018	32.9%	19.3%	56.0%

Year to Year Trend Comparisons

The table below contains the trended survey results across composites.

Table 66:Trended Survey Results Across Composites

Summary Rate Scores					
Composite / Attribute	**MY 2020 Result**	**Variance Compared to Previous Year**	**Variance Compared to SPH Commercial Benchmark BoB/ Aggregate**	**2019**	**2018**
Overall Satisfaction with the Alliance	**85%**	Significantly Higher	Significantly Higher	67.8%	81.1%
All Other Plans (Comparative Rating)	**56%**	Significantly Higher	Significantly Higher	43.8%	49.8%
Finance Issues	**45%**	Higher	Significantly Higher	36.2%	41.7%
Utilization and Quality Management	**51%**	Higher	Significantly Higher	48.2%	45.2%
Network/Coordination of Care	**39%**	Higher	Significantly Higher (Aggregate)	36.6%	40.9%
Pharmacy	**33%**	Lower	Significantly Higher (Aggregate)	34.1%	35.6%

Summary Rate Scores					
Composite / Attribute	**MY 2020 Result**	**Variance Compared to Previous Year**	**Variance Compared to SPH Commercial Benchmark BoB/ Aggregate**	**2019**	**2018**
Health Plan Call Center Staff	**54%**	Higher	Significantly Higher	44.5 %	52.8 %
Provider Relations	**62%**	Higher	Significantly Higher	57.3 %	53.5 %

The Alliance identified significant higher composite scores in 7 of 8 composites compared to 2019 scores. 8 of 8 composite scores are significantly higher than vendor commercial BoB and/or aggregate scores. Survey results indicate that the Alliance is performing above the 75th percentile in 7 of 8 composites and near the median in Network/Coordination of Care composite score.

SPH Alliance POWER List:

Promote and Leverage Strengths (Top 5 Listed)

1. The health plan's facilitation/support of appropriate clinical care for patients.
2. Procedures for obtaining pre-certification/referral/authorization information.
3. Timeliness of obtaining pre-certification/referral/authorization information.
4. Overall satisfaction with health plan's call center service.
5. Helpfulness of health plan call center staff in obtaining referrals for patients in your care.

Next Steps: Establish a cross functional workgroup will study opportunities within SHP POWER listing to promote and leverage identified strengths for ongoing improvements using the PDSA process.

Grievances and Appeals

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan in an effort to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into two processes, complaints and appeals. In both instances, the details of the member's complaints are collected, processed, and reviewed and actions are taken to resolve the issue.

A **Grievance** is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. A grievance may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the Alliance to make an authorization decision. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

A **Complaint** is the same as "grievance".

An **Appeal** refers to an appeal of any adverse decisions that are not about coverage.

An **UM Appeal** is defined as a review of an Adverse Benefit Determination. The state regulations do not explicitly define the term "Appeal", they do delineate specific requirements for types of Grievances that would fall under the new federal definition of Appeal. These types of Grievances involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit.

The Alliance's Grievance and Appeals (G&A) department monitors grievances (complaints) and appeals on a quarterly basis to identify issues affecting quality of care and service within the provider network. Providers exceeding the maximum amount of complaints are subject to disciplinary action.

A. Annual Grievance and Appeals Report – 2020

The quarterly grievance and appeals report is presented to the Health Care Quality Committee for systematic aggregation, evaluation of complaints, assessment of trends, and analysis for quality improvement. When trends are identified appropriate action will be taken to correct the problems. Grievance and Appeals are processed in accordance with DMHC regulations, DHCS APL 17-006 and NCQA Accreditation Standards.

Table 67: Standards/Benchmarks

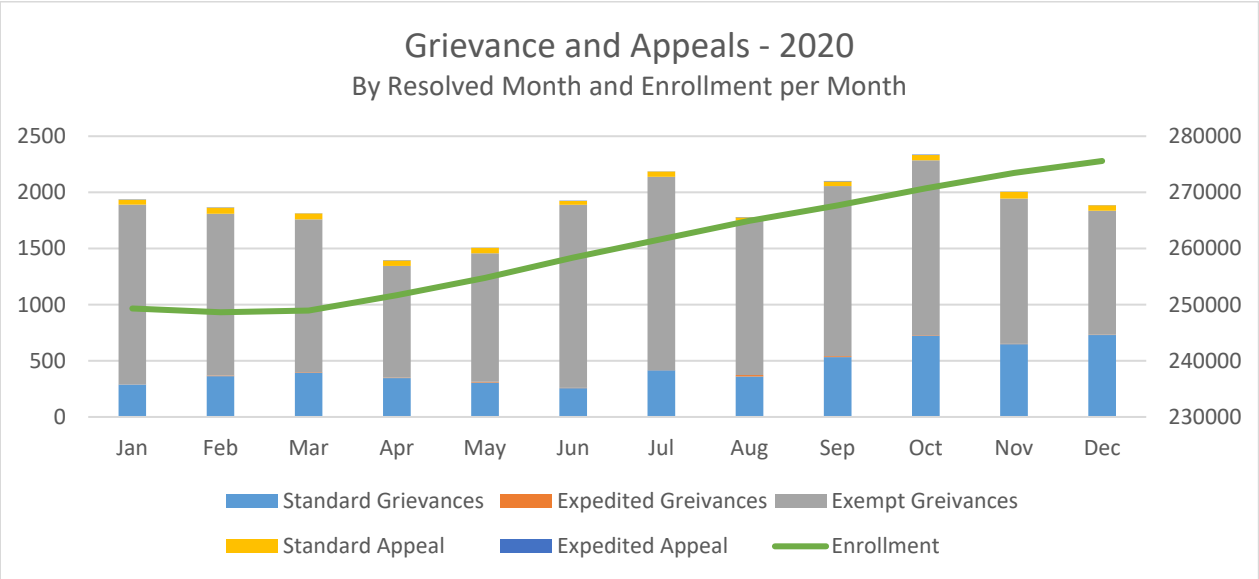
Case Type	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members
Standard Grievance	5,370	30 Calendar Days	95% compliance within standard	5,254	97.8%	
Expedited Grievance	61	72 Hours	95% compliance within standard	55	90.2%	

Case Type	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members
Exempt Grievance	16,731	Next Business Day	95% compliance within standard	16,705	99.8%	
Standard Appeal	553	30 Calendar Days	95% compliance within standard	552	99.8%	
Expedited Appeal	29	72 Hours	95% compliance within standard	28	96.6%	
2020 Total Cases:	22,744		95% compliance within standard	22,594	99.3%	7.28

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

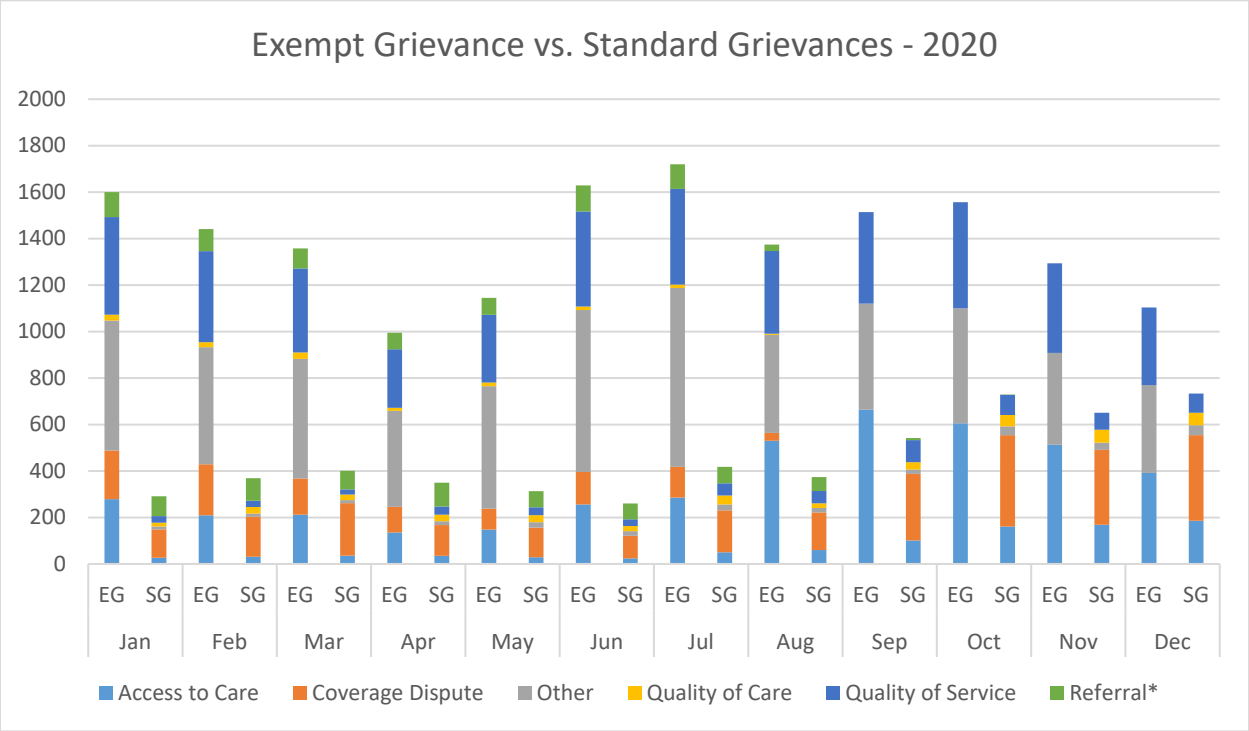
Our goal of 95% compliance rate within the expedited grievances turnaround time (72 hours) was not met. Four complaints with regard to Solara Medical Supplies and two cases with regard to medication.

Table 68: 2020 Grievance ad Appeals Tracking and Trending



There was an overall increase of standard grievances processed during the year, this was due to a change in process for grievances related to coverage disputes. In response to our DMHC Routine Follow-Up Survey, there was a finding that stated that coverage disputes were inappropriately handled as exempt grievance, complaints resolved by the next business day; therefore, exempt from written communication to the member. The Department's findings stated that these disputes should be handled as standard grievances. Starting August 2020, all coverage disputes were sent to the Grievance and Appeals Department to be resolved as standard grievances which requires a written acknowledgement and written resolution letter to be sent to the member.

Table 69:Exempt Grievance vs. Standard Grievances - 2020



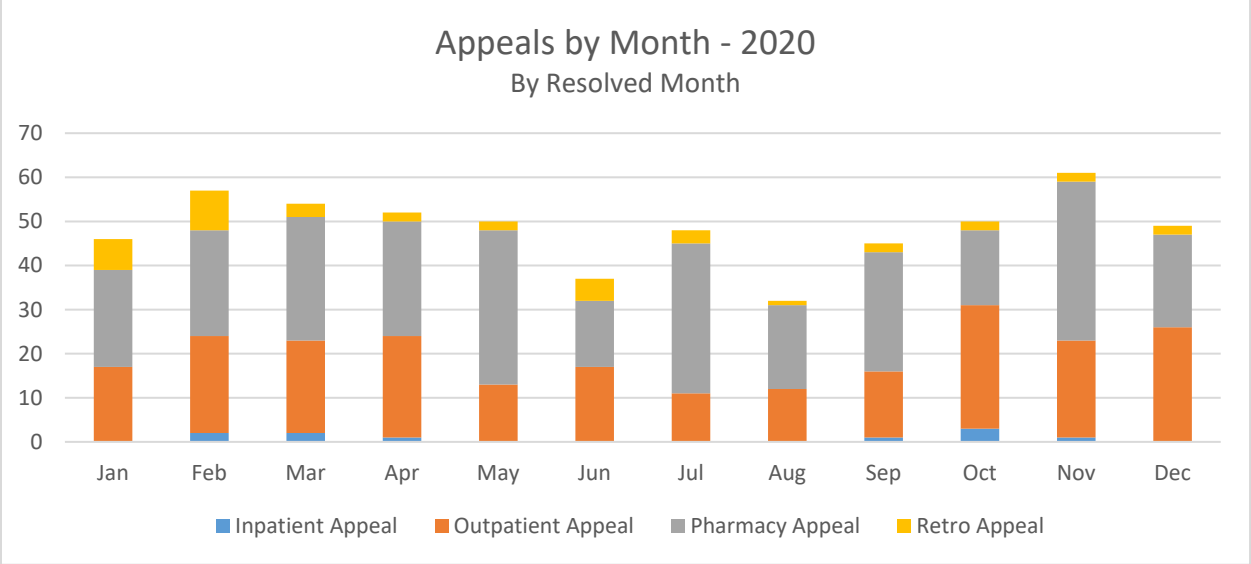
*Referral category was discontinued in August 2020, grievances related to referral are now rolled up into Access to Care.

- Process change for coverage disputes, all cases that fall under that category have to be forwarded to the G&A Department for written correspondence even if they could be resolved within the next business day, and examples include:
  - Member calling to ask for reimbursement of monies paid, we used to capture as exempt and refer them to the website to complete the reimbursement form.
  - Member calling with regards to being balanced billed, member services used to contacted the provider to bill the Alliance.

- Denied pharmacy services at point of sale, member services used to educate the member that they were either OON or the medication required a PA and close as an exempt grievance.

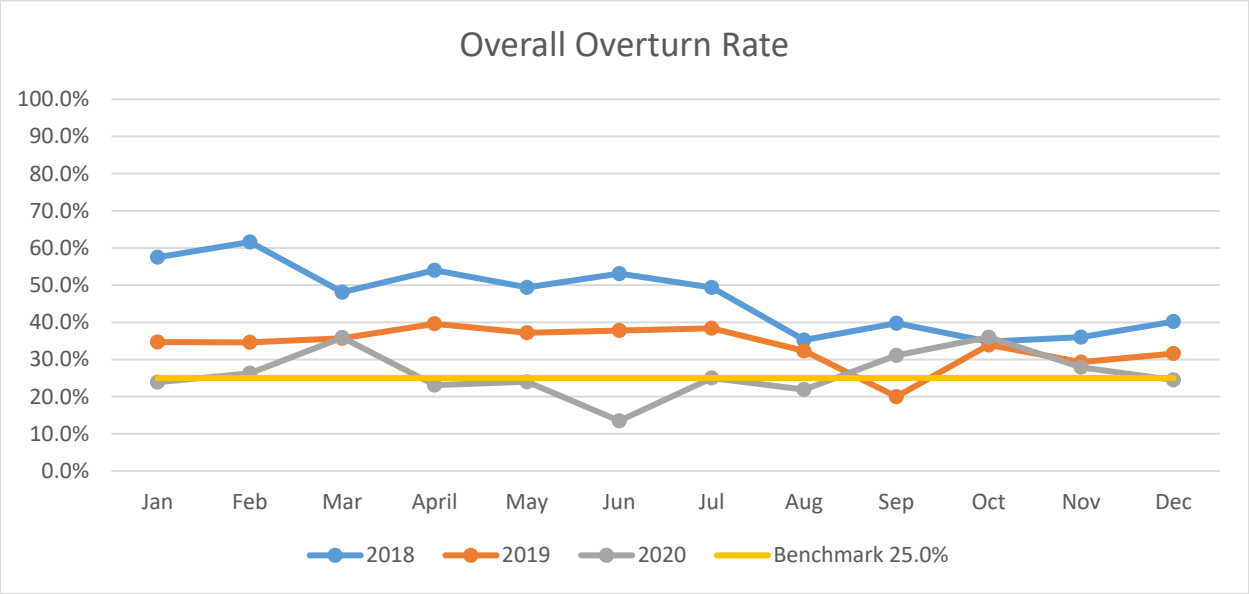
- IHSS Copays, we have had an increase of grievances related to IHSS members calling to complain about copays. The Alliance waived copays for IHSS members due to COVID-19, it was effective from 3/16 through 7/31, and members are upset that they now have to pay when they have not been paying since March. These complaints fall under coverage disputes and are being handled by the G&A Department.
- The appeals resolved in Q3 2020 experienced a decreased compared to the other quarters, this can be attributed to members not being able to get into their doctors office for routine appointments due to COVID-19.

Table 70: Appeals by Month - By Resolved Month



The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of 2020; we averaged 26.1%which was slightly over our goal.

Table 71:Overall Overturn Rate



Cultural And Linguistic Needs Of Members

The Alliance QI Department conducts a quarterly of the Alliance's membership cultural and linguistic makeup as well as the provider network with respect to member accessibility. The assessment is meant to enhance the Alliance's ability to provide access to high quality, culturally appropriate healthcare to our members and focuses on the following areas:

- Cultural and Linguistic needs of members;
- Provision of interpreter services
- PCP language capacity

The Alliance strives to ensure members have access to a PCP who can speak their language or to appropriate interpreters. For members who have not chosen a PCP upon enrollment, the Alliance will assign a member to a PCP based on characteristics, including language. In 2020, the Alliance identified the following threshold languages.

Table 72:: 2020 Threshold Languages

Total by Plan	Threshold Languages		
Medi-Cal **269,862**	English	167,015	61.89%
	Spanish	53,819	19.94%
	Chinese	25,125	9.31%
	Vietnamese	8,471	3.14%

Total by Plan	Threshold Languages		
Group Care 5,954	English	3,547	59.57%
	Chinese	1,381	23.19%
	Spanish	294	4.94%

Table 73: Member Ethnicity – Medi-Cal

MEDI-CAL	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2019	Jan - Dec 2020	% YTD Membership in Jan - Dec 2020 (minus) % of Membership in Jan - Dec 2019	Dec 2020	Dec 2020 %
Hispanic (Latino)	28.04%	28.30%	0.26%	76,720	28.43%
Other	17.52%	18.36%	0.83%	50,699	18.79%
Black (African American)	17.81%	17.51%	-0.30%	46,297	17.16%
Chinese	10.97%	10.76%	-0.20%	28,442	10.54%
Other Asian / Pacific Islander	10.73%	10.49%	-0.24%	28,247	10.47%
White	9.79%	9.43%	-0.36%	25,582	9.48%
Vietnamese	4.29%	4.19%	-0.10%	11,044	4.09%
Unknown	0.62%	0.75%	0.13%	2,227	0.83%
American Indian Or Alaskan Native	0.24%	0.23%	-0.02%	604	0.22%
Total Members				**269,862**	

Source: Alliance Monthly Membership Report December 2020

Medi-Cal Ethnicity Discussion: 2020 saw an overall increase in membership, but only slight changes in ethnicities as a percent of the Medi-Cal membership. Hispanic (Latino) members make up almost 30%, all Asian members combined make up over 25%, and Black (African American) members over17% of our Medi-Cal membership.

Table 74: Member Ethnicity – Group Care

GROUP CARE	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2019	Jan - Dec 2020	% YTD Membership in Jan - Dec 2020 (minus) % of Membership in Jan - Dec 2019	Dec 2020	Dec 2020 %
Unknown	33.96%	31.10%	-2.86%	1,805	30.32%
Other Asian / Pacific Islander	26.48%	28.66%	2.18%	1,790	30.06%
Chinese	12.32%	13.09%	0.76%	759	12.75%
Black (African American)	11.80%	11.36%	-0.43%	671	11.27%
Other	6.94%	6.90%	-0.04%	393	6.60%
Hispanic (Latinx)	3.47%	3.71%	0.24%	227	3.81%
Vietnamese	2.97%	3.00%	0.04%	176	2.96%
White	1.94%	2.04%	0.10%	126	2.12%
American Indian Or Alaskan Native	0.11%	0.13%	0.01%	7	0.12%
Total Members				**5,954**	

Group Care Ethnicity Discussion: The largest group who identified their ethnicity was the Other Asian/Pacific Islander, representing over 30% of the Group Care membership. The percent of Group Care members with unknown ethnicity continues to decline, although still higher than desired.

Table 75: Member and Provider Languages Spoken – Medi-Cal

MEDI-CAL	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2019	Jan - Dec 2020	% YTD Membership in Jan - Dec 2020 (minus) % of Membership in Jan - Dec 2019	Dec 2020	Dec 2020 %
English	61.87%	61.42%	-0.45%	167,015	61.89%
Spanish	19.29%	19.89%	0.60%	53,819	19.94%
Chinese	9.73%	9.61%	-0.12%	25,125	9.31%
Unknown	3.48%	3.49%	0.01%	9,291	3.44%
Vietnamese	3.31%	3.24%	-0.07%	8,471	3.14%
Other Non-English	1.72%	1.74%	0.02%	4,543	1.68%
Farsi	0.60%	0.61%	0.00%	1,598	0.59%
Total Members				269,862	

Medi-Cal Language Discussion: Our Medi-Cal members are approximately 3/5 English-speaking, 1/5 Spanish-speaking, 1/10 Chinese-speaking 3/100 Vietnamese-speaking. There are no significant changes from last year.

Table 76: Member and Provider Languages Spoken – Group Care

GROUP CARE	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2019	Jan - Dec 2020	% YTD Membership in Jan - Dec 2020 (minus) % of Membership in Jan - Dec 2019	Dec 2020	Dec 2020 %
English	60.55%	59.56%	-0.99%	3,547	59.57%
Chinese	22.31%	23.29%	0.98%	1,381	23.19%
Spanish	4.92%	4.94%	0.02%	294	4.94%
Unknown	4.20%	4.13%	-0.07%	243	4.08%
Vietnamese	3.64%	3.63%	-0.01%	214	3.59%
Other Non-English	2.79%	2.85%	0.06%	177	2.97%
Farsi	1.59%	1.59%	0.00%	98	1.65%
Total Members				5,954	

Group Care Language Discussion: Group Care members continue to speak predominately English 3/5 of the Group Care members, followed by Chinese-speaking (over1/5) and Spanish-speaking (1/20).

A. Practitioner Language Capacity

During 2020, the Alliance's Provider Relations staff conducted in-person surveys during provider office visits to verify languages spoken by providers. The chart below is a comparison of identified languages spoken by the plan's members to its provider network at the end of Quarter 4 2020. Please note, multi-lingual providers are counted for each language spoken by the individual.

Table 77:MCAL Provider Network vs. Members Comparison of Identified Languages

	2019Q4			2020Q4			Change			
Language	PCPs	Members	Members per PCP	PCPs	Members	Members per PCP	# PCPs	% PCPs	# Members	% Members
English	503	122,728	243	519	137,496	264	16	3.2%	14,768	12%
Spanish	111	42,823	385	121	48,715	402	10	9.0%	5,892	14%
Chinese	68	22,367	328	68	23,110	339	0	0.0%	743	3%
Vietnamese	12	7,885	657	16	8,088	505	4	33.3%	203	3%
Arabic	7	2,062	294	6	2,203	367	-1	-14.3%	141	7%
Farsi	7	1,522	217	6	1,498	249	-1	-14.3%	-24	-2%
Total**	**890**	**209,727**		**910**	**231,656**		20	2.2%	21,929	10%

Source: Q4 2019 and Q4 2020 Provider Impact Reports

Table 78: MCAL PCPs & Members by Language

	2019Q4	2020Q4	Change
Language	Members per PCP	Members per PCP	Difference
English	243	264	Decline ↑21
Spanish	385	402	Decline ↑17
Chinese	328	339	Decline ↑21
Vietnamese	657	505	Improvement ↓152
Arabic	294	367	Decline ↑73
Farsi	217	249	Decline ↑32

* A number of PCPs do not have a primary language designated in the data we receive. Also, multi-lingual providers are counted for each language they speak.

The Alliance also identified and reviewed significant changes and trends related to provider language capacity. In 2020 the Plan experienced overall decline in Medi-Cal membership for all languages as well as a decline in PCPs speaking all languages except for Arabic. However, PCPs per member increased for Vietnamese. The plan will continue to monitor the decline to see if it persists and whether there are grievances that might require taking action.

Table 79:Group Care Provider Network vs. Members Comparison of Identified Languages

	2019Q4			2020Q4			Change			
Language	PCPs	Members	Members per PCP	PCPs	Members	Members per PCP	# PCPs	% PCPs	# Members	% Members
English	376	3,647	9	402	3,545	8	26	6.9%	-102	-3%
Chinese	59	1,407	23	60	1,383	23	1	1.7%	-24	-2%
Spanish	81	303	3	93	295	3	12	14.8%	-8	-3%
Vietnamese	10	224	22	14	215	15	4	40.0%	-9	-4%
Farsi	5	90	18	5	98	19	0	0.0%	8	9%
Arabic	7	15	2	6	9	1	-1	-14.3%	-6	-40%
Total**	**685**	**6,094**		**722**	**5,953**		37	5.4%	-141	-2%

Table 80: Group Care PCPs & Members by Language

	2019Q4	2020Q4	Change
Language	Members per PCP	Members per PCP	Difference
English	9	8	Improvement ↓ 1
Chinese	23	23	No change
Spanish	3	3	No change
Vietnamese	22	15	Improvement ↓ 7
Farsi	18	19	Decline ↑ 1
Arabic	2	1	Improvement ↓ 1

Our Group Care members, while being a significantly smaller population, have access to most of our extensive Medi-Cal network of providers. As a result, all languages have at least 1 PCP per 25 members.

In addition, the Alliance continues to monitor provider language capacity levels and trends quarterly though the following:

- Review of provider and member spoken language capacity comparison
- Review of grievances related to provider language capacity
- Monitoring of interpreter services provided

In the absence of a practitioner who speaks a member's preferred language, the Alliance ensures the provision of interpreter services at the time of appointment. The Alliance has three

interpreter vendors to ensure coverage for both telephonic and in-person interpreters are available for all our members' health care needs. In 2020, the Alliance provided over 12,700 telephonic interpreter services. In addition, we completed just approximately 13,645 requests for interpreter services at the time of appointment. This represents over 99.5% fulfillment with prescheduled interpreter requests. The volume for in-person interpreters decreased from over 20,000 in 2019 due to COVID-19 reduction in in-person office visits.

Analysis Of 2020 Quality Program Evaluation and Effectiveness

The Alliance has identified the challenges and barriers to improvement throughout the 2020 QI Evaluation measurement year. Both challenges and achievements helped to inform our 2021 QI Work Plan. The COVID-19 pandemic and PHE brought unexpectant challenges that impacted our members, provider partners and staff. 2021 will bring an abundance of opportunities for improvement in ensuring that our members have high quality, safe, timely, effective, efficient, equitable, patient centered care. Recommended activities and interventions for the upcoming year consider these challenges and barriers in working toward success and achievement of the Alliance's goals in 2021.

Challenges and barriers to achieving objectives encountered within the 2020 program year included but, are not limited to:

- COVID-19 pandemic and PHE shelter in place resulted in multiple quality initiatives and activities paused due to PHE
- COVID-19 changes to interpreter needs from in-person to telephonic and video.
- Drop in health education program participation due to pandemic and move to virtual formats for classes.
- HEDIS measurement results impedes optimal strategic rapid cycle PDSA implementation for quality improvement activities
- Member Services call center "call abandonment" rate negatively impacted by staffing challenges

Program major accomplishments with objectives met for 2020 include but are not limited to:

- Adequate QI program resources to carry out roles, functions, and responsibilities
- A consistent and stable QI committee and program structure
- Successful administration of all timely access surveys within the expected timeframes, allowing for timely analysis and implementation of next steps with providers and within the Alliance
- Implementation of a revised provider CAP Process in which corrective action plans (CAPs) were revised to minimize administrative burden on provider offices to document corrective plan and resolution

- Increased Provider Satisfaction Survey scores in 2020 for five (5) of six (6) departments
- HCQC meetings held 6 times within 2020 and remains active in ensuring requirements of the QI Program were met despite PHE
- Stable and consistent Senior Level Physician involvement and Appropriate External and Internal Leadership
- Improved HEDIS performance rates for most measures; above the MPL for all accountable HEDIS metrics
- Deployment of a Pediatric Care Coordination Pilot to promote access to care and EPSDT service utilization in partnership with direct, delegate, and CBOs.
- Improved targeted focus on direct and delegate provider education and outreach collaboration with Provider Services to improve access to care using gap in care reports
- Continued focus on health promotion and education that resulted in higher CAHPS scores
- Improved turn-around times and root cause analysis of PQIs
- Implementation of Phase I and Phase II of the PQI Application database
- Ongoing / successful performance improvement projects
- Robust Health Education and Cultural and Linguistic Programs
- Launched new on-demand telephonic and video interpreter capacity.
- In response to COVID-19 stay and home restrictions transitioned over half of interpreter services to video and telephonic.
- Moved Member Advisory Committee and member input to virtual formats to ensure continued member input into programs and services.
- Worked with community providers to move a majority of health education program offerings to virtual formats or 1:1 telephonic supports.
- Enhanced Disease Management Program
- Cost effective approach to quality and safety of care and services utilizing community resources such as:
    - Substance Abuse Disorder Program
    - Ongoing Performance Improvement Projects
- Alliance received certification as a Center of Excellence for superior performance in the Alliance Member Services Call Center.
- Updated grievance tracking system for capturing exempt grievances and accurate reporting and PQI referral submission to Quality department
- Comprehensive monitoring of all practitioners during credentialing / re-credentialing to ensure high quality network.
- QI Program was evaluated, discussed and approved by the HCQC Committee

The HCQC has evaluated the approved the overall effectiveness of the Alliance QI Program and the 2021 Work Plan and determined its progress in meeting safe, clinical practice, goals, based on an assessment of performance in all aspects of the QI Program. The committee determines no need to restructure or change the QI program for the subsequent 2020 year.