ALAMEDA Alliance FOR HEALTH

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

Board of Governors

Regular Meeting

Friday, May 13th, 2022
12:00 p.m. – 2:00 p.m.

Video Conference Call Only

1240 South Loop Road, Alameda, CA 94502

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, May 13th, 2022
12:00 p.m. – 2:00 p.m.

Video Conference Call

Alameda, CA 94502

IMPORTANT PUBLIC HEALTH AND SAFETY MESSAGE REGARDING PARTICIPATION AT ALAMEDA ALLIANCE FOR HEALTH BOARD MEETINGS

STATE OR LOCAL OFFICIALS CONTINUE TO IMPOSE OR RECOMMEND MEASURES TO PROMOTE SOCIAL DISTANCING.

AS A RESULT OF THE COVID-19 VIRUS, AND RESULTING ORDERS AND DIRECTION FROM THE PRESIDENT OF THE UNITED STATES, THE GOVERNOR OF THE STATE OF CALIFORNIA, AND THE ALAMEDA COUNTY HEALTH OFFICER, THE PUBLIC WILL NOT BE PERMITTED TO PHYSICALLY ATTEND THE ALAMEDA ALLIANCE FOR HEALTH MEETING TO WHICH THIS AGENDA APPLIES.

YOU MAY SUBMIT COMMENTS ON ANY AGENDA ITEM OR ON ANY ITEM NOT ON THE AGENDA, IN WRITING VIA MAIL TO "ATTN: ALLIANCE BOARD," 1240 SOUTH LOOP ROAD, ALAMEDA, CA 94502; OR THROUGH E-COMMENT AT jmurray@alamedaalliance.org. YOU MAY WATCH THE MEETING LIVE BY LOGGING IN VIA COMPUTER AT THE FOLLOWING LINK JOIN MEETING OR MAY LISTEN TO THE MEETING BY CALLING IN TO THE FOLLOWING TELEPHONE NUMBER: 1-408-418-9388 ACCESS CODE 1469807782. IF YOU USE THE LINK AND PARTICIPATE VIA COMPUTER, YOU MAY, THROUGH THE USE OF THE CHAT FUNCTION, REQUEST AN OPPORTUNITY TO SPEAK ON ANY AGENDIZED ITEM, INCLUDING GENERAL PUBLIC COMMENT. YOUR REQUEST TO SPEAK MUST BE RECEIVED BEFORE THE ITEM IS CALLED ON THE AGENDA. IF YOU PARTICIPATE BY TELEPHONE, YOU MAY SUBMIT ANY COMMENTS VIA THE E-COMMENT EMAIL ADDRESS DESCRIBED ABOVE OR PROVIDE COMMENT DURING THE MEETING AT THE END OF EACH TOPIC.

PLEASE NOTE: THE ALAMEDA ALLIANCE FOR HEALTH IS MAKING EVERY EFFORT TO FOLLOW THE SPIRIT AND INTENT OF THE BROWN ACT AND OTHER APPLICABLE LAWS REGULATING THE CONDUCT OF PUBLIC MEETINGS, IN ORDER TO MAXIMIZE TRANSPARENCY AND PUBLIC ACCESS. DURING EACH AGENDA ITEM, YOU WILL BE PROVIDED A REASONABLE AMOUNT OF TIME TO PROVIDE PUBLIC COMMENT. THE BOARD WOULD APPRECIATE, HOWEVER, IF COMMUNICATIONS OF PUBLIC COMMENTS RELATED TO ITEMS ON THE AGENDA, OR ITEMS NOT ON THE AGENDA, ARE PROVIDED PRIOR TO THE COMMENCEMENT OF THE MEETING.

1. **CALL TO ORDER**

   (A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on May 13th, 2022, at 12:00 p.m. in Alameda County, California, by Dr. Evan Seevak, Presiding Officer. This meeting is to take place by video conference call.)

2. **ROLL CALL**

3. **AGENDA APPROVAL OR MODIFICATIONS**

4. **INTRODUCTIONS**

5. **CONSENT CALENDAR**

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

   a) **APRIL 8th, 2022, BOARD OF GOVERNORS MEETING MINUTES**

   b) **MAY 10th, 2022, FINANCE COMMITTEE MEETING MINUTES**

6. **BOARD MEMBER REPORTS**

   a) **COMPLIANCE ADVISORY COMMITTEE**

   b) **FINANCE COMMITTEE**

   c) **BOARD RETREAT – SEPTEMBER 9th, 2022**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

   a) **REVIEW AND APPROVE MARCH 2022 MONTHLY FINANCIAL STATEMENTS**

   b) **BOARD OF GOVERNORS EFFECTIVENESS ENGAGEMENT**

   c) **MENTAL HEALTH MILD-TO-MODERATE AND AUTISM SPECTRUM DISORDER SERVICES**

9. **STANDING COMMITTEE UPDATES**

   a) **PEER REVIEW AND CREDENTIALING COMMITTEE**

10. **STAFF UPDATES**

11. **UNFINISHED BUSINESS**

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

14. ADJOURNMENT

NOTICE TO THE PUBLIC

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

The agenda may also be accessed through the Alameda Alliance for Health's Web page at

NOTICE TO THE PUBLIC

At 1:45 p.m., the Board of Governors will determine which of the remaining agenda items can be considered and acted upon prior to 2:00 p.m. and will continue all other items on which additional time is required until a future Board meeting. All meetings are scheduled to terminate at 2:00 p.m.

The Board meets regularly on the second Friday of each month. Due to the pandemic (COVID-19), this meeting is held as a video conference call only. Meetings begin at 12:00 noon unless otherwise noted. Meeting agendas and approved minutes are kept current on the Alameda Alliance for Health's website at www.alamedaalliance.org.

An agenda is provided for each Board of Governors meeting, which lists the items submitted for consideration. Prior to the listed agenda items, the Board may hold a study session to receive information or meet with another committee. A study session is open to the public; however, no public testimony is taken, and no decisions are made. Following a study session, the regular meeting will begin at 12:00 noon. At this time, the Board allows oral communications from the public to address the Board on items NOT listed on the agenda. Oral comments to address the Board of Governors are limited to three minutes per person.

Staff Reports are available. To obtain a document, please call the Clerk of the Board at 510-747-6160.

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

Public Input: If you are interested in addressing the Board, you may submit comments on any agenda item or on any item not on the agenda, in writing via mail to "Attn: Alliance Board," 1240 S. Loop Road, Alameda,

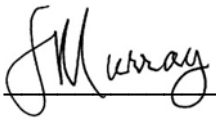
CA 94502; or through e-comment at jmurray@alamedaalliance.org. You may also provide comments during the meeting at the end of each topic.

Supplemental Material Received After the Posting of the Agenda: Any supplemental writings or documents distributed to a majority of the Board regarding any item on this agenda after the posting of the agenda will be available for public review. To obtain a document, please call the Clerk of the Board at 510-747-6160.

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

Americans With Disabilities Act (ADA): It is the intention of the Alameda Alliance for Health to comply with the Americans with Disabilities Act (ADA) in all respects. If, as an attendee or a participant at this meeting, you will need special assistance beyond what is normally provided, the Alameda Alliance for Health will attempt to accommodate you in every reasonable manner. Please contact the Clerk of the Board, Jeanette Murray, at 510-747-6160 at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodations to attend or participate in meetings on a regular basis.

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org on May 6th, 2022, by 12:00 p.m.



_____Clerk of the Board – Jeanette Murray

ALAMEDA Alliance FOR HEALTH

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Consent Calendar

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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Board of Governors Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING
April 8th, 2022
12:00 pm – 2:00 pm
(Video Conference Call)
Alameda, CA

SUMMARY OF PROCEEDINGS

Board of Governors on Conference Call: Dr. Evan Seevak (Chair), Rebecca Gebhart (Vice-Chair), Nicholas Peraino, Dr. Marty Lynch, Byron Lopez, Dr. Rollington Ferguson, James Jackson, Dr. Noha Aboelata, Aarondeep Basrai, Supervisor Dave Brown, Andrea Schwab-Galindo

Alliance Staff Present on Conference Call: Scott Coffin, Dr. Steve O'Brien, Gil Riojas, Anastacia Swift, Ruth Watson, Matt Woodruff, Sasi Karaiyan, Tiffany Cheang, Michelle Lewis

Guests Present on Conference Call:

Excused: Dr. Kelley Meade, Natalie Williams, Dr. Michael Marchiano

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
Dr. Evan Seevak	The regular board meeting was called to order by Dr. Seevak at 12:03 pm. The following public announcement was read. "The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County levels, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with Assembly Bill 361 for the duration of the proclaimed State of emergency." "Audience, during each agenda item, you will be provided a reasonable amount of time to provide public comment."	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
2. ROLL CALL			
Dr. Evan Seevak	A telephonic roll call was taken of the Board Members, and a quorum was confirmed.	None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
Dr. Evan Seevak	None	None	None
4. INTRODUCTIONS			
Dr. Evan Seevak	None	None	None
5. CONSENT CALENDAR			
Dr. Evan Seevak	Dr. Seevak presented the April 8th, 2022, Consent Calendar. a) March 11th, 2022, Board of Governors Meeting Minutes b) April 5th, 2022, Finance Committee Meeting Minutes Motion to Approve April 8th, 2022, Board of Governors Consent Calendar. A roll call vote was taken, and the motion passed.	Motion to Approve April 8th, 2022, Board of Governors Consent Calendar. Motion: Dr. R. Ferguson Second: Rebecca Gebhart Vote: Yes No opposed or abstained.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY COMMITTEE			
Rebecca Gebhart	The Compliance Advisory Committee (CAC) was held telephonically on April 8th, 2022, at 10:30 am. Rebecca Gebhart gave the following Compliance Advisory Committee updates. 2021 Delegation Audits: • All the delegates met their performance metrics for 2021, and the audit season for delegates has concluded. • The Alliance has issued preliminary reports for CHCN, Beacon, and CFMG. In between the preliminary audit findings and the final report, there are discussions with each delegate. • At the Compliance Committee meeting in the month of May, we will explain when and how board members hear about delegate findings, including the range from routine to egregious findings. If you are interested in this, you can come to the Compliance Committee meeting and be a part of this discussion; we will report a summary of the discussion to the full Board. 2022 DHCS Survey & Audit Preparations: • Currently in process: The audit has been taking place from April 4th and will continue through April 15th. The time period being looked at is April 2021 through March 2022. • The staff did extensive prep for the audit, including 10 mock audit interview sessions each an hour to an hour and a half. Packets with tips and resources and incorporated questions from prior audits and questions that focused on areas related to repeat findings were provided. • The staff is doing a great job supporting the team to prepare for these important audits. We will likely have self-reported findings in May, but if not, we will bring them to the Board in June. DMHC Financial Audit: • Scheduled for August 15th, 2022. • The DMHC Financial Audit happens every 3 years – it examines cash assets, liabilities, and all the financial topics associated with the budget,	Informational update to the Board of Governors. Vote not required.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	and financial statements, and looks at claims. It specifically targets late claims, claims that had an interest calculation, denied claims, high dollar claims, and provider disputes. • We anticipate receiving an entrance letter around May or early June. Gil will prepare a brief summary of our last three (3) years of financial services audits for the Compliance Committee. The audit prep on the financial side is facilitated by the annual Moss Adams audit. DMHC Behavioral Health Investigation: • This audit is a Group Care Audit. • We were not in the first cohort of plans being audited in 2021, but we have been notified that we will be part of the 2022 cohort. Staff is trying to obtain information on the outcomes of the first cohort 2021 audit. • The Group Care product, Mild to Moderate Behavioral Health Network, and the SMI Network are administered by Beacon. Medi-Cal RX Transition: • The transition and turnarounds are improving. • One milestone we discussed is July 1st, 2022 – the end of grandfathering of prior offs in this transition process. Providers will be responsible for making the renewed prior off happen. DHCS has been sending instructions to providers and pharmacies and has increased the number of pathways to submit prior offs. Informational update to the Board of Governors. Vote not required.		
6. b. BOARD MEMBER REPORT – FINANCE COMMITTEE			
Dr. R. Ferguson	The Finance Committee was held telephonically on Tuesday, April 5th, 2022. Highlights: • Revenue: The MCO tax adjustment had a significant impact on our revenue statement. We anticipated that it would be $6M; the State has	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	suggested that it is $12M. There is reconciliation to decide on the correct amount. o From 2014 and 2016, the federal government had deemed that California was not compliant with the MCO tax. The State subsequently adjusted how it was calculating its MCO tax. o There are 2 questions: (1) The actual amount the Alliance owes, and (2) can the State ask us to return the money already given to us? o The Executive Team is working on these questions. • ESG Investing update: Upon joining the Finance Committee, James Jackson raised the question of social investing. • Currently, we invest around $280M in terms of our average daily balance. Approximately 78% of that is in investments within 90 days, and 1% is in investments over 180 days. The Alliance team modeled $16.5M to invest in green funds. • Based on that modeling, there could be a potential loss of $15,000-$20,000 for investing in green funds with the current market model. The Finance Committee recommended and voted on $16.5M to be invested in green funds. Informational update to the Board of Governors. Vote not required.		
7. CEO UPDATE			
Scott Coffin	Scott Coffin, Chief Executive Officer, presented the following updates: • Scott recognized Gil Riojas and his team for their work regarding social investing. Executive Summary:	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Finances: • Update on our preliminary budget for FY2023: We are on schedule to present to the Finance Committee and the Board of Governors in the month of June. • We will be finalizing the budget in May and delivering the final budget in December, which will also contain the Q1 forecast. Enrollment: • During the past 2 years of the pandemic, the Alliance's Medi-Cal enrollment has increased by nearly 70,000 children and adults. The enrollment continues to increase each month. • As of the first part of April we are reaching the 309,000 members. Each month, we continue to set enrollment records, and this growth in Medi-Cal is tied to the public health emergency. • The United States Health and Human Services Agency is potentially going to terminate the public health emergency declaration related to COVID-19 in the coming weeks. That will trigger California's Governor to terminate the emergency status in California and then in counties following the order. • Once the executive order terminates, it triggers the restart of the redetermination process at a federal level. Health and Human Services has issued a 60-day grace period, which will help members in Alameda County to prepare for the change and allow the health plans to engage with our members to ensure a smooth transition. We will be working with Alameda County Social Services Agency on this effort. Medi-Cal Coverage Ambassador Program: • This week, the California Department of Health Care Services announced a Medi-Cal Coverage Ambassador Program. This program is tied in with the reinstatement of the redetermination process. It's about outreach and making connections with individuals to make sure they understand what is coming. • The State has opened the Ambassador Program to all of California – anyone can become an ambassador. The Ambassador Program is about spreading the word and sharing with our Medi-Cal enrollees the changes coming up that are related to the public health emergency and answering questions. We will keep the Board informed and pass out the State's invitation.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Question: Do you have a number reflecting where you think we will end up 12 months from now with enrollment; how many members do you think we will have? Answer: We may get up to 325,000 enrollees, then see a decline, but we are currently working on a revised forecast, and we will bring back the estimates at the next meeting. Key Performance Indicators/Operations Dashboard: • Regulatory metrics: We are working on our member grievances and enacted a remediation plan to improve our compliance in future months. • For the expedited member agreements category, we were at 40%, which is 55% below compliance. The metric measures the turnaround time for these expedited grievances that are required within a 72-hour time period; we had a total of five (5) expedited grievances, and two (2) were processed correctly within the timeframe; three (3) were not. A remediation plan is in place to address deficiencies. Program Implementations: • The transition of the mild to moderate health services and autism spectrum services – on October 1st, Beacon Health Options will no longer administer the mild to moderate mental health and autism spectrum services. • The services they are delegated for include quality improvement, utilization management, case management, credentialing, claims, member services, cultural and linguistics, and provider training. These services span across the entire organization; this is a major initiative. As of October 1st, Alameda Alliance will be administering these services for both lines of business, Medi-Cal and Group Care. Last year in April, the Board approved the direction to proceed forward with a transition away from Beacon and bringing this service in-house. • Next month, we will be presenting to the Finance Committee and the Board of Governors the revised implementation costs, the recurring costs, resources needed to complete the transition, and our overall approach to completing this in-sourcing. We will come back with more information on this.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	CalAIM Incentive Programs: • We have five (5) different CalAIM initiatives that occur – January 1st, 2023. ○ ECM – Enhanced Care Management Services, a phased-based approach, and the addition of new populations into the ECM program of services that we currently rolled out on January 1st of this year. The other major initiatives are Long Term Care, Justice Involved, which is the coordinated re-entry with the justice system; Behavioral Health in schools, which is the behavioral health integration; and Population Health, which is not just within the organization, but also with our delegates. All these initiatives are currently in operational readiness phase. We will keep the Board updated on these initiatives. • A presentation is scheduled in June for the Board of Governors meeting on the Long Term Care program. • The incentive funding is being used to build capacity and invest in infrastructure. It is about incentivizing our community-based organizations. We are developing a process that will address the incentive funding life cycles and includes how the application process works, the evaluation, and the awarding of the incentives. • A presentation, which is our second presentation for next month, will be to the Finance Committee and the Board of Governors that outlines each of these programs and what we currently understand on the funding process and the dollar allocations. Each of these programs identifies dollars for investing in local infrastructure. Most of the funding is tied to performance metrics and outcomes, and that is what we want to step the Board through. We're engaged with the Department of Health Care Services through webinars and direct meetings to understand how these programs are intended to work and how the funding will be distributed. We will be updating the Board next month on where we stand, but there will be more updates as we learn more going throughout the year. Scott Coffin concluded by thanking the Alliance staff and team for successfully preparing the audit. He introduced the new Director of Compliance and Special Investigations Unit Sheila Tagle. Question: Could you say a little more about what population health management is going to mean in the Alliance context?		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Answer: Population health management is going to be a requirement – that we have a population health structure. The State is looking at it with two (2) major components, one (1) for us to have an NCQA based population health structure in the way we're looking at our data with a patient-needs assessment and (2) we're populating our case management programs as well as our quality initiative based on our own population health data, and that population health structure be integrated, or connected to the county as a whole. In addition, the State is putting together a population health service, which is a health information and social determinant of help information exchange; this has been launched as an RFP from the State. Question: For example, to a group of patients with hypertension, diabetes, or other chronic conditions, what does it mean in practice? Answer: This is theoretical. Hypertension; if it's disproportional to where the expectation should be, then we would look at the following: are there disparity issues or equity issues; are there particular, geographic, or types of population? With this information, develop programs interventions, look for partners, and maybe address our community supports or structure related to addressing it, trying to tie it all together along with the programs we have. Question: For behavioral health and schools, I read in the notes that it's going to be a partnership with school districts – the Alliance is going to fund the program and help support the design, but won't be staffing, right? Answer: You are correct. We are not going to staff it. Our goal here is to tap into what is already out there in schools. We have been working with the County Office of Education with the schools and communities, and we have had twelve (12) school districts sign up and say they are interested in being part of this program. We have met with eleven (11) of the twelve (12) to set the stage. The first stage that we must do is an assessment with the county; we want it to be a county-wide assessment, and from there, we design interventions. We'd like to tap into interventions that have already been identified and are somewhat in flight so that we can support them, and make sure they get the right data that we can submit to the State. We are also working on how we will determine what those interventions are, and how we will allocate the dollars.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Informational update to the Board of Governors. Vote not required.		
8. a. BOARD BUSINESS – REVIEW AND APPROVE FEBRUARY 2022 MONTHLY FINANCIAL STATEMENTS			
Gil Riojas	Gil Riojas gave the following February 2022 Finance updates: Enrollment: • For the month ending February 28th, 2022, the Alliance had an enrollment over 304,000 members, a net income of $3.4M, and the tangible net equity was 561% of the required amount. • Our enrollment has increased by nearly 1,300 members since January 2022, and on a fiscal YTD, we gained nearly 16,000 members since June 2021. Net Operating Results: • For the fiscal YTD ending February 28th, 2022, the actual net income was $4.5M, and the budgeted net loss was $7.1M. Revenue: • For the month ending February 28th, 2022, the actual revenue was $92.1M vs. the budgeted revenue of $95.9M. • For the fiscal year ending February 28th, 2022, the actual revenue was $780.2M vs. the budgeted revenue of $782.4M. Medical Expense: • For the month ending February 28th, 2022, the actual medical expense was $83.2M, and the budgeted medical expense was $85.6M. • For the fiscal year ending February 28th, 2022, the actual medical expense was $733.1M vs. the budgeted medical expense of $736.5M. • On a PMPM basis, medical expense is 1.6% favorable to the budget.	Motion to Approve February 2022, Monthly Financial Statements as presented. Motion: Dr. R. Ferguson Second: Dr. Marty Lynch Vote: Yes No opposed or abstained.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Medical Loss Ratio (MLR): • For the month ending February 28th, 2022, the MLR was 90.3% and 94.0% for the fiscal year-to-date. Administrative Expense: • For the month ending February 28th, 2022, the actual administrative expense was $5.4M vs. the budgeted administrative expense of $10.7M. • For the fiscal YTD ending February 28th, 2022, the actual administrative expense was $42.5M vs. the budgeted administrative expense $53.0M. Other Income / (Expense): • As of February 28th, 2022, our YTD interest income from investments is $387,817 and YTD claims interest expense is $262,135. Tangible Net Equity (TNE): • Tangible net equity results continue to remain healthy, and at the end of February 28th, 2022, the TNE was reported at 561% of the required amount. Cash Position and Assets: • For the month ending February 28th, 2022, the Alliance reported $283.7M in cash; $185.4M in uncommitted cash. Our current ratio is above the minimum required at 1.70 compared to the regulatory minimum of 1.0. Capital Investment: • Fiscal year-to-date capital assets acquired: $234,000. • Annual capital budget: $1.4M. Anastasia Swift provided an update on the vacancy rate: the current vacancy rate is 12%, which has dropped from last month's 14% vacancy rate due to hiring. Motion to Approve February 2022, Monthly Financial Statements as presented.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	A roll call vote was taken, and the motion passed.		
8. b. BOARD BUSINESS – REVIEW AND APPROVE RESOLUTION #2022-01 NOMINATING NATALIE WILLIAMS FOR REAPPOINTMENT TO DESIGNATED CONSUMER MEMBER SEAT			
Scott Coffin	Review and Approve Resolution #2022-01 Nominating Natalie Williams for Reappointment to Designated Consumer Member Seat Scott Coffin read the following Staff Report for Resolution #2022-01: • The Consumer Member Seat will expire June 29th, 2022 and Ms. Williams has chosen to serve an additional 2-year term. • Pursuant to Section 3.F. of the Alliance Bylaws and has been recommended for reappointment by the Chief Executive Officer. • Section 3.J.1. of the Bylaws provides that the Board shall review the recommendation and that the Board's approval shall be by resolution. • Resolution 2022-01 provides for the approval of Ms. Williams to Regular Seat #7, Consumer Member for reappointment. If the resolution is passed and adopted by the Board of Governors, it will be sent to the Alameda County Board of Supervisors who will vote on Ms. Williams' reappointment to Regular Seat #7, Consumer Member. • There are no fiscal impacts related to this action. Motion to Approve Resolution #2022-01 as presented. A roll call vote was taken, and the motion passed.	Motion to Approve Resolution #2022-01 Nominating Natalie Williams for Reappointment to Designated Consumer Member Seat Motion: Dr. Ferguson Second: Dr. Aboelata Vote: Yes No opposed or abstained.	None
8. c. BOARD BUSINESS – COVID-19 VACCINATION AND INCENTIVES PROGRESS REPORT			
Matthew Woodruff	Matt Woodruff reported on the COVID-19 Vaccination and Incentives Progress Report. Vaccination Progress: • As of March 28th, 2022, 75.1% of Medi-Cal members 12 years and older are vaccinated.	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• We are currently ranked 4th in the State for Managed Care Plans. We also averaged 12% increase among all key measured populations that the State had asked us to measure. • For our homebound Medi-Cal members and our Medi-Cal members aged 50-64 we ended up at 86.3%. • The target rate was either 30% above the baseline or 85%, so we did not hit the 30% or 85% for measure 1, but we did for measure 2, so hopefully, we will get a financial boost from that in around June. • The State took a baseline measurement on August 29th, and we averaged around a twelve (12%) to thirteen (13%) increase overall. Comparatively, we will see how we do when the final report comes out, probably this summer. Funding: • Originally, when we filed for the program, the State awarded us $1.2M, and that was for filling out all the paperwork correctly and doing it on time. To date, on all the different programs that the Alliance put back into the community to try and increase vaccination rates, we spent about $1.4M. • Last month on March 18th, we received $970K from the State, which was a nice boost. We didn't hit 85% on any measure until the final measurement period. • We may see more funding coming in June, depending on how the State ends up calculating the final measures. • With the extra funding, the extra $706K will be going back into incentive funding. Question: The Alliance ranked 4th in the State. Do you know how many plans there are in the State? Answer: I do know the plans above us – San Francisco was number 1, Santa Clara was number 2, San Mateo was number 3, and then the Alliance – we were fourth out of twenty-five. Question: With the incentive program, is that directly to members, or is it also to providers, systems, and clinics?		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Answer: Under the State program, it was to members and providers. There was a portion that the Alliance put into our original program for providers. We are doing calculations now; that money will probably be going out this month or the beginning of next month. For the member incentives, the State is reimbursing us. If any member calls in and we can verify that they did receive their vaccines before the February 28th deadline for the State, they will receive a $50 gift card; anything after the deadline, they receive a $10 gift card from the Alliance. Question: Did the three Health Plans reach the 85% target and were all targets the same? Answer: None of the Health Plans reached 85%. In the mid-70s that was the highest. Question: Why was it so hard for plans to get to 85%? Answer: We knew from the very beginning it was going to be hard; we were going to have to average 2,000 vaccines a week to reach that target. There were some weeks where we were above 2,000 vaccinations for that week, but it didn't change our vaccination rate because of the overall new members that came in. Question: The new members that came in, were they totally new to the plan and not familiar with the services? Answer: That is correct, they are new to the plan and new to managed care, or they could have been new to Medi-Cal. It will take them some time, even though I know our outreach team does invite all new members to new member orientation, and we do training for anyone who wants to show up. Question: Do you know of the different strategies the Alliance used to try to increase vaccination rates? Do you have any sense of what was most effective? Answer: Any movement helped; for example, in our text messaging campaign, we did see members that were vaccinated; for the radio spots we did with the African American Wellness Project, we know members who listened to that program became vaccinated. Informational update to the Board of Governors. Vote not required.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
9. a. STANDING COMMITTEE UPDATES – PEER REVIEW AND CREDENTIALING COMMITTEE			
Dr. Steve O'Brien	The Peer Review and Credentialing Committee (PRCC) was held telephonically on March 15th, 2022. Dr. Steve O'Brien gave the following Committee updates: • We credentialed thirty-eight (38) initial applicants. Additionally, twenty-five (25) providers were re-credentialed at this meeting. • There were twelve (12) providers terminated. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None
9. b. STANDING COMMITTEE UPDATES – PHARMACY AND THERAPEUTICS COMMITTEE			
Dr. Steve O'Brien	The Pharmacy &Therapeutics Committee (P&T) was held telephonically on March 15th, 2022. Dr. Steve O'Brien gave the following Committee updates: • On P&T that evening, we received eight (8) therapeutic categories and drug monographs, eighteen (18) formulary modifications, and twenty-six (26) prior off guidelines that were updated. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
9. c. STANDING COMMITTEE UPDATES – HEALTH CARE QUALITY COMMITTEE			
Dr. Steve O'Brien	The Health Care Quality Committee (HCQC) was held telephonically on March 17th, 2022. Dr. Steve O'Brien gave the following Committee updates: • Dr. Sanjay Bhatt, our Senior Medical Director, and our new Senior Director of Behavioral Health, Dr. Peter Currie, gave an update on behavioral health insourcing. • Loc Tran, the new Manager of Access to Care in the Quality Improvement Department, was introduced to the HCQC. • Policies and Procedures were reviewed as per the annual audit requirement. • The Committee received an ECM and Community Support update, and the UM and CM compliance documents – which are the program, the evaluation, and the work plan. • An update on Medi-Cal Rx was provided. • Dr. Laura Miller, CMO, has stepped down from her role, and Dr. Tri Do has been appointed as the interim CMO during the recruitment process. Question: Are you aware of the impending crisis in primary care, with finding physicians to practice primary care, and whether there is a way we can track that? Answer: We hear about it from our provider partners, and we talked about it at the administrative level. In our network, we have plenty of PCPs now. Our directly contracted network, our PCP roster, is aging very rapidly, and it's hard to say what will happen. Presently, we are good; it will be hard to project over the next couple of years. Question: What are we doing about this? I was especially concerned about what happened over the pandemic because a lot of members left private practice in the area – to wait for it to happen could be a disaster, especially given what is going to happen in 2024, so I think it is something we must start looking at aggressively.	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Answer: One thing that worked well during the pandemic and that we will continue to have is telehealth – telehealth, especially for PCP's was used more than ever before. We will have to grow that program. We are looking at new provider networks, and we may be bringing on some new providers in the next year or two specifically because of what's taking place in 2024. Informational update to the Board of Governors. Vote not required.		
9. d. STANDING COMMITTEE UPDATES – MEMBERS ADVISORY COMMITTEE			
Scott Coffin	The Member Advisory Committee (MAC): • Chairperson Natalie Williams facilitated the quarterly Member Advisory Committee, supported by Linda Ayala. A presentation was delivered on the COVID-19 Vaccination Campaign by Matt Woodruff, our Chief Operating Officer, followed by a presentation by the CEO, Scott Coffin, on the Three (3) Year Alliance Strategic Plan, and Ten (10) Year Roadmap. • Dr. Helen Lee presented to the Committee on the Hepatitis C and treatment methods, followed by Jennifer Karmelich, our Director of Quality Assurance. Jennifer presented the third and fourth quarter grievance and appeals results for 2021. • Michelle Lewis, our Senior Manager of Communications and Outreach presented the 2021 Community Outreach Report. • Linda Ayala, our Manager of Health Education in our Quality Division also presented, and the meeting was adjourned by our Chairperson Natalie Williams. • The next MAC meeting is scheduled for June 16th, 2022. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
10. STAFF UPDATES			
Scott Coffin	None	None	None
11. UNFINISHED BUSINESS			
Scott Coffin	None	None	None
12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Scott Coffin	There are two topics that we are going to bring back to the Board of Governors for next month: • (1) Long Term Care Transition • (2) Mild, Moderate, and Autism Spectrum Service Transition. Informational update to the Board of Governors. Vote not required.	None	None
13. PUBLIC COMMENT (NON-AGENDA ITEMS)			
Dr. Evan Seevak	None	None	None
14. ADJOURNMENT			
Dr. Evan Seevak	Dr. Evan Seevak adjourned the meeting at 1:31 pm.	None	None

Respectfully Submitted by: Danube Serri
Legal Analyst, Legal Services.

ALAMEDA Alliance FOR HEALTH

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Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

May 10th, 2022
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted by Teleconference

Committee Members on Conference Call: Dr. Rollington Ferguson, Dr. Michael Marchiano, Nick Peraino, Gil Riojas

Board of Governor members on Conference Call: James Jackson

Alliance Staff on Conference Call: Scott Coffin, Tiffany Cheang, Richard Golfin III, Sasi Karaiyan, Dr. Steve O'Brien, Anastacia Swift, Ruth Watson, Matt Woodruff, Shulin Lin, Carol van Oosterwijk, Linda Ly, Jennifer Vo, Dorna Serri, Sheila Tagle, Christine Corpus

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
CALL TO ORDER, ROLL CALL, and INTRODUCTIONS			
Dr. Rollington Ferguson	Dr. Ferguson called the Finance Committee meeting to order at 8:00 am. The following public announcement was read. "The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County level, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with Assembly Bill 361 for the duration of the proclaimed state of emergency." A telephonic Roll Call was then conducted.		
CONSENT CALENDAR			
Dr. Rollington Ferguson	Dr. Ferguson presented the Consent Calendar. April 5th, 2022, Finance Committee Minutes were approved at the Board of Governors meeting April 8th, 2022, and not presented today.	There were no modifications to the Consent Calendar, and no items to approve.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
a.) CEO Update			
Scott Coffin	Scott Coffin provided updates to the committee on the following: **<u>Fiscal Year 2023 Budget</u>:** Preliminary fiscal year 2023 Budget is tracking to be presented to the Finance Committee and Board of Governors in June. This will include six months of operating expense related to some major initiatives that will be going live on January 1st, 2023, including Long-Term Care, Population Health, and the Justice-Involved Initiatives, which are all part of the CalAIM program. Increased staffing is being considered for these initiatives, as well as the Mental Health and Autism Spectrum Disorder insourcing, as we consider what it will all mean to the organization. As a result, there is a significant amount of administrative oversight being added as part of the next fiscal year budget. Update will be provided to Board on Friday regarding the Beacon transition (Mental Health and Autism Spectrum Disorder insourcing). **<u>Medi-Cal Incentive Programs:</u>** These are commonly referred to as CalAIM initiatives and they are tied to the Governor's budget. There are currently five (5) different programs that are enacted right now, and the Board has requested a "walk through" of all the programs at the upcoming Board Meeting this Friday. We will explain where we currently stand with these programs as well as where we see the programs going throughout the remainder of the year. There are significant dollars involved with these programs, and each provides different opportunities to build capacity and infrastructure in Alameda County. We will be looking to define the process by which to distribute these funds.	Informational update to the Finance Committee Vote not required	
b.) Review and approve March 2022 Monthly Financial Statements			
Gil Riojas	**<u>March 2022 Financial Statement Summary</u>** **Enrollment:** Current enrollment is 306,787 and continues to trend upward. Total enrollment has increased by 2,335 members from February 2022, and 18,233 members since June 2021. Increases were primarily in the Child, Adult, and Optional Expansion categories of aid, and include slight increases in the Duals and SPD categories of aid. Group Care remains relatively flat. Future enrollment trends will be impacted by the anticipated end of the Public Health Emergency (PHE) and addition of new members scheduled to transition from the County HealthPAC program in May.	<u>Motion to accept</u> **<u>March 2022 Financial Statements</u>** <u>Motion</u>: Dr. Marchiano <u>Seconded</u>: N. Peraino Vote taken. No opposed or abstained.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Net Income: For the month ending March 31st, 2022, the Alliance reported a Net Income of $8.4 million (versus budgeted Net Income of $2.2 million). The favorable variance is attributed to higher than anticipated Revenue and lower than anticipated Administrative Expenses, which was slightly offset by higher than anticipated Medical Expenses. For the year-to-date, the Alliance recorded a Net Income of $12.9 million versus a budgeted Net Loss of $4.9 million. **Revenue:** For the month ending March 31st, 2022, actual Revenue was at $109.1 million vs. our budgeted amount of $94.8 million. The favorable variance is largely due to the reversal of the MCO Tax obligation. The State completed their reconciliation of the MCO Tax going back to Fiscal Years 2014, 2015, and 2016. As a reminder, the State originally determined that we owed them a little over $12.0 million, but our calculation process led us to accrue approximately $6.0 million, leaving a $6 million gap. Upon further investigation and reconciliation, it was determined that the State had miscalculated the MCO Tax revenue, and we did not owe the full $12 million. The additional $6.0 million that we accrued was added back into our revenue. **Question:** Nick Peraino asked if we are now clear of this issue or if it could come back up. Gil answered that he believes we are clear for the years that were included in this reconciliation. He further added that we believe our calculation methods are correct and moving forward the years following the most recent reconciliation are being accrued properly. **Medical Expense:** Actual Medical Expenses for the month were $95.2 million, vs. our budgeted amount of $85.0 million. For the year-to-date, actual Medical Expenses were $828.2 million versus budgeted $821.5 million. Drivers leading to the favorable variance can be seen on the tables on page 11. Further explanation of the variances can be seen on pages 11 and 12. **Medical Loss Ratio:** Our MLR ratio for this month was reported at 87.2%. Year-to-date MLR was at 93.1% vs our annual budgeted percentage 91.5%.	Motion Passed	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Administrative Expense: Actual Administrative Expenses for the month ending March 31st, 2022 were $5.2 million vs. our budgeted amount of $7.6 million. Our Administrative Expense represents 4.8% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date. Reasons for the favorable month-end variances, as well as the favorable year-to-date variances can be attributed to 1) COVID-19 Vaccination Incentives, 2) Delayed timing of new project start dates for Consultants, Computer Support Services, and Purchased Services, and 3) Delayed hiring of new employees. **Other Income / (Expense):** As of March 31st, 2022, our realized YTD interest income from investments was $157,000. YTD claims interest expense is $300,000. **TangibleNet Equity (TNE):** We reported a TNE of 575%, with an excess of $180.4 million. This remains a healthy number in terms of our reserves. **Cash and Cash Equivalents:** We reported $386.2 million in cash; $164.1 million is uncommitted. Our current ratio is above the minimum required at 1.47 compared to regulatory minimum of 1.0. **Capital Investments:** We have spent $234,000 in Capital Assets year-to-date. Our annual capital budget is $1.4 million. **Question:** Dr. Marchiano asked how the Beacon Health transition was going to roll out. Scott Coffin answered that there would be a presentation given on Friday to the full Board regarding the implementation of the program as well as the expectations we have specifically towards access to care.		
UNFINISHED BUSINESS / DISCUSSION			
	Following the approval of the March Financials, Dr. Ferguson led the committee in a brief discussion regarding a few items from past meetings that remain open/unresolved.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Dr. Ferguson asked if the Committee, and subsequently the Board could be updated regularly regarding any system integrity issues, as well as any pending lawsuits. These are questions that can be asked of the Committee related to the Moss Adams annual audits, and Board members by our audit agencies, and he'd like to be better prepared for them. Scott Coffin answered that there is currently a security report included in the Board of Governor's packet, and that we will look at highlighting any attacks on the system. He further confirmed that any lawsuits pending are brought to the Board's attention during closed session. Dr. Ferguson asked for a follow-up on the status of the cost analysis of owning a larger building versus owning one building and renting space out of another. Scott Coffin answered that the Facilities Selection Committee is still in process of recruiting and that one more Board member is needed to participate in order to begin the analysis process. Scott Coffin gave a brief update on Major Organ Transplant as follows: **Major Organ Transplant (MOT):** Currently the major provider in our local area of Major Organ Transplant is the University of California San Francisco (UCSF) system. As part of the covered benefit that went live on January 1st, 2022, the expectation was that the State of California would negotiate a case rate with the University system as a whole (state-wide). The negotiation is still pending today, five-months into the calendar year. We do have arrangements between the Alliance and UCSF to treat our members, but the case rate is still pending. Additionally, the number of active patients waiting to be served is higher than anticipated. Matt Woodruff added that we are currently under a Letter of Agreement with UCSF for all transplants pending the negotiation with the State. **Question:** Dr. Ferguson asked what the possible impact on the Budget would be. Dr. O'Brien provided further information that we currently have over 100 members in various stages of the process of transplant, with the majority being on pre-transplant evaluation or post-transplant stabilization stages, and the minority being on the waitlist. Gil Riojas added that we have been receiving incremental additional revenue related to MOT since January and that the State has also implemented a risk corridor that will potentially mitigate any significant losses from MOT. Scott Coffin further added that in addition to the risk corridor, the State has demonstrated a willingness to discuss the actual experience with Managed Care Health Plans. In the month of March, and again in April, we		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	escalated our request for the finalization of the case rate to the Department of Health Care Services.		
ADJOURNMENT			
Dr. Rollington Ferguson	Dr. Ferguson requested a motion to adjourn the meeting. The meeting adjourned at 8:37 am.	Motion to adjourn: N. Peraino Seconded: J. Jackson No opposed or abstained.	

Respectfully Submitted by:
Christine E. Corpus, Executive Assistant to CFO

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CEO Update

Scott Coffin

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

From: **Scott Coffin, Chief Executive Officer**

Date: **May 13th, 2022**

Subject: **CEO Report**

- **Financials:**

  - Revenue $109 million in March 2022, and $889 million Year-to-Date (YTD).

    - Medical expenses for March were $95.1 million, and $828 million year-to-date, representing the nine months of the fiscal year, and 5.4% in administrative expenses.

  - Tangible Net Equity (TNE): Financial reserves are 575% above the regulatory requirement, representing $180.4 million in excess TNE.

  - Total enrollment 306,787 in March 2022, increasing by more than 2,300 Medi-Cal members as compared to February. Preliminary enrollment in the month of May exceeds 311,000 members.

  - Medi-Cal enrollment increases range from 1,200 to 1,500 members per month. Approximately 5,000 to 6,000 new Medi-Cal beneficiaries are projected to enroll in the months of June and July 2022 related to the transition of undocumented adults (age 50 and over) into Medi-Cal managed care; population is currently enrolled in Alameda County's HealthPAC program.

  - The Public Health Emergency is approved through July, and is anticipated to be terminated by Governor Newsom in August or September; the Medi-Cal re-determination process will resume following the termination of the Governor's Executive Order.

  - Net Operating Performance by Line of Business:

	March	YTD
Medi-Cal.....	$8.9M	$14.1M
Group Care	($449K)	($1.2M)
Totals	$8.4M	$12.9M

- **Key Performance Indicators:**

  - Regulatory Metrics:

    Standard member grievances (turnaround within 30 calendar days) met compliance at 95% based on 671 cases. 90% of the expedited grievances (9 of 10) were processed with the 'three calendar day' turnaround requirement. A remediation plan was implemented for standard and exempt grievances, and the performance is improving.

    Encounter data submissions, for institutional claims 180 days or less, missed by 2.5% for the month of April. The technical issue that caused the error has been corrected, and the encounter data metric is expected to resume full compliance.

  - Non-Regulatory Metrics:

    The Member Services call center received 11,939 inbound calls in March, approximately 17% lower than previous month. The average wait time to speak with a Member Services Representative was 4 minutes and 30 seconds, resulting in 16% abandonment rate; 51% of inbound calls were answered in 30 seconds or less, or 19% below the internal 70% service goal. The Member Services Team implemented a remediation plan in January, including the recent addition of an external call center vendor to support the inbound call queues.

- **Program Implementations [2022-2023]**

  The following program implementations are currently in the operational readiness phase, and being administered through the Alliance's Integrated Planning Division.

  Medi-Cal and Group Care:

  - Presentation today to the Board of Governors on the insourcing of Mental Health & Autism Spectrum Services.
  - Go-Live date extended by 30 days to 11/1/22.

  Medi-Cal Only:

  - CalAIM: Recipe4Health is targeted for July 2022 go-live
  - CalAIM: New ECM Populations of Focus phases in 2023

- CalAIM: Long-Term Care begins 1/1/23
- CalAIM: Justice Involved begins 1/1/23
- CalAIM: Behavioral Health in schools begins 1/1/23
- CalAIM: Population Health begins 1/1/23

- **Regulatory Audits & NCQA**

  - The NCQA re-accreditation survey is scheduled for June 2022. Applies to both lines of business, Group Care and Medi-Cal. A risk has been identified that may impact the accreditation status, and a mitigation plan is being developed to address the self-identified deficiencies.
  - The DMHC routine financial survey is scheduled for mid-August.
  - The DMHC focused mental health parity audit is pending confirmation, and is expected to occur in calendar year 2022.

- **Kaiser Permanente**

  - Week of May 2nd, 2022: Joint Hearing Health & Budget & Fiscal Review Subcommittee No. 3 on Health & Human Services.
  - Alameda Alliance subcontracts with Kaiser today, and 46,000 children and adults are assigned into the Kaiser system.
  - DHCS negotiated a direct contract with Kaiser Permanente, effective 1/1/2024, 5-year term in 32 counties.
    - Kaiser presently serves about 900,000 Medi-Cal beneficiaries statewide through a combination of direct-contracts and sub-delegated arrangements in 22 counties.
    - Addition of 10 counties currently being served by Kaiser with non-Medicaid products (i.e., employer-based, commercial), with option to expand into Medi-Cal
  - Contract requires Kaiser to increase Medi-Cal enrollment by 25% statewide (~225,000) over the life of the contract, in specific areas of counties where Kaiser facilities exist.
  - Permission-to-Enroll (PTE) eligibility process, and is based on a person's previous affiliation within last 12 months (currently 6 months in Alameda County); PTE also applies to dependents, known as "family linkages".
    - Enrollment eligibility is limited to specific zip codes in each county as part of the PTE process, based on location of Kaiser's facilities.
  - PTE restrictions do not apply to foster youth (open enrollment).
  - State Administration's Budget proposal was amended into AB 2724 (Assembly Member Arambula) on March 24th. AB 2724 is referred to as the "Alternate Health Care Service Plan" bill.

May 13th, 2022

Medi-Cal Incentive Programs

Alameda Alliance for Health

Presented by:

Tiffany Cheang, Chief of Analytics

Scott Coffin, Chief Executive Officer

Section 1. Overview

- The Medi-Cal incentive programs are funded by the State of California/DHCS and authorized through the American Rescue Plan Act, Home- and Community-Based Services, State general funds, and other waivers.
- Participation in the incentive programs is voluntary, and the incentive funding paid by the DHCS can be recouped if performance outcomes and measures are not met.
- Funding is allocated to build capacity in local health systems, and is intended to establish sustainable operations to continue functioning after the incentive programs complete. Alameda Alliance will also be applying incentive funds to expand current infrastructure, and to develop more resources for members, providers, and community-based organizations.
- Leveraging the available guidance from State agencies, the managed care health plans are responsible for developing an evaluation, selection, and payment process.
- Incentive payments are aligned with the payment tranches from the State of California. Periodically, required performance reports are assessed by the DHCS, and are used to calculate the awarded amounts. The DHCS assesses the program's performance by examining the actual outcomes and changes in quality metrics.
- Alameda Alliance and Anthem are partnering to develop a single application process for providers and community-based organizations to apply for incentive funding (i.e. CalAIM incentive program, #3 in this document).
- In FY2023, the creation of a new department, called "Incentives & Reporting", is included in the preliminary budget. The department reports into the Integrated Planning Division, and is responsible for enterprise reporting of outcomes (quality, performance), generating reports, and coordinating directly with community-based organizations.

Section 2. Incentive Program Summary (2022 – 2024)

Incentive Program	Duration	Maximum	Awarded	Paid Out
1) Behavioral Health Integration	2021-2022	$756K	$200K	$200K
2) COVID-19 Vaccine	2021-2022	$8.4M	$2.1M	$1.4M
3) CalAIM	2022-2024	$14.8M	$7.4M	In Process
4) Student Behavioral Health	2022-2024	$9.7M	$381K	Pending
5) Housing and Homelessness	2022-2023	$44.3M	Pending	Pending
Totals		**$78M**	**$10.1M**	**$1.6M**

*Statewide funding exceeds $3.5 billion, and the maximum allowable incentive dollars for Alameda Alliance is $78 million (approximately 2.2% of total funding).

Section 3. Description of the Incentive Programs

Program #1. Behavioral Health Integration Incentive Program.

- Description & Purpose:
  - The incentive program is designed to incentivize improvement of physical and behavioral health outcomes, care delivery efficiency, and patient experience. The goal is to increase provider network integration at all levels of integration (those just starting behavioral health integration in their practices as well as those that want to take their integration to the next level), focus on new target populations or health disparities, and improve the level of integration or impact of behavioral and physical health.
    - Program Years: **1/1/2021 - 12/31/2022**
    - Maximum allocation to Alameda Alliance: **$756K**.
    - Payments issued: **$200K awarded** to two contracted providers (Lifelong Medical and Bay Area Community Health).

Program #2. COVID-19 Vaccine Incentive Program.

- Description & Purpose:
  - The incentive program began in October 2021 and ended on February 28th, 2022. The vaccine program targeted children and adults enrolled in Medi-Cal managed care, ages 12 and older. During the vaccination campaign, the vaccination rates for Medi-Cal beneficiaries increased by 13.2%, from 62.2% to 75.4%. The Alliance was awarded $2.2 million, or 26% of the available funding. This incentive program ended on February 28th, 2022.
    - Program Years: **10/1/2021 - 2/28/2022**
    - Maximum allocation to Alameda Alliance: **$8.4 million**.
    - Earned incentive dollars: **$2.2 million**.
    - Payments issued to Providers: **$1.4 million awarded** to approximately nineteen (19) organizations across Alameda County. Member incentives continue to be paid for eligible members receiving COVID-19 vaccinations.

Program #3. CalAIM Incentive Payment Program.

- Description & Purpose:
  - CalAIM's Enhanced Care Management (ECM) and Community Supports programs began launching on January 1st, 2022. The purpose of this incentive program is to expand ECM and Community Supports by building capacity, investing in delivery system infrastructure, addressing disparities and equity, adding community supports, and improving quality.

- Any provider or community-based organization is invited to apply for incentive funding. In order to qualify for funding, the participating organizations are required to join the Alliance's ECM and Community Supports program, and to meet specified outcomes and performance measures.
    - Program Years: 1/1/2022 - 6/30/2024
    - Maximum allocation to Alameda Alliance: $14.8 million (year 1).
    - Earned incentive dollars: $7.4 million.
    - Payments issued to Providers: In Process.
    - Current Status:
- Application packets distributed to current ECM and CS providers in Alameda County, in partnership with Anthem. Webinar scheduled for May 13th to review the application materials and address questions. Additional funding for the second year is anticipated after the first status report is submitted to the DHCS.

Program #4. Student Behavioral Health Incentive Program:

- Description & Purpose:
    - Statewide $389 million is designated over a three-year period (January 1st, 2022-December 31st, 2024) for incentive payments to Medi-Cal managed care plans that meet predefined goals and metrics. The goals and metrics are associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for TK-12 children in public schools. Public charter schools are also included.
    - The purpose of this incentive program is to invest in three priority areas of school-based behavioral health services: planning and coordination, infrastructure, and prevention and early intervention.
        - Program Years: 1/1/2022 - 12/31/2024
        - Maximum allocation to Alameda Alliance: $9.7M.
        - Earned incentive dollars: $381K.
        - Payments issued to Providers: Pending.
        - Current Status:
    - Alameda County HCSA, Center for Healthy Schools, and Alameda County Office of Education are engaged to develop an assessment plan. The assessment is scheduled to conclude by end of 2022 and would outline the interventions that will be implemented in calendar year 2023. Additional funding may be awarded after the assessment is submitted to the DHCS.

Program #5. Housing and Homelessness Incentive Program:

- Description & Purpose:
    - This incentive program is built upon the DHCS' quality strategy and the Home- and Community Based Spending Plan. The spending plan focuses on addressing homelessness and unhoused people, and encompasses the community-based residential continuum pilots for older, frail adults and disabled

populations. The plan includes the assisted living waiver waitlist, community care expansion program, and other services.

- Address homelessness and housing insecurity as social determinants of health. Developing a local homelessness plan will be jointly created with Alameda County Health Care Services Agency and Alameda Alliance, and submitted to the DHCS. The existing partnership that originated during the Whole Person Care and Health Home Pilots (2017 – 2021) would be extended to build more capacity and to support more referrals for housing services, and to better coordinate housing needs.
- This incentive program enables further investing in the expansion of street medicine, data management systems, and staffing to attain three measurement areas: 1) local partnerships to address disparities and equity, 2) infrastructure to support housing navigation, and 3) service delivery and member engagement.
    - Program Years: 1/1/2022 - 3/31/2024
    - Maximum allocation to Alameda Alliance: $44.3 million.
    - Earned incentive dollars: Pending.
    - Payments issued to Providers: Pending.
    - State Guidance: DHCS APL 22-007
    - Current Status:
- The guidance was issued by the DHCS on May 5th,2022 and is being reviewed. The first submission is due to the DHCS on June 30th, 2022; outlines the current landscape, funding availability, strategies to address housing gaps, and measurement criteria. The intersections of housing services funded through the Homeless Housing, Assistance and Prevention grant program are considered by the DHCS, as well as the alignment to the overall housing strategy
- Approximately $19.9 million is allotted for calendar year 2022, and $24.4 million is allotted for calendar year 2023. The first three months in calendar year 2024 have not been communicated by the DHCS. Payments issued in September 2022, June 2023, and March 2024.

ALAMEDA Alliance FOR HEALTH

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Executive Dashboard

OPERATIONS DASHBOARD

MAY 2022

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Financials

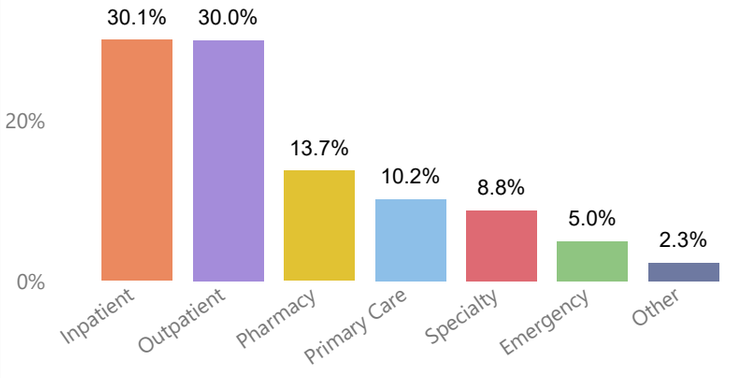
Income & Expenses

	MARCH 2022	FISCAL YTD
REVENUE	$ 109.1 M	$ 889.4 M
MEDICAL EXPENSE	$ (95.2) M	$ (828.2) M
ADMIN EXPENSE	$ (5.2) M	$ (47.7) M
OTHER	$ (323) K	$ (546) K
NET INCOME	$ 8.4 M	$ 12.9 M

Gross Margin %

6.9%

Medical Expenses



Liquid Reserves

MLR Net %

93.1%

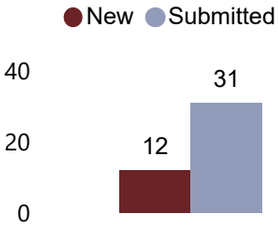
TNE %

575.2%

TNE $

$218.3M

Reinsurance Cases



Balance Sheet

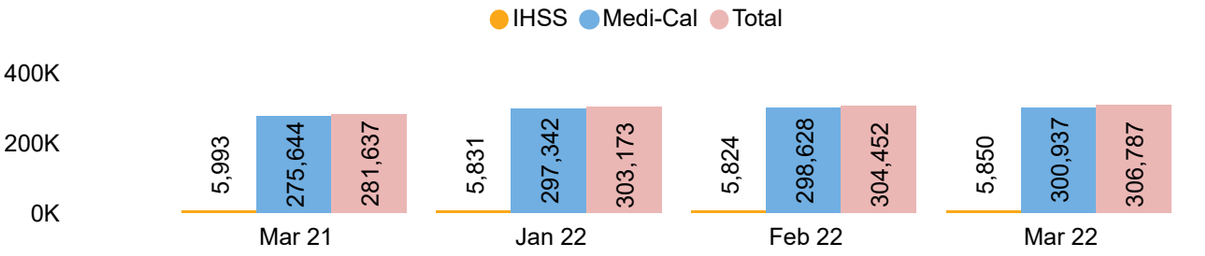
Cash Equivalents	$386.2M
Pass-Through Liabilities	$222.1M
Uncommitted Cash	$164.1M
Working Capital	$174.2M

Current Ratio %

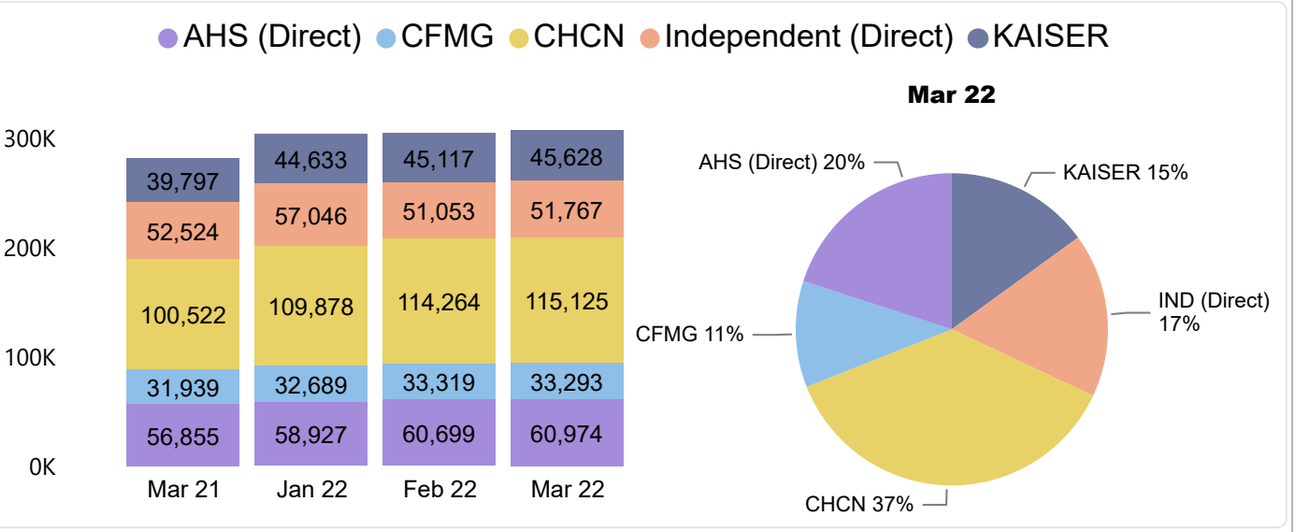
147.0%

Membership

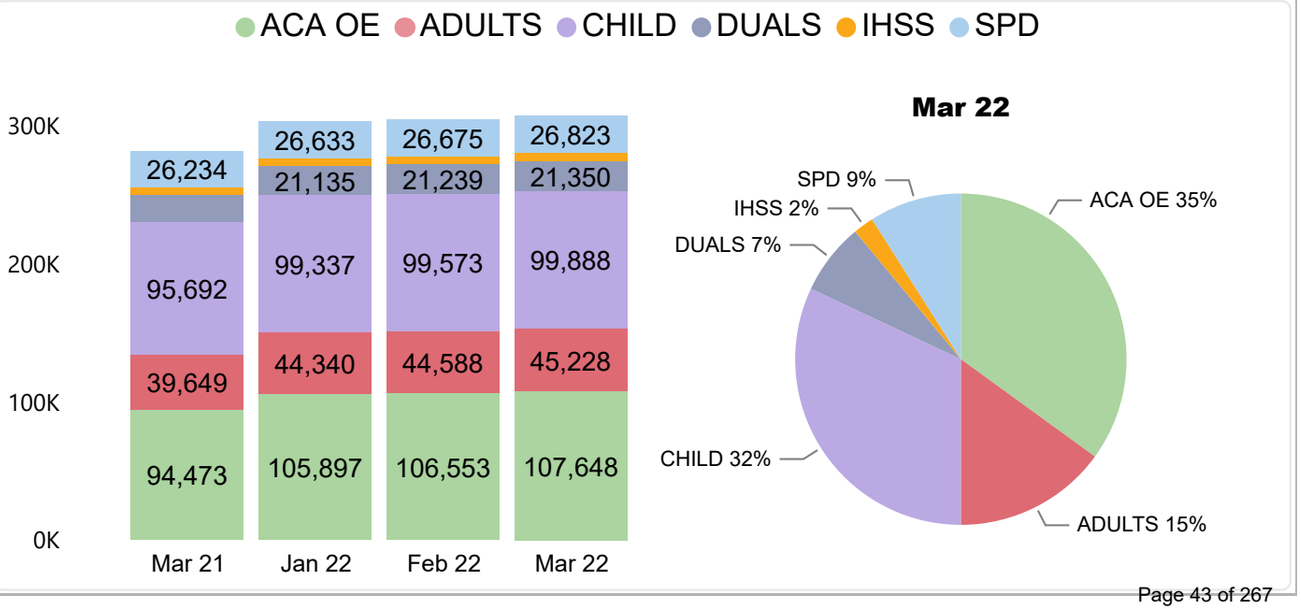
By Plan



By Network



By Category



OPERATIONS DASHBOARD

MAY 2022

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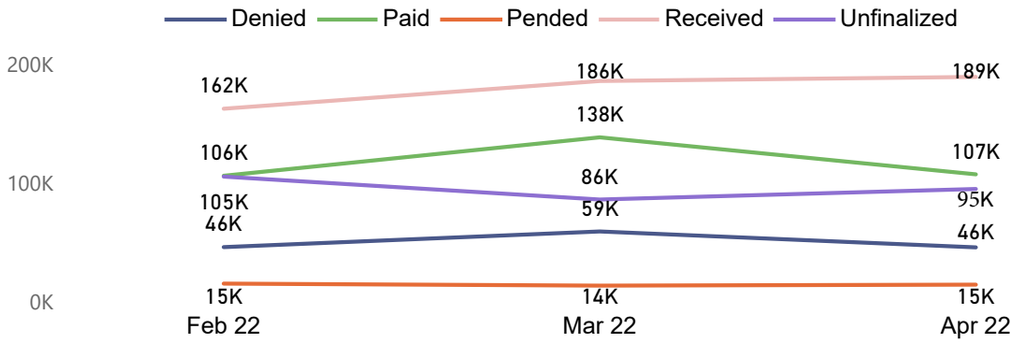
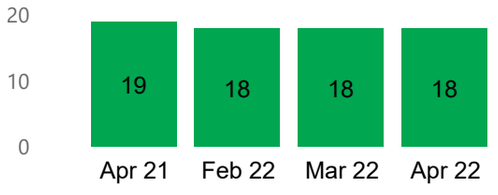
Claims

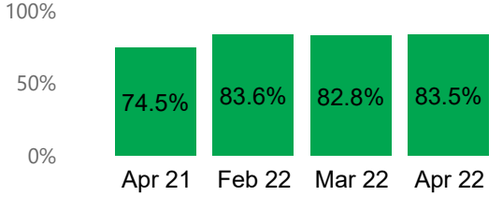
Claims Processing



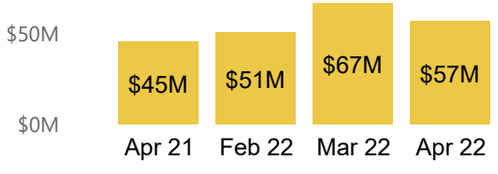
Average Payment TAT (Days)



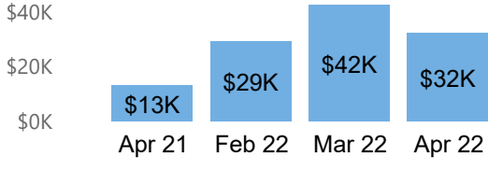
Auto Adjudication Rate (%)



Claims Paid ($)

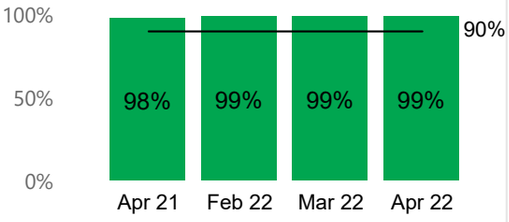


Interest Paid ($)

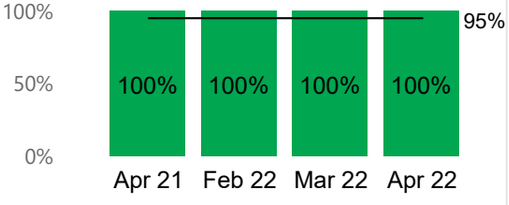


Claims Compliance

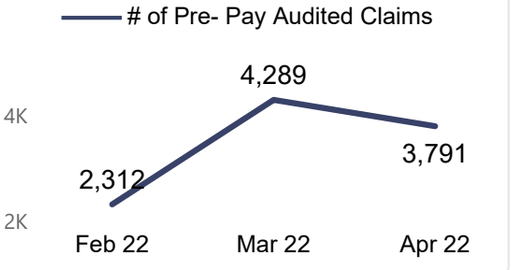
Processed 30 Cal Days (%)



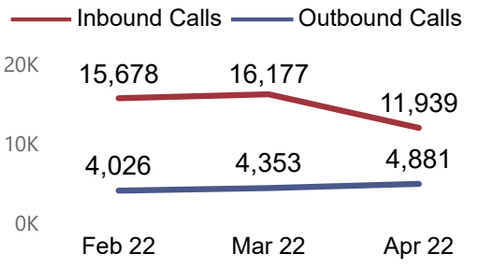
Processed 45 Work Days (%)



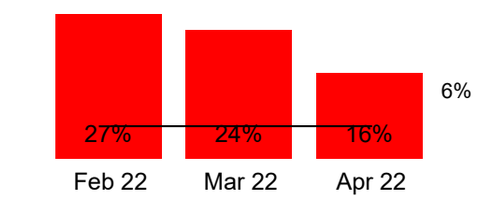
Claims Auditing



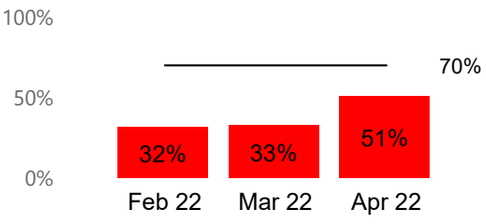
Member Services



Abandoned Call Rate (%)

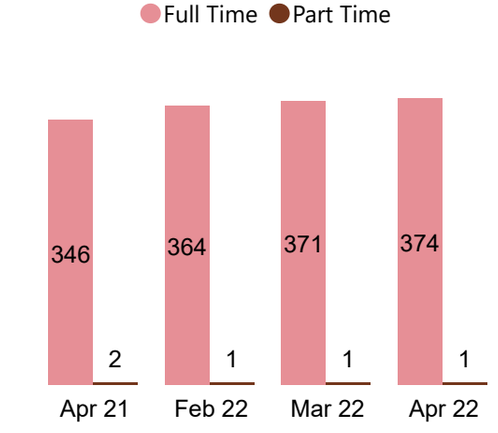


Calls Answered in 60 Seconds (%)

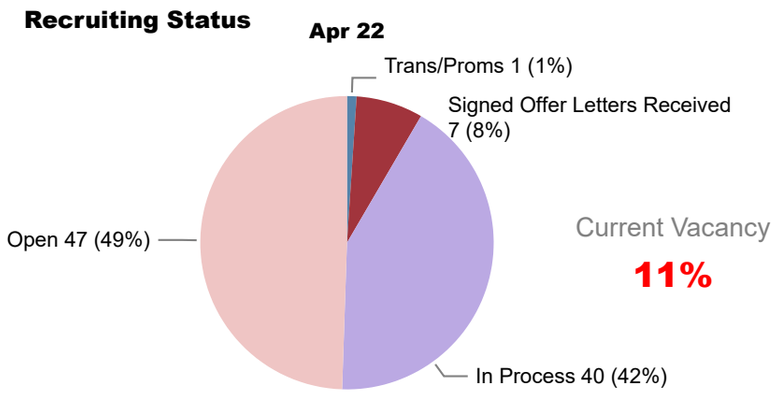


Average Call Times	Feb 22	Mar 22	Apr 22
Wait Time	08:30	08:49	04:30
Call Duration	05:43	05:56	06:58

Human Resources

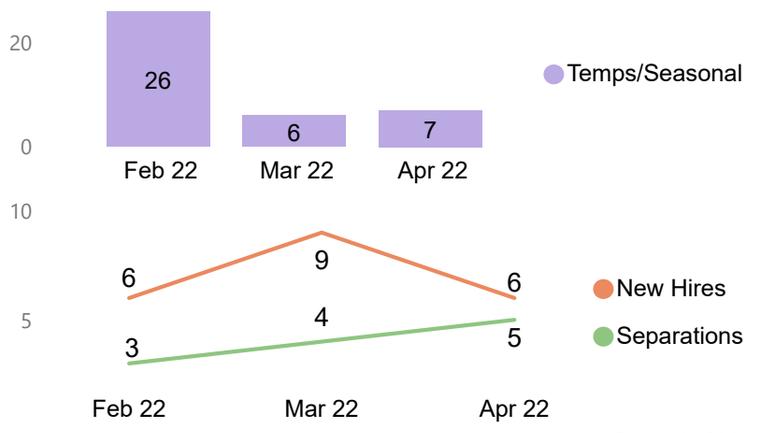


Recruiting Status



Current Vacancy

11%



Provider Services

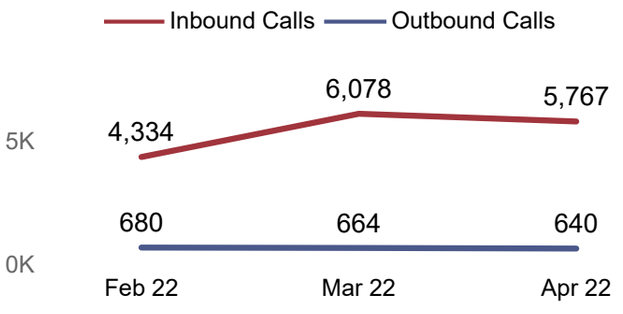
Provider Network

Hospital	17
Specialist	8,388
Primary Care Physician	731
Skilled Nursing Facility	66
Urgent Care	9
Health Centers (FQHCs and Non-FQHCs)	68
Transportation	380
TOTAL	**9,659**

Provider Credentialing

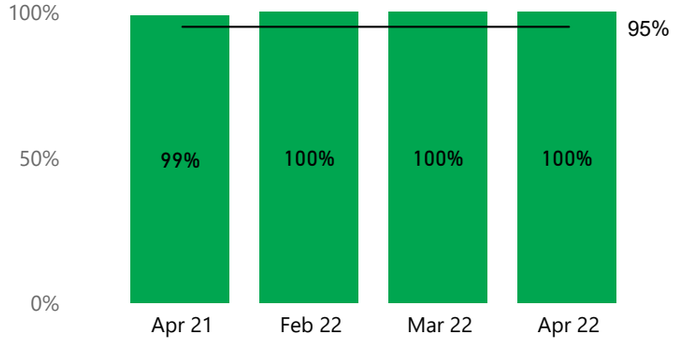
1,414

Provider Call Center



Provider Disputes & Resolutions

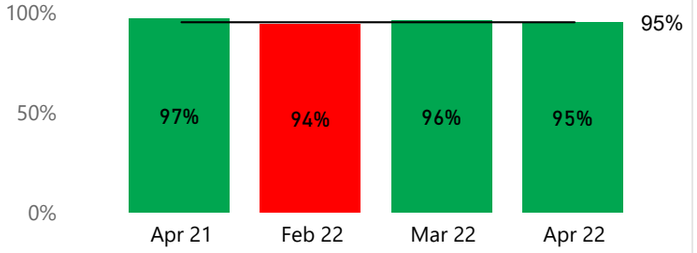
Turnaround Compliance (45 business days)



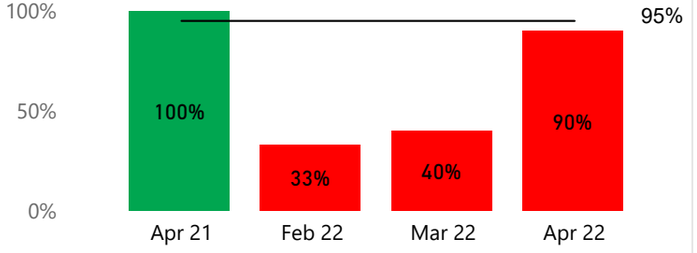
Compliance

Member Grievances

Standard (30 calendar days)

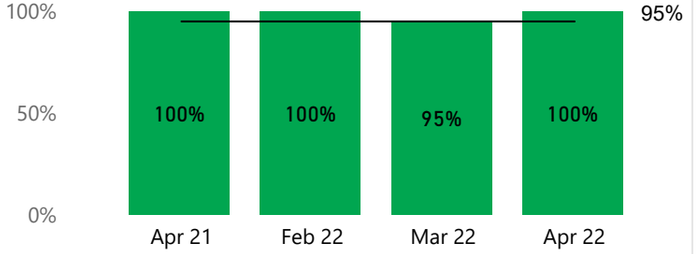


Expedited (3 calendar days)

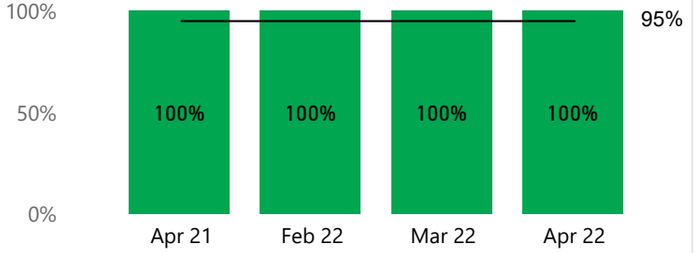


Member Appeals

Standard (30 calendar days)

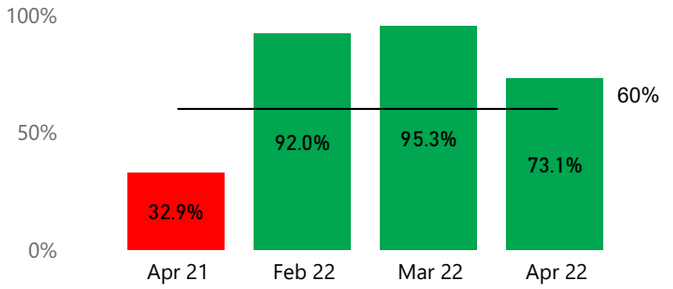


Expedited (3 calendar days)

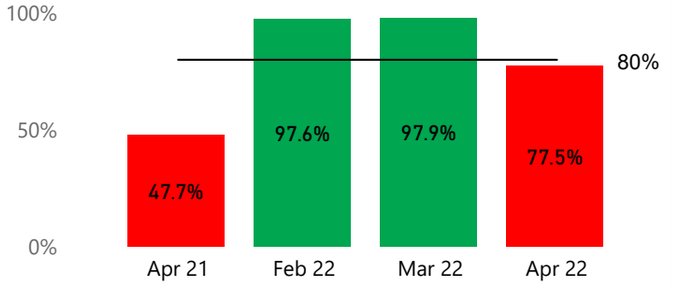


Encounter Data

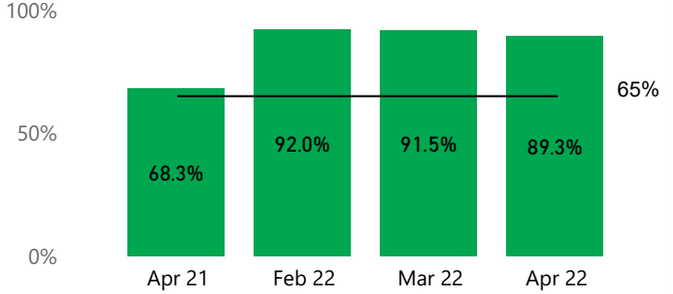
Institutional 0-90 days



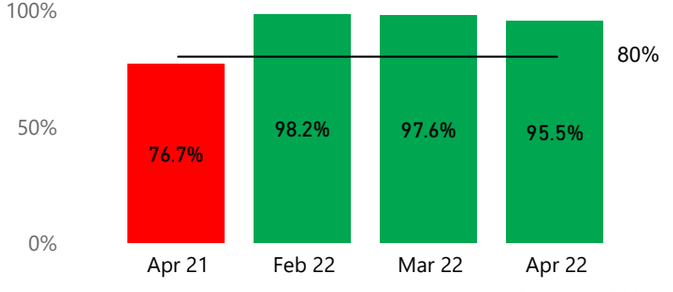
Institutional 0-180 days



Professional 0-90 days

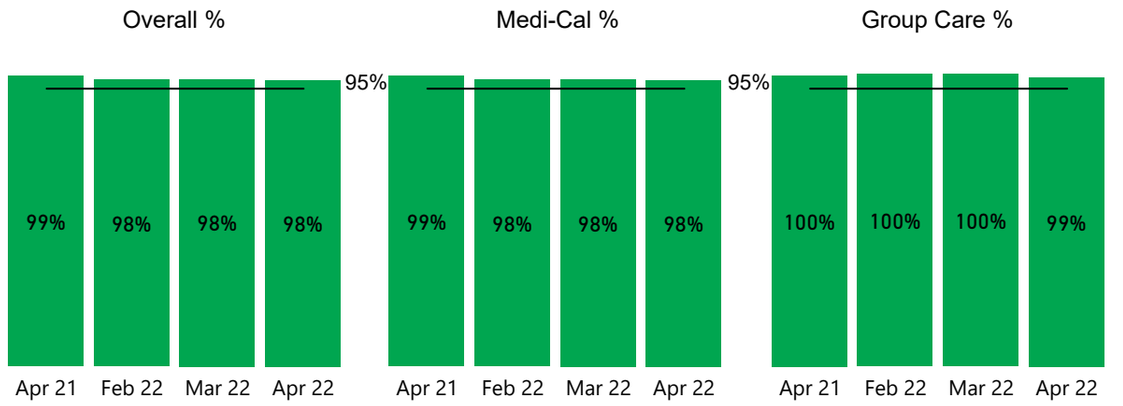


Professional 0-180 days

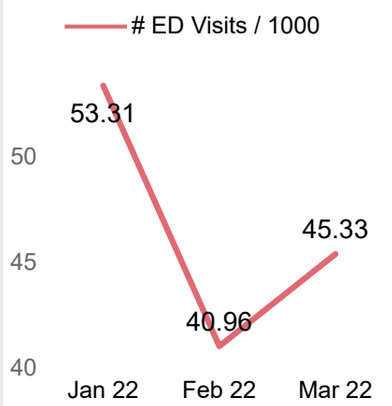


Health Care Services

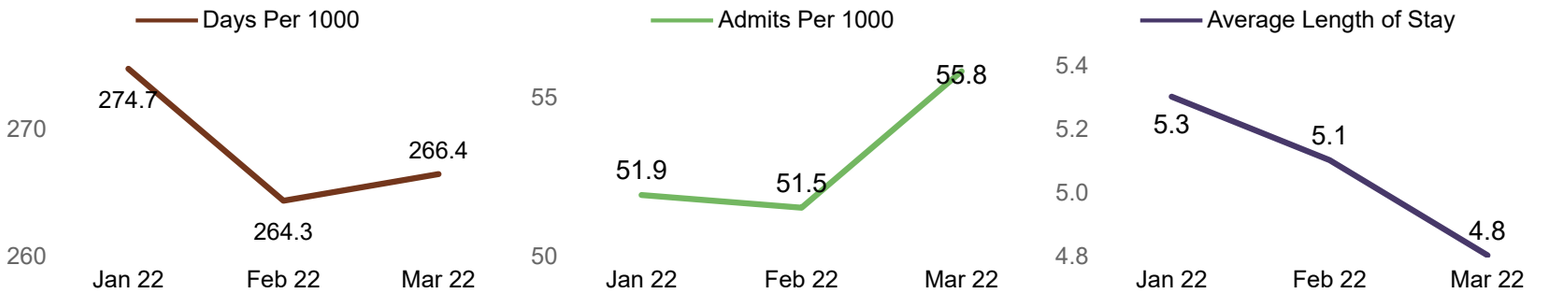
Authorization Turnaround



ED Utilization

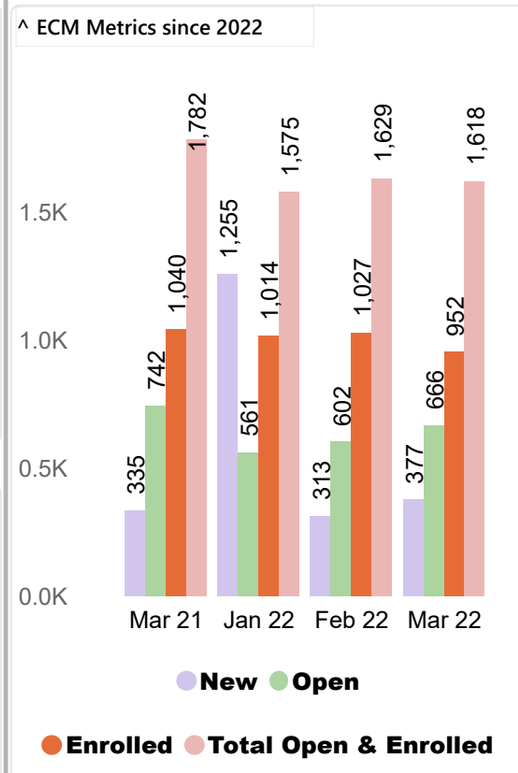


Inpatient Utilization

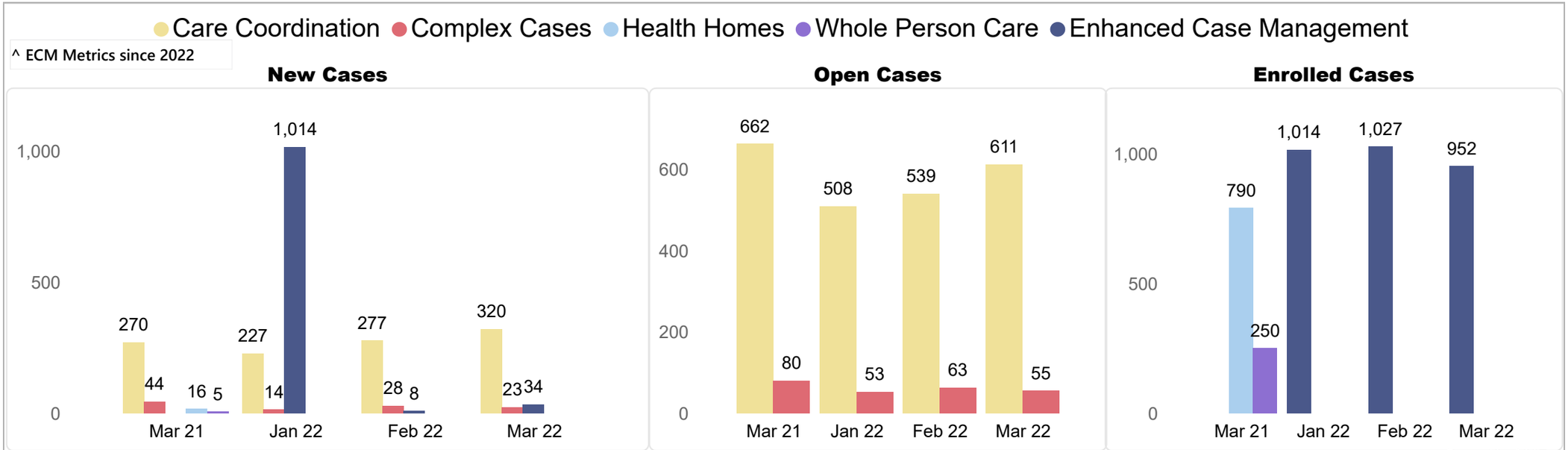


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Apr 21	Feb 22	Mar 22	Apr 22
HEALTHsuite System	100.0%	98.9%	100.0%	100.0%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Apr 21	Feb 22	Mar 22	Apr 22
Denial Rate Excluding Partial Denials (%)	3.8%	4.0%	3.5%	3.3%
Overall Denial Rate (%)	3.8%	4.5%	4.1%	3.9%
Partial Denial Rate (%)	0.1%	0.6%	0.6%	0.6%

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

Pharmacy Authorizations

Authorizations	Apr 21	Feb 22	Mar 22	Apr 22
Approved Prior Authorizations	954	18	17	19
Closed Prior Authorizations	589	63	59	67
Denied Prior Authorizations	655	25	31	33
Total Prior Authorizations	2,198	106	107	119

ALAMEDA Alliance FOR HEALTH

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COVID-19 Dashboard

COVID-19 Vaccination Summary as % of Population (Ages >= 5 Years) v4

Data as of: 2022-05-09

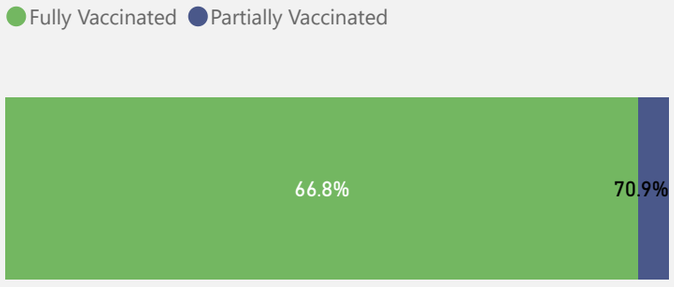
Network: All | **LOB:** All | **City:** All

ALAMEDA Alliance FOR HEALTH

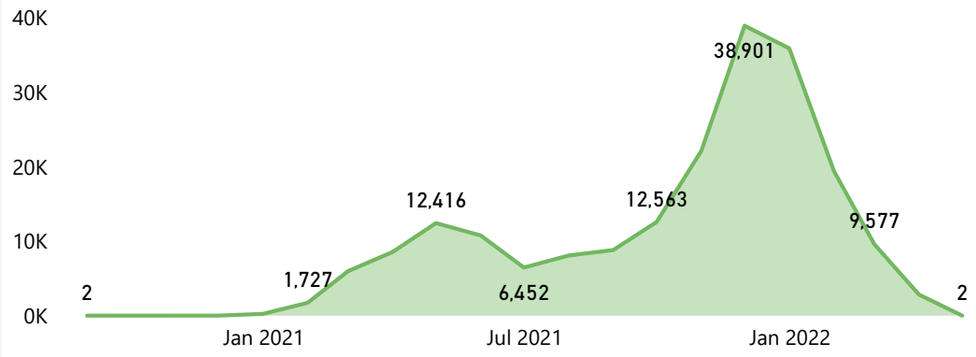
Members Fully Or Partially Vaccinated: 204,202

% Fully Or Partially Vaccinated: 70.9%

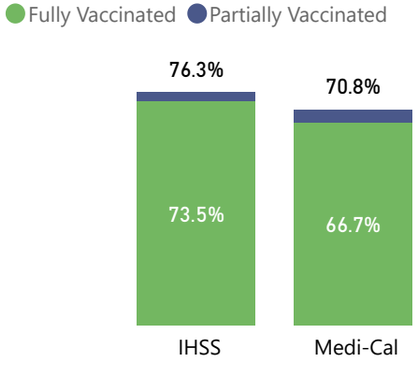
Breakout by Status



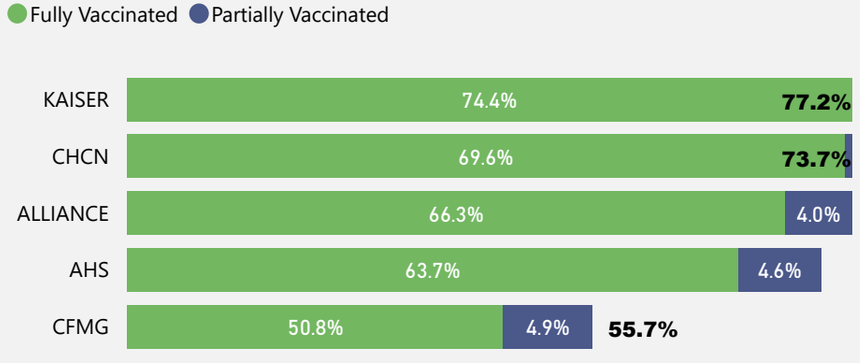
Monthly Trend



Medi-Cal vs IHSS

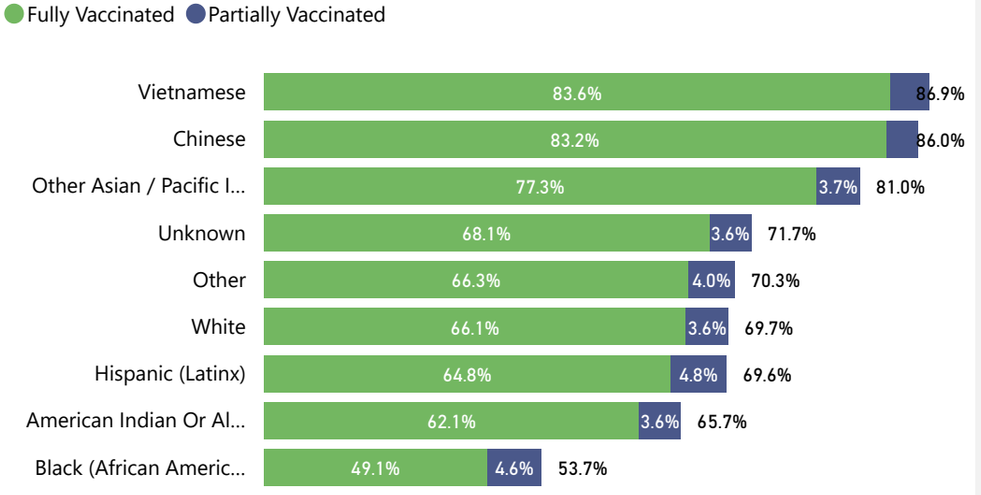


Network

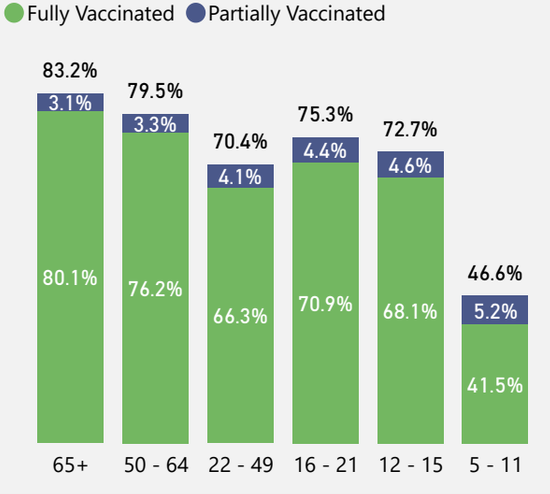


Top 15 Cities	Fully Vaccinated	Partially Vaccinated
ALAMEDA	73.2%	3.2%
ALBANY	76.6%	3.4%
BERKELEY	70.5%	3.9%
CASTRO VALLEY	70.0%	3.8%
DUBLIN	68.2%	4.2%
EMERYVILLE	64.2%	4.2%
FREMONT	69.4%	3.8%
HAYWARD	66.1%	3.9%
LIVERMORE	60.3%	4.2%
NEWARK	67.5%	3.6%
OAKLAND	63.9%	4.6%
PLEASANTON	68.7%	3.7%
SAN LEANDRO	69.7%	3.6%
SAN LORENZO	73.1%	3.8%
UNION CITY	72.3%	3.6%

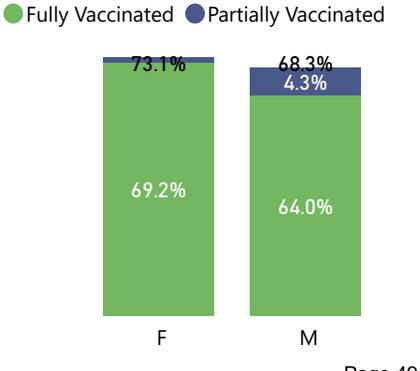
Ethnicity



Age Category



Gender



COVID-19 Vaccination Summary Member Counts (Ages >= 5 Years) v4

Data as of: 2022-05-09

Network: All | **LOB:** All | **City:** All

ALAMEDA Alliance FOR HEALTH

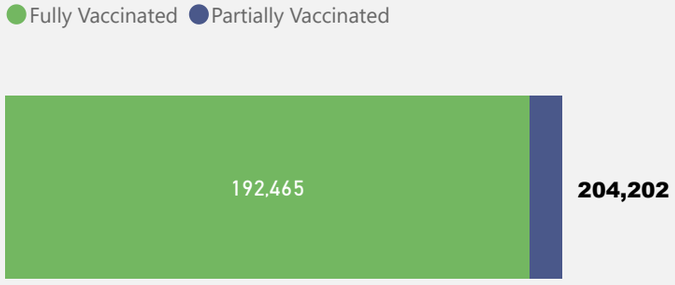
Members Fully Or Partially Vaccinated:

204,202

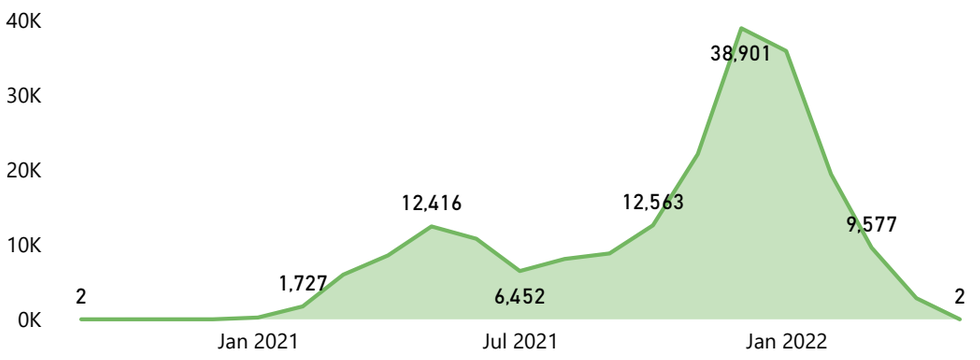
% Fully Or Partially Vaccinated:

70.9%

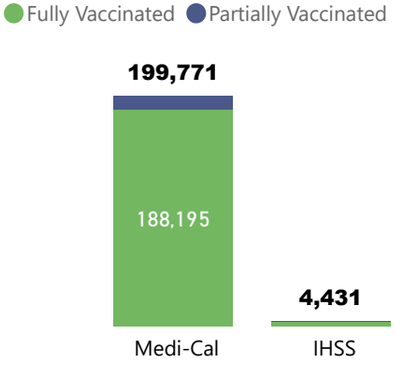
Breakout by Status



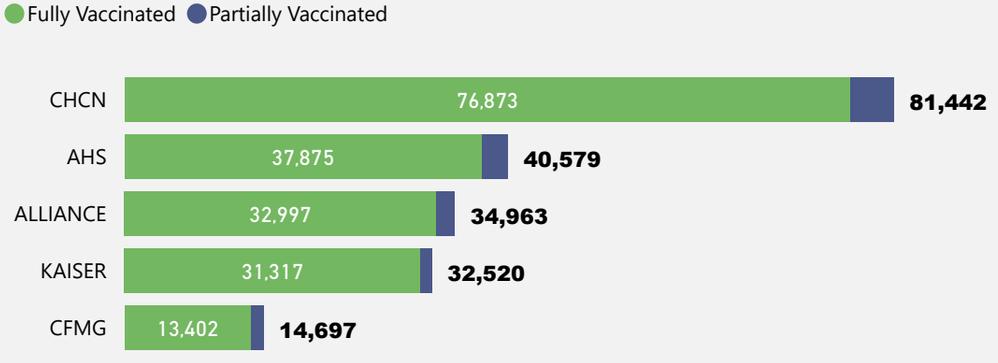
Monthly Trend



Medi-Cal vs IHSS

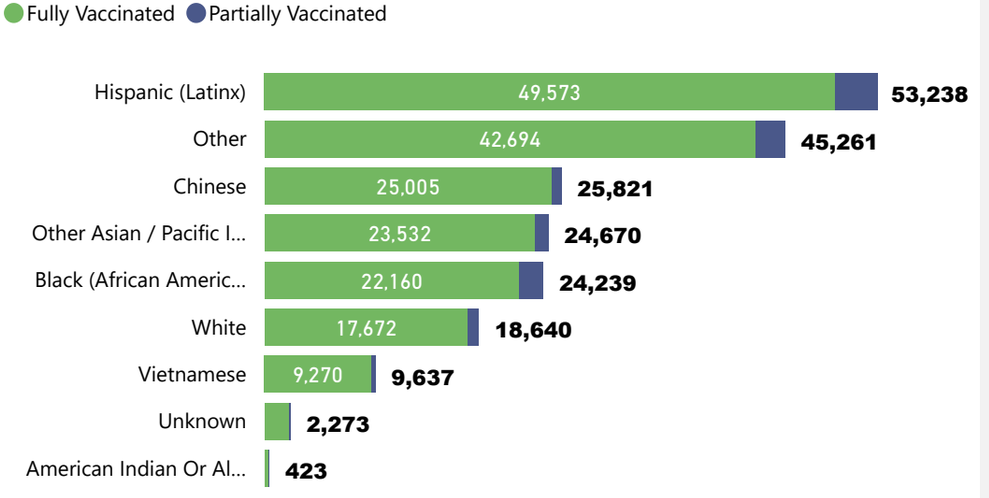


Network

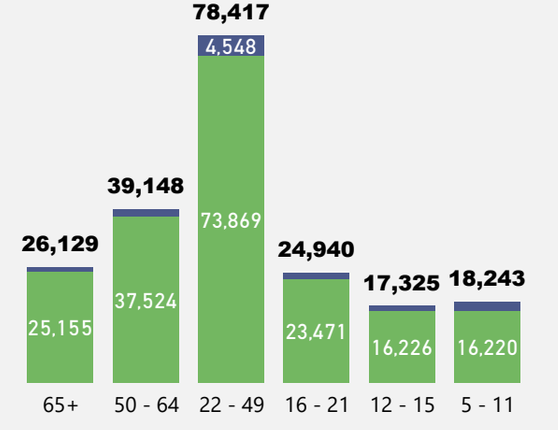


Top 15 Cities	Fully Vaccinated	Partially Vaccinated
ALAMEDA	8,273	359
ALBANY	1,375	61
BERKELEY	7,878	433
CASTRO VALLEY	5,145	277
DUBLIN	3,593	223
EMERYVILLE	1,262	83
FREMONT	18,475	1,023
HAYWARD	29,042	1,697
LIVERMORE	5,236	364
NEWARK	4,505	243
OAKLAND	72,089	5,142
PLEASANTON	3,356	183
SAN LEANDRO	18,069	931
SAN LORENZO	4,436	233
UNION CITY	8,863	436

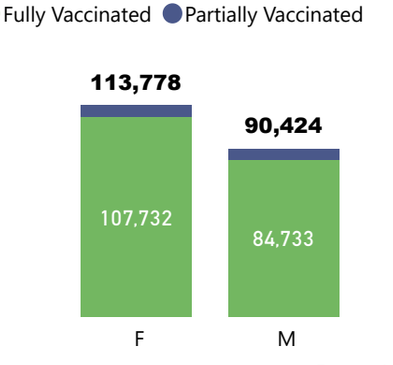
Ethnicity



Age Category



Gender



ALAMEDA Alliance FOR HEALTH

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Legislative Tracking

2022 Legislative Tracking List

The following is a list of state bills tracked by the Public Affairs Department that were introduced during the 2021 and 2022 Legislative Sessions. This list includes 2-year bills introduced in 2021 that did not make it through the legislature and have moved through the legislature in 2022, as well as bills introduced in 2022. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership. **The bills on this list are updated as of 5/6/2022.**

Medi-Cal (Medicaid)

Bills in process in house of origin (introduced in 2022):

- **AB 1355 (Levine – D) Medi-Cal: Independent Medical Review System**
  - **Introduced:** 2/19/2021
  - **Status:** 5/4/2022 Referred to Coms. on HEALTH and JUD.
  - **Summary:** Would require the State Department of Health Care Services to establish the Independent Medical Review System (IMRS) for the Medi-Cal program, commencing on January 1st, 2023, which generally models specified requirements of the Knox-Keene Health Care Service Plan Act. The bill would provide that any Medi-Cal beneficiary appeal involving a disputed health care service is eligible for review under the IMRS if certain requirements are met and would define "disputed health care service" as any service covered under the Medi-Cal program that has been denied, modified, or delayed by a decision of the department, or by one of its contractors, including, but not limited to, a Medi-Cal managed care plan, that makes a final decision, in whole or in part, due to a finding that the service is not medically necessary. The bill would require information on the IMRS to be displayed in or on specified material, including the "myMedi-Cal: How to Get the Health Care You Need" publication and the department's internet website.

- **AB 1859 (Levine – D) Mental Health Services**
  - **Introduced:** 2/8/2022
  - **Status:** 4/27/2022 From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 2.) Re-referred to Com. on APPR
  - **Summary:** Would require a health care service plan or a health insurance policy issued, amended, or renewed on or after January 1st, 2023, that includes coverage for mental health services to, among other things, approve the provision of mental health services for persons who are detained for 72-hour treatment and evaluation under the Lanterman-Petris-Short Act and to schedule an initial outpatient appointment for that person with a licensed mental health professional on a date that is within 48 hours of the person's release from detention. The bill would prohibit a noncontracting provider of covered mental health services from billing the previously described enrollee or insured more than the cost-sharing amount the enrollee or insured would pay to a contracting provider for those services.

- **AB 1880 (Arambula – D) Prior Authorization and Step Therapy**

- **Introduced:** 1/24/2022
- **Status:** 4/20/2022 Re-referred to Com. on APPR.
- **Summary:** Current law authorizes a health care service plan or health insurer to require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition, as specified. Current law requires a health care service plan or health insurer to expeditiously grant a step therapy exception request if the health care provider submits justification and supporting clinical documentation, as specified. Current law permits a health care provider or prescribing provider to appeal a denial of a step therapy exception request for coverage of a nonformulary drug, a prior authorization request, or a step therapy exception request, consistent with the current utilization management processes of the health care service plan or health insurer. Current law also permits an enrollee or insured, or the enrollee's or insured's designee or guardian, to appeal a denial of a step therapy exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing a grievance under a specified provision. This bill would require health care service plan's or health insurer's utilization management process to ensure that an appeal of a denial of an exception request is reviewed by a clinical peer of the health care provider or prescribing provider, as specified.

- **AB 1892 (Flora - R) Medi-Cal: orthotic and prosthetic appliances**
  - **Introduced:** 2/9/2022
  - **Status:** 5/4/2022 In committee: Set, first hearing. Referred to suspense file.
  - **Summary:** Under the Medi-Cal program, current law requires the State Department of Health Care Services to establish a list of covered services and maximum allowable reimbursement rates for prosthetic and orthotic appliances and requires that the list be published in provider manuals. Current law prohibits reimbursement for prosthetic and orthotic appliances from exceeding 80% of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar services. This bill would instead require reimbursement for these appliances to be set at least at 80% of the lowest maximum allowance for California established by the federal Medicare Program, and would require that reimbursement to be adjusted annually, as specified.

- **AB 1900 (Arambula – D): Medi-Cal: income level for maintenance**
  - **Introduced:** 2/9/2022
  - **Status:** 4/6/2022 In committee: Set, first hearing. Referred to suspense file.
  - **Summary:** Under current law, certain medically needy persons with higher incomes qualify for Medi-Cal with a share of cost, if they meet specified criteria. Under current law, the share of thecost for those persons is generally the total after deducting an amount for maintenance from the person's monthly income. Current law requires the State Department of Health Care Services to establish income levels for maintenance at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. Under existing law, for a single individual, the amount of the income level for maintenance per month is based on a calculation of 80% of the highest amount that would ordinarily be paid to a family of 2 persons, without any income or resources, under specified cash assistance provisions, multiplied by the federal financial participation rate, adjusted as specified. This bill, to the extent that any necessary federal authorization is obtained, would increase the above-described income level for maintenance per month to be equal to the income limit for Medi-Cal without a share of cost for

individuals who are 65 years of age or older or are disabled, generally totaling 138% of the federal poverty level.

- **AB 1929 (Gabriel - D) Medi-Cal: violence preventive services**
  - **Introduced:** 2/10/2022
  - **Status:** 4/27/2022 In committee: Set, first hearing. Referred to suspense file.
  - **Summary:** Would require the State Department of Health Care Services to establish a community violence prevention and recovery program, under which violence preventive services would be provided by qualified violence prevention professionals, as defined, as a covered benefit under the Medi-Cal program, in order to reduce the incidence of violent injury or reinjury, trauma, and related harms, and promote trauma recovery, stabilization, and improved health outcomes. Under the bill, the services would be available to a Medi-Cal beneficiary who (1) has been violently injured as a result of community violence, as defined, (2) for whom a licensed health care provider has determined that the beneficiary is at significant risk of experiencing violent injury as a result of community violence, or (3) has experienced chronic exposure to community violence. The bill would authorize the department to meet these requirements by ensuring that qualified violence prevention professionals are designated as community health workers.

- **AB 1930 (Arambula - D) Medi-Cal: comprehensive perinatal services**
  - **Introduced:** 2/10/2022
  - **Status:** 4/27/2022 From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 1.) (April 26th). Re-referred to Com. on APPR.
  - **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy. This bill, during the one-year post pregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27th, 2021, during pregnancy and the initial 60-day post pregnancy period in effect on that date. The bill would require the department to collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered.

- **AB 1937 (Patterson - R) Medi-Cal: out-of-pocket pregnancy costs**
  - **Introduced:** 2/10/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/18/2022)
  - **Summary:** Would require the State Department of Health Care Services, on or before July 1st, 2023, to establish a health expense account program for pregnant Medi-Cal beneficiaries and pregnant subscribers of the Medi-Cal Access Program. The bill would make a Medi-Cal beneficiary who is pregnant or a pregnant subscriber of the Medi-Cal Access Program eligible for reimbursement for "out-of-pocket pregnancy-related costs," as specified, in an amount not to exceed $1,250. The bill would require the person to submit the request for reimbursement within 3 months of the end of the pregnancy in order to be reimbursed. The bill would require the

department to seek to maximize federal financial participation in implementing the program. The bill would require the department, to the extent federal financial participation is unavailable, to implement the program only with state funds. The bill would require the department to contract out for purposes of implementing the health expense account program, as specified. The bill would authorize the department to implement the above-described provisions through all-county or plan letters, or similar instructions, and would require regulatory action no later than January 1st, 2026.

- **AB 1944 (Lee – D) Local governments: open and public meetings**
  - **Introduced:** 1/24/2022
  - **Status:** 5/4/2022 Coauthors revised. From committee. Do pass (Ayes 5. Noes 2.) (May 4th).
  - **Summary:** The Ralph M. Brown Act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. Current law, until January 1st, 2024, authorizes a local agency to use teleconferencing without complying with those specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect, or in other situations related to public health. This bill would require the agenda to identify any member of the legislative body that will participate in the meeting remotely.

- **AB 1995 (Arambula - D) Medi-Cal: premiums or contribution**
  - **Introduced:** 1/24/2022
  - **Status:** 4/27/2022 In committee: Set, first hearing. Referred to suspense file.
  - **Summary:** Current law requires that Medi-Cal benefits be provided to optional targeted low-income children, as defined, based on a certain income eligibility threshold. Current law also establishes the Medi-Cal Access Program, which provides health care services to a woman who is pregnant or in her postpartum period and whose household income is between certain thresholds, and to a child under 2 years of age who is delivered by a mother enrolled in the program, as specified. Current law also establishes a program under which certain employed persons with disabilities are eligible for Medi-Cal benefits based on income and other criteria. Existing law requires the department to exercise the option, available to the state under federal law, to impose specified monthly premiums, based on income level, for the above-described children and employed persons with disabilities. Existing law requires the department to determine schedules for subscriber contribution amounts for persons enrolled in the Medi-Cal Access Program. This bill would eliminate the premiums and subscriber contributions for the above-described populations.

- **AB 2007 (Valladares – R) Health care language assistance services**
  - **Introduced:** 2/14/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/24/2022)

- **Summary:** The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Current law requires the Department of Managed Health Care to adopt regulations establishing standards and requirements for health care service plans to provide enrollees with appropriate access to language assistance in obtaining health care services. Current law requires the department to report biennially to, among others, the Legislature, regarding plan compliance with the standards. This bill would instead require the department to provide that report 3 times a year.

- **AB 2024 (Friedman - D) Health care coverage: diagnostic imaging**
  - **Introduced:** 2/14/2022
  - **Status:** 5/2/2022 Re-referred to Com. on APPR.
  - **Summary:** Current law requires a health care service plan contract issued, amended, delivered, or renewed on or after January 1st, 2000, or an individual or group policy of disability insurance or self-insured employee welfare benefit plan to provide coverage for mammography for screening or diagnostic purposes upon referral by specified professionals. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2023, to provide coverage for screening mammography, medically necessary diagnostic or supplemental breast examinations, or testing for screening or diagnostic purposes upon referral by specified professionals. The bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2023, from imposing cost sharing for screening mammography, medically necessary or supplemental breast examinations, or testing, unless the contract or policy is a high deductible health plan and the deductible has not been satisfied for the year.

- **AB 2029 (Wicks - D) Health care coverage: treatment for infertility**
  - **Introduced:** 2/14/2022
  - **Status:** 5/4/2022 Referred to Com. on APPR.
  - **Summary:** Would require a health care service plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1st, 2023, to provide coverage for the diagnosis and treatment of infertility and fertility services, as specified, up to a lifetime maximum benefit of $75,000. The bill would except specialty health care service plan contracts and disability insurance policies from that requirement. The bill also would require a small group health care service plan contract or disability insurance policy, except a specialized contract or policy, that is issued, amended, or renewed on or after January 1st, 2023, to offer coverage for the treatment of infertility, as specified. The bill would revise the definition of infertility and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and health insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contract holders and policyholders and prospective group contract holders and policyholders. With respect to a health care service plan, the bill would not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services for the delivery of health care services pursuant to specified provisions.

- **AB 2077 (Calderon - D) Medi-Cal: monthly maintenance amount: personal and incidental needs**

- **Introduced:** 2/14/2022
- **Status:** 4/6/2022 In committee: Set, first hearing. Referred to suspense file.
- **Summary:** Current law requires the State Department of Health Care Services to establish income levels for maintenance needs at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Existing law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $80.

- **AB 2117 (Gipson – D) Mobile stroke units**
  - **Introduced:** 2/14/2022
  - **Status:** 4/28/2022 Read second time. Ordered to Consent Calendar.
  - **Summary:** Current law provides for the licensure and regulation of health facilities by the State Department of Public Health and defines various types of health facilities for those purposes. This bill would define "mobile stroke unit" to mean a multijurisdictional mobile facility that serves as an emergency response critical care ambulance under the direction and approval of a local emergency medical services (EMS) agency, and as a diagnostic, evaluation, and treatment unit, providing radiographic imaging, laboratory testing, and medical treatment under the supervision of a physician in person or by telehealth, for patients with symptoms of a stroke, to the extent consistent with any federal definition of a mobile stroke unit, as specified.

- **AB 2123 (Villapudua – D) Bringing Health Care into Communities Act of 2023**
  - **Introduced:** 2/15/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was H. & C.D. on 3/28/2022)
  - **Summary:** Current law establishes various programs to facilitate the expansion of the health care workforce in rural and underserved communities, including, but not limited to, the Health Professions Career Opportunity Program and the California Registered Nurse Education Program. This bill, the Bringing Health Care into Communities Act of 2023, would establish the Bringing Health Care into Communities Program to be administered by the agency to provide housing grants to specified health professionals to be used for mortgage payments for a permanent residence in a health professional shortage area, as specified. Under the bill, a health professional would be eligible for a grant for up to 5 years. The bill would make its provisions operative upon appropriation by the Legislature.

- **AB 2304 (Bonta – D) Nutrition Assistance: “Food as Medicine”**
  - **Introduced:** 2/16/2022
  - **Status:** 2/17/2022 From printer. May be heard in committee March 19th.
  - **Summary:** Current law provides for the California Health and Human Services Agency, which includes the State Department of Health Care Services, the State Department of Public Health, and the State Department of Social Services. Current law establishes various programs and services under those departments, including the Medi-Cal program, under which qualified low-

income individuals receive health care services, such as enteral nutrition products, the California Special Supplemental Nutrition Program for Women, Infants, and Children, which is administered by the State Department of Public Health and counties and under which nutrition and other assistance are provided to eligible individuals who have been determined to be at nutritional risk, and the CalFresh program, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county. This bill would declare the intent of the Legislature to enact the Wilma Chan Food as Medicine Act of 2022.

- **AB 2352 (Nazarian - D) Prescription drug coverage**
  - **Introduced:** 2/16/2022
  - **Status:** 4/27/2022 In committee: Set, first hearing. Referred to suspense file.
  - **Summary:** Current law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price, and requires that payment apply to the applicable deductible. This bill would require a health care service plan or health insurer that provides prescription drug benefits and maintains one or more drug formularies to furnish specified information about a prescription drug upon request by an enrollee or insured, or their prescribing provider. The bill would require the plan or insurer to respond in real time to that request and ensure the information is current no later than one business day after a change is made. The bill would prohibit a health care service plan or health insurer from, among other things, restricting a prescribing provider from sharing the information furnished about the prescription drug or penalizing a provider for prescribing a lower cost drug.

- **AB 2402 (Rubio - D) Medi-Cal: continuous eligibility**
  - **Introduced:** 2/17/2022
  - **Status:** 3/30/2022 Co-authors revised. From committee. Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 0.) (March 29th) Re-referred to Com. on APPR.
  - **Summary:** Current law requires the State Department of Health Care Services, to the extent federal financial participation is available, to exercise a federal option to extend continuous eligibility for the Medi-Cal program to children 19 years of age and younger until the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age. Under this bill, a child under 5 years of age would be continuously eligible for Medi-Cal, including without regard to income, until the child reaches 5 years of age. The bill would prohibit the redetermination of Medi-Cal eligibility before the child reaches 5 years of age, unless the department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and, except as specified, on the availability of federal financial participation.

- **AB 2449 (Rubio – D) Open meetings: local agencies: teleconferences**
  - **Introduced:** 1/24/2022
  - **Status:** 5/4/2022 From committee: Do pass. (Ayes 7. Noes 1.) (May 4th)

- **Summary:** Current law, until January 1st, 2024, authorizes a local agency to use teleconferencing without complying with specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect, or in other situations related to public health. This bill would authorize a local agency to use teleconferencing without complying with those specified teleconferencing requirements if at least a quorum of the members of the legislative body participates in person from a singular location clearly identified on the agenda that is open to the public and situated within the local agency's jurisdiction. The bill would impose prescribed requirements for this exception relating to notice, agendas, the means and manner of access, and procedures for disruptions. The bill would require the legislative body to implement a procedure for receiving and swiftly resolving requests for reasonable accommodation for individuals with disabilities, consistent with federal law.

- **AB 2458 (Weber – D) California Children's Services: reimbursement rates.**
  - **Introduced:** 2/17/2022
  - **Status:** 4/6/2022 In committee: Set, first hearing. Referred to suspense file.
  - **Summary:** Would make legislative findings relating to the need for an increase in the reimbursement rates for physician services provided under the California Children's Services (CCS) Program. Under the bill, subject to an appropriation, and commencing January 1st, 2023, those reimbursement rates would be increased by adding at least 25% to the above-described augmentation percentage relative to the applicable Medi-Cal rates. The bill would make the rate increase applicable only if the services are provided by a physician in a practice in which at least 30% of the practice's pediatric patients are Medi-Cal beneficiaries.

- **AB 2539 (Choi - R) Public health: COVID-19 vaccination: proof of status**
  - **Introduced:** 2/17/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was PRINT on 2/17/2022)
  - **Summary:** Would require a public or private entity that requires a member of the public to provide documentation regarding the individual's vaccination status for any COVID-19 vaccine as a condition of receipt of any service or entrance to any place to accept a written medical record or government-issued digital medical record in satisfaction of the condition, as specified.

- **AB 2581 (Salas – D) Health Care Service Plans: Mental Health and Substance Use Disorders: Provider Credentials**
  - **Introduced:** 2/18/2022
  - **Status:** 4/27/2022 From committee: Do pass and re-refer to Com. on APPR. With recommendation: To Consent Calendar. (Ayes 14. Noes 0.) (April 26th). Re-referred to Com. on APPR.
  - **Summary:** Current law requires a health care service plan contract issued, amended, or renewed on or after January 1st, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. For provider contracts issued, amended, or renewed on and after January 1st, 2023, this bill would require a health care service plan that provides coverage for mental health and substance use disorders and credentials health care providers of those services for the health care service plan's networks, to assess and verify the qualifications of a health care provider within 60 days after receiving a

completed provider credentialing application. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **AB 2659 (Patterson - R) Medi-Cal managed care: midwifery services**
  - **Introduced:** 2/18/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 3/10/2022)
  - **Summary:** Would require a Medi-Cal managed care plan to have within its provider network at least one licensed midwife (LM) and one certified-nurse midwife (CNM) within each county where the Medi-Cal managed care plan provides services to Medi-Cal beneficiaries. The bill would exempt a Medi-Cal managed care plan from that requirement for purposes of a given county if no LM or CNM is available in that county or if no LM or CNM in that county accepts Medi-Cal payments. If a Medi-Cal managed care plan is exempt from that requirement, the bill would require the Medi-Cal managed care plan to reevaluate its network adequacy for midwifery care in the county on an annual basis and to make a good faith effort to work with the appropriate professional midwifery organizations for LMs and CNMs, and their respective licensing and regulatory agencies, to assist in determining the availability of midwives in the county who accept Medi-Cal payments. The bill would also require a Medi-Cal managed care plan to have within its provider network at least one licensed alternative birth center specialty clinic within each county where the Medi-Cal managed care plan provides services to Medi-Cal beneficiaries provided that at least one qualified licensed alternative birth center specialty clinic is available in that county and is willing to contract with the Medi-Cal managed care plan.

- **AB 2680 (Arambula - D) Medi-Cal: Community Health Navigator Program**
  - **Introduced:** 2/19/2022
  - **Status:** 4/27/2022 Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (April 26th). Re-refer to Com. on APPR.
  - **Summary:** Current law also authorizes a county to collaborate with a community-based organization to maintain up-to-date contact information in order to assist with the timely submission of annual reaffirmation forms, among others. This bill would require the State Department of Health Care Services to create the Community Health Navigator Program to make direct grants to qualified community-based organizations, as defined, to conduct targeted outreach, enrollment, retention, and access activities for Medi-Cal-eligible individuals and families. The bill would specify the basis for issuing a grant, including specified factors in the applicant's service area. The bill would require the department to contract with a private foundation to administer the grant application and allocation process. The bill would require the department to contract with specified providers to furnish training and technical assistance to grant recipients. The bill would also require the department to coordinate and partner with Covered California and counties that elect to participate, on an approach for outreach, enrollment, retention, and access activities for marketing to eligible individuals, including the development of a joint application tracker system to allow specified persons and entities to track application and referrals between commercial and Medi-Cal enrollment progress and facilitation of quarterly meetings on enrollment and access barriers and solutions, among other requirements.

- **AB 2724 (Arambula – D) Medi-Cal: alternate health care service plan**

- **Introduced:** 2/18/2022
- **Status:** 4/25/2022 Re-referred to Com. on APPR.
- **Summary:** Would authorize the State Department of Health Care Services to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP), as defined, to serve as a primary Medi-Cal managed care plan for specified eligible beneficiaries in geographic regions designated by the department. The bill would prohibit the AHCSP from denying enrollment to any of those eligible beneficiaries unless the department or the Department of Managed Health Care has ordered the AHCSP to cease enrollment in a service area. The bill would require the contract with the AHCSP to include the same standards and requirements, except with respect to enrollment, as for other Medi-Cal managed care plans, as specified. The bill would require the Health Care Options Program, which is an entity overseen by the department for Medi-Cal managed care education and enrollment, to disenroll any member of an AHCSP if the member meets any one of the reasons for disenrollment enumerated in specified regulations.

- **AB 2727 (Wood – D) Medi-Cal Eligibility**
  - **Introduced:** 1/24/2022
  - **Status:** 3/31/2022 Read second time. Ordered to third reading.
  - **Summary:** Current law prohibits the use of resources, including property or other assets, to determine Medi-Cal eligibility for applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods, and requires the department to seek federal authority to disregard all resources as authorized by the flexibilities provided under federal law. Current law conditions implementation of that provision on the Director of Health Care Services determining that systems have been programmed for those disregards and they are communicating that determination in writing to the Department of Finance, no sooner than January 1st, 2024. Existing law also conditions implementation of that provision on receipt of any necessary federal approvals and the availability of federal financial participation. Current law states the intent of the Legislature to provide, to the extent practicable, through the Medi-Cal program, for health care for those aged and other persons, including family persons who lack sufficient annual income to meet the costs of health care, and whose other assets are so limited that their application toward the costs of that care would jeopardize the person or family's future minimum self-maintenance and security. This bill would, commencing on January 1st, 2024, remove from that statement of legislative intent the above-described assets as an eligibility criterion.

- **AB 2813 (Santiago - D) Long-Term Services and Supports Benefit Program**
  - **Introduced:** 2/18/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was AGING & L.T.C. on 3/17/2022)
  - **Summary:** Would require the California Department of Aging, upon appropriation, in conjunction with an unspecified board operating under the auspices of the State Treasurer, to establish and administer a Long-Term Services and Supports Benefits Program with the purpose of providing supportive care to aging Californians and those with physical disabilities. The bill would establish the Long-Term Services and Supports Benefit Program Fund and would require the department and the board to administer the program using proceeds from the fund. The bill would require an individual to have paid into the fund for an unspecified number of years to be eligible to receive benefits pursuant to the program.

- **AB 2833 (Irwin – D) COVID-19 testing capacity**
  - **Introduced:** 2/18/2022
  - **Status:** 5/2/2022 Re-referred to Com. on APPR.
  - **Summary:** Current law sets forth various provisions specific to COVID-19 testing, including, among others, provisions relating to health care coverage for testing and certain programs or requirements for the workplace or educational setting. This bill would require the State Department of Public Health to make plans to ensure that the laboratory infrastructure in the state is sufficient and prepared for COVID-19 testing capacity to be scaled, within a period of 2 calendar weeks, to 500,000 tests per day, and for results of at least 90% of those COVID-19 tests to be returned to the individuals tested and to the department within 24 hours of collection of the testing samples. The bill would require the department, for purposes of making these plans, to prioritize local public health laboratories and the state laboratory and to consider sufficient staffing.

- **AB 2942 (Daly - D) Prescription drug cost sharing**
  - **Introduced:** 2/18/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 3/17/2022)
  - **Summary:** Current law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price. This bill would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received or to be received, in connection with the dispensing or administration of the drug. The bill would require a health care service plan or health insurer to, among other things, pass through to each enrollee or insured at the point of sale a good faith estimate of their decrease in cost sharing. The bill would require a health care service plan or health insurer to calculate an enrollee's or insured's defined cost sharing and provide that information to the dispensing pharmacy, as specified.

- **AB 2516 (Aguiar-Curry - D) Health care coverage: human papillomavirus**
  - **Introduced:** 2/17/2022
  - **Status:** 4/27/2022 From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 1.) (April 26th) Re-referred on Com. on APPR.
  - **Summary:** Current law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2002, to provide coverage for an annual cervical cancer screening test, including a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA). Current law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law also establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department, under which comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level, and who is eligible to receive these services. This bill would expand the coverage requirement for an annual cervical cancer screening test to

disability insurance policies that provide coverage for hospital, medical, or surgical benefits and would require a health care service plan contract or disability insurance policy that provides coverage for hospital, medical, or surgical benefits issued, amended, or renewed on or after January 1st, 2023, to provide coverage without cost sharing for the HPV vaccine for persons for whom the vaccine is FDA approved.

- **SB 853 (Wiener – D) Prescription drug coverage**
  - **Introduced:** 1/19/2022
  - **Status:** 4/29/2022 Set for hearing May 9th
  - **Summary:** Current law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law prohibits a health care service plan contract that covers prescription drug benefits or a specified health insurance policy from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which it was approved by the federal Food and Drug Administration if specified conditions are met. Current law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. This bill would expand the above-described prohibitions to prohibit limiting or excluding coverage of a dose of a drug or dosage form. The bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2023, that covers prescription drug benefits to provide coverage for a drug, dose of a drug, or dosage form during utilization review and any appeals if that drug has been previously approved for a medical condition of the enrollee or insured and has been prescribed by a health care provider.

- **SB 858 (Wiener – D) Health care service plans: discipline: civil penalties.**
  - **Introduced:** 1/19/2022
  - **Status:** 4/28/2022 Read second time and amended. Re-referred to Com. on APPR.
  - **Summary:** The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Current law authorizes the Director of the Department of Managed Health Care to take disciplinary measures, including the imposition of civil penalties, against a licensee when the director determines that the licensee has committed an act or omission constituting grounds for disciplinary action, as specified. Under current law, a person who violates the act, or a rule or order adopted or issued under the act, is generally liable for a civil penalty not to exceed $2,500 per violation. Current law also includes various provisions that assess specific civil and administrative penalties for certain violations. Fines and penalties under the act are deposited into the Managed Care Administrative Fines and Penalties Fund, and used, upon appropriation by the Legislature, for designated purposes. This bill would increase the base amount of the civil penalty from $2,500 per violation to not less than $25,000 per violation, which would be adjusted annually commencing January 1st, 2024, as specified. The bill would multiply the amounts of other specified civil and administrative penalties by 4, commencing January 1st, 2023, and would also annually adjust those penalties, commencing January 1st, 2024.

- **SB 871 (Pan – D) Public Health: Immunization**
  - **Introduced:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 3/17/2022)
  - **Status:** 2/24/2022 Referral to Com on JUD. Rescinded because of the limitation placed on committee hearings due to ongoing health and safety risks of the COVID-19 virus.
  - **Summary:** Current law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, childcare center, day nursery, nursery school, family day care home, or development center, unless prior to their admission to that institution they have been fully immunized against various diseases, including measles, mumps, pertussis, hepatitis B, and any other disease deemed appropriate by the State Department of Public Health, as specified. Current law authorizes an exemption from those provisions for medical reasons. Under existing law, notwithstanding the above-described prohibition, full immunization against hepatitis B is not a condition by which the governing authority admits or advances a pupil to the 7th grade level of a public or private elementary or secondary school. This bill would remove the above-described exception relating to hepatitis B. The bill would additionally prohibit the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, childcare center, day nursery, nursery school, family day care home, or development center, unless prior to their admission to that institution they have been fully immunized against COVID-19.

- **SB 912 (Limon – D) Biomarker testing**
  - **Introduced:** 2/3/2022
  - **Status:** 4/29/2022 Set for hearing May 9th
  - 2/9/2022 Referred to Com. on HEALTH.
  - **Summary:** Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1st, 2023, to provide coverage for biomarker testing, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition if the test is supported by medical and scientific evidence, as prescribed. This bill would apply these provisions relating to biomarker testing to the Medi-Cal program, including Medi-Cal managed care plans, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **SB 923 (Wiener – D) Gender- affirming care**
  - **Introduced:** 1/25/2022
  - **Status:** 5/2/2022 From committee with author's amendments. Read second time and amended. Re-referred to Com. on APPR.
  - **Summary:** Would require a Medi-Cal managed care plan, a PACE organization, a health care service plan, or a health insurer, as specified, to require its staff to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for individuals who identify as TGI. The bill would specify the required components of the training and would make use of any training curricula subject to approval by the respective departments. The bill would require an individual to complete a refresher course if a complaint has been filed,

and a decision has been made in favor of the complainant against that individual for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary.

- **SB 958 (Limon - D) Medication and Patient Safety Act of 2022**
  - **Introduced:** 2/09/2022
  - **Status:** 5/2/2022 May 2nd hearing. Place on APPR suspense file.
  - **Summary:** Would prohibit a health care service plan or health insurer, or its designee, from requiring a vendor to dispense an infused or injected medication directly to a patient with the intent that the patient will transport the medication to a health care provider for administration. The bill would authorize a plan or insurer, or its designee, to arrange for an infused or injected medication to be administered in an enrollee's or insured's home when the treating health care provider and patient determine home administration is in the best interest of the patient. The bill would prohibit a plan or insurer, or its designee, from requiring an infused or injected medication to be supplied by a vendor specified by the plan or insurer, or its designee, as a condition of coverage, unless specified criteria are met.

- **SB 966 (Limon – D) Federally qualified health centers and rural health clinics**
  - **Introduced:** 2/09/2022
  - **Status:** 4/18/2022 April 18th hearing: Placed on APPR suspense file.
  - **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. "Visit" is defined as a face-to-face encounter between an FQHC or RHC patient and any of specified health care professionals, including a physician, a licensed clinical social worker, or a marriage and family therapist. This bill would also include, within the definition of a visit, a face-to-face encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when supervised by a licensed behavioral health practitioner as required by the Board of Behavioral Sciences, as specified. The bill would make this provision operative 60 days after the termination of the national emergency declared on March 13th, 2020.

- **SB 974 (Portantino - D) Health care coverage: diagnostic imaging**
  - **Introduced:** 2/10/2022
  - **Status:** 4/29/2022 Set for hearing May 9th.
  - **Summary:** Would require a health care service plan contract, an individual or group policy of disability insurance that provides hospital, medical, or surgical coverage, or a self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1st, 2023, to provide coverage without imposing cost sharing for screening mammography and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee or insured indicated to have a risk factor associated with breast cancer.

- **SB 987 (Portantino – D) California Cancer Equity Act**
  - **Introduced:** 2/14/2022
  - **Status:** 4/29/2022 Set for hearing May 9th.

- **Summary:** Would require a Medi-Cal managed care plan to include in its contracted provider network at least one National Cancer Institute (NCI)-Designated Cancer Center, as specified, and ensure that any beneficiary diagnosed with a complex cancer diagnosis, as defined, is referred to an NCI-Designated Cancer Center within 15 business days of the diagnosis, unless the beneficiary selects a different cancer treatment provider. This bill contains other related provisions and other existing laws.

- **SB 1019 (Gonzalez – D) Medi-Ca managed care plans: mental health benefits**
  - **Introduced:** 2/14/2022
  - **Status:** 4/25/2022 April 25th hearing: Placed on APPR suspense file.
  - **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law requires a Medi-Cal managed care plan to provide mental health benefits covered in the state plan, excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver. This bill would require a Medi-Cal managed care plan to conduct annual outreach and education to its enrollees regarding the mental health benefits that are covered by the plan, and to also develop annual outreach and education to inform primary care physicians regarding those mental health benefits.

- **SB 1033 (Pan – D) Health care coverage**
  - **Introduced:** 2/15/2022
  - **Status:** 4/29/2022 Set for hearing May 9th.
  - **Summary:** Current law requires the Department of Managed Health Care and Insurance Commissioner, in developing the regulations, to require health care service plans and health insurers to assess the linguistic needs of the enrollee and insured population, and to provide for translation and interpretation for medical services, as indicated. Current law requires the regulations to include, among other things, requirements for conducting assessments of the enrollees and insured groups, and requires health care service plans and health insurers to update the needs assessment, demographic profile, and language translation requirements every 3 years. This bill would require the Department of Managed Health Care and the commissioner to revise these regulations, no later than July 1st, 2023, and to require health care service plans and health insurers to assess the cultural, linguistic, and health-related social needs of the enrollees and insured groups for the purpose of identifying and addressing health disparities, improving health care quality and outcomes, and addressing population health.

- **SB 1089 Medi-Cal Eyeglasses: Prison Industry Authority**
  - **Introduced:** 1/24/2022
  - **Status:** 4/29/2022 Set for hearing May 9th.
  - **Summary:** Current law establishes the Prison Industry Authority within the Department of Corrections and Rehabilitation and authorizes it to operate industrial, agricultural, and service enterprises that will provide products and services needed by the state, or any political subdivision of the state, or by the federal government, or any department, agency, or corporation of the federal government, or for any other public use. Current law requires state agencies to purchase these products and services at the prices fixed by the authority. Current law also requires state agencies to make maximum utilization of these products and consult with the staff of the authority to develop new products and adapt existing products to meet their needs. This bill, for purposes of Medi-Cal

reimbursement for covered optometric services, would authorize a provider to obtain eyeglasses from a private entity, as an alternative to the purchase of eyeglasses from the Prison Industry Authority.

- **SB 1180 (Pan – D) Medi-Cal: time and distance standards for managed care services**
  - **Introduced:** 2/17/2022
  - **Status:** 4/28/2022 From committee: Do pass and re-refer to Com. on APPR with APPR with recommendation: To consent calendar. (Ayes 10. Noes 0.) (April 27) Re-refer to Com. on APPR.
  - **Summary:** Current law establishes, until January 1st, 2023, certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. This bill would extend the operation of those standards to January 1st, 2026, and would require the department to seek input from stakeholders, as specified, prior to January 1st, 2025, to determine what changes are needed to these provisions.

- **SB 1184 (Cortese - D) Confidentiality of Medical Information Act: school-linked services coordinators**
  - **Introduced:** 2/17/2022
  - **Status:** 5/5/2022 Read third time and amended. Ordered to second reading.
  - **Summary:** The Confidentiality of Medical Information Act prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information, as defined, regarding a patient of the provider of health care or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as prescribed. The act authorizes a provider of health care or a health care service plan to disclose medical information in certain circumstances, including by authorizing disclosure to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient. This bill would additionally authorize a provider of health care or a health care service plan to disclose medical information to a school-linked services coordinator, as prescribed. The bill would define the term “school-linked services coordinator” as an individual located on a school campus or under contract by a county behavioral health provider agency for the treatment and health care operations and referrals of students and their families that holds any of certain credentials, including a services credential with a specialization in pupil personnel services, as specified.

- **SB 1207 (Portantino – D) Health care coverage: maternal and pandemic-related mental health conditions**
  - **Introduced:** 2/17/2022
  - **Status:** 4/29/2022 Set for hearing May 9th.
  - **Summary:** Current law requires health care service plans and health insurers to provide specified mental health and substance use disorder coverage, and requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. Current law requires health care service plans and health insurers, by July 1st, 2019, to develop, consistent with sound clinical principles and

processes, a maternal mental health program designed to promote quality and cost-effective outcomes, as specified. This bill would make findings and declarations relating to the effect of the COVID-19 pandemic on mental health in California and the importance of outreach, education, and access to quality mental health treatment. The bill would extend the deadline for establishment of the maternal mental health program to July 1st, 2023.

- **SB 1298 (Ochoa Bogh - R) Behavioral Health Continuum Infrastructure Program**
  - **Introduced:** 2/18/2022
  - **Status:** 5/2/2022 May 2nd hearing: Placed on APPR suspense file.
  - **Summary:** Current law authorizes the State Department of Health Care Services to, subject to an appropriation, establish a Behavioral Health Continuum Infrastructure Program. Current law authorizes the department, pursuant to this program, to award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources to build or expand the capacity of various treatment and rehabilitation options for persons with behavioral health disorders, as specified. This bill would authorize the department, in awarding the above-described grants, to give preference to qualified entities that are intending to place their projects in specified facilities or properties.

- **SB 1361 (Kamlager - D) Prescription drugs: cost sharing: pharmacy benefit managers**
  - **Introduced:** 2/18/2022
  - **Status:** 5/4/2022 Withdrawn from committee. Re-referred to Com. on APPR.
  - **Summary:** Current law provides for the regulation of health insurers by the Department of Insurance under the authority of the Insurance Commissioner. Current law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price. This bill, commencing no later than January 1st, 2024, would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would require a health care service plan or health insurer to, among other things, pass through to each enrollee or insured at the point of sale a good faith estimate of the enrollee's or insured's decrease in cost sharing. The bill would require a health care service plan or health insurer to calculate an enrollee's or insured's defined cost sharing and provide that information to the dispensing pharmacy, as specified.

- **SB 1379 (Ochoa Bogh - R) Pharmacy: remote services**
  - **Introduced:** 2/18/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was B., P. & E.D. on 3/9/2022)
  - **Summary:** The Controlled Substances Act regulates, among other matters, the dispensing by prescription of controlled substances, which are classified into schedules, and the Pharmacy Law regulates, among other matters, the dispensing by prescription of dangerous drugs and dangerous devices, which also include controlled substances. Current law authorizes a prescriber, a prescriber's authorized agent, or a pharmacist to electronically enter a prescription or order from outside of a pharmacy or hospital, as specified, except for prescriptions for controlled substances classified in Schedules II, III, IV, or V. Under current law, a violation of these

provisions is a crime. This bill would extend the authority to remotely enter a prescription or order to include prescriptions for controlled substances classified in Schedules II, III, IV, or V. The bill would also authorize a pharmacist to perform various services remotely, as specified, on behalf of a pharmacy located in California and under the written authorization of a pharmacist-in-charge.

Bills moved for action in second house:

- **SB 245 (Gonzalez – D) Health Care Coverage: Abortion Services: Cost of Sharing**
  - **Introduced:** 1/24/2022
  - **Status:** 3/22/2022 Chaptered by Secretary of State – Chapter 11, Statutes of 2022
  - **Summary:** Would prohibit a health care service plan or an individual or group policy or certificate of health insurance or student blanket disability insurance that is issued, amended, renewed, or delivered on or after January 1st, 2023, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion and abortion-related services, as specified. The bill would prohibit a health care service plan and an insurer subject to these requirements from imposing utilization management or utilization review on the coverage for outpatient abortion services. The bill would require that for a contract, certificate, or policy that is a high deductible health plan, the cost-sharing prohibition would apply once the enrollee's or insured's deductible has been satisfied for the benefit year. The bill would not require an individual or group contract or policy to cover an experimental or investigational treatment. The bill's requirements would also apply to Medi-Cal managed care plans and their providers, independent practice associations, preferred provider groups, and all delegated entities that provide physician services, utilization management, or utilization review. The bill would require the Department of Managed Health Care and the Department of Insurance to adopt related regulations on or before January 1st, 2026.

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Finance

Gil Riojas

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

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

Date: **May 13th, 2022**

Subject: **Finance Report – March 2022**

Executive Summary

- For the month ended March 31st, 2022, the Alliance had enrollment of 306,787 members, a Net Income of $8.4 million and 575% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$109,123	$889,35
Medical Expense	95,193	828,246
Admin. Expense	5,203	47,655
Other Inc. / (Exp.)	(323)	(546)
Net Income	**$8,404**	**$12,908**

Net Income by Program:

	Month	YTD
Medi-Cal	$8,853	$14,094
Group Care	(449)	(1,185)
	$8,404	**$12,908**

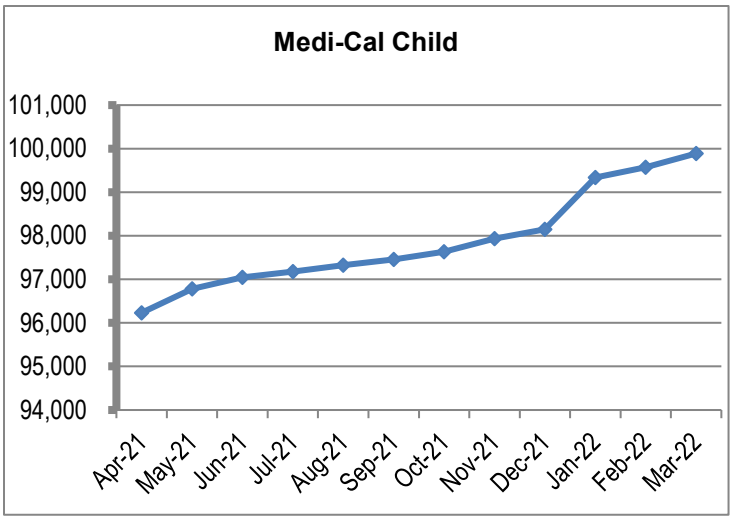
Enrollment

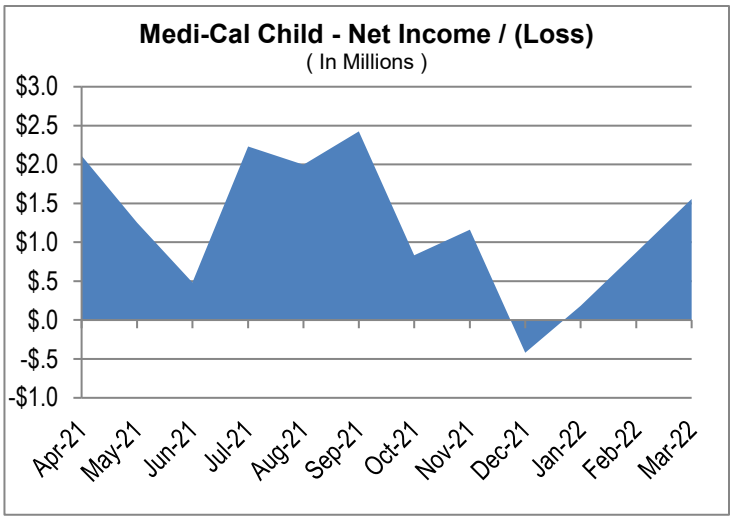
- Total enrollment increased by 2,335 members since February 2022.
- Total enrollment increased by 18,233 members since June 2021.

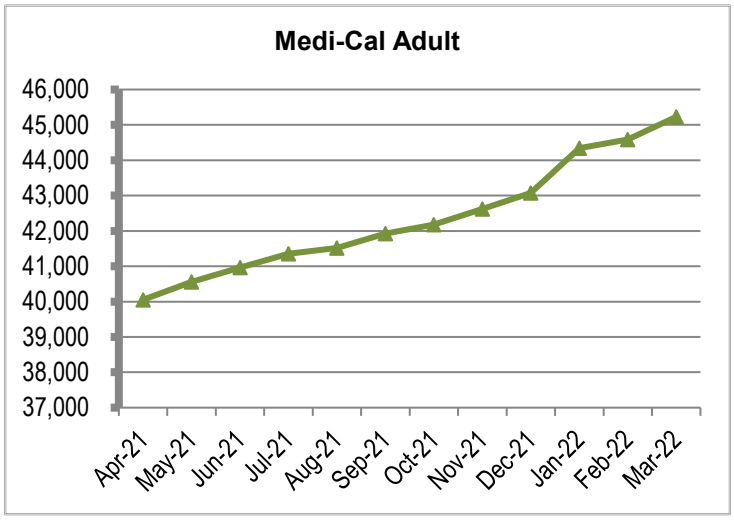
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

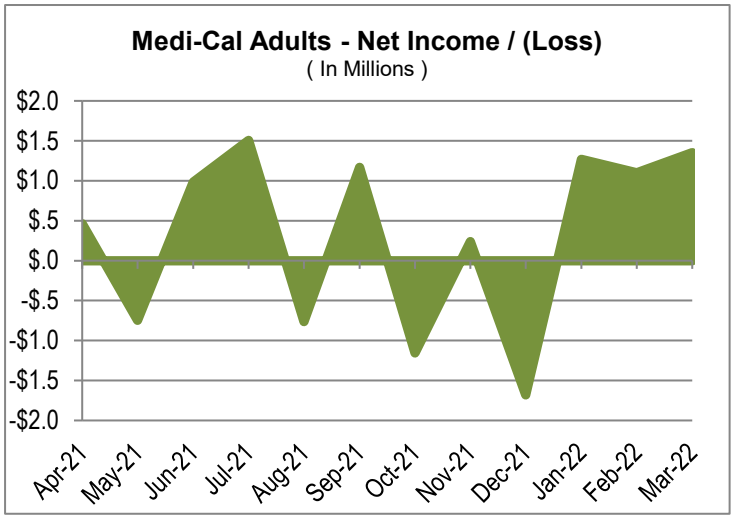
Enrollment					Member Months			
March-2022					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
45,227	42,315	2,912	6.9%	Adult	386,833	380,295	6,538	1.7%
99,889	97,661	2,228	2.3%	Child	884,483	881,272	3,211	0.4%
26,820	25,976	844	3.2%	SPD	238,337	236,835	1,502	0.6%
21,349	20,382	967	4.7%	Duals	187,328	185,430	1,898	1.0%
107,652	99,913	7,739	7.7%	ACA OE	924,075	905,559	18,516	2.0%
300,937	**286,247**	**14,690**	**5.1%**	**Medi-Cal Total**	**2,621,056**	**2,589,391**	**31,665**	**1.2%**
5,850	5,852	(2)	0.0%	Group Care	52,760	52,877	(117)	-0.2%
306,787	**292,099**	**14,688**	**5.0%**	**Total**	**2,673,816**	**2,642,268**	**31,548**	**1.2%**

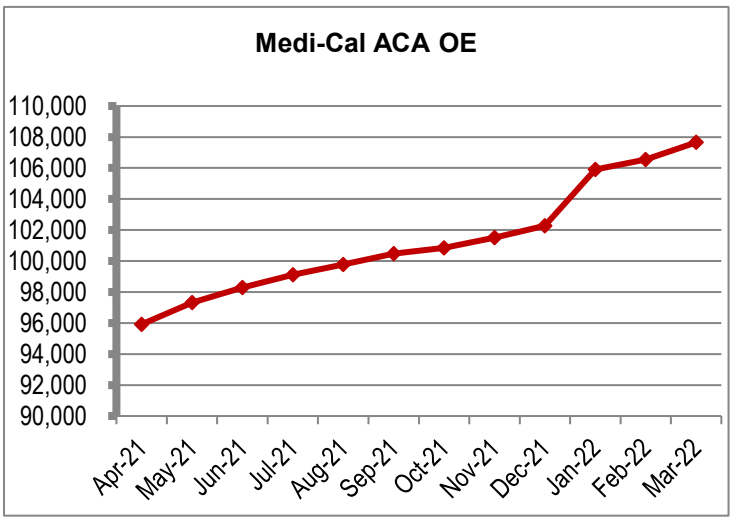
Enrollment and Profitability by Program and Category of Aid

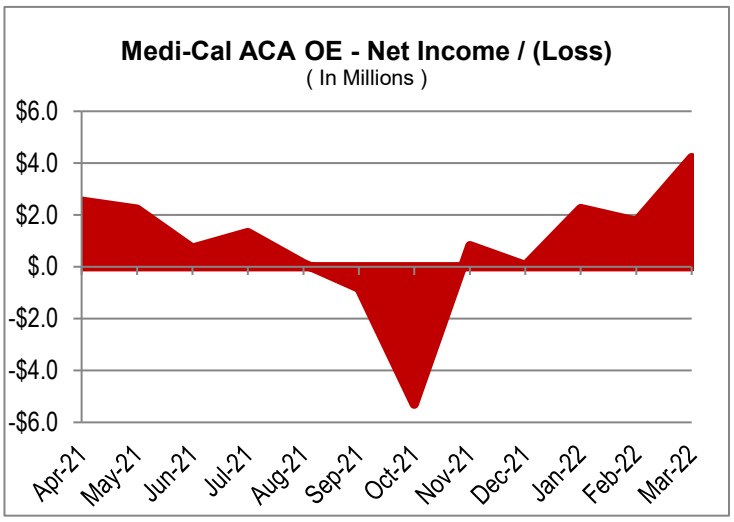




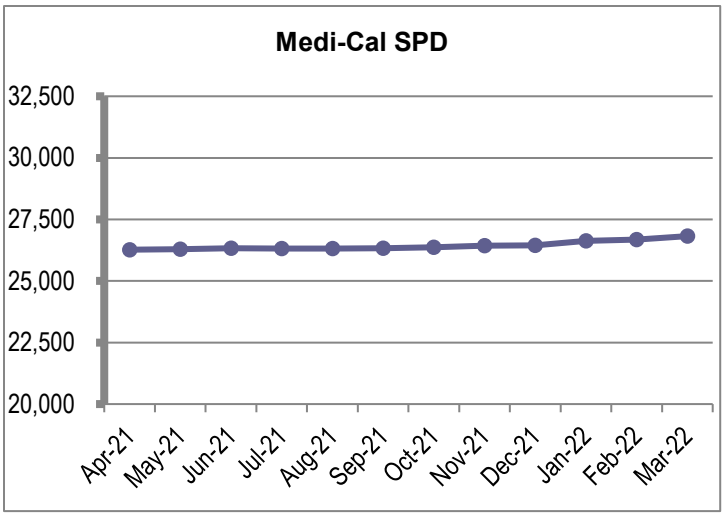


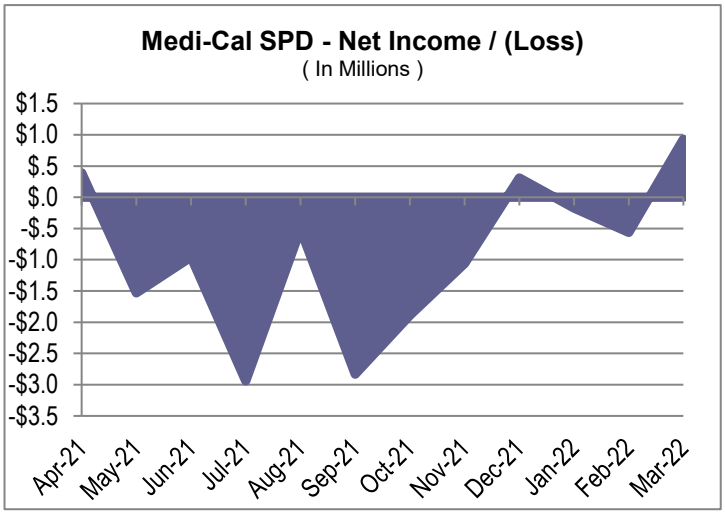


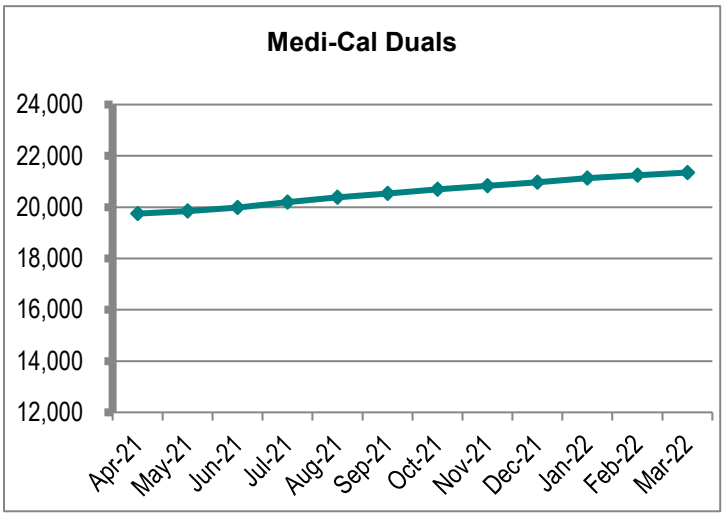


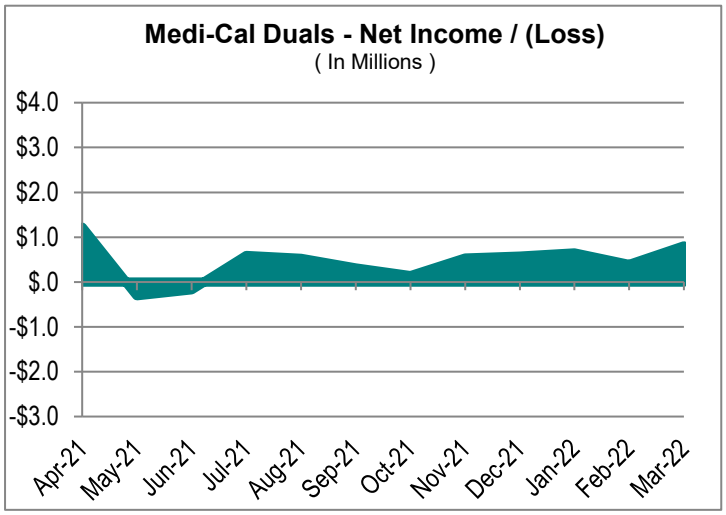


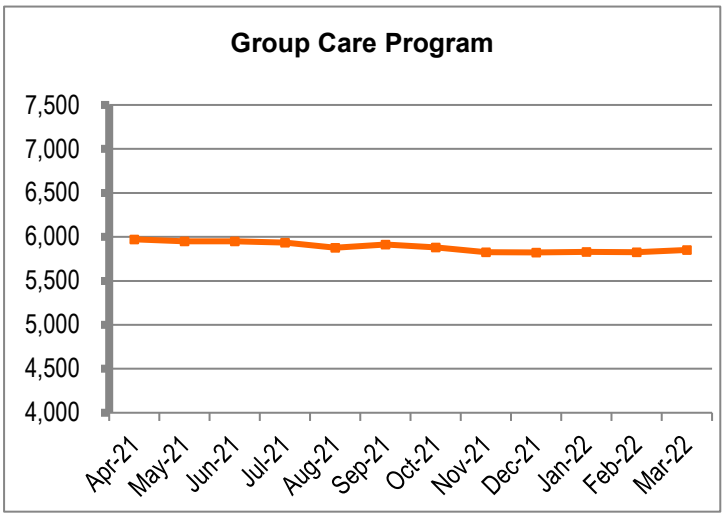
Enrollment and Profitability by Program and Category of Aid

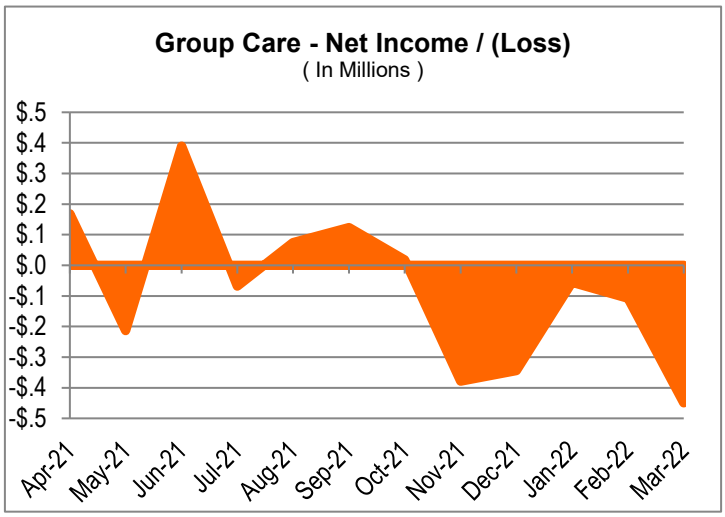




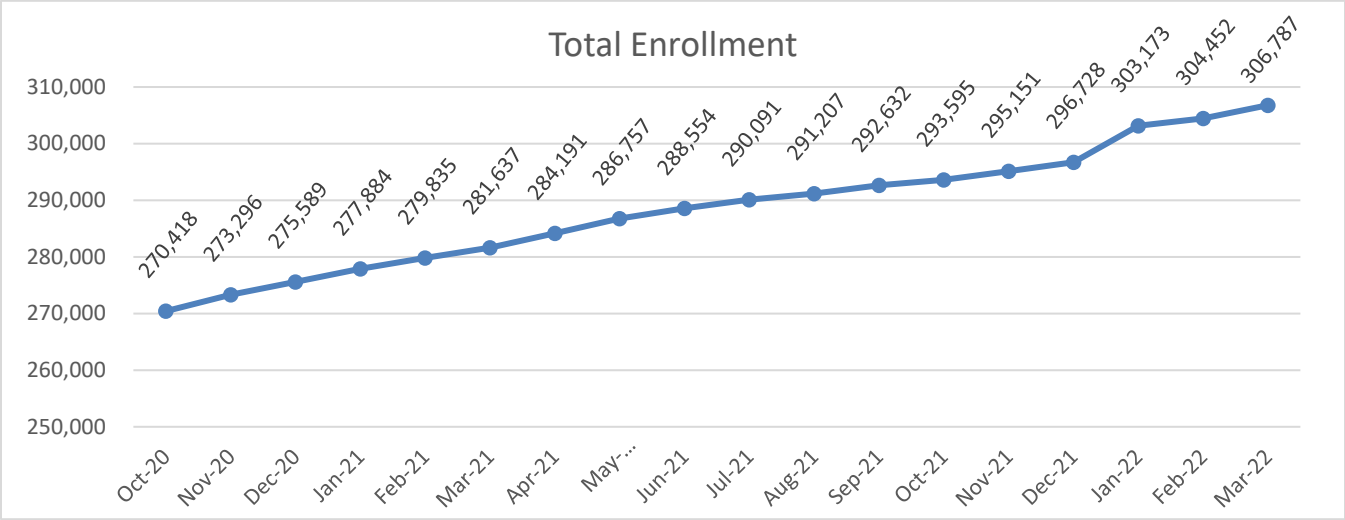


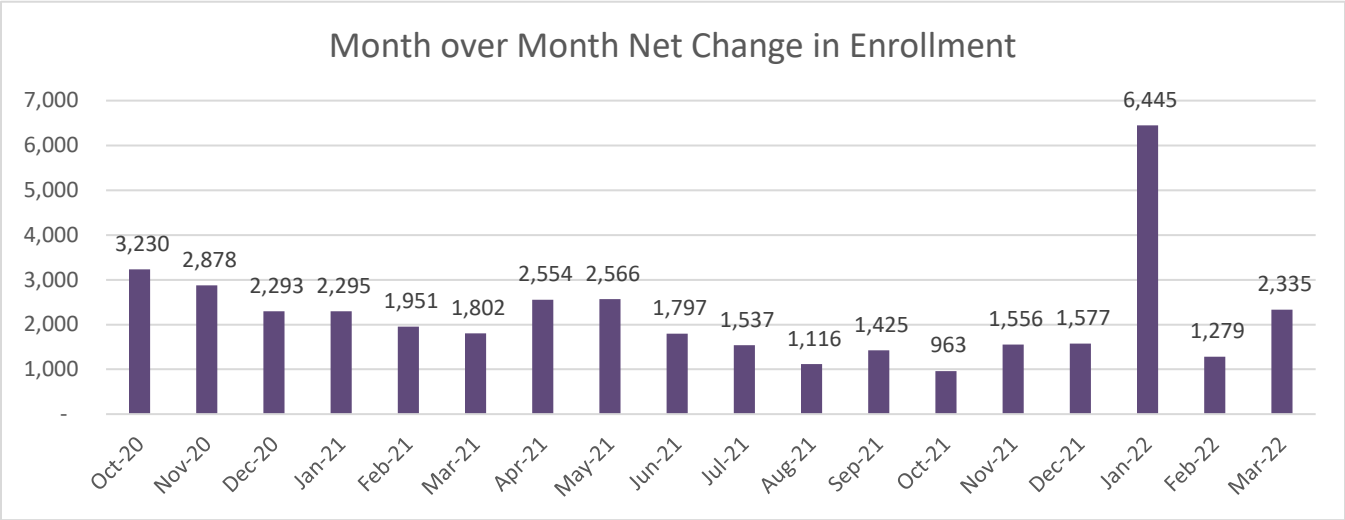






Net Change in Enrollment



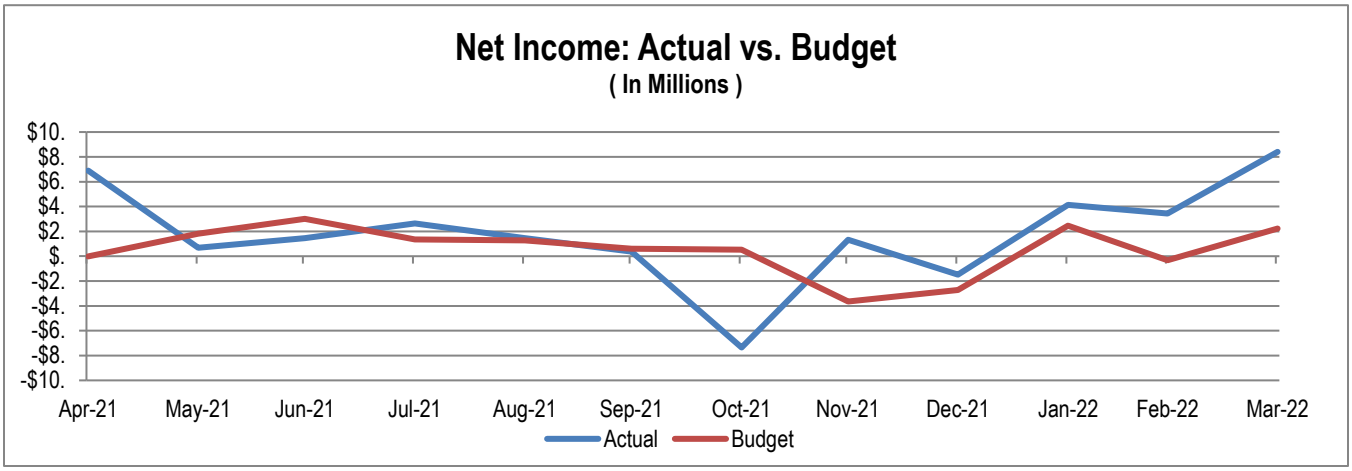


- Total monthly enrollment continues to increase. Future enrollment trends will be impacted by the anticipated end of the Public Health Emergency (PHE) and addition of new members scheduled to transition from the County HealthPAC program in May.

Net Income

- For the month ended March 31st, 2022:
  - Actual Net Income: $8.4 million.
  - Budgeted Net Income: $2.2 million.

- For the fiscal YTD ended March 31st, 2022:
  - Actual Net Income: $12.9 million.
  - Budgeted Net Loss: $4.9 million.

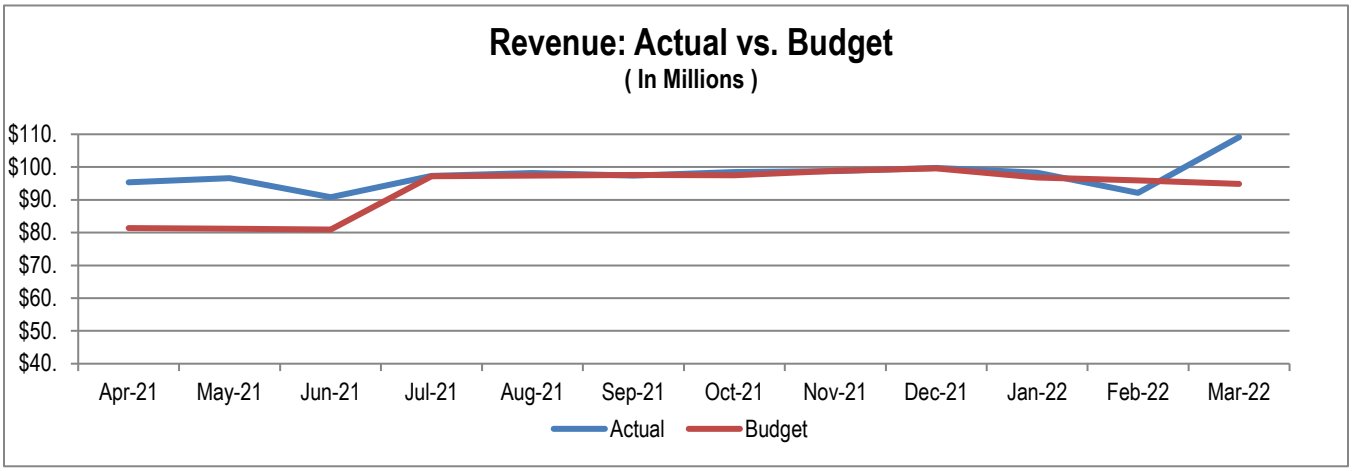


- The favorable variance of $6.2 million in the current month is primarily due to:
  - Favorable $14.3 million higher than anticipated Revenue.
  - Favorable $2.4 million lower than anticipated Administrative Expense.
  - Unfavorable $10.2 million higher than anticipated Medical Expense.

Revenue

- For the month ended March 31st, 2022:
  - Actual Revenue: $109.1 million.
  - Budgeted Revenue: $94.8 million.

- For the fiscal YTD ended March 31st, 2022:
  - Actual Revenue: $889.4 million.
  - Budgeted Revenue: $877.2 million.

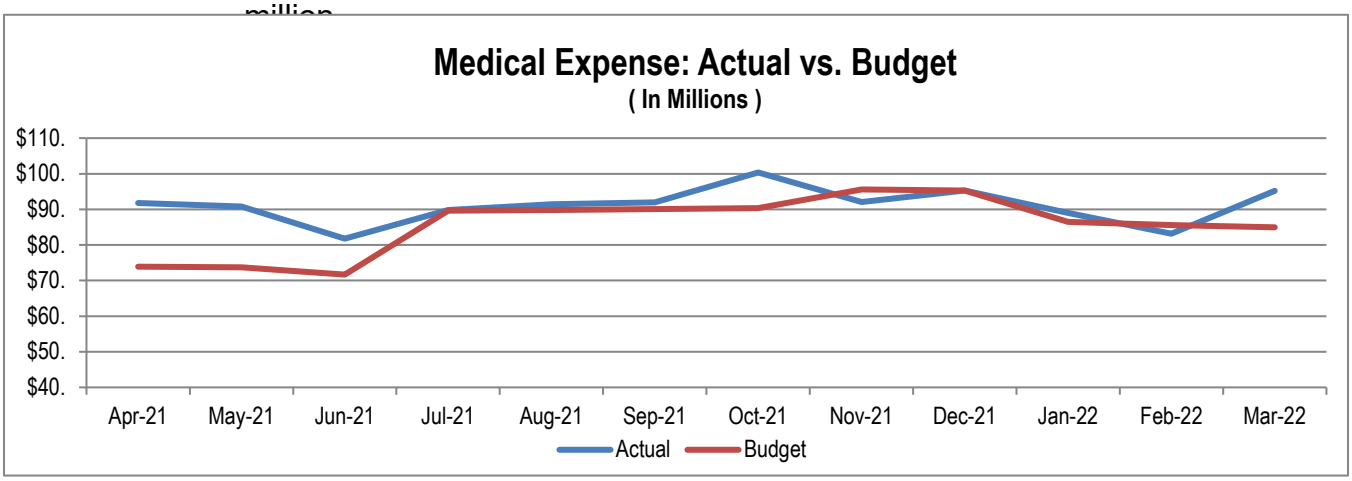


- For the month ended March 31st, 2022, the favorable revenue variance of $14.3 million is largely due to favorable $6.7 million retroactive MCO Tax adjustment for FY14-FY16, favorable $3.0 million in Medi-Cal Base Capitation revenue, favorable $1.5 million CalAIM Incentive revenue, and favorable$1.5 million Behavioral Health Supplemental revenue.

Medical Expense

- For the month ended March 31st, 2022:
  - Actual Medical Expense: $95.2 million.
  - Budgeted Medical Expense: $85.0 million.

- For the fiscal YTD ended March 31st, 2022:
  - Actual Medical Expense: $828.2 million.
  - Budgeted Medical Expense: $821.5 million.



- Reported financial results include medical expense, which contains estimates for Incurred-But-Not-Paid (IBNP) claims. Calculation of monthly IBNP is based on historical trends and claims payment. The Alliance's IBNP reserves are reviewed on a quarterly basis by the company's external actuaries.

- For March, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $1.4 million. The estimate for prior years increased by $4.5 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)

Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$200,098,068	$0	$200,098,068	$200,915,030	$816,962	0.4%
Primary Care FFS	39,865,437	$31,826	$39,897,262	40,457,993	$592,556	1.5%
Specialty Care FFS	41,602,270	$217,225	$41,819,494	42,015,682	$413,412	1.0%
Outpatient FFS	72,999,183	$450,359	$73,449,542	75,421,743	$2,422,560	3.2%
Ancillary FFS	49,945,595	$254,642	$50,200,237	44,989,730	($4,955,865)	-11.0%
Pharmacy FFS	112,248,901	$1,519,771	$113,768,672	109,462,801	($2,786,100)	-2.5%
ER Services FFS	40,889,627	$247,188	$41,136,816	40,242,093	($647,534)	-1.6%
Inpatient Hospital & SNF FFS	247,250,420	$1,771,359	$249,021,779	247,911,031	$660,611	0.3%
Other Benefits & Services	15,968,689	$0	$15,968,689	17,082,788	$1,114,100	6.5%
Net Reinsurance	(539,049)	$0	($539,049)	501,774	$1,040,822	207.4%
	$820,329,140	**$4,492,370**	**$824,821,511**	**$819,000,663**	**($1,328,477)**	**-0.2%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

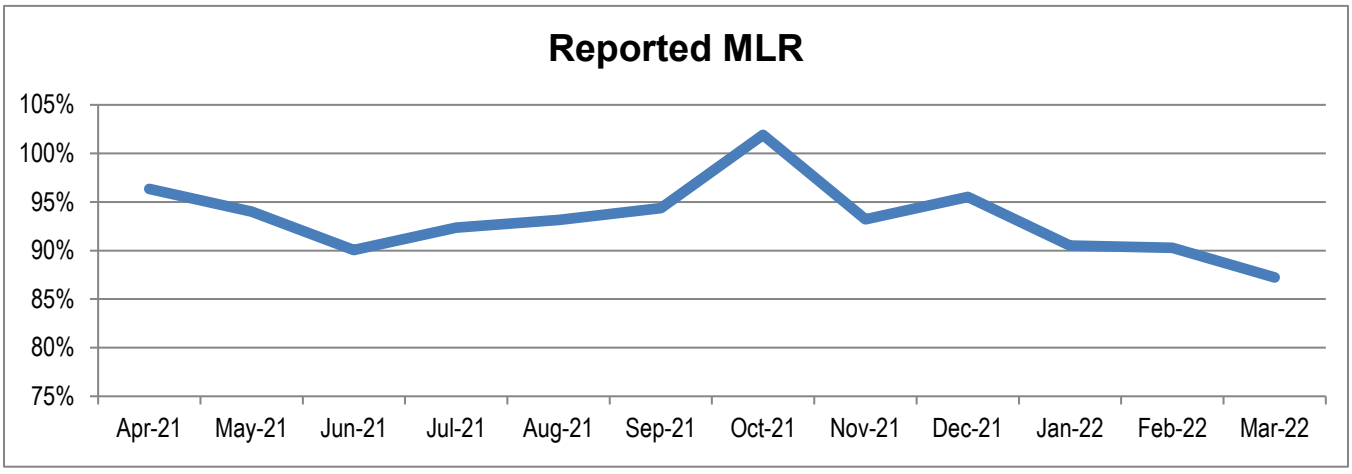
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$74.84	$0.00	$74.84	$76.04	$1.20	1.6%
Primary Care FFS	$14.91	$0.01	$14.92	$15.31	$0.40	2.6%
Specialty Care FFS	$15.56	$0.08	$15.64	$15.90	$0.34	2.2%
Outpatient FFS	$27.30	$0.17	$27.47	$28.54	$1.24	4.4%
Ancillary FFS	$18.68	$0.10	$18.77	$17.03	($1.65)	-9.7%
Pharmacy FFS	$41.98	$0.57	$42.55	$41.43	($0.55)	-1.3%
ER Services FFS	$15.29	$0.09	$15.39	$15.23	($0.06)	-0.4%
Inpatient Hospital & SNF FFS	$92.47	$0.66	$93.13	$93.83	$1.35	1.4%
Other Benefits & Services	$5.97	$0.00	$5.97	$6.47	$0.49	7.6%
Net Reinsurance	($0.20)	$0.00	($0.20)	$0.19	$0.39	206.2%
	$306.80	**$1.68**	**$308.48**	**$309.96**	**$3.16**	**1.0%**

- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $1.3 million unfavorable to final budget. On a PMPM basis, medical expense is 1.0% favorable to budget.
    - Capitated Expense is unfavorable to budget primarily due to timing of submissions for BHT.
    - Primary Care Expense is below budget driven by favorable utilization in the ACA OE population and favorable unit cost in the SPD and Dual populations.
    - Specialty Care is favorable compared to budget generally driven by favorable utilization in the ACA OE and Adult populations.

- Outpatient Expense is under budget, driven by favorable utilization partially offset by unfavorable unit cost.
- Ancillary Expense is above budget due to Home Heath, DME, Outpatient Therapy, Laboratory and Radiology, Non-Emergency Transportation, Other Medical Professional, ECM and Community Supports and Ambulance offset by CBAS and Hospice service categories. Overall utilization is unfavorable partially offset by favorable unit cost.
- Pharmacy Expense is above budget due to unfavorable Non-PBM expense, driven mostly by unfavorable unit cost in the ACA OE, Adult and Group Care populations.
- Emergency Room Expense is unfavorable, due to unfavorable unit cost in the Child population and unfavorable utilization in the ACA OE population.
- Inpatient Expense is under budget driven by favorable unit cost, partially offset by unfavorable utilization.
- Inpatient Expense is under budget driven by favorable unit cost offset by unfavorable utilization.
- Other Benefits & Services are slightly favorable to budget, primarily due to open positions in the Clinical Organization and lower than expected costs in incentive programs and purchased services, partially offset by CalAIM Incentive expenses, which were not included in the Budget.
- Net Reinsurance year-to-date is favorable to budget because the Plan has received recoveries at higher levels than expected.

Medical Loss Ratio (MLR)

- The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 87.2% for the month and 93.1% for the fiscal year-to-date.



Administrative Expense

- For the month ended March 31st, 2022:
  - Actual Administrative Expense: $5.2 million.
  - Budgeted Administrative Expense: $7.6 million.
- For the fiscal YTD ended March 31st, 2022:
  - Actual Administrative Expense: $47.7 million.
  - Budgeted Administrative Expense: $60.7 million.

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

Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$3,246,821	$3,665,203	$418,382	11.4%	Employee Expense	$27,050,545	$29,744,782	$2,694,237	9.1%
315,767	312,072	(3,695)	-1.2%	Medical Benefits Admin Expense	4,973,187	4,984,082	10,895	0.2%
656,785	2,168,665	1,511,880	69.7%	Purchased & Professional Services	6,249,086	11,424,293	5,175,207	45.3%
983,516	1,503,601	520,085	34.6%	Other Admin Expense	9,382,346	14,543,504	5,161,158	35.5%
$68,547	$93,016	$2,446,652	26.3%	Total Administrative Expense	$752,733	$830,930	$13,041,497	9.4%

The year-to-date variances include:

- COVID-19 Vaccination Incentives.
- Delayed timing of new project start dates for Consultants, Computer Support Services and Purchased Services.
- Delayed hiring of new employees.

Administrative loss ratio (ALR) represented 4.8% of net revenue for the month and 5.4% of net revenue year-to-date.

Other Income / (Expense)

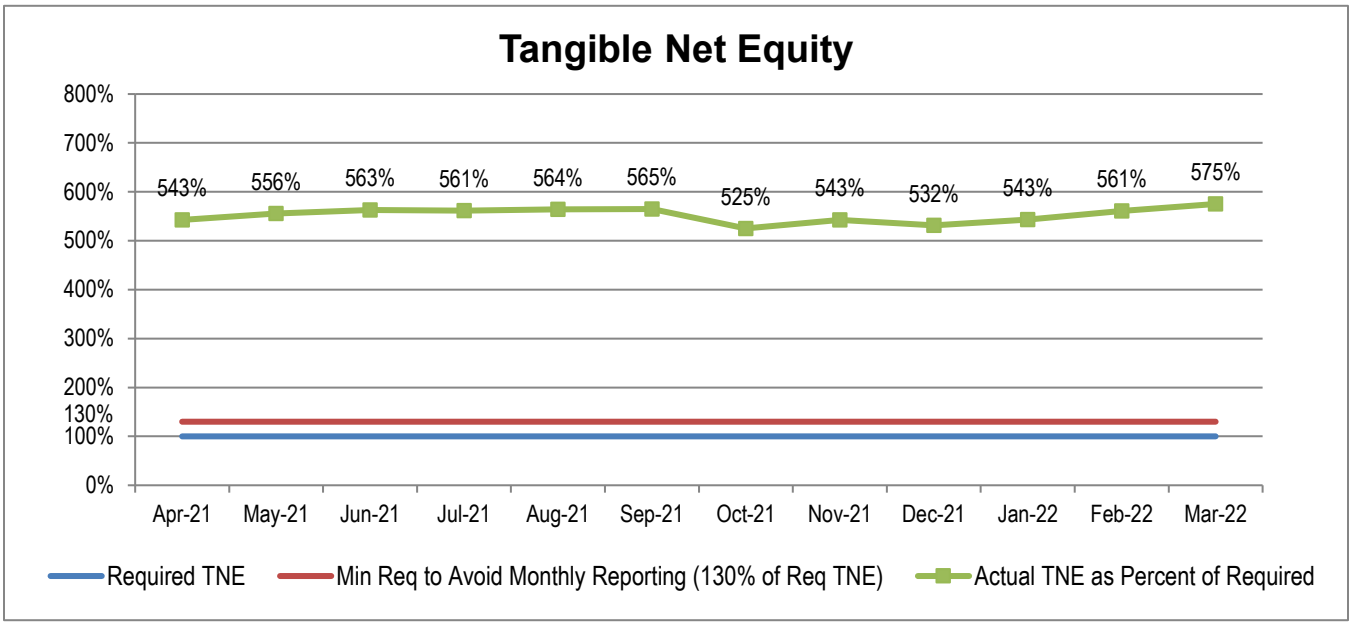
Other Income & Expense is comprised of investment income and claims interest.

- Fiscal year-to-date net investment revenue is $157,000.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $300,000.

Tangible Net Equity (TNE)

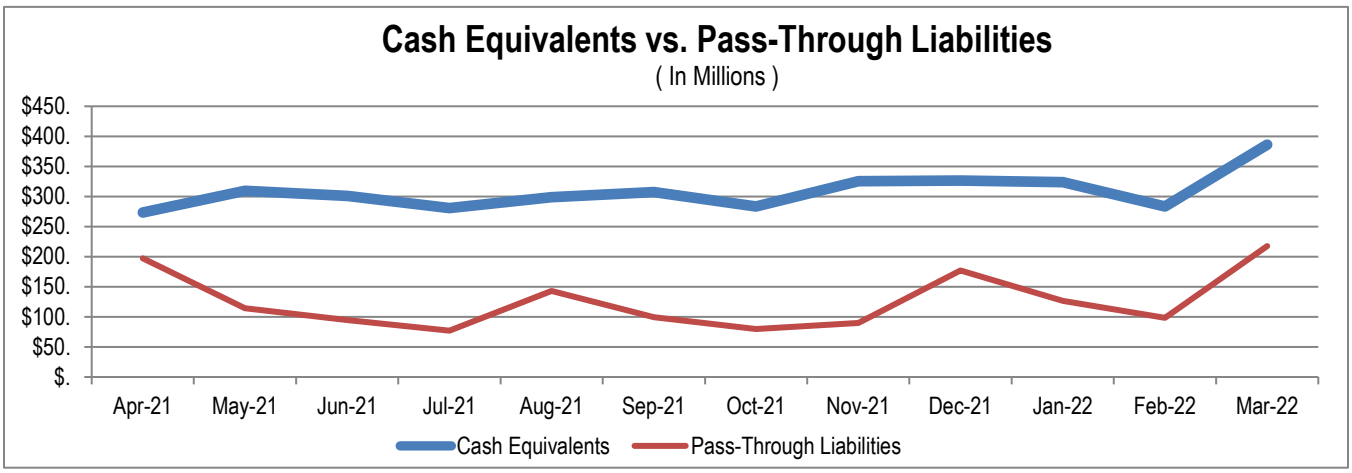
- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to consumers. TNE is a calculation of a company's total tangible assets minus the company's total liabilities. The Alliance exceeds DMHC's required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

- Required TNE $38.0 million
- Actual TNE $218.3 million
- Excess TNE $180.4 million
- TNE as % of Required TNE 575%



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

- Key Metrics
  - Cash & Cash Equivalents $386.2 million
  - Pass-Through Liabilities $222.1 million
  - Uncommitted Cash $164.1 million
  - Working Capital $174.2 million
  - Current Ratio 1.47 (regulatory minimum is 1.0)



Capital Investment

- Fiscal year-to-date capital assets acquired: $234,000.
- Annual capital budget: $1.4 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

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

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET (WITH MEDICAL EXPENSE BY PAYMENT TYPE)
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
300,937	286,247	14,690	5.1%	1 - Medi-Cal	2,621,056	2,589,391	31,665	1.2%
5,850	5,852	(2)	0.0%	2 - Group Care	52,760	52,877	(117)	(0.2%)
306,787	**292,099**	**14,688**	**5.0%**	**3 - Total Member Months**	**2,673,816**	**2,642,268**	**31,548**	**1.2%**
				REVENUE				
$109,123,036	**$94,816,628**	**$14,306,408**	**15.1%**	**4 - TOTAL REVENUE**	**$889,356,179**	**$877,202,504**	**$12,153,675**	**1.4%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
24,116,525	22,035,439	(2,081,086)	(9.4%)	5 - Capitated Medical Expense	200,098,068	200,915,044	816,976	0.4%
				Fee for Service Medical Expenses:				
31,706,807	27,440,012	(4,266,795)	(15.5%)	6 - Inpatient Hospital & SNF FFS Expense	249,021,779	247,911,033	(1,110,746)	(0.4%)
4,610,944	4,529,503	(81,441)	(1.8%)	7 - Primary Care Physician FFS Expense	39,897,262	40,457,988	560,726	1.4%
4,642,537	4,616,135	(26,402)	(0.6%)	8 - Specialty Care Physician Expense	41,819,494	42,015,683	196,189	0.5%
7,611,836	6,335,861	(1,275,975)	(20.1%)	9 - Ancillary Medical Expense	50,200,237	44,989,729	(5,210,509)	(11.6%)
7,895,506	8,145,410	249,904	3.1%	10 - Outpatient Medical Expense	73,449,542	75,421,741	1,972,199	2.6%
4,706,160	4,290,091	(416,069)	(9.7%)	11 - Emergency Expense	41,136,816	40,242,095	(894,721)	(2.2%)
6,477,699	5,094,900	(1,382,799)	(27.1%)	12 - Pharmacy Expense	113,768,672	109,462,807	(4,305,865)	(3.9%)
67,651,489	60,451,912	(7,199,578)	(11.9%)	13 - Total Fee for Service Expense	609,293,803	600,501,076	(8,792,727)	(1.5%)
3,362,737	2,328,672	(1,034,065)	(44.4%)	14 - Other Benefits & Services	19,331,426	19,411,444	80,018	0.4%
62,239	134,275	72,036	53.6%	15 - Reinsurance Expense	(476,809)	636,050	1,112,859	175.0%
95,192,991	**84,950,298**	**(10,242,694)**	**(12.1%)**	**17 - TOTAL MEDICAL EXPENSES**	**828,246,487**	**821,463,614**	**(6,782,873)**	**(0.8%)**
13,930,045	**9,866,330**	**4,063,715**	**41.2%**	**18 - GROSS MARGIN**	**61,109,692**	**55,738,890**	**5,370,802**	**9.6%**
				ADMINISTRATIVE EXPENSES				
3,246,822	3,665,203	418,381	11.4%	19 - Personnel Expense	27,050,544	29,744,782	2,694,237	9.1%
315,767	312,072	(3,695)	(1.2%)	20 - Benefits Administration Expense	4,973,188	4,984,082	10,894	0.2%
656,781	2,168,665	1,511,884	69.7%	21 - Purchased & Professional Services	6,249,088	11,424,293	5,175,205	45.3%
983,515	1,503,601	520,086	34.6%	22 - Other Administrative Expense	9,382,347	14,543,504	5,161,157	35.5%
5,202,885	**7,649,541**	**2,446,656**	**32.0%**	**23 -Total Administrative Expense**	**47,655,168**	**60,696,661**	**13,041,493**	**21.5%**
8,727,159	**2,216,789**	**6,510,370**	**293.7%**	**24 - NET OPERATING INCOME / (LOSS)**	**13,454,525**	**(4,957,771)**	**18,412,295**	**371.4%**
				OTHER INCOME / EXPENSE				
(322,992)	**8,751**	**(331,743)**	**(3,790.9%)**	**25 - Total Other Income / (Expense)**	**(546,117)**	**41,440**	**(587,557)**	**(1,417.8%)**
$8,404,167	**$2,225,540**	**$6,178,627**	**277.6%**	**26 - NET INCOME / (LOSS)**	**$12,908,408**	**($4,916,331)**	**$17,824,739**	**362.6%**
4.8%	8.1%	3.3%	40.9%	27 - Admin Exp % of Revenue	5.4%	6.9%	1.6%	22.6%

ALAMEDA ALLIANCE FOR HEALTH
SUMMARY BALANCE SHEET 2022
CURRENT MONTH VS. PRIOR MONTH
March 31, 2022

	March	February	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$37,291,391	$53,264,413	($15,973,022)	-29.99%
Short-Term Investments	348,925,042	230,404,150	118,520,891	51.44%
Interest Receivable	292,168	273,353	18,815	6.88%
Other Receivables - Net	150,297,034	131,641,850	18,655,184	14.17%
Prepaid Expenses	5,127,523	5,428,857	(301,335)	-5.55%
Prepaid Inventoried Items	28,741	4,951	23,790	480.50%
CalPERS Net Pension Asset	(1,665,176)	(1,665,176)	0	0.00%
Deferred CalPERS Outflow	4,501,849	4,501,849	0	0.00%
TOTAL CURRENT ASSETS	**544,798,572**	**423,854,247**	**120,944,324**	**28.53%**
OTHER ASSETS:				
Long-Term Investments	37,987,619	28,740,697	9,246,922	32.17%
Restricted Assets	350,000	350,000	0	0.00%
TOTAL OTHER ASSETS	**38,337,619**	**29,090,697**	**9,246,922**	**31.79%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	9,626,797	9,626,797	0	0.00%
Furniture And Equipment	11,540,223	11,540,223	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Construction in Process	275,666	275,666	0	0.00%
Internally-Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	37,169,134	37,169,134	0	0.00%
Less: Accumulated Depreciation	(31,416,075)	(31,347,529)	(68,546)	0.22%
NET PROPERTY AND EQUIPMENT	**5,753,059**	**5,821,605**	**(68,546)**	**-1.18%**
TOTAL ASSETS	**$588,889,250**	**$458,766,549**	**$130,122,701**	**28.36%**
CURRENT LIABILITIES:				
Accounts Payable	$3,699,423	$2,974,142	$725,281	24.39%
Pass-Through Liabilities	222,118,231	98,253,753	123,864,478	126.07%
Claims Payable	20,980,727	16,166,369	4,814,358	29.78%
IBNP Reserves	109,069,132	116,953,749	(7,884,617)	-6.74%
Payroll Liabilities	5,458,757	5,250,172	208,585	3.97%
CalPERS Deferred Inflow	859,093	859,093	0	0.00%
Risk Sharing	8,124,932	8,124,932	0	0.00%
Provider Grants/ New Health Program	260,506	270,058	(9,552)	-3.54%
TOTAL CURRENT LIABILITIES	**370,570,800**	**248,852,266**	**121,718,534**	**48.91%**
TOTAL LIABILITIES	**370,570,800**	**248,852,266**	**121,718,534**	**48.91%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	204,569,809	204,569,809	0	0.00%
Year-to Date Net Income / (Loss)	12,908,408	4,504,241	8,404,167	186.58%
TOTAL NET WORTH	**218,318,450**	**209,914,283**	**8,404,167**	**4.00%**
TOTAL LIABILITIES AND NET WORTH	**$588,889,250**	**$458,766,549**	**$130,122,701**	**28.36%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 3/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$88,101,685	$320,186,955	$561,298,341	$846,845,734
Commercial Premium Revenue	2,183,510	6,543,632	13,070,657	19,758,719
Other Income	(37,670)	275,851	1,309,340	2,025,974
Investment Income	(263,148)	(608,232)	(498,311)	(439,937)
Cash Paid To:				
Medical Expenses	(98,088,591)	(264,554,304)	(551,074,384)	(825,977,732)
Vendor & Employee Expenses	(3,965,478)	(14,009,097)	(30,204,216)	(46,096,475)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	(12,069,692)	47,834,805	(6,098,573)	(3,883,717)
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	0	(121,290)	(127,632)	(233,657)
Net Cash Provided By (Used In) Financing Activities	0	(121,290)	(127,632)	(233,657)
Cash Flows from Investing Activities:				
Changes in Investments	(9,246,922)	(33,017,500)	(37,987,619)	(37,987,619)
Restricted Cash	123,864,478	44,981,248	122,839,120	127,285,694
Net Cash Provided By (Used In) Investing Activities	114,617,556	11,963,748	84,851,501	89,298,075
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**102,547,864**	**59,677,263**	**78,625,296**	**85,180,701**
Cash @ Beginning of Period	283,668,564	326,539,162	307,591,124	301,035,737
Subtotal	$386,216,428	$386,216,425	$386,216,420	$386,216,438
Rounding	5	8	13	(5)
Cash @ End of Period	**$386,216,433**	**$386,216,433**	**$386,216,433**	**$386,216,433**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$8,404,167	$15,969,622	$8,437,577	$12,908,407
Depreciation	68,545	220,173	467,911	752,735
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	(18,674,000)	27,296,229	(20,011,319)	(14,184,977)
Prepaid Expenses	277,545	545,211	403,337	1,017,862
Trade Payables	725,281	579,916	1,259,805	(599,716)
Claims payable & IBNP	(3,070,259)	2,801,267	3,098,083	(4,279,885)
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	199,033	422,394	246,046	501,852
Subtotal	(12,069,688)	47,834,812	(6,098,560)	(3,883,722)
Rounding	(4)	(7)	(13)	5
Cash Flows from Operating Activities	**($12,069,692)**	**$47,834,805**	**($6,098,573)**	**($3,883,717)**
Rounding Difference	(4)	(7)	(13)	5

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 3/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,183,510	$6,543,632	$13,070,657	$19,758,719
Total	2,183,510	6,543,632	13,070,657	19,758,719
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	106,941,082	292,662,284	582,088,691	867,487,389
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	0	0	0
Premium Receivable	(18,839,397)	27,524,671	(20,790,350)	(20,641,655)
Total	88,101,685	320,186,955	561,298,341	846,845,734
Investment & Other Income Cash Flows				
Other Revenue (Grants)	(37,670)	275,851	1,309,340	2,025,974
Interest Income	(244,333)	(359,236)	(237,004)	(157,340)
Interest Receivable	(18,815)	(248,996)	(261,307)	(282,597)
Total	(300,818)	(332,381)	811,029	1,586,037
Medical & Hospital Cash Flows				
Total Medical Expenses	(95,192,992)	(267,345,157)	(555,064,993)	(828,246,485)
Other Receivable	184,212	20,554	1,040,338	6,739,275
Claims Payable	4,814,358	3,141,400	(7,262,071)	(12,483,542)
IBNP Payable	(7,884,617)	(340,133)	10,360,154	10,428,574
Risk Share Payable	0	0	0	(2,224,917)
Health Program	(9,552)	(30,968)	(147,812)	(190,637)
Other Liabilities	0	0	0	0
Total	(98,088,591)	(264,554,304)	(551,074,384)	(825,977,732)
Administrative Cash Flows				
Total Administrative Expenses	(5,245,434)	(15,807,759)	(32,729,127)	(47,959,845)
Prepaid Expenses	277,545	545,211	403,337	1,017,862
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	725,281	579,916	1,259,805	(599,716)
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	208,585	453,362	393,858	692,489
Depreciation Expense	68,545	220,173	467,911	752,735
Total	(3,965,478)	(14,009,097)	(30,204,216)	(46,096,475)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**(12,069,692)**	**47,834,805**	**(6,098,573)**	**(3,883,717)**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 3/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(9,246,922)	(33,017,500)	(37,987,619)	(37,987,619)
	(9,246,922)	(33,017,500)	(37,987,619)	(37,987,619)
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	123,864,478	44,981,248	122,839,120	127,285,694
Restricted Cash	0	0	0	0
	123,864,478	44,981,248	122,839,120	127,285,694
Fixed Asset Cash Flows				
Depreciation expense	68,545	220,173	467,911	752,735
Fixed Asset Acquisitions	0	(121,290)	(127,632)	(233,657)
Change in A/D	(68,545)	(220,173)	(467,911)	(752,735)
	0	(121,290)	(127,632)	(233,657)
Total Cash Flows from Investing Activities	**114,617,556**	**11,842,458**	**84,723,869**	**89,064,418**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**102,547,864**	**59,677,263**	**78,625,296**	**85,180,701**
Rounding	5	8	13	(5)
Cash @ Beginning of Period	283,668,564	326,539,162	307,591,124	301,035,737
Cash @ End of Period	**$386,216,433**	**$386,216,433**	**$386,216,433**	**$386,216,433**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 3/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$8,404,167	$15,969,622	$8,437,577	$12,908,407
Add back: Depreciation	68,545	220,173	467,911	752,735
Receivables				
Premiums Receivable	(18,839,397)	27,524,671	(20,790,350)	(20,641,655)
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	(18,815)	(248,996)	(261,307)	(282,597)
Other Receivable	184,212	20,554	1,040,338	6,739,275
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	(18,674,000)	27,296,229	(20,011,319)	(14,184,977)
Prepaid Expenses	277,545	545,211	403,337	1,017,862
Trade Payables	725,281	579,916	1,259,805	(599,716)
Claims Payable, IBNR & Risk Share				
IBNP	(7,884,617)	(340,133)	10,360,154	10,428,574
Claims Payable	4,814,358	3,141,400	(7,262,071)	(12,483,542)
Risk Share Payable	0	0	0	(2,224,917)
Other Liabilities	0	0	0	0
Total	(3,070,259)	2,801,267	3,098,083	(4,279,885)
Unearned Revenue				
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	208,585	453,362	393,858	692,489
Health Program	(9,552)	(30,968)	(147,812)	(190,637)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	199,033	422,394	246,046	501,852
Cash Flows from Operating Activities	**($12,069,688)**	**$47,834,812**	**($6,098,560)**	**($3,883,722)**
Difference (rounding)	4	7	13	(5)

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF MARCH 2022

	Child	Adult	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	99,889	45,227	26,820	107,652	21,349	300,937	5,850	306,787
Net Revenue	$14,456,442	$16,204,386	$30,144,389	$41,716,203	$4,418,106	$106,939,526	$2,183,510	$109,123,036
Medical Expense	$12,453,025	$14,104,131	$27,287,077	$35,475,593	$3,437,539	$92,757,365	$2,435,627	$95,192,991
Gross Margin	$2,003,417	$2,100,255	$2,857,311	$6,240,610	$980,567	$14,182,161	($252,117)	$13,930,045
Administrative Expense	$427,812	$704,776	$1,811,502	$1,905,405	$166,928	$5,016,423	$186,462	$5,202,885
Operating Income / (Expense)	$1,575,605	$1,395,479	$1,045,810	$4,335,205	$813,639	$9,165,738	($438,579)	$8,727,159
Other Income / (Expense)	($19,963)	($42,316)	($118,014)	($121,831)	($10,138)	($312,262)	($10,730)	($322,992)
Net Income / (Loss)	$1,555,642	$1,353,163	$927,796	$4,213,374	$803,501	$8,853,476	($449,309)	$8,404,167
Revenue PMPM	$144.73	$358.29	$1,123.95	$387.51	$206.95	$355.36	$373.25	$355.70
Medical Expense PMPM	$124.67	$311.85	$1,017.42	$329.54	$161.02	$308.23	$416.35	$310.29
Gross Margin PMPM	$20.06	$46.44	$106.54	$57.97	$45.93	$47.13	($43.10)	$45.41
Administrative Expense PMPM	$4.28	$15.58	$67.54	$17.70	$7.82	$16.67	$31.87	$16.96
Operating Income / (Expense) PMPM	$15.77	$30.86	$38.99	$40.27	$38.11	$30.46	($74.97)	$28.45
Other Income / (Expense) PMPM	($0.20)	($0.94)	($4.40)	($1.13)	($0.47)	($1.04)	($1.83)	($1.05)
Net Income / (Loss) PMPM	$15.57	$29.92	$34.59	$39.14	$37.64	$29.42	($76.80)	$27.39
Medical Loss Ratio	86.1%	87.0%	90.5%	85.0%	77.8%	86.7%	111.5%	87.2%
Gross Margin Ratio	13.9%	13.0%	9.5%	15.0%	22.2%	13.3%	-11.5%	12.8%
Administrative Expense Ratio	3.0%	4.3%	6.0%	4.6%	3.8%	4.7%	8.5%	4.8%
Net Income Ratio	10.8%	8.4%	3.1%	10.1%	18.2%	8.3%	-20.6%	7.7%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE - MARCH 2022

	Medi-Cal							
	Child	Adult	SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Member Months	884,483	386,833	238,337	924,075	187,328	2,621,056	52,760	2,673,816
Net Revenue	$112,253,427	$128,157,944	$248,361,706	$346,826,625	$33,996,539	$869,596,240	$19,759,939	$889,356,179
Medical Expense	$97,469,988	$118,563,674	$240,252,187	$324,733,886	$27,921,567	$808,941,302	$19,305,185	$828,246,487
Gross Margin	$14,783,439	$9,594,269	$8,109,519	$22,092,740	$6,074,971	$60,654,938	$454,754	$61,109,692
Administrative Expense	$3,909,753	$6,459,187	$16,656,673	$17,475,174	$1,529,704	$46,030,491	$1,624,677	$47,655,168
Operating Income / (Expense)	$10,873,686	$3,135,082	($8,547,153)	$4,617,565	$4,545,268	$14,624,447	($1,169,923)	$13,454,525
Other Income / (Expense)	($33,705)	($100,784)	($177,732)	($201,215)	($17,397)	($530,833)	($15,283)	($546,117)
Net Income / (Loss)	$10,839,980	$3,034,298	($8,724,886)	$4,416,351	$4,527,871	$14,093,614	($1,185,206)	$12,908,408
Revenue PMPM	$126.91	$331.30	$1,042.06	$375.32	$181.48	$331.77	$374.53	$332.62
Medical Expense PMPM	$110.20	$306.50	$1,008.04	$351.42	$149.05	$308.63	$365.91	$309.76
Gross Margin PMPM	$16.71	$24.80	$34.03	$23.91	$32.43	$23.14	$8.62	$22.85
Administrative Expense PMPM	$4.42	$16.70	$69.89	$18.91	$8.17	$17.56	$30.79	$17.82
Operating Income / (Expense) PMPM	$12.29	$8.10	($35.86)	$5.00	$24.26	$5.58	($22.17)	$5.03
Other Income / (Expense) PMPM	($0.04)	($0.26)	($0.75)	($0.22)	($0.09)	($0.20)	($0.29)	($0.20)
Net Income / (Loss) PMPM	$12.26	$7.84	($36.61)	$4.78	$24.17	$5.38	($22.46)	$4.83
Medical Loss Ratio	86.8%	92.5%	96.7%	93.6%	82.1%	93.0%	97.7%	93.1%
Gross Margin Ratio	13.2%	7.5%	3.3%	6.4%	17.9%	7.0%	2.3%	6.9%
Administrative Expense Ratio	3.5%	5.0%	6.7%	5.0%	4.5%	5.3%	8.2%	5.4%
Net Income Ratio	9.7%	2.4%	-3.5%	1.3%	13.3%	1.6%	-6.0%	1.5%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$3,246,822	$3,665,203	$418,381	11.4%	Personnel Expenses	$27,050,544	$29,744,782	$2,694,237	9.1%
315,767	312,072	(3,695)	(1.2%)	Benefits Administration Expense	4,973,188	4,984,082	10,894	0.2%
656,781	2,168,665	1,511,884	69.7%	Purchased & Professional Services	6,249,088	11,424,293	5,175,205	45.3%
294,506	295,073	567	0.2%	Occupancy	2,349,406	2,485,830	136,424	5.5%
64,684	299,549	234,865	78.4%	Printing Postage & Promotion	1,706,483	1,909,905	203,422	10.7%
604,640	878,936	274,296	31.2%	Licenses Insurance & Fees	4,467,821	5,330,109	862,288	16.2%
19,685	30,043	10,358	34.5%	Supplies & Other Expenses	858,637	4,817,660	3,959,023	82.2%
1,956,064	3,984,338	2,028,274	50.9%	Total Other Administrative Expense	20,604,623	30,951,879	10,347,256	33.4%
$5,202,885	**$7,649,541**	**$2,446,656**	**32.0%**	**Total Administrative Expenses**	**$47,655,168**	**$60,696,661**	**$13,041,493**	**21.5%**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
$2,205,233	$2,209,046	$3,813	0.2%	Salaries & Wages	$17,895,650	$18,418,930	$523,280	2.8%
232,815	242,954	10,140	4.2%	Paid Time Off	1,854,718	1,998,727	144,009	7.2%
3,110	4,346	1,236	28.4%	Incentives	17,662	24,048	6,386	26.6%
0	25,000	25,000	100.0%	Severance Pay	0	125,000	125,000	100.0%
14,021	37,054	23,033	62.2%	Payroll Taxes	366,234	484,355	118,121	24.4%
21,285	14,589	(6,696)	(45.9%)	Overtime	250,631	231,076	(19,555)	(8.5%)
189,899	187,359	(2,540)	(1.4%)	CalPERS ER Match	1,404,603	1,503,419	98,816	6.6%
0	0	0	0.0%	Mandated Covid -19 Supplemental Sick Leave	10,398	10,400	2	0.0%
517,960	700,996	183,036	26.1%	Employee Benefits	4,353,914	5,052,019	698,105	13.8%
47	0	(47)	0.0%	Personal Floating Holiday	103,396	112,983	9,587	8.5%
71	17,068	16,997	99.6%	Employee Relations	43,748	121,244	77,496	63.9%
7,410	9,482	2,072	21.9%	Work from Home Stipend	63,390	73,028	9,638	13.2%
25	2,254	2,229	98.9%	Transportation Reimbursement	629	7,313	6,684	91.4%
461	21,307	20,846	97.8%	Travel & Lodging	1,932	51,609	49,677	96.3%
32,860	68,063	35,203	51.7%	Temporary Help Services	501,047	772,746	271,699	35.2%
11,351	80,463	69,112	85.9%	Staff Development/Training	65,534	377,285	311,751	82.6%
10,273	45,222	34,949	77.3%	Staff Recruitment/Advertising	117,058	380,600	263,542	69.2%
3,246,822	**3,665,203**	**418,381**	**11.4%**	**Total Employee Expenses**	**27,050,544**	**29,744,782**	**2,694,237**	**9.1%**
				Benefit Administration Expense				
24,687	52,443	27,756	52.9%	RX Administration Expense	2,536,046	2,607,412	71,366	2.7%
272,812	243,041	(29,771)	(12.2%)	Behavioral Hlth Administration Fees	2,277,661	2,222,540	(55,121)	(2.5%)
18,268	16,588	(1,680)	(10.1%)	Telemedicine Admin Fees	159,481	154,130	(5,351)	(3.5%)
315,767	**312,072**	**(3,695)**	**(1.2%)**	**Total Employee Expenses**	**4,973,188**	**4,984,082**	**10,894**	**0.2%**
				Purchased & Professional Services				
167,412	750,958	583,547	77.7%	Consulting Services	2,403,144	4,058,920	1,655,776	40.8%
353,685	747,725	394,040	52.7%	Computer Support Services	2,549,275	4,207,642	1,658,367	39.4%
11,645	11,583	(62)	(0.5%)	Professional Fees-Accounting	120,282	108,239	(12,043)	(11.1%)
0	10	10	100.0%	Professional Fees-Medical	95	50	(45)	(90.5%)
51,791	272,893	221,102	81.0%	Other Purchased Services	309,788	1,204,346	894,558	74.3%
(30,547)	5,000	35,547	710.9%	Maint.& Repair-Office Equipment	7,696	46,809	39,113	83.6%
24,250	124,951	100,701	80.6%	HMS Recovery Fees	342,740	736,030	393,290	53.4%
0	125,001	125,001	100.0%	MIS Software (Non-Capital)	0	250,002	250,002	100.0%
17,951	28,000	10,049	35.9%	Hardware (Non-Capital)	178,345	300,117	121,772	40.6%
12,574	21,492	8,918	41.5%	Provider Relations-Credentialing	113,235	152,206	38,971	25.6%
48,022	81,052	33,030	40.8%	Legal Fees	224,486	359,932	135,446	37.6%
656,781	**2,168,665**	**1,511,884**	**69.7%**	**Total Purchased & Professional Services**	**6,249,088**	**11,424,293**	**5,175,205**	**45.3%**
				Occupancy				
68,546	93,016	24,470	26.3%	Depreciation	752,735	830,930	78,195	9.4%
70,286	70,286	0	0.0%	Building Lease	634,947	634,947	0	0.0%
34,366	2,006	(32,360)	(1,613.1%)	Leased and Rented Office Equipment	50,598	18,152	(32,446)	(178.7%)
10,887	14,879	3,992	26.8%	Utilities	111,968	128,678	16,710	13.0%
93,410	71,401	(22,009)	(30.8%)	Telephone	671,459	646,406	(25,053)	(3.9%)
17,012	43,485	26,473	60.9%	Building Maintenance	127,699	226,717	99,018	43.7%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$294,506	**$295,073**	**$567**	**0.2%**	**Total Occupancy**	**$2,349,406**	**$2,485,830**	**$136,424**	**5.5%**
				Printing Postage & Promotion				
15,988	38,085	22,097	58.0%	Postage	290,857	396,642	105,786	26.7%
4,590	7,000	2,410	34.4%	Design & Layout	24,080	51,888	27,808	53.6%
16,981	41,465	24,484	59.0%	Printing Services	523,655	502,764	(20,891)	(4.2%)
4,066	2,500	(1,566)	(62.6%)	Mailing Services	36,693	23,394	(13,299)	(56.8%)
5,038	3,225	(1,813)	(56.2%)	Courier/Delivery Service	37,074	32,353	(4,721)	(14.6%)
0	334	334	100.0%	Pre-Printed Materials and Publications	601	4,603	4,002	86.9%
0	0	0	0.0%	Promotional Products	0	2,500	2,500	100.0%
0	150	150	100.0%	Promotional Services	0	150	150	100.0%
10,500	198,290	187,790	94.7%	Community Relations	633,655	751,477	117,823	15.7%
0	0	0	0.0%	Health Education-Member	(67)	0	67	0.0%
7,522	8,500	978	11.5%	Translation - Non-Clinical	159,935	144,134	(15,801)	(11.0%)
64,684	**299,549**	**234,865**	**78.4%**	**Total Printing Postage & Promotion**	**1,706,483**	**1,909,905**	**203,422**	**10.7%**
				Licenses Insurance & Fees				
0	100,000	100,000	100.0%	Regulatory Penalties	0	100,000	100,000	100.0%
20,647	20,800	153	0.7%	Bank Fees	183,466	185,665	2,199	1.2%
61,920	61,377	(543)	(0.9%)	Insurance	554,564	552,391	(2,173)	(0.4%)
379,650	614,311	234,661	38.2%	Licenses, Permits and Fees	3,072,931	3,816,116	743,185	19.5%
142,422	82,448	(59,974)	(72.7%)	Subscriptions & Dues	656,859	675,937	19,078	2.8%
604,640	**878,936**	**274,296**	**31.2%**	**Total Licenses Insurance & Postage**	**4,467,821**	**5,330,109**	**862,288**	**16.2%**
				Supplies & Other Expenses				
2,482	16,566	14,084	85.0%	Office and Other Supplies	41,906	127,239	85,333	67.1%
3,300	2,399	(901)	(37.5%)	Ergonomic Supplies	20,811	49,279	28,468	57.8%
472	6,662	6,190	92.9%	Commissary-Food & Beverage	5,542	25,507	19,965	78.3%
534	0	(534)	0.0%	Miscellaneous Expense	534	0	(534)	0.0%
0	4,150	4,150	100.0%	Member Incentive Expense	4,850	27,650	22,800	82.5%
12,897	0	(12,897)	0.0%	Covid-19 Vaccination Incentive Expense	784,197	4,581,255	3,797,058	82.9%
0	100	100	100.0%	Covid-19 IT Expenses	0	500	500	100.0%
0	166	166	100.0%	Covid-19 Non IT Expenses	797	6,230	5,433	87.2%
19,685	**30,043**	**10,358**	**34.5%**	**Total Supplies & Other Expense**	**858,637**	**4,817,660**	**3,959,023**	**82.2%**
$5,202,885	**$7,649,541**	**$2,446,656**	**32.0%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$47,655,168**	**$60,696,661**	**$13,041,493**	**21.5%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED MARCH 31, 2022

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Network Hardware	IT-FY22-07	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Cisco UCS Blade	IT-FY22-08	$ -		**$ -**	$ 100,000	$ 100,000
	Veeam Backup	IT-FY22-10	$ -		**$ -**	$ 60,000	$ 60,000
	Call Center Hardware	IT-FY22-11	$ -		**$ -**	$ 100,000	$ 100,000
	Network / AV Cabling	IT-FY22-13	$ -		**$ -**	$ 150,000	$ 150,000
Hardware Subtotal			**$ -**	**$ -**	**$ -**	**$ 560,000**	**$ 560,000**
2. Software:							
	Patch Management	AC-FY22-01	$ -		**$ -**	$ 20,000	$ 20,000
	Zerto Licenses (DR - Replication Orchestration)	AC-FY22-02	$ -		**$ -**	$ 50,000	$ 50,000
	Monitoring Software	AC-FY22-03	$ -		**$ -**	$ 40,000	$ 40,000
	Identity and Access Management (Security)	AC-FY22-04	$ -		**$ -**	$ 40,000	$ 40,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 150,000**	**$ 150,000**
3. Building Improvement:							
	1240 Emergency Generator (carryover from FY21)	FA-FY22-06	**$ 227,316**		**$ 227,316**	$ 360,800	$ 133,484
	1240 Electrical Requirements for EV Charging Stations (est.)	FA-FY22-07	$ -		**$ -**	$ 20,000	$ 20,000
	1240 EV Charging stations installation, fees (est. only)	FA-FY22-08	$ -		**$ -**	$ 50,000	$ 50,000
	1240 Seismic Improvements (carryover from FY21)	FA-FY22-09	$ -		**$ -**	$ 50,000	$ 50,000
	Contingency	FA-FY22-16	**$ 6,341**		**$ 6,341**	$ 100,000	$ 93,659
Building Improvement Subtotal			**$ 233,657**	**$ -**	**$ 233,657**	**$ 580,800**	**$ 347,143**
4. Furniture & Equipment:							
	Replace, reconfigure, re-design workstations/add barriers or plexiglass	FA-FY22-20	$ -		**$ -**	$ 125,000	$ 125,000
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ 125,000**	**$ 125,000**
GRAND TOTAL			**$ 233,657**	**$ -**	**$ 233,657**	**$ 1,415,800**	**$ 1,182,143**

5. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 3/31/22	**$ 37,169,134**
Fixed Assets @ Cost - 6/30/21	**$ 36,935,477**
Fixed Assets Acquired YTD	**$ 233,657**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2022

TANGIBLE NET EQUITY (TNE)	Jul-21	Aug-21	QTR. END Sep-21	Oct-21	Nov-21	QTR. END Dec-21	Jan-22	Feb-22	QTR. END Mar-22
Current Month Net Income / (Loss)	$2,645,613	$1,455,041	$370,178	($7,350,897)	$1,314,900	($1,496,048)	$4,122,017	$3,443,438	$8,404,167
YTD Net Income / (Loss)	$2,645,613	$4,100,654	$4,470,832	($2,880,065)	($1,565,165)	($3,061,213)	$1,060,804	$4,504,242	$12,908,409
Actual TNE									
Net Assets	$208,055,654	$209,510,696	$209,880,873	$202,529,977	$203,844,876	$202,348,828	$206,470,845	$209,914,283	$218,318,450
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$208,055,654**	**$209,510,696**	**$209,880,873**	**$202,529,977**	**$203,844,876**	**$202,348,828**	**$206,470,845**	**$209,914,283**	**$218,318,450**
Increase/(Decrease) in Actual TNE	$3,467,237	$1,455,042	$370,177	($7,350,896)	$1,314,899	($1,496,048)	$4,122,017	$3,443,438	$8,404,167
Required TNE[(1)]	**$37,061,269**	**$37,134,762**	**$37,155,961**	**$38,560,140**	**$37,568,385**	**$38,067,278**	**$38,019,954**	**$37,402,476**	**$37,954,630**
Min. Req'd to Avoid Monthly Reporting (130% of Required TNE)	$48,179,650	$48,275,191	$48,302,749	$50,128,181	$48,838,900	$49,487,461	$49,425,940	$48,623,218	$49,341,019
TNE Excess / (Deficiency)	$170,994,385	$172,375,934	$172,724,912	$163,969,837	$166,276,491	$164,281,550	$168,450,891	$172,511,807	$180,363,820
Actual TNE as a Multiple of Required	**5.61**	**5.64**	**5.65**	**5.25**	**5.43**	**5.32**	**5.43**	**5.61**	**5.75**

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

LIQUID TANGIBLE NET EQUITY									
Net Assets	$208,055,654	$209,510,696	$209,880,873	$202,529,977	$203,844,876	$202,348,828	$206,470,845	$209,914,283	$218,318,450
Fixed Assets at Net Book Value	(6,161,088)	(6,073,778)	(6,093,339)	(6,013,994)	(5,931,375)	(5,851,942)	(5,774,186)	(5,821,605)	(5,753,060)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$201,544,566**	**$203,086,918**	**$203,437,534**	**$196,165,983**	**$197,563,501**	**$196,146,886**	**$200,346,659**	**$203,742,678**	**$212,215,390**
Liquid TNE as Multiple of Required	**5.44**	**5.47**	**5.48**	**5.09**	**5.26**	**5.15**	**5.27**	**5.45**	**5.59**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2022

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

	Actual Jul-21	Actual Aug-21	Actual Sep-21	Actual Oct-21	Actual Nov-21	Actual Dec-21	Actual Jan-22	Actual Feb-22	Actual Mar-22	Actual Apr-22	Actual May-22	Actual Jun-22	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	97,179	97,324	97,460	97,636	97,935	98,150	99,337	99,573	99,889				884,483
Adult	41,358	41,519	41,924	42,177	42,623	43,077	44,340	44,588	45,227				386,833
SPD	26,320	26,316	26,330	26,366	26,427	26,450	26,633	26,675	26,820				238,337
ACA OE	99,105	99,783	100,469	100,844	101,508	102,264	105,897	106,553	107,652				924,075
Duals	20,194	20,388	20,535	20,692	20,832	20,964	21,135	21,239	21,349				187,328
Medi-Cal Program	284,156	285,330	286,718	287,715	289,325	290,905	297,342	298,628	300,937				2,621,056
Group Care Program	5,935	5,877	5,914	5,880	5,826	5,823	5,831	5,824	5,850				52,760
Total	**290,091**	**291,207**	**292,632**	**293,595**	**295,151**	**296,728**	**303,173**	**304,452**	**306,787**				**2,673,816**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	131	145	136	176	299	215	1,187	236	316				2,841
Adult	392	161	405	253	446	454	1,263	248	639				4,261
SPD	(3)	(4)	14	36	61	23	183	42	145				497
ACA OE	824	678	686	375	664	756	3,633	656	1,099				9,371
Duals	206	194	147	157	140	132	171	104	110				1,361
Medi-Cal Program	1,550	1,174	1,388	997	1,610	1,580	6,437	1,286	2,309				18,331
Group Care Program	(13)	(58)	37	(34)	(54)	(3)	8	(7)	26				(98)
Total	**1,537**	**1,116**	**1,425**	**963**	**1,556**	**1,577**	**6,445**	**1,279**	**2,335**				**18,233**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	34.2%	34.1%	34.0%	33.9%	33.8%	33.7%	33.4%	33.3%	33.2%				33.7%
Adult % of Medi-Cal	14.6%	14.6%	14.6%	14.7%	14.7%	14.8%	14.9%	14.9%	15.0%				14.8%
SPD % of Medi-Cal	9.3%	9.2%	9.2%	9.2%	9.1%	9.1%	9.0%	8.9%	8.9%				9.1%
ACA OE % of Medi-Cal	34.9%	35.0%	35.0%	35.0%	35.1%	35.2%	35.6%	35.7%	35.8%				35.3%
Duals % of Medi-Cal	7.1%	7.1%	7.2%	7.2%	7.2%	7.2%	7.1%	7.1%	7.1%				7.1%
Medi-Cal Program % of Total	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.1%	98.1%	98.1%				98.0%
Group Care Program % of Total	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	1.9%	1.9%	1.9%				2.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**				**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2022

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

	Actual Jul-21	Actual Aug-21	Actual Sep-21	Actual Oct-21	Actual Nov-21	Actual Dec-21	Actual Jan-22	Actual Feb-22	Actual Mar-22	Actual Apr-22	Actual May-22	Actual Jun-22	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	53,189	53,441	53,246	53,081	53,438	52,288	57,046	51,053	51,767				478,549
Alameda Health System	58,045	57,812	58,060	58,049	58,073	58,590	58,927	60,699	60,974				529,229
	111,234	111,253	111,306	111,130	111,511	110,878	115,973	111,752	112,741				1,007,778
Delegated:													
CFMG	32,217	32,167	32,217	32,232	32,266	32,573	32,689	33,319	33,293				292,973
CHCN	104,433	105,113	106,050	106,808	107,583	109,059	109,878	114,264	115,125				978,313
Kaiser	42,207	42,674	43,059	43,425	43,791	44,218	44,633	45,117	45,628				394,752
Delegated Subtotal	178,857	179,954	181,326	182,465	183,640	185,850	187,200	192,700	194,046				1,666,038
Total	**290,091**	**291,207**	**292,632**	**293,595**	**295,151**	**296,728**	**303,173**	**304,452**	**306,787**				**2,673,816**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(24)	19	53	(176)	381	(633)	5,095	(4,221)	989				1,483
Delegated:													
CFMG	20	(50)	50	15	34	307	116	630	(26)				1,096
CHCN	1,094	680	937	758	775	1,476	819	4,386	861				11,786
Kaiser	447	467	385	366	366	427	415	484	511				3,868
Delegated Subtotal	1,561	1,097	1,372	1,139	1,175	2,210	1,350	5,500	1,346				16,750
Total	**1,537**	**1,116**	**1,425**	**963**	**1,556**	**1,577**	**6,445**	**1,279**	**2,335**				**18,233**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	38.3%	38.2%	38.0%	37.9%	37.8%	37.4%	38.3%	36.7%	36.7%				37.7%
Delegated:													
CFMG	11.1%	11.0%	11.0%	11.0%	10.9%	11.0%	10.8%	10.9%	10.9%				11.0%
CHCN	36.0%	36.1%	36.2%	36.4%	36.5%	36.8%	36.2%	37.5%	37.5%				36.6%
Kaiser	14.5%	14.7%	14.7%	14.8%	14.8%	14.9%	14.7%	14.8%	14.9%				14.8%
Delegated Subtotal	61.7%	61.8%	62.0%	62.1%	62.2%	62.6%	61.7%	63.3%	63.3%				62.3%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**				**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2022

	Budget Jul-21	Budget Aug-21	Budget Sep-21	Budget Oct-21	Budget Nov-21	Budget Dec-21	Budget Jan-22	Budget Feb-22	Budget Mar-22	Budget Apr-22	Budget May-22	Budget Jun-22	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	97,179	97,324	97,460	97,636	97,812	97,988	99,591	98,621	97,661	96,710	95,743	94,811	1,168,536
Adult	41,358	41,519	41,924	42,177	42,430	42,683	43,156	42,733	42,315	41,901	41,482	41,076	504,754
SPD	26,320	26,316	26,330	26,366	26,402	26,438	26,467	26,220	25,976	25,734	26,997	26,745	316,311
ACA OE	99,105	99,783	100,469	100,844	101,219	101,594	101,787	100,845	99,913	98,990	104,404	103,436	1,212,389
Duals	20,194	20,388	20,535	20,692	20,849	21,006	20,796	20,588	20,382	20,178	19,976	19,776	245,360
Medi-Cal Program	284,156	285,330	286,718	287,715	288,712	289,709	291,797	289,007	286,247	283,513	288,602	285,844	3,447,350
Group Care Program	5,935	5,877	5,914	5,880	5,863	5,852	5,852	5,852	5,852	5,852	5,852	5,852	70,433
Total	**290,091**	**291,207**	**292,632**	**293,595**	**294,575**	**295,561**	**297,649**	**294,859**	**292,099**	**289,365**	**294,454**	**291,696**	**3,517,783**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(346)	145	136	176	176	176	1,603	(970)	(960)	(951)	(967)	(932)	(2,714)
Adult	1,053	161	405	253	253	253	473	(423)	(418)	(414)	(419)	(406)	771
SPD	122	(4)	14	36	36	36	29	(247)	(244)	(242)	1,263	(252)	547
ACA OE	3,254	678	686	375	375	375	193	(942)	(932)	(923)	5,414	(968)	7,585
Duals	676	194	147	157	157	157	(210)	(208)	(206)	(204)	(202)	(200)	258
Medi-Cal Program	4,760	1,174	1,388	997	997	997	2,088	(2,790)	(2,760)	(2,734)	5,089	(2,758)	6,448
Group Care Program	(74)	(58)	37	(34)	(17)	(11)	0	0	0	0	0	0	(157)
Total	**4,686**	**1,116**	**1,425**	**963**	**980**	**986**	**2,088**	**(2,790)**	**(2,760)**	**(2,734)**	**5,089**	**(2,758)**	**6,291**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	34.2%	34.1%	34.0%	33.9%	33.9%	33.8%	34.1%	34.1%	34.1%	34.1%	33.2%	33.2%	33.9%
Adult % of Medi-Cal	14.6%	14.6%	14.6%	14.7%	14.7%	14.7%	14.8%	14.8%	14.8%	14.8%	14.4%	14.4%	14.6%
SPD % of Medi-Cal	9.3%	9.2%	9.2%	9.2%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.4%	9.4%	9.2%
ACA OE % of Medi-Cal	34.9%	35.0%	35.0%	35.0%	35.1%	35.1%	34.9%	34.9%	34.9%	34.9%	36.2%	36.2%	35.2%
Duals % of Medi-Cal	7.1%	7.1%	7.2%	7.2%	7.2%	7.3%	7.1%	7.1%	7.1%	7.1%	6.9%	6.9%	7.1%
Medi-Cal Program % of Total	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
Group Care Program % of Total	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2022

	Budget Jul-21	Budget Aug-21	Budget Sep-21	Budget Oct-21	Budget Nov-21	Budget Dec-21	Budget Jan-22	Budget Feb-22	Budget Mar-22	Budget Apr-22	Budget May-22	Budget Jun-22	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted	111,234	111,253	111,306	111,130	111,539	111,951	112,449	111,411	110,386	109,370	112,142	111,106	1,335,277
Delegated:													
CFMG	32,217	32,167	32,217	32,232	32,294	32,356	32,848	32,529	32,214	31,902	31,716	31,408	386,100
CHCN	104,433	105,113	106,050	106,808	107,165	107,525	108,250	107,240	106,240	105,250	107,230	106,231	1,277,535
Kaiser	42,207	42,674	43,059	43,425	43,577	43,729	44,102	43,679	43,259	42,843	43,366	42,951	518,871
Delegated Subtotal	178,857	179,954	181,326	182,465	183,036	183,610	185,200	183,448	181,713	179,995	182,312	180,590	2,182,506
Total	**290,091**	**291,207**	**292,632**	**293,595**	**294,575**	**295,561**	**297,649**	**294,859**	**292,099**	**289,365**	**294,454**	**291,696**	**3,517,783**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(81)	19	53	(176)	409	412	498	(1,038)	(1,025)	(1,016)	2,772	(1,036)	(209)
Delegated:													
CFMG	(159)	(50)	50	15	62	62	492	(319)	(315)	(312)	(186)	(308)	(968)
CHCN	1,533	680	937	758	357	360	725	(1,010)	(1,000)	(990)	1,980	(999)	3,331
Kaiser	3,394	467	385	366	152	152	373	(423)	(420)	(416)	523	(415)	4,138
Delegated Subtotal	4,768	1,097	1,372	1,139	571	574	1,590	(1,752)	(1,735)	(1,718)	2,317	(1,722)	6,501
Total	**4,686**	**1,116**	**1,425**	**963**	**980**	**986**	**2,088**	**(2,790)**	**(2,760)**	**(2,734)**	**5,089**	**(2,758)**	**6,291**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	38.3%	38.2%	38.0%	37.9%	37.9%	37.9%	37.8%	37.8%	37.8%	37.8%	38.1%	38.1%	38.0%
Delegated:													
CFMG	11.1%	11.0%	11.0%	11.0%	11.0%	10.9%	11.0%	11.0%	11.0%	11.0%	10.8%	10.8%	11.0%
CHCN	36.0%	36.1%	36.2%	36.4%	36.4%	36.4%	36.4%	36.4%	36.4%	36.4%	36.4%	36.4%	36.3%
Kaiser	14.5%	14.7%	14.7%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.8%	14.7%	14.7%	14.7%
Delegated Subtotal	61.7%	61.8%	62.0%	62.1%	62.1%	62.1%	62.2%	62.2%	62.2%	62.2%	61.9%	61.9%	62.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2022

	Variance Jul-21	Variance Aug-21	Variance Sep-21	Variance Oct-21	Variance Nov-21	Variance Dec-21	Variance Jan-22	Variance Feb-22	Variance Mar-22	Variance Apr-22	Variance May-22	Variance Jun-22	Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	123	162	(254)	952	2,228				3,211
Adult	0	0	0	0	193	394	1,184	1,855	2,912				6,538
SPD	0	0	0	0	25	12	166	455	844				1,502
ACA OE	0	0	0	0	289	670	4,110	5,708	7,739				18,516
Duals	0	0	0	0	(17)	(42)	339	651	967				1,898
Medi-Cal Program	0	0	0	0	613	1,196	5,545	9,621	14,690				31,665
Group Care Program	0	0	0	0	(37)	(29)	(21)	(28)	(2)				(117)
Total	**0**	**0**	**0**	**0**	**576**	**1,167**	**5,524**	**9,593**	**14,688**				**31,548**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	0	0	0	0	(28)	(1,073)	3,524	341	2,355				5,119
Delegated:													
CFMG	0	0	0	0	(28)	217	(159)	790	1,079				1,899
CHCN	0	0	0	0	418	1,534	1,628	7,024	8,885				19,489
Kaiser	0	0	0	0	214	489	531	1,438	2,369				5,041
Delegated Subtotal	0	0	0	0	604	2,240	2,000	9,252	12,333				26,429
Total	**0**	**0**	**0**	**0**	**576**	**1,167**	**5,524**	**9,593**	**14,688**				**31,548**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2022

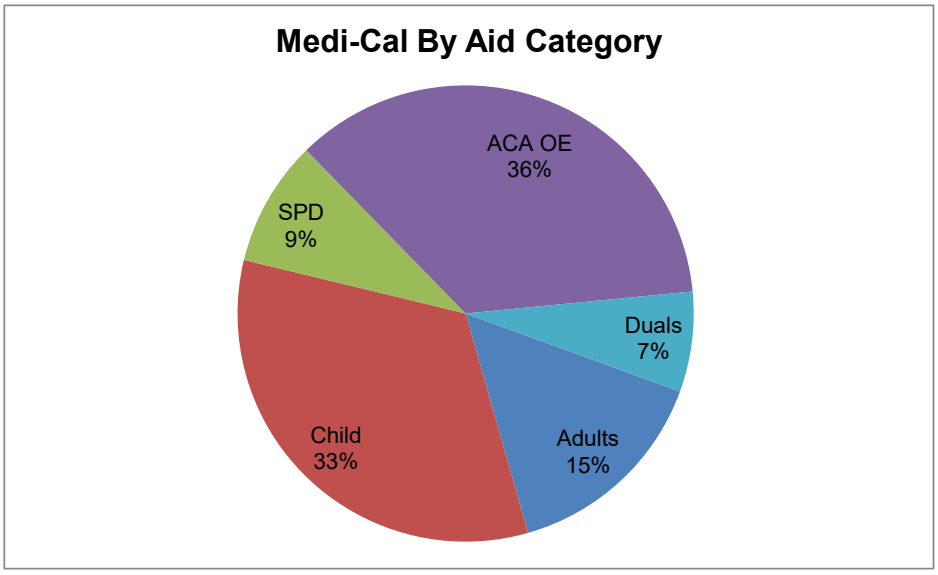
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
($5,030,484)	$1,817,258	$6,847,742	376.8%	PCP-Capitation	$9,954,568	$16,651,372	$6,696,804	40.2%
10,161,981	3,152,517	(7,009,464)	(222.3%)	PCP-Capitation - FQHC	34,345,597	27,414,119	(6,931,478)	(25.3%)
289,140	271,908	(17,232)	(6.3%)	Specialty-Capitation	2,543,976	2,502,588	(41,388)	(1.7%)
3,336,040	3,293,647	(42,393)	(1.3%)	Specialty-Capitation FQHC	28,464,376	28,570,378	106,002	0.4%
379,098	362,254	(16,844)	(4.6%)	Laboratory-Capitation	3,316,841	3,277,671	(39,170)	(1.2%)
919,896	876,297	(43,599)	(5.0%)	Transportation (Ambulance)-Cap	8,371,439	8,020,612	(350,827)	(4.4%)
223,651	213,839	(9,812)	(4.6%)	Vision Cap	1,956,543	1,935,730	(20,813)	(1.1%)
84,239	79,218	(5,021)	(6.3%)	CFMG Capitation	741,267	729,170	(12,097)	(1.7%)
167,847	165,504	(2,343)	(1.4%)	Anc IPA Admin Capitation FQHC	1,433,916	1,437,373	3,457	0.2%
10,378,548	9,992,262	(386,286)	(3.9%)	Kaiser Capitation	95,129,954	94,929,118	(200,836)	(0.2%)
2,276,269	757,465	(1,518,804)	(200.5%)	BHT Supplemental Expense	5,825,291	6,620,875	795,584	12.0%
0	0	0	0.0%	Hep-C Supplemental Expense	102,679	100,877	(1,802)	(1.8%)
374,937	483,422	108,485	22.4%	Maternity Supplemental Expense	2,998,338	3,676,040	677,702	18.4%
555,363	569,848	14,485	2.5%	DME - Cap	4,913,283	5,049,121	135,838	2.7%
24,116,525	**22,035,439**	**(2,081,086)**	**(9.4%)**	**5-TOTAL CAPITATED EXPENSES**	**200,098,068**	**200,915,044**	**816,976**	**0.4%**
				FEE FOR SERVICE MEDICAL EXPENSES:				
(3,994,691)	0	3,994,691	0.0%	IBNP-Inpatient Services	5,732,953	0	(5,732,953)	0.0%
(119,842)	0	119,842	0.0%	IBNP-Settlement (IP)	171,984	0	(171,984)	0.0%
(319,575)	0	319,575	0.0%	IBNP-Claims Fluctuation (IP)	458,633	0	(458,633)	0.0%
31,485,631	26,142,482	(5,343,149)	(20.4%)	Inpatient Hospitalization-FFS	212,121,935	241,381,089	29,259,154	12.1%
1,677,293	0	(1,677,293)	0.0%	IP OB - Mom & NB	11,072,448	0	(11,072,448)	0.0%
491,753	0	(491,753)	0.0%	IP Behavioral Health	2,051,591	0	(2,051,591)	0.0%
1,039,057	1,297,530	258,473	19.9%	IP - Long Term Care	10,036,771	6,529,944	(3,506,827)	(53.7%)
1,447,181	0	(1,447,181)	0.0%	IP - Facility Rehab FFS	7,375,464	0	(7,375,464)	0.0%
31,706,807	**27,440,012**	**(4,266,795)**	**(15.5%)**	**6-Inpatient Hospital & SNF FFS Expense**	**249,021,779**	**247,911,033**	**(1,110,746)**	**(0.4%)**
(262,115)	0	262,115	0.0%	IBNP-PCP	(250,848)	0	250,848	0.0%
(7,863)	0	7,863	0.0%	IBNP-Settlement (PCP)	(7,522)	0	7,522	0.0%
(20,968)	0	20,968	0.0%	IBNP-Claims Fluctuation (PCP)	(20,065)	0	20,065	0.0%
1,302	0	(1,302)	0.0%	Telemedicine FFS	8,820	0	(8,820)	0.0%
1,484,403	1,305,309	(179,094)	(13.7%)	Primary Care Non-Contracted FF	10,766,662	24,273,849	13,507,187	55.6%
68,745	80,679	11,934	14.8%	PCP FQHC FFS	458,007	406,242	(51,765)	(12.7%)
1,938,086	3,143,515	1,205,429	38.3%	Prop 56 Direct Payment Expenses	16,576,395	15,777,897	(798,498)	(5.1%)
13,393	0	(13,393)	0.0%	Prop 56 Hyde Direct Payment Expenses	39,917	0	(39,917)	0.0%
75,586	0	(75,586)	0.0%	Prop 56-Trauma Expense	678,411	0	(678,411)	0.0%
97,724	0	(97,724)	0.0%	Prop 56-Dev. Screening Exp.	892,422	0	(892,422)	0.0%
649,243	0	(649,243)	0.0%	Prop 56-Fam. Planning Exp.	5,764,490	0	(5,764,490)	0.0%
573,408	0	(573,408)	0.0%	Prop 56-Value Based Purchasing	4,990,573	0	(4,990,573)	0.0%
4,610,944	**4,529,503**	**(81,441)**	**(1.8%)**	**7-Primary Care Physician FFS Expense**	**39,897,262**	**40,457,988**	**560,726**	**1.4%**
(849,612)	0	849,612	0.0%	IBNP-Specialist	81,373	0	(81,373)	0.0%
3,045,405	4,611,234	1,565,829	34.0%	Specialty Care-FFS	21,865,425	41,990,945	20,125,520	47.9%
110,067	0	(110,067)	0.0%	Anesthesiology - FFS	1,013,469	0	(1,013,469)	0.0%
938,184	0	(938,184)	0.0%	Spec Rad Therapy - FFS	6,764,567	0	(6,764,567)	0.0%
132,592	0	(132,592)	0.0%	Obstetrics-FFS	1,016,292	0	(1,016,292)	0.0%
227,644	0	(227,644)	0.0%	Spec IP Surgery - FFS	2,457,907	0	(2,457,907)	0.0%
601,350	0	(601,350)	0.0%	Spec OP Surgery - FFS	4,712,677	0	(4,712,677)	0.0%
479,914	0	(479,914)	0.0%	Spec IP Physician	3,509,297	0	(3,509,297)	0.0%
50,448	4,901	(45,547)	(929.3%)	SCP FQHC FFS	389,537	24,738	(364,799)	(1,474.6%)
(25,488)	0	25,488	0.0%	IBNP-Settlement (SCP)	2,440	0	(2,440)	0.0%
(67,967)	0	67,967	0.0%	IBNP-Claims Fluctuation (SCP)	6,510	0	(6,510)	0.0%
4,642,537	**4,616,135**	**(26,402)**	**(0.6%)**	**8-Specialty Care Physician Expense**	**41,819,494**	**42,015,683**	**196,189**	**0.5%**
(212,612)	0	212,612	0.0%	IBNP-Ancillary	1,198,407	0	(1,198,407)	0.0%
(6,378)	0	6,378	0.0%	IBNP Settlement (ANC)	35,953	0	(35,953)	0.0%
(17,009)	0	17,009	0.0%	IBNP Claims Fluctuation (ANC)	95,872	0	(95,872)	0.0%
510,329	0	(510,329)	0.0%	Acupuncture/Biofeedback	3,925,012	0	(3,925,012)	0.0%
165,151	0	(165,151)	0.0%	Hearing Devices	858,694	0	(858,694)	0.0%
42,227	0	(42,227)	0.0%	Imaging/MRI/CT Global	294,167	0	(294,167)	0.0%
50,729	0	(50,729)	0.0%	Vision FFS	430,231	0	(430,231)	0.0%
27,843	0	(27,843)	0.0%	Family Planning	205,214	0	(205,214)	0.0%
1,361,502	0	(1,361,502)	0.0%	Laboratory-FFS	7,011,752	0	(7,011,752)	0.0%
128,982	0	(128,982)	0.0%	ANC Therapist	848,289	0	(848,289)	0.0%
0	0	0	0.0%	ANC Diagnostic Procedures	(166)	0	166	0.0%
322,233	0	(322,233)	0.0%	Transportation (Ambulance)-FFS	2,679,729	0	(2,679,729)	0.0%
28,424	0	(28,424)	0.0%	Transportation (Other)-FFS	1,127,623	0	(1,127,623)	0.0%
533,227	0	(533,227)	0.0%	Hospice	4,720,120	0	(4,720,120)	0.0%
599,993	0	(599,993)	0.0%	Home Health Services	5,919,903	0	(5,919,903)	0.0%
0	3,421,529	3,421,529	100.0%	Other Medical-FFS	0	35,043,746	35,043,746	100.0%

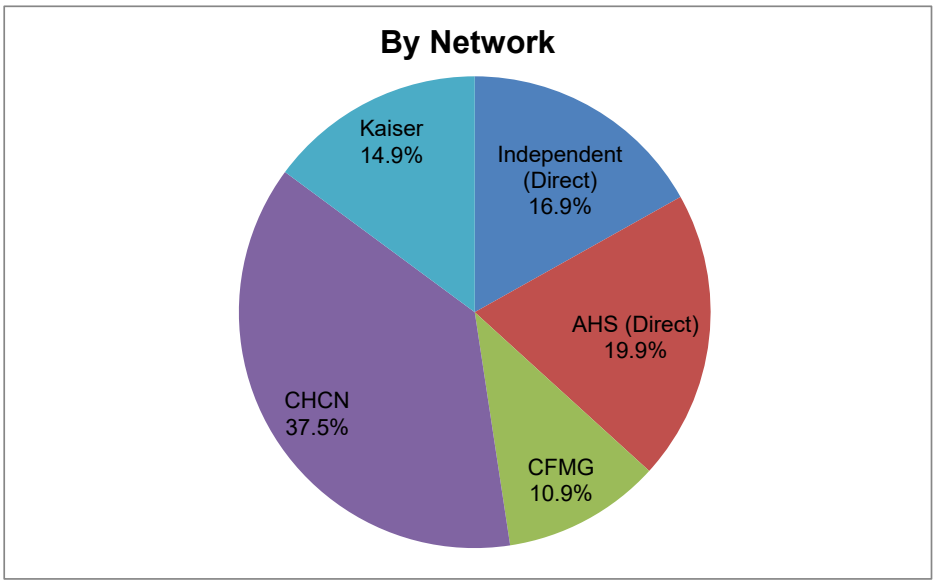
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
($129,131)	$0	$129,131	0.0%	HMS Medical Refunds	($260,107)	$0	$260,107	0.0%
(962)	0	962	0.0%	Refunds-Medical Payments	75	0	(75)	0.0%
597,711	0	(597,711)	0.0%	DME & Medical Supplies	4,283,586	0	(4,283,586)	0.0%
0	0	0	0.0%	Denials	167	0	(167)	0.0%
625,997	581,334	(44,663)	(7.7%)	GEMT Direct Payment Expense	5,365,255	2,928,203	(2,437,052)	(83.2%)
525,101	0	(525,101)	0.0%	Community Based Adult Services (CBAS)	4,101,123	0	(4,101,123)	0.0%
846,570	711,131	(135,439)	(19.0%)	ECM Base FFS Ancillary	2,523,691	2,152,176	(371,515)	(17.3%)
40	9,999	9,959	99.6%	ECM Outreach FFS Ancillary	40	30,000	29,960	99.9%
398,608	398,608	0	0.0%	CS - Housing Deposits FFS Ancillary	1,195,823	1,195,824	0	0.0%
407,667	407,667	0	0.0%	CS - Housing Tenancy FFS Ancillary	1,223,001	1,223,001	0	0.0%
298,956	298,956	0	0.0%	CS - Housing Navigation Services FFS Ancillary	896,868	896,868	0	0.0%
241,313	241,312	(1)	0.0%	CS - Medical Respite FFS Ancillary	723,938	723,936	(2)	0.0%
230,081	230,081	0	0.0%	CS - Medically Tailored Meals FFS Ancillary	690,244	690,243	(1)	0.0%
35,244	35,244	0	0.0%	CS - Asthma Remediation FFS Ancillary	105,733	105,732	(1)	0.0%
7,611,836	**6,335,861**	**(1,275,975)**	**(20.1%)**	**9-Ancillary Medical Expense**	**50,200,237**	**44,989,729**	**(5,210,509)**	**(11.6%)**
(1,091,554)	0	1,091,554	0.0%	IBNP-Outpatient	955,745	0	(955,745)	0.0%
(32,746)	0	32,746	0.0%	IBNP Settlement (OP)	28,674	0	(28,674)	0.0%
(87,325)	0	87,325	0.0%	IBNP Claims Fluctuation (OP)	76,460	0	(76,460)	0.0%
1,672,328	8,145,410	6,473,082	79.5%	Out-Patient FFS	11,664,296	75,421,741	63,757,445	84.5%
1,525,577	0	(1,525,577)	0.0%	OP Ambul Surgery - FFS	11,748,802	0	(11,748,802)	0.0%
1,255,095	0	(1,255,095)	0.0%	OP Fac Imaging Services-FFS	10,102,206	0	(10,102,206)	0.0%
1,050,455	0	(1,050,455)	0.0%	Behav Health - FFS	15,193,581	0	(15,193,581)	0.0%
1,329,348	0	(1,329,348)	0.0%	Behavioral Health Therapy - FFS	3,088,473	0	(3,088,473)	0.0%
516,155	0	(516,155)	0.0%	OP Facility - Lab FFS	4,213,145	0	(4,213,145)	0.0%
128,676	0	(128,676)	0.0%	OP Facility - Cardio FFS	914,569	0	(914,569)	0.0%
50,755	0	(50,755)	0.0%	OP Facility - PT/OT/ST FFS	431,689	0	(431,689)	0.0%
1,578,741	0	(1,578,741)	0.0%	OP Facility - Dialysis FFS	15,031,902	0	(15,031,902)	0.0%
7,895,506	**8,145,410**	**249,904**	**3.1%**	**10-Outpatient Medical Expense Medical Expense**	**73,449,542**	**75,421,741**	**1,972,199**	**2.6%**
(364,421)	0	364,421	0.0%	IBNP-Emergency	1,068,008	0	(1,068,008)	0.0%
(10,932)	0	10,932	0.0%	IBNP Settlement (ER)	32,039	0	(32,039)	0.0%
(29,153)	0	29,153	0.0%	IBNP Claims Fluctuation (ER)	85,441	0	(85,441)	0.0%
693,094	0	(693,094)	0.0%	Special ER Physician-FFS	5,606,562	0	(5,606,562)	0.0%
4,417,573	4,290,091	(127,482)	(3.0%)	ER-Facility	34,344,766	40,242,095	5,897,329	14.7%
4,706,160	**4,290,091**	**(416,069)**	**(9.7%)**	**11-Emergency Expense**	**41,136,816**	**40,242,095**	**(894,721)**	**(2.2%)**
(328,258)	0	328,258	0.0%	IBNP-Pharmacy	609,471	0	(609,471)	0.0%
(9,848)	0	9,848	0.0%	IBNP Settlement (RX)	18,286	0	(18,286)	0.0%
(26,260)	0	26,260	0.0%	IBNP Claims Fluctuation (RX)	48,760	0	(48,760)	0.0%
870,110	359,493	(510,617)	(142.0%)	Pharmacy-FFS	71,571,327	70,413,989	(1,157,338)	(1.6%)
6,024,048	4,753,539	(1,270,509)	(26.7%)	Pharmacy- Non-PBM FFS-Other Anc	45,671,281	42,531,370	(3,139,911)	(7.4%)
(52,092)	0	52,092	0.0%	HMS RX Refunds	(725,324)	0	725,324	0.0%
0	(18,132)	(18,132)	100.0%	Pharmacy-Rebate	(3,425,129)	(3,482,552)	(57,423)	1.6%
6,477,699	**5,094,900**	**(1,382,799)**	**(27.1%)**	**12-Pharmacy Expense**	**113,768,672**	**109,462,807**	**(4,305,865)**	**(3.9%)**
67,651,489	**60,451,912**	**(7,199,578)**	**(11.9%)**	**13-TOTAL FFS MEDICAL EXPENSES**	**609,293,803**	**600,501,076**	**(8,792,727)**	**(1.5%)**
0	(47,204)	(47,204)	100.0%	Clinical Vacancy	0	(291,767)	(291,767)	100.0%
80,939	121,494	40,555	33.4%	Quality Analytics	673,538	745,469	71,931	9.6%
421,878	519,109	97,231	18.7%	Health Plan Services Department Total	3,648,708	4,325,291	676,583	15.6%
340,948	432,377	91,429	21.1%	Case & Disease Management Department Total	4,752,643	5,036,401	283,758	5.6%
1,836,923	240,318	(1,596,605)	(664.4%)	Medical Services Department Total	4,461,823	1,595,925	(2,865,898)	(179.6%)
340,786	754,725	413,939	54.8%	Quality Management Department Total	4,071,222	5,993,210	1,921,988	32.1%
54,507	125,552	71,045	56.6%	HCS Behavioral Health Department Total	277,636	471,936	194,300	41.2%
167,141	128,037	(39,104)	(30.5%)	Pharmacy Services Department Total	1,072,268	1,152,087	79,819	6.9%
119,615	54,264	(65,351)	(120.4%)	Regulatory Readiness Total	373,587	382,892	9,305	2.4%
3,362,737	**2,328,672**	**(1,034,065)**	**(44.4%)**	**14-Other Benefits & Services**	**19,331,426**	**19,411,444**	**80,018**	**0.4%**
				Reinsurance Expense				
(498,200)	(402,827)	95,373	(23.7%)	Reinsurance Recoveries	(5,395,385)	(4,235,884)	1,159,501	(27.4%)
560,440	537,102	(23,338)	(4.3%)	Stop-Loss Expense	4,918,575	4,871,934	(46,641)	(1.0%)
62,239	**134,275**	**72,036**	**53.6%**	**15-Reinsurance Expense**	**(476,809)**	**636,050**	**1,112,859**	**175.0%**
95,192,991	**84,950,298**	**(10,242,694)**	**(12.1%)**	**17-TOTAL MEDICAL EXPENSES**	**828,246,487**	**821,463,614**	**(6,782,873)**	**(0.8%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**Mar 2022**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	45,228	15%	9,012	9,246	713	18,055	8,202
Child	99,888	33%	7,698	9,048	30,390	34,607	18,145
SPD	26,823	9%	8,149	4,218	1,049	11,345	2,062
ACA OE	107,648	36%	16,358	35,266	1,141	40,823	14,060
Duals	21,350	7%	8,146	2,324	-	7,721	3,159
Medi-Cal	300,937		49,363	60,102	33,293	112,551	45,628
Group Care	5,850		2,404	872	-	2,574	-
Total	**306,787**	**100%**	**51,767**	**60,974**	**33,293**	**115,125**	**45,628**
Medi-Cal %	98.1%		95.4%	98.6%	100.0%	97.8%	100.0%
Group Care %	1.9%		4.6%	1.4%	0.0%	2.2%	0.0%
	Network Distribution		*16.9%*	*19.9%*	*10.9%*	*37.5%*	*14.9%*
			% Direct:	**37%**		**% Delegated:**	**63%**

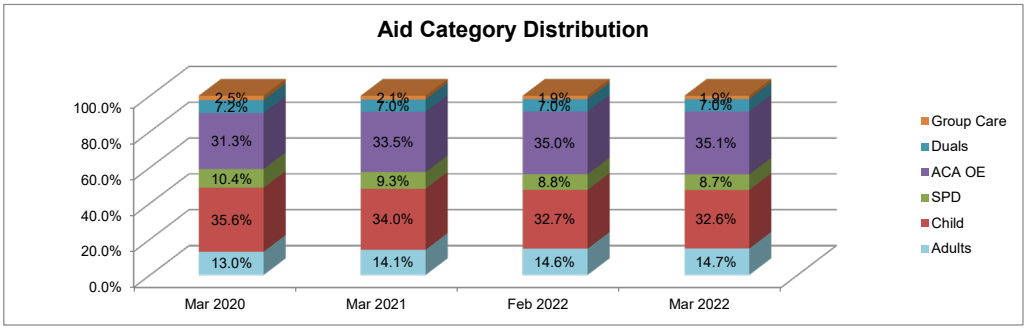




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

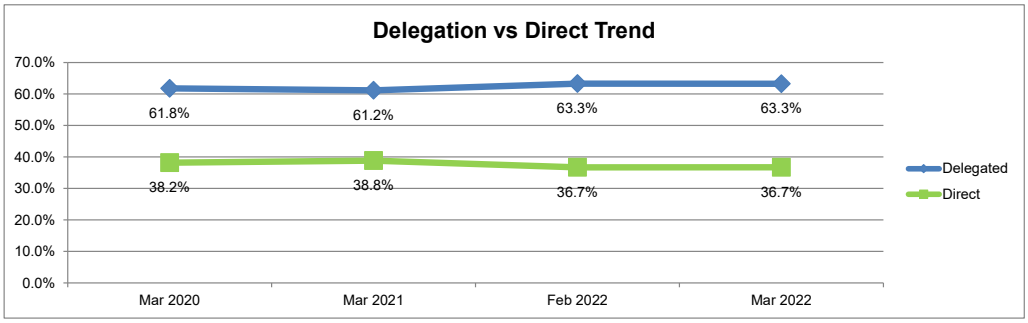
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020 to Mar 2021	Mar 2021 to Mar 2022	Feb 2022 to Mar 2022
Adults	32,017	39,649	44,588	45,228	13.0%	14.1%	14.6%	14.7%	23.8%	14.1%	1.4%
Child	87,919	95,692	99,573	99,888	35.6%	34.0%	32.7%	32.6%	8.8%	4.4%	0.3%
SPD	25,778	26,234	26,675	26,823	10.4%	9.3%	8.8%	8.7%	1.8%	2.2%	0.6%
ACA OE	77,199	94,473	106,553	107,648	31.3%	33.5%	35.0%	35.1%	22.4%	13.9%	1.0%
Duals	17,869	19,596	21,239	21,350	7.2%	7.0%	7.0%	7.0%	9.7%	9.0%	0.5%
Medi-Cal Total	240,782	275,644	298,628	300,937	97.5%	97.9%	98.1%	98.1%	14.5%	9.2%	0.8%
Group Care	6,125	5,993	5,824	5,850	2.5%	2.1%	1.9%	1.9%	-2.2%	-2.4%	0.4%
Total	**246,907**	**281,637**	**304,452**	**306,787**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**14.1%**	**8.9%**	**0.8%**



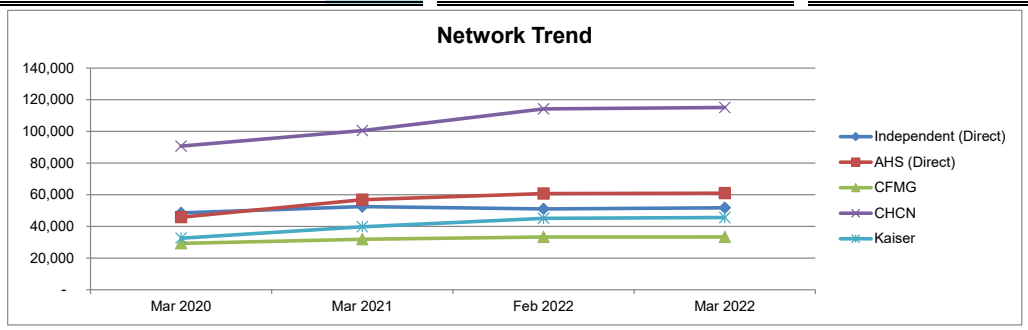
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020 to Mar 2021	Mar 2021 to Mar 2022	Feb 2022 to Mar 2022
Delegated	152,555	172,258	192,700	194,046	61.8%	61.2%	63.3%	63.3%	12.9%	12.6%	0.7%
Direct	94,352	109,379	111,752	112,741	38.2%	38.8%	36.7%	36.7%	15.9%	3.1%	0.9%
Total	**246,907**	**281,637**	**304,452**	**306,787**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**14.1%**	**8.9%**	**0.8%**



Network Trend

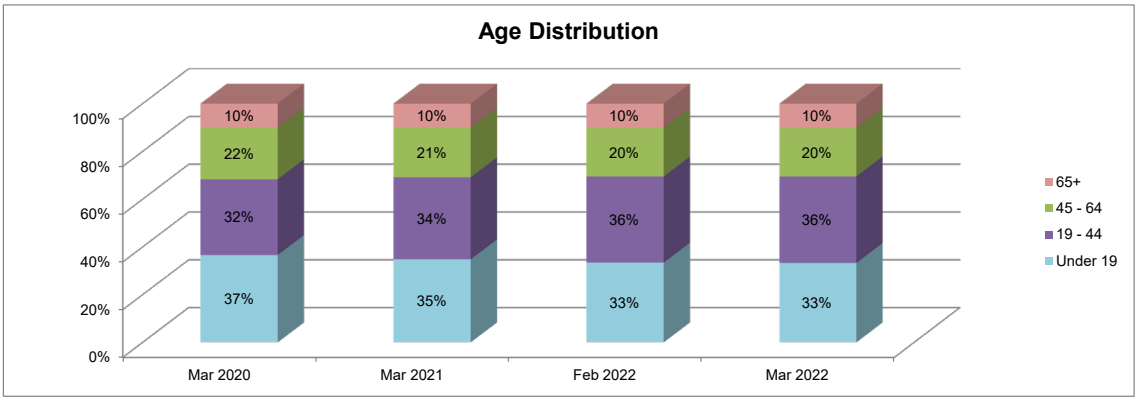
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020 to Mar 2021	Mar 2021 to Mar 2022	Feb 2022 to Mar 2022
Independent (Direct)	48,546	52,524	51,053	51,767	19.7%	18.6%	16.8%	16.9%	8.2%	-1.4%	1.4%
AHS (Direct)	45,806	56,855	60,699	60,974	18.6%	20.2%	19.9%	19.9%	24.1%	7.2%	0.5%
CFMG	29,278	31,939	33,319	33,293	11.9%	11.3%	10.9%	10.9%	9.1%	4.2%	-0.1%
CHCN	90,726	100,522	114,264	115,125	36.7%	35.7%	37.5%	37.5%	10.8%	14.5%	0.8%
Kaiser	32,551	39,797	45,117	45,628	13.2%	14.1%	14.8%	14.9%	22.3%	14.7%	1.1%
Total	**246,907**	**281,637**	**304,452**	**306,787**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**14.1%**	**8.9%**	**0.8%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

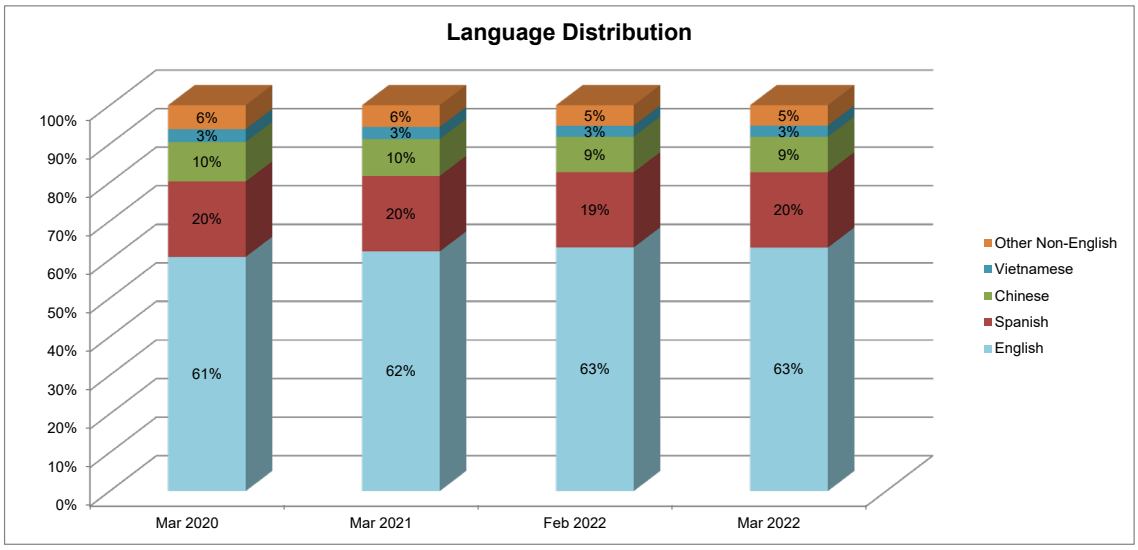
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020 to Mar 2021	Mar 2021 to Mar 2022	Feb 2022 to Mar 2022
Under 19	90,475	98,054	101,831	102,146	37%	35%	33%	33%	8%	4%	0%
19 - 44	78,297	96,750	109,790	111,172	32%	34%	36%	36%	24%	15%	1%
45 - 64	53,374	58,732	61,957	62,347	22%	21%	20%	20%	10%	6%	1%
65+	24,761	28,101	30,874	31,122	10%	10%	10%	10%	13%	11%	1%
Total	**246,907**	**281,637**	**304,452**	**306,787**	**100%**	**100%**	**100%**	**100%**	**14%**	**9%**	**1%**



Language Trend

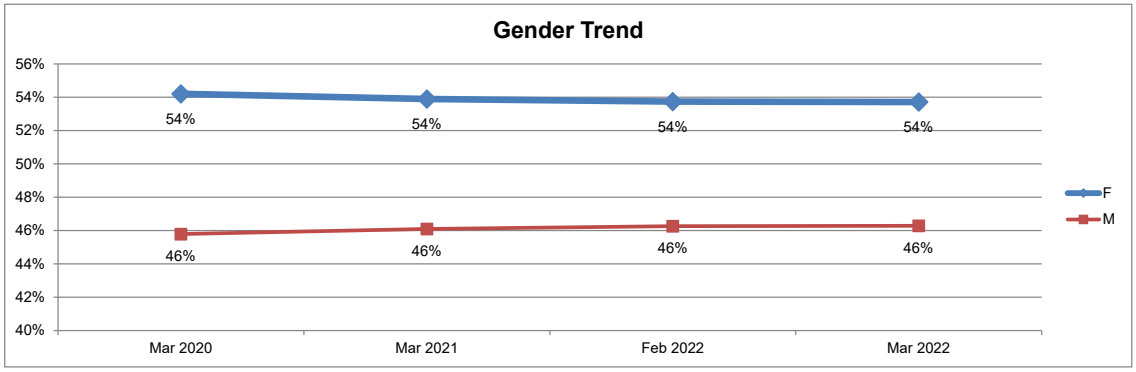
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020 to Mar 2021	Mar 2021 to Mar 2022	Feb 2022 to Mar 2022
English	149,817	174,804	192,183	193,534	61%	62%	63%	63%	17%	11%	1%
Spanish	48,269	55,172	59,339	59,913	20%	20%	19%	20%	14%	9%	1%
Chinese	25,274	26,957	28,043	28,316	10%	10%	9%	9%	7%	5%	1%
Vietnamese	8,259	8,791	8,819	8,888	3%	3%	3%	3%	6%	1%	1%
Other Non-English	15,288	15,913	16,068	16,136	6%	6%	5%	5%	4%	1%	0%
Total	**246,907**	**281,637**	**304,452**	**306,787**	**100%**	**100%**	**100%**	**100%**	**14%**	**9%**	**1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

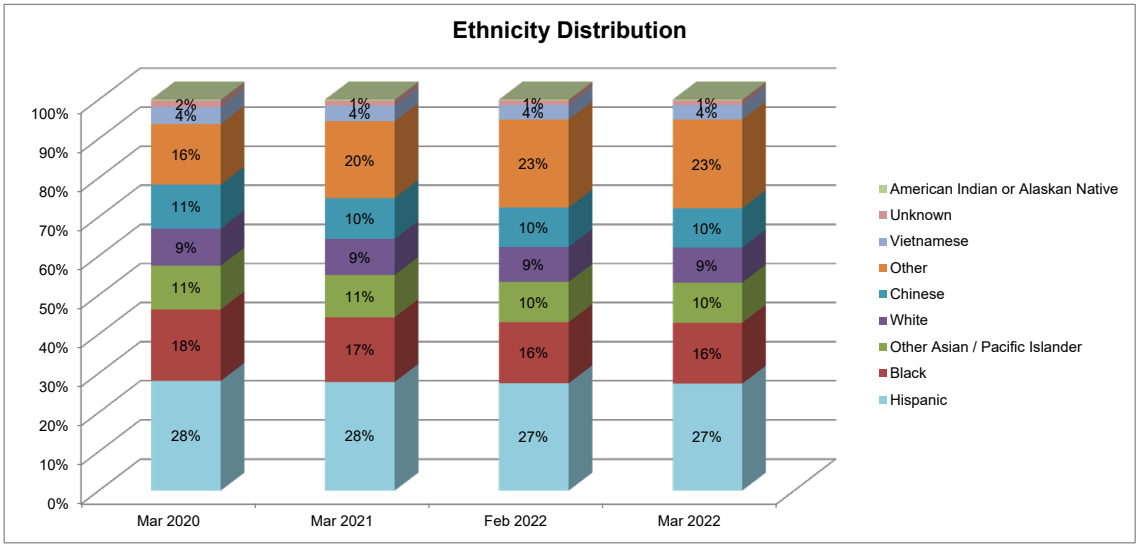
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020 to Mar 2021	Mar 2021 to Mar 2022	Feb 2022 to Mar 2022
F	133,844	151,807	163,606	164,784	54%	54%	54%	54%	13%	9%	1%
M	113,063	129,830	140,846	142,003	46%	46%	46%	46%	15%	9%	1%
Total	**246,907**	**281,637**	**304,452**	**306,787**	**100%**	**100%**	**100%**	**100%**	**14%**	**9%**	**1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020	Mar 2021	Feb 2022	Mar 2022	Mar 2020 to Mar 2021	Mar 2021 to Mar 2022	Feb 2022 to Mar 2022
Hispanic	69,186	78,149	83,453	83,813	28%	28%	27%	27%	13%	7%	0%
Black	45,120	46,663	47,596	47,769	18%	17%	16%	16%	3%	2%	0%
Other Asian / Pacific Islander	27,695	30,465	31,340	31,540	11%	11%	10%	10%	10%	4%	1%
White	23,400	25,931	27,221	27,426	9%	9%	9%	9%	11%	6%	1%
Chinese	27,724	29,519	30,703	30,921	11%	10%	10%	10%	6%	5%	1%
Other	38,390	55,311	68,575	69,621	16%	20%	23%	23%	44%	26%	2%
Vietnamese	10,722	11,298	11,400	11,419	4%	4%	4%	4%	5%	1%	0%
Unknown	4,103	3,680	3,520	3,633	2%	1%	1%	1%	-10%	-1%	3%
American Indian or Alaskan Native	567	621	644	645	0%	0%	0%	0%	10%	4%	0%
Total	**246,907**	**281,637**	**304,452**	**306,787**	**100%**	**100%**	**100%**	**100%**	**14%**	**9%**	**1%**



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

Medi-Cal By City

City	Mar 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	118,520	39%	12,801	28,794	14,114	49,862	12,949
Hayward	46,737	16%	7,028	10,251	5,364	15,773	8,321
Fremont	27,224	9%	9,771	4,231	935	7,704	4,583
San Leandro	27,167	9%	4,373	4,163	3,427	10,254	4,950
Union City	12,646	4%	3,884	2,030	518	3,787	2,427
Alameda	11,579	4%	2,111	1,863	1,642	4,087	1,876
Berkeley	11,307	4%	1,647	1,649	1,322	4,957	1,732
Livermore	9,231	3%	1,017	767	1,893	3,864	1,690
Newark	6,913	2%	1,799	2,231	224	1,340	1,319
Castro Valley	7,550	3%	1,297	1,216	1,097	2,375	1,565
San Lorenzo	6,428	2%	866	1,106	737	2,357	1,362
Pleasanton	5,012	2%	943	435	523	2,249	862
Dublin	5,398	2%	986	449	675	2,269	1,019
Emeryville	2,045	1%	334	400	307	646	358
Albany	1,886	1%	275	218	359	642	392
Piedmont	366	0%	49	98	23	98	98
Sunol	59	0%	13	10	5	18	13
Antioch	22	0%	10	6	3	2	1
Other	847	0%	159	185	125	267	111
Total	**300,937**	**100%**	**49,363**	**60,102**	**33,293**	**112,551**	**45,628**

Group Care By City

City	Mar 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,937	33%	473	360	-	1,104	-
Hayward	643	11%	320	138	-	185	-
Fremont	627	11%	463	49	-	115	-
San Leandro	585	10%	228	90	-	267	-
Union City	327	6%	227	31	-	69	-
Alameda	277	5%	111	18	-	148	-
Berkeley	167	3%	49	9	-	109	-
Livermore	80	1%	28	1	-	51	-
Newark	146	2%	86	38	-	22	-
Castro Valley	186	3%	84	19	-	83	-
San Lorenzo	122	2%	52	14	-	56	-
Pleasanton	58	1%	22	3	-	33	-
Dublin	107	2%	37	9	-	61	-
Emeryville	34	1%	11	6	-	17	-
Albany	15	0%	7	1	-	7	-
Piedmont	14	0%	4	-	-	10	-
Sunol	-	0%	-	-	-	-	-
Antioch	27	0%	6	8	-	13	-
Other	498	9%	196	78	-	224	-
Total	**5,850**	**100%**	**2,404**	**872**	**-**	**2,574**	**-**

Total By City

City	Mar 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	120,457	39%	13,274	29,154	14,114	50,966	12,949
Hayward	47,380	15%	7,348	10,389	5,364	15,958	8,321
Fremont	27,851	9%	10,234	4,280	935	7,819	4,583
San Leandro	27,752	9%	4,601	4,253	3,427	10,521	4,950
Union City	12,973	4%	4,111	2,061	518	3,856	2,427
Alameda	11,856	4%	2,222	1,881	1,642	4,235	1,876
Berkeley	11,474	4%	1,696	1,658	1,322	5,066	1,732
Livermore	9,311	3%	1,045	768	1,893	3,915	1,690
Newark	7,059	2%	1,885	2,269	224	1,362	1,319
Castro Valley	7,736	3%	1,381	1,235	1,097	2,458	1,565
San Lorenzo	6,550	2%	918	1,120	737	2,413	1,362
Pleasanton	5,070	2%	965	438	523	2,282	862
Dublin	5,505	2%	1,023	458	675	2,330	1,019
Emeryville	2,079	1%	345	406	307	663	358
Albany	1,901	1%	282	219	359	649	392
Piedmont	380	0%	53	98	23	108	98
Sunol	59	0%	13	10	5	18	13
Antioch	49	0%	16	14	3	15	1
Other	1,345	0%	355	263	125	491	111
Total	**306,787**	**100%**	**51,767**	**60,974**	**33,293**	**115,125**	**45,628**

ALAMEDA Alliance FOR HEALTH

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

Board of Governors Effectiveness Engagement

BSA report

BOARD SELF-ASSESSMENT

Alameda Alliance for Health | March 2022

BoardSource®

Welcome

Dear Nonprofit Leader,

Congratulations on the completion of your BoardSource Board Self-Assessment. Enclosed you will find the results of your board's recent self-assessment. This report summarizes the responses to the survey, and should serve as a starting point for discussion and reflection about your board's core strengths, as well as areas that may need more attention.

The report is organized into four broad categories, which provide a framework for exploring the relationship between who serves on the board (The People), the culture it cultivates (The Culture), the way it fulfills its work responsibilities (The Work), and how all these efforts come together to position the organization to achieve your important mission (The Impact). The report also benchmarks your board's responses against other nonprofit organizations that have answered the same questions, which may be helpful as you consider your board's performance relative to your peers across the country.

As you review the report, we encourage you to consider the following:

- What stands out? Is there anything in the report that is especially surprising, or that you'd like to understand better through conversations as a full board?
- Does the board seem to be well aligned in terms of its assessment of its performance, or are there indications that different board members are experiencing the board's leadership performance differently? If the latter, why might that be?
- To what extent is your board meeting its own expectations? In what ways is the board happy with its leadership performance, and where is it signaling a desire to improve? Do any natural priorities emerge from the ratings?
- Based on what you see in the self-assessment, what are the top one to three areas where you think the board should focus its development efforts?

These questions may help your board unlock new insights about its leadership and help you determine what goals you want to set and prioritize for your own board development and growth. We encourage you to formalize those goals or priorities as an action plan to guide your board development efforts. BoardSource has a wide range of resources and tools that can support you in those efforts, some of which are highlighted throughout this report. We also encourage you to explore www.boardsource.org to learn more about other ways we can assist your board, whether through our consulting services, educational programming, or research and leadership on issues of great importance to boards, the social sector, and our society as a whole.

Thank you for the important work that you do, and for trusting BoardSource to be your partner. We applaud you for making this investment in your board's leadership, and look forward to being a continued resource to you as you lead your organization's important mission and work.

Sincerely,

Anne Wallestad, President and CEO
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Washington, DC 20001-4590
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assessments@boardsource.org

Alameda Alliance for Health Board Assessment 2022

Results Overview At-A-Glance

This report provides an overview of how well the board and the chief executive think the board is meeting its ten areas of governance responsibility as organized into the four broad categories. The scores for individual questions are averaged within each area of responsibility, and the scores for each responsibility are then averaged within each of the four overarching categories mentioned earlier: The People, The Culture, The Work, and The Impact. These board responsibilities and categories align with *Leading with Intent*, BoardSource's national index of nonprofit board practices.

As you read through this report, we encourage you to familiarize yourself with *Leading with Intent*, as well as with one of BoardSource's most popular books, *Navigating the Organizational Lifecycle: A Capacity-Building Guide for Nonprofit Board Leaders*.

The scores below are based on this answer scale: 0 = Poor; 1 = Fair; 2 = OK; 3 = Good; 4 = Excellent.

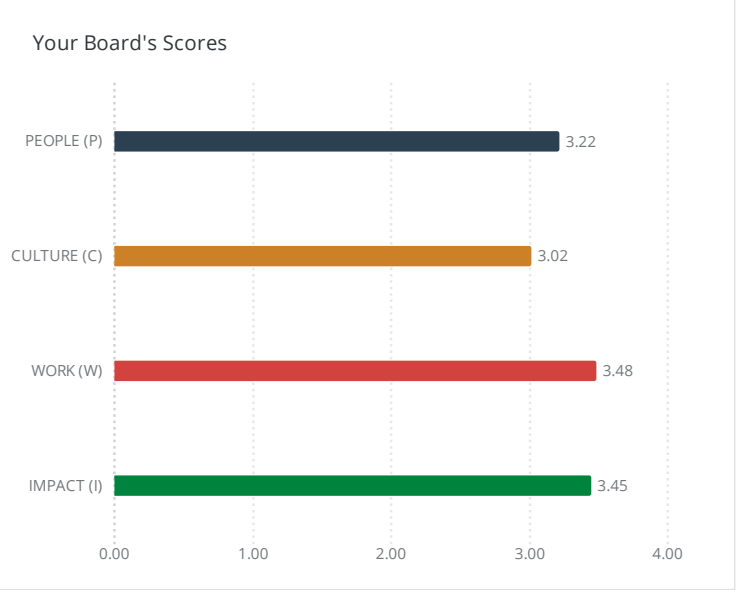
Benchmarking Overview

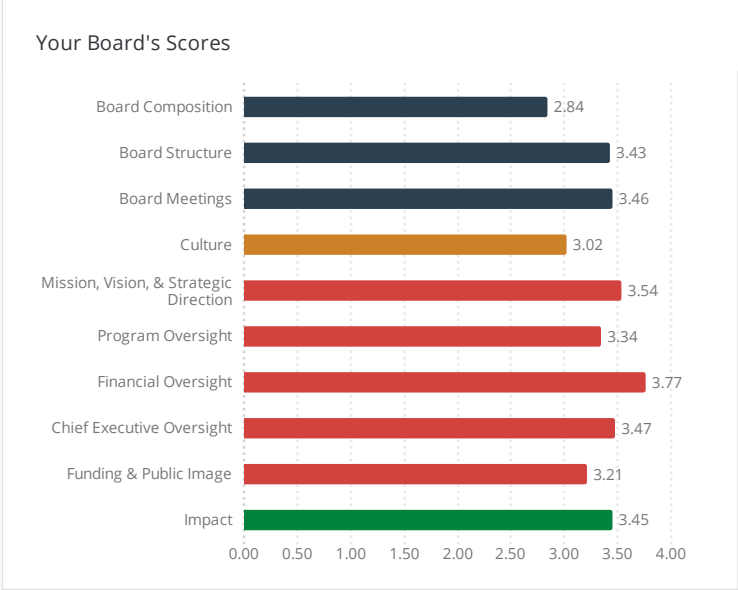
By comparing your performance as a governing body against that of your peers, you will be able to identify how your performance differs. Please use the benchmarking data as one point of reference within the context and history of your organization to help you focus on your strengths and consider potential areas for growth. It is important to note that our benchmarking offering does not necessarily reflect "best practices" that boards are recommended to follow, but rather is simply a jumping-off point, to be able to start a meaningful conversation with your board about where they stand on their work.

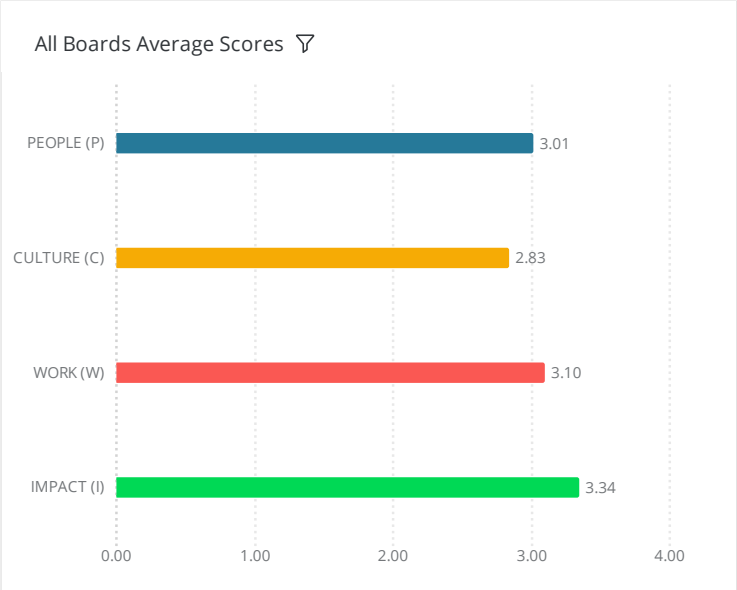
Our report benchmarks your data against other nonprofit organizations that have answered the same questions in BoardSource's Board Self-Assessment (BSA) surveys since 2013. It automatically updates in real time and as such is always changing. We revised our survey in 2018, therefore the audience size and makeup you are benchmarked against in this report may vary question by question. BoardSource endeavors to benchmark each question by the largest possible audience for maximum data integrity.

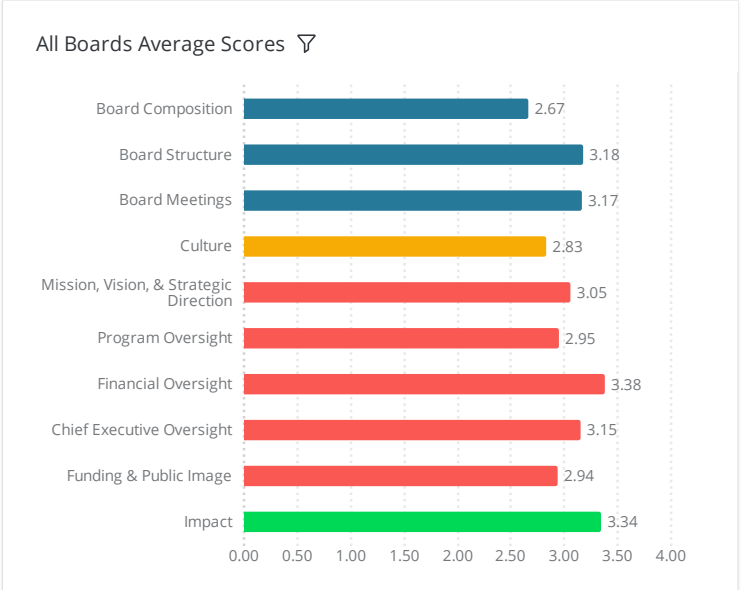
Results Overview

The graphs below show how your board has assessed its performance in the four categories (left) and ten responsibilities (right) of nonprofit boards.



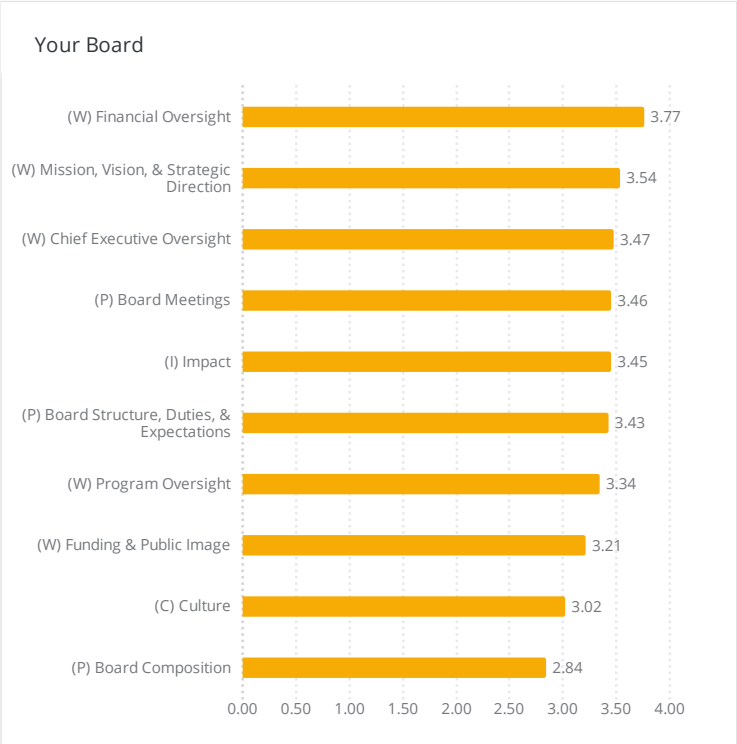


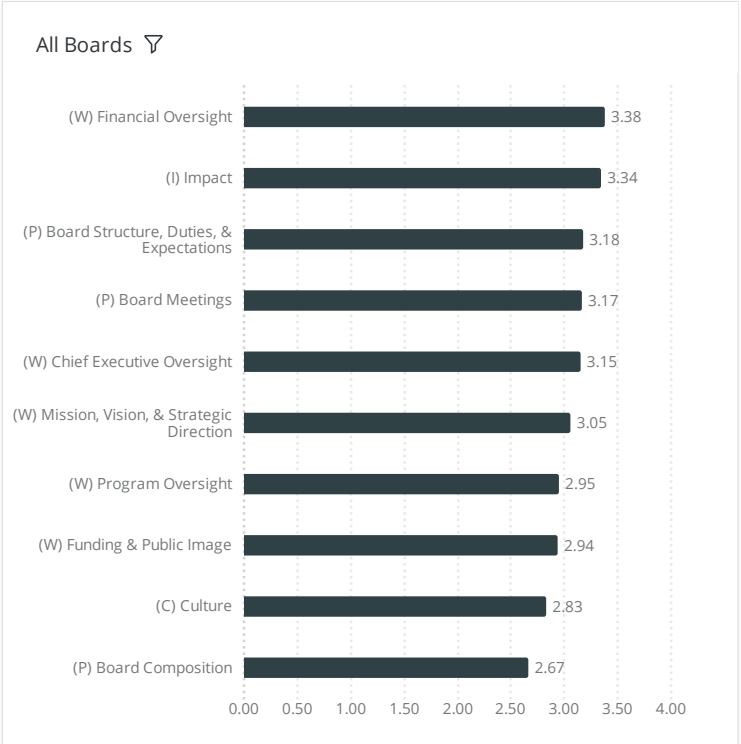




Highest to Lowest Ranked Responsibilities

The graph below shows how your board has assessed its performance — from highest to lowest — in the ten areas of responsibility. The board is performing well in those responsibilities that appear at the top of the graph. The board is performing acceptably in those responsibilities that fall in the middle of the graph, but it may want to monitor its performance. Those responsibilities that fall at the bottom of the graph may require board attention or merit further discussion.

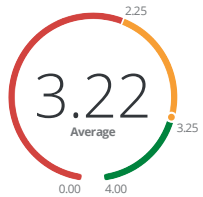




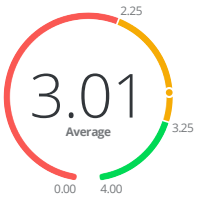
P | The People

Having the right people on the board makes higher performance — in both the board's internal and external functions — more likely. This section assesses the overall balance of who serves on the board (board composition), how people are organized (board structure), and how they deliberate together (board meetings).

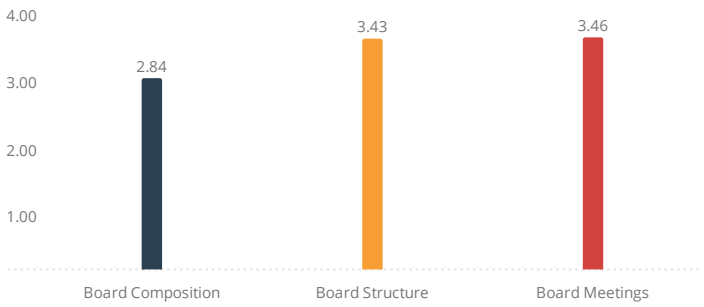
People Score - Your Board



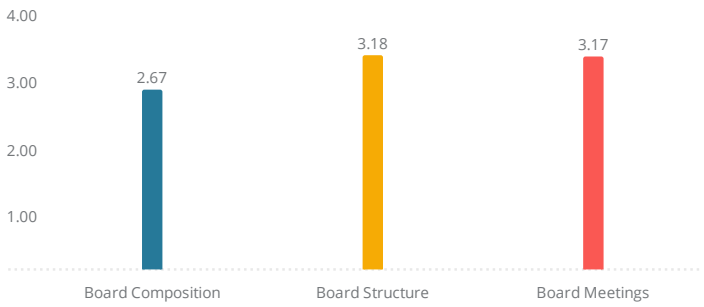
People Score - All Boards



The People Scores - Your Board



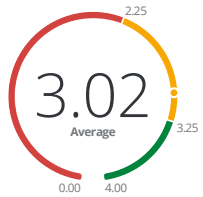
The People Scores - All Boards



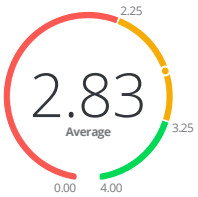
C | The Culture

How the board conducts its work — from group dynamics to its relationship with the chief executive — can help or hinder the board's ability to carry out its work. This section explores the board's performance in creating conditions for the healthy functioning of the board as a collective leadership body.

The Culture Score - Your Board



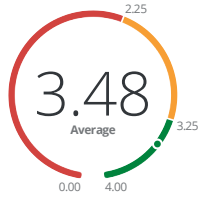
The Culture Score - All Boards



W | The Work

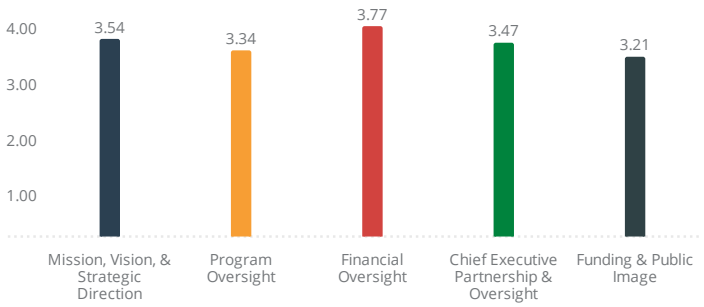
Boards are charged with many important responsibilities both within and outside the boardroom. This section explores board performance in five areas of responsibilities that are categorized as board work: mission, vision, and strategic direction; program oversight; financial oversight; oversight of the chief executive; and funding and public image.

The Work Score - Your Board

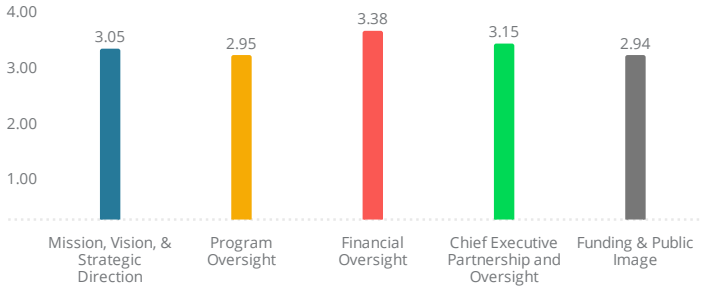


The Work Score - All Boards

The Work Scores - Your Board



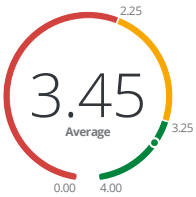
The Work Scores - All Boards



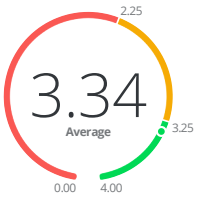
I | The Impact

This section explores the board's perception of its impact on organizational performance. The questions reflected here assess the board's connection to the organization's strategy, reputation, and overall effectiveness.

The Impact Score - Your Board



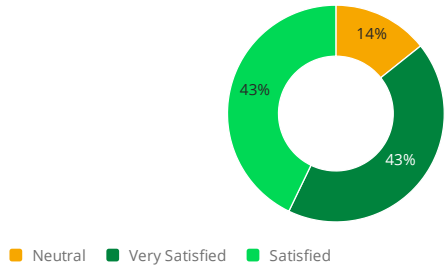
The Impact Score - All Boards



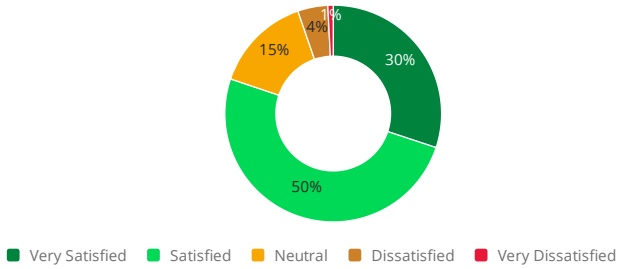
Overall Effectiveness as a Leadership Body

The following graphs reflect the board's thinking about its overall effectiveness. Because the percentages are based on the perceptions of your individual board members, this information can be used to spark a full board discussion on whether the members feel they are collectively meeting their responsibilities.

Your Board



All Boards

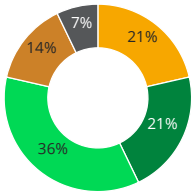


Leadership Resilience

Hypothetically, if your chief executive were to suddenly leave his or her post, how confident are you that your board understands the organization well enough to make informed decisions about how the organization should be led (not just in terms of who the leader should be, but what the new leader will confront)?

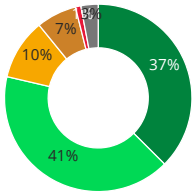
This is a hypothetical question that seeks to understand leadership resilience; it is not intended to serve any other purpose. As such, the scores from this question are not factored into your board's overall IMPACT score.

Your Board



Neutral Very Confident Confident Low Confidence
Don't Know/No Opinion

All Boards



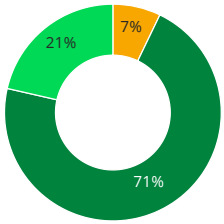
Very Confident Confident Neutral Low Confidence No Confidence
Don't Know/No Opinion

Board Service Experience

Individual Board Member Experience

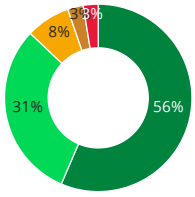
Individuals serve on nonprofit boards for a variety of reasons. The percentages in this graph provide an overall sense of whether your individual board members feel that they have adequate opportunities to use their time, talent, and expertise to advance the mission of your organization.

Your Board



Neutral Very Satisfying Satisfying

All Boards

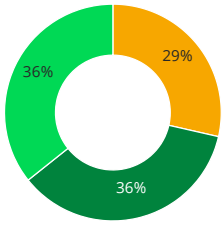


Very Satisfying Satisfying Neutral Disappointing
Very Disappointing

Level of Commitment and Involvement

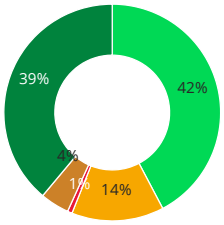
The board self-assessment survey asks board members to identify their fellow board members' level of commitment and involvement, typically described as board engagement. Engaged board members make it a priority to attend and participate in all board meetings, take initiative, and jump into action when the chief executive needs expert guidance or opinion. Furthermore, engaged board members use their personal connections and affiliations to support the organization, volunteer for leadership positions on the board, and, by example, encourage others to do the same. The graphs below show the board's level of satisfaction with

Your Board



Neutral Very Satisfied Satisfied

All Boards



Satisfied Neutral Very Disatisfied Dissatisfied Very Satisfied

General Open-Ended Responses

Comments appear exactly as they were entered in the survey.

What are the two or three most important areas the board should address to improve its performance in the next year or two?

Anticipating and improving HEDIS Entering Medicare Market Anticipating, Correctly Projecting and Reacting to The Challenge of Kaiser

1. Better clarity on leadership role in the organization given the nature of being a managed care plan with a strong CEO who is the expert on managed care; 2. Improve the Board packet by reducing it's size, the goal would be to improve the ability of members to read and process and discuss the information presented

mental health parity / quality metrics health disparities and our efforts to eliminate them

Maintaining focus on the SDOH and the impact on the provision of care, and ensuring that the AA Board is reflective of the community we serve.

Short term investments and Long term investments

Financials and quality measures

The board can make improvements through increased community involvement and participation in events in our community.

involve quieter board members adequately resource change to cal AIM services plan for growing older and disabled focus

1. Delegate to CEO more 2. Track progress on key strategic initiatives 3. Ensure AAH has resources to respond to a lot of anticipated change in programming.

Work on team building between the board members. Zoom works but not ideal for team building.

1. ensuring the plan continues to stay in regulatory compliance 2. seeing the COHS transition through

1. Bringing mental health service in house 2. Focus on quality of care, including HEDIS metrics, particularly as we transition back from the pandemic 3. Maintaining/improving access to care as experienced by our members and provider partners.

What organizational issues or challenges require strategic direction or guidance from the board?

Anticipate challenges of Return to office. Adequacy of structural facilities and consideration for purchasing same

1. The rate of discretionary growth that the organization undertakes, or other organizational changes that are not mandated (such as becoming a single plan county). In regulatory areas we often do not have a choice about ramping up a new activity, but there are some discretionary areas. The Board should be more involved in decisions related to discretionary areas and it seems that the Board does not, but also defers to the CEO in this areas as well as in the regulatory areas. 2. Monitoring that the infrastructure is sufficient to carry out the mandates of the organization, the dashboards and metrics are valuable tools for the Board to review to look for weaknesses or issues that need to be addressed.

Changes in terms of our responsibility/transparency/accountability as we move to a single plan county Investment of discretionary revenue for special projects

The impending changes pertaining to Kaiser in this marketplace.

None I can see

The loosening of pandemic measures and uncertain economic conditions

The largest organizational issue we are facing is the move to a single plan model and the financial impacts the organization faces.

2 and 3 in question above.

CalAim Behavioral Health

Balancing the multitude of responsibilities given to us over the past one to two years and most importantly prioritizing their importance.

Keeping track of all the changes in Medi-Cal and how those changes impact the Alliance.

1. Prioritizing in the setting of many projects 2. Dictating strategy in the setting of a changing environment (Kaiser, Single Plan County...)

What other comments or suggestions would you like to offer?

None

The Alliance continues to get stronger and meets new challenges very well, due to the strong and committed staff. I would like to identify ways for the Board to contribute more to the organization's well being.

I feel like the board has been very effective in the years since our conservatorship. The committees have done an excellent job in increasing our compliance to regulations and financial oversight.

No more results to show

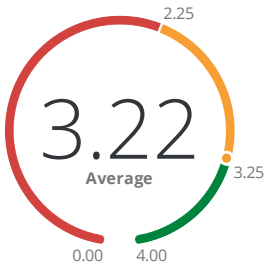
Alameda Alliance for Health

P | The PEOPLE

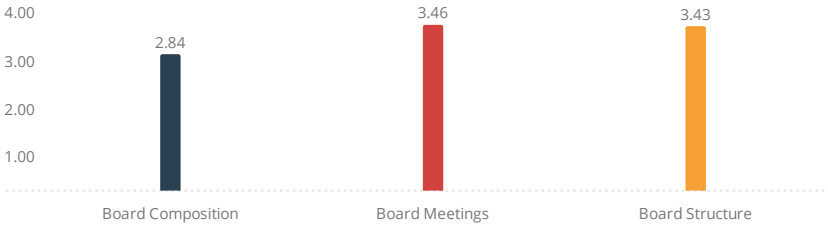
Includes:
Board Composition
Board Structure
Board Meetings

Having the right people on the board makes higher performance — in both the board's internal and external functions — more likely. The most successful boards are thoughtfully composed as it relates to skillsets, leadership styles, and diversity of thought and background. This section of the report explores who serves on your board, how it is organized as a collective body, and how it structures and conducts its board meetings.

Your People Score



Your role score is based on the following responsibility scores:



Board Composition | Section Detail

People are the lifeblood of any organization, and — for a nonprofit organization — that includes the board of directors, which is responsible for its own composition and leadership. A good board is composed of individuals who contribute critically needed skills, experience, perspective, wisdom, contacts, time, and other resources to the organization. A well-conceived board-building plan helps the board to identify, recruit members and cultivate officers. New members are oriented to contribute and understand the board's responsibilities and the organization's core activities. Board member rotation ensures that the board is infused with new ideas yet remains a manageable size.

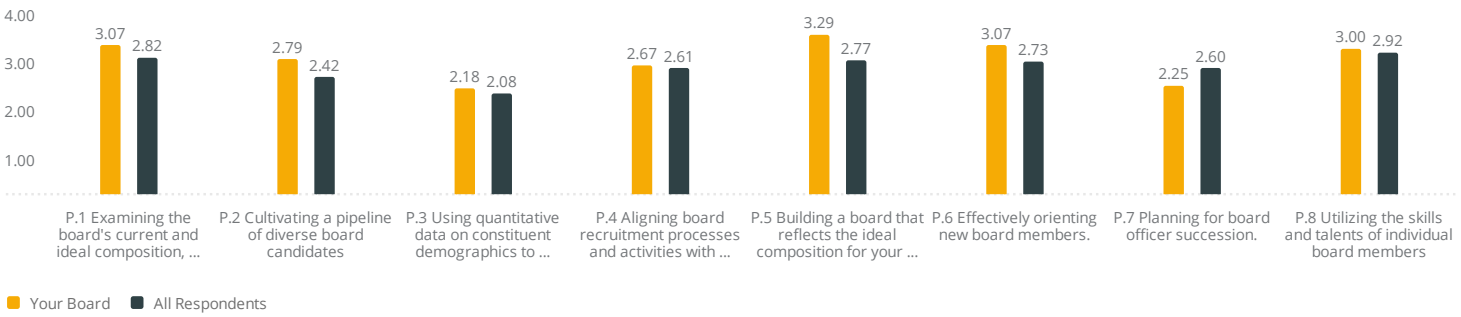
Strengthen Performance through Action

1. Approach recruitment and board building as an ongoing and strategic cycle.
2. If necessary, enhance the profile of your organization to make it attractive to strong board candidates.
3. Create a solid orientation program for new members no matter the extent of their previous board experience.
4. If you have one, ensure your governance committee is fully engaged and involves every board member in the board-building process by recommending or cultivating potential new board members.

Recommended Resources - Board Composition

- Book: *The Board Building Cycle*
- Free Community Resource: Taking Action on Board Diversity: Five Questions to Get You Started
- Member Resource: Recruiting the Right Board Members

Average Score



Question Breakdowns

(Please rate the board's performance in the following:)

Excellent Good Ok Fair Poor NA / Don't Know

P.1 Examining the board's current and ideal composition, including demographic diversity, to ensure that the board has the perspective it needs.

P.2 Cultivating a pipeline of diverse board candidates.

P.3 Using quantitative data on constituent demographics to define what the ideal board composition looks like, including projections on anticipated changes.

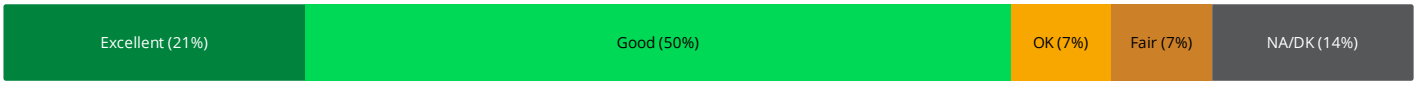
P.4 Aligning board recruitment processes and activities with stated goals for board composition.

P.5 Building a board that reflects the ideal composition for your organization's mission and work.

P.6 Effectively orienting new board members.

P.7 Planning for board officer succession.

P.8.Utilizing the skills and talents of individual board members.



To what extent does your board's specific expectations for board membership enhance - rather than impede - the board's ability to cultivate a diverse and inclusive board that brings it closer to the community the organization serves?

Membership determined by statute...does not really apply

many board seats are mandated by the by-laws for providers or health systems, which brings a strong provider perspective to the Board. member seats bring the member perspective. at-large seats bring needed skills and other constituents' perspectives.

I think the AA's Board membership expectations balance well the expertise and experience sought with the inclusiveness that is critical to representational balance.

My expectations enhance my understanding of the different aspects of the Alliance and the decisions of the board.

The boards composition reflects our membership and mission very well. We have members from the medical community, labor, and local government that provide unique insights into many different situations we come across.

Membership is good .....could use more older adult and disabled expertise as policy shifts to take on more older adult responsibility and complex adult care....and demographics shift/

Specific seats from stakeholder organizations creates a structured cross representation.

Scott does a stand up job with diversity and board composition including in the past having patients that use the alliance serve on the board. Keep this up!

By drawing on the providers that also serve the organization's members

We have been struggling to find a community member to fill the vacant seat on the board. We also have an opportunity to look at the defined seats and whether we need to make an adjustment if there seems to be a gap.

Would you like to provide any comments or context to your ratings for this section?

I am not clear on whether there are effective board member orientations, as I cannot see this aspect. I know there is a binder. There is little in the way of board development, and little opportunity for members to work together to set and achieve goals.

Because many of the seats are pre-designated, these are difficult questions to answer. However, as a board member, I have not been aware of how member selection has occurred before it comes to a vote.

no

board recruitment seems to be in response to bylaws required categories.....leaves only few spots to strategize recruitment....all could be more systematic...

Highest rating possible here.

A lot of the recruitment of new board is done through word of mouth which is good for continuity but does not set up a pipeline of new candidates. It's also challenging because we don't often look at the demographics of the community we serve.

We don't have a great deal of turnover on the board and also leave some of the succession planning to the individual organizations that appoint board members.

No more results to show

How can the board improve its performance in this area?

Schedule Board retreats and opportunities for members to work together

Increased transparency on member selection and working on succession planning

This should be an ongoing topic of discussion and review to ensure the inclusivity targets are being met.

I'm not sure how to do this but including more representation/input from the LGBTQ community that is active in Alameda County.

I think the board makeup is reflective of our mission and I don't see any issues with it.

again..just be a little more systematic approach to bring in expertise related to populations served through CalAIM and demographic changes.

Build out recruitment committee.

Reappoint a alliance patient member to serve on the board to fully ascertain a balanced perspective.

We could do more planning and goal setting around board composition

We could discuss setting goals for representation on the board?

Board Structure, Duties, and Expectations | Section Detail

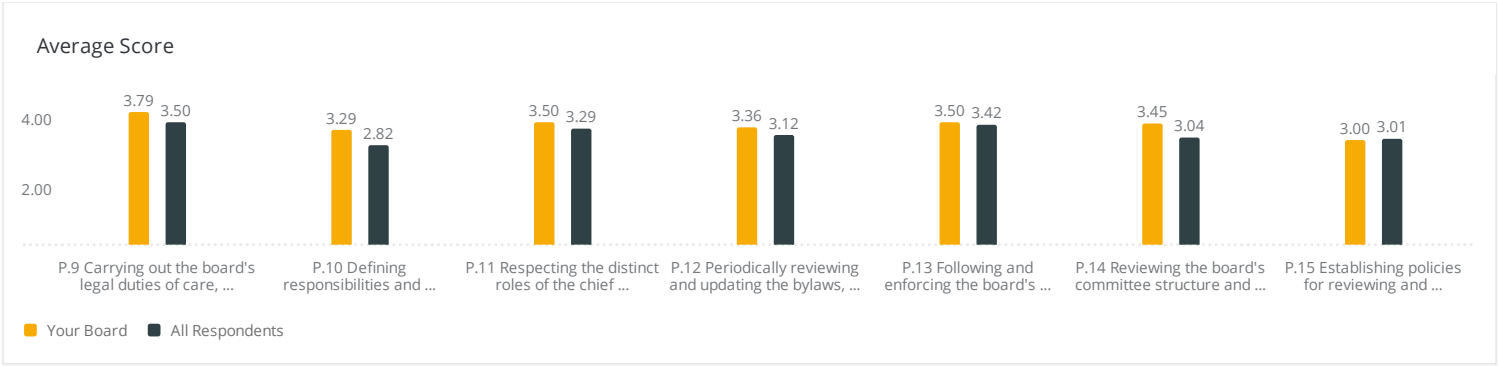
The board is responsible for making sure its own practices are appropriate and up-to-date. Every board needs structure — rules, guidelines, and boundaries — and should operate in accordance with the structure provided by the organization's bylaws, policies, and procedures. It is also important for the board to periodically review and revise the bylaws, policies, and procedures as necessary. Finally, the board should be strategic about its use of committees and task forces, ensuring that each has a written charter and capable leadership.

Strengthen Performance through Action

1. Periodically assess your board's workload, committee structure, lifecycle requirements, need for diversity, and legal mandates to ensure that your board is managed well.
2. View your bylaws and policies as evolving documents needing regular review; ensure timely amendments when necessary.
3. Consider using time-limited task forces in lieu of standing committees for those activities that are not ongoing.

Recommended Resources - Board Structure

- Free Community Resource: Are Your Board Committees Working Well?
- Member Resource: The Care and Feeding of Your Board: A Checklist for a Top-Level Governance Committee
- Free Community Resource: Bylaws Dos and Don'ts



Question Breakdowns

(Please rate the board's performance in the following:)

Excellent Good Ok Fair Poor NA / Don't Know

P.9 Carrying out the board's legal duties of care, loyalty, and obedience.

P.10 Defining responsibilities and setting expectations for board member performance.

P.11 Respecting the distinct roles of the chief executive, board, and staff.

P.12 Periodically reviewing and updating the bylaws, board policies, and board procedures.

P.13 Following and enforcing the board's conflict-of-interest policy.

P.14 Reviewing the board's committee structure and use of task forces to ensure they effectively support the work of the board.

P.15 Establishing policies for reviewing and refreshing the board, including term limits.

Size Matters

The primary guide for determining board size is the board's function, which may change over time depending on organizational lifecycle, board responsibilities, committee structure, legal mandates, need for diversity, and maintaining a manageable group. Variables such as these make it impossible to recommend a standard size for all boards; however, it is difficult to imagine that a board with fewer than five members is able to incorporate all the desired qualities and capacity of an effective board, or that an exceptionally large board is able to engage every member in a constructive manner. Regardless of size, all board members must be engaged, as all are equally accountable for the organization.

# of Voting Board Members - Your Board

Average # of Voting Board Members - All Boards

16

Committees

Committees can be a practical way to structure and manage the board's work. Standing committee structure should be lean and strategic and complemented by the use of task forces. Only ongoing board activities warrant a standing committee. Otherwise, time-limited task forces are efficient and utilize board members' time, interest, and expertise in a meaningful manner. Committees and task forces are more effective when their charter and scope of work are clearly defined by the board.

# of Standing Committees - Your Board

Average # of Standing Committees - All Boards

5

Would you like to provide any comments or context to your ratings for this section?

No.

Board is good and responsible in this area.

I believe we perform top notch in all theses areas. Nothing in my MInd stands out to change. When there is a perception that things are working well so long as compliance meets state standards ,leave it alone.

I think at times, the board should take more of a hands-off approach to the executive staff

The addition of the compliance committee has been an excellent move and utilizes the skills and interests of one or more of our board members. We have not been very strict about enforcing and reviewing term limits.

No more results to show

How can the board improve its performance in this area?

I am relatively new to the Board, so I do not feel equipped to answer this question at this time.

It would be helpful having periodic updates about board structure, duties, and expectations.

maybe a little more orientation fo new members

Planning for recruitments.

Simplify reporting. Possibly it can't be simplified.

We could review the conflict of interest policy on a more regular basis.

No more results to show

Board Meetings | Section Detail

Meetings are when boards exercise their governance authority. Because board meeting time is a precious and limited resource, board members must make board meeting attendance a priority and structure their meetings in an efficient and effective manner. Without concerted efforts, it is easy to waste time and resources, dampen members' enthusiasm and interest, and meet without demonstrable results. Board members who prepare for and attend meeting are able to participate in educated and independent decision-making.

Meetings need to be managed. A well-designed agenda helps the board chair guide the discussion and keep all members focused on the work at hand. Board members lose interest if they are not challenged and able to utilize their special skills. Listening to repetitive reports is not a constructive use of limited meeting time. Make sure that the majority of your board's meeting time is spent on future issues. By planning ahead and focusing on activities before, during, and after the meeting, you move closer to efficient meeting procedures and outcomes that meet the expectations.

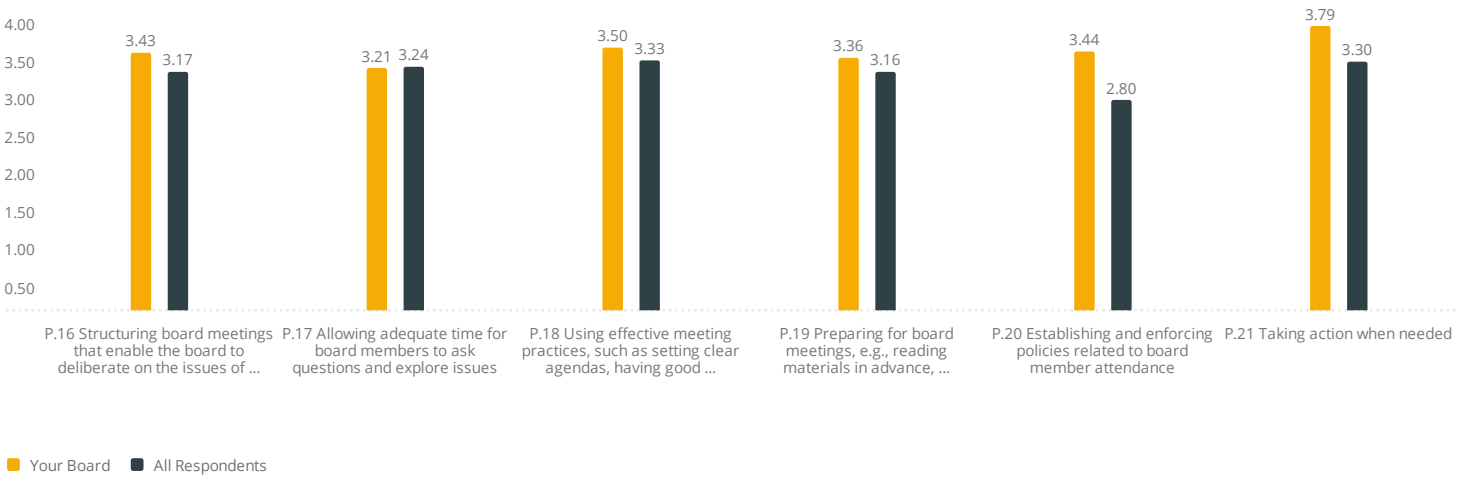
Strengthen Performance through Action

1. Shape your board meetings in such a way that they invite board engagement.
2. Approach meetings as a vital resource in service to the organization's sustainability and plan accordingly.
3. Make sure the agenda ties in with the strategic plan. Focus on your big issues.
4. Board members: Read the materials sent to you in advance of the meeting. Come to the meeting prepared. Be ready to participate.

Recommended Resources - Board Meetings

- Free Community Resource: Board Meeting Preparation:10 Tips for Chief Executives and Board Chairs
- Member Resource: Facilitating an Engaged Board

Average Score



Question Breakdowns

(Please rate the board's performance in the following:)

P.16 Structuring board meetings that enable the board to deliberate on the issues of greatest organizational importance.

P.17 Allowing adequate time for board members to ask questions and explore issues.

P.18 Using effective meeting practices, such as setting clear agendas, having good facilitation, and managing time well.

P.19 Preparing for board meetings, e.g., reading materials in advance, following up on assignments.

P.20 Establishing and enforcing policies related to board member attendance.

P.21 Taking action when needed.

Would you like to provide any comments or context to your ratings for this section?

the board meetings rarely involve deliberation, mostly the members are absorbing information and asking clarifying questions. the board packet is way too long, and the length perhaps provides an excuse for members to not read and prepare for meetings. board members do not receive any assignments ever but staff receive assignments are always prompt about follow up. i do not know if there are enforced policies regarding attendance.

I feel that there are ample opportunities for dialogue and input.

With the pandemic and remote meetings it has been difficult. I feel that in person meetings were much more engaging than teleconferences. I hope that we can return to in person meetings soon.

board meetings are appropriate and run well.

Overall excellent work.

board meetings tend to run long

The meeting packets are very long. I'd like to see them cut down or at least sorted/prioritized more clearly to make the packet more accessible to board members. I also think we have focused too much on finance since our take-over by the state. This has limited how much we focus on other issues like quality of care, access to care, strategy.... Personally, I'd like to hear more about quality, access... getting updates on our strategic plan...

No more results to show

How can the board improve its performance in this area?

reduce the size of the board packet, frame discussions in advance with options for board consideration

More focus on our mission and discussion of initiatives that can further our mission.

No suggestions.

The board can increase the meeting time to allow for more participation or, to not extend the meeting time, finding ways to explore topics or ask questions without violating the Brown Act.

maybe a one paragraph executive summary at beginning of each staff report included in the packet...

Deck is very thick. Summary helps. I sometimes need help with acronyms.

Ensure diversity on the board, include a patient representative, possibly consider every other month meeting times and possibly transition back to in person.

We may want to consider having fewer items in each board meeting or switching the order so that the most pressing items that need board approval are taken first and then other non-action items are placed at the end.

The meeting packets are very long. I'd like to see them cut down or at least sorted/prioritized more clearly to make the packet more accessible to board members. I also think we have focused too much on finance since our take-over by the state. This has limited how much we focus on other issues like quality of care, access to care, strategy.... Personally, I'd like to hear more about quality, access... getting updates on our strategic plan...

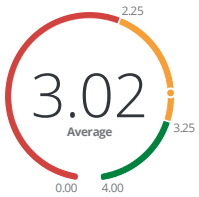
No more results to show

Alameda Alliance for Health

C | The CULTURE

How the board conducts its work — from group dynamics to its relationship with the chief executive — can help or hinder the board's ability to carry out its work. Likewise, board culture and dynamics are also affected by who serves on the board and the nature of the work that the board undertakes.

Your Culture Score



Culture | Section Detail

How board members communicate with each other, work as a team, and make decisions all define the culture of the board. The combination of formal and informal rules, traditions, and agreements that develop over time inform how a board interacts, deliberates, and ultimately performs as a governing body.

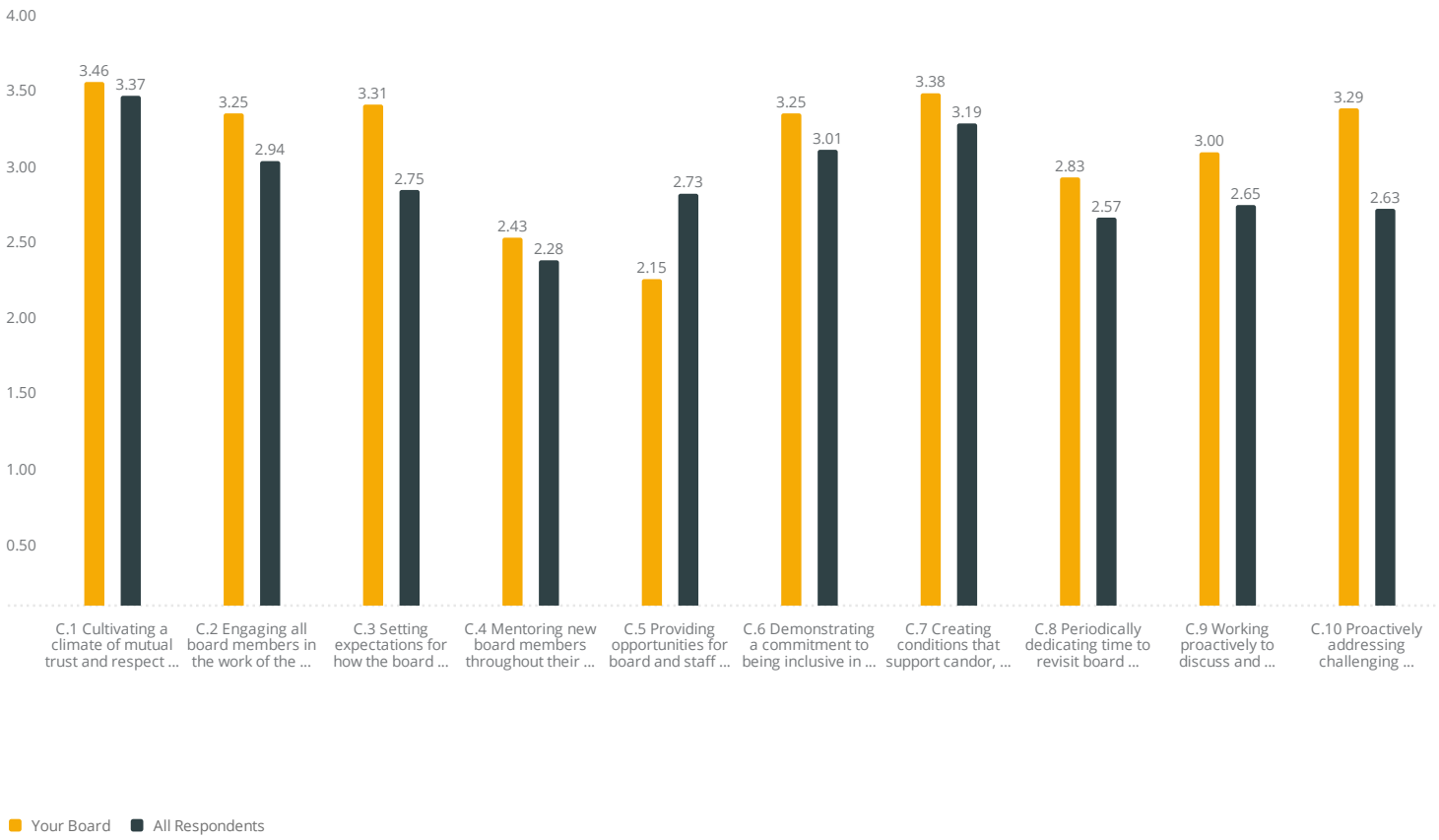
Strengthen Performance Through Action

- Consider board culture as a key factor in board performance.
- Envision, as a team, what an ideal board culture would look like.
- Reflect on what investments have been made to date toward a healthy board culture.

Recommended Resources - Board Culture

- Free Community Resource: Governing as a Team
- Member Resource: 18 Questions About Board Culture
- Member Resource: Eight Ways to Increase Your Board's Ability to Work as a Team

Average Score



Question Breakdowns

(Please rate the board's performance in the following:)

Excellent Good Ok Fair Poor NA / Don't Know

C.1 Cultivating a climate of mutual trust and respect between board members.

C.2 Engaging all board members in the work of the board.

C.3 Setting expectations for how the board works together as a part of board orientation.

C.4 Mentoring new board members throughout their first year on the board.

C.5 Providing opportunities for board and staff to get to know each other.

C.6 Demonstrating a commitment to being inclusive in processes, decision making, and officer/committee chair selection.

C.7 Creating conditions that support candor, robust discussions, and ensure all voices are heard.

C.8 Periodically dedicating time to revisit board values and behaviors, and how they impact the work of the board.

C.9 Working proactively to discuss and address any dynamics within the board or between board members that may be negatively impacting the board's ability to share power equally.

C.10 Proactively addressing challenging board behavior.

Would you like to provide any comments or context to your ratings for this section?

these questions were difficult, i often feel that board members are sitting on the board keeping an eye on the health of the organization for the benefit of their constituency and organization, rather than on the effectiveness of the organization in serving the Medi-Cal population.

Meetings tend to be mostly procedural and we do not vote on many items of importance. As a public board with proprietary concerns related to contractors, what we discuss in meetings can feel narrow/limited, while major decisions are made by staff/administratively. Items often don't come to the board for discussion unless they are in litigation, at which time we may become aware of a relationship for the first time.

I think Dr. Seevak and Scott encourage and support a collegial and healthy Board environment.

Board culture and norms good...respect good...

No

Encourage mixers or other "get togethers" to get to know the board members more on a peronsal level. Possibly 5 minute presentations on your hobby or other interest is a way to "break the ice".

No more results to show

How can the board improve its performance in this area?

identify ways for members to work together

Perhaps contracts or other arrangements can be brought to the board if they exceed a certain dollar amount or could have a particular impact on the organization.

No suggestions.

For opportunities for board/staff to know each other, there may be opportunities once the pandemic conditions get better.

some board members are less active in discussion and participation....good to find ways to encourage them...

Everyone is respectful of diverse opinions but I think the CEO one on ones help mitigate some challenging conversations.

Scott is a great role model and leader!

The idea of mentoring new board members is intriguing, we do not have a practice of doing that

We have an opportunity to continue to improve the onboarding of new members. While we have an orientation and 1:1 with existing board leaders, we do not have ongoing mentoring or check-ins with new board members. We also have a relatively transparent process for selecting leaders on the board but likely can improve this to make it more inclusive. Finally, we do not have many opportunities for the board members to get to know each other, particularly in the age of teleconferences.

No more results to show

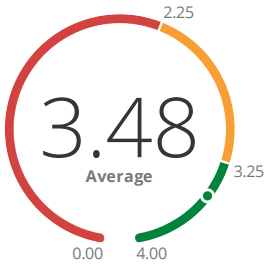
Alameda Alliance for Health

W | The WORK

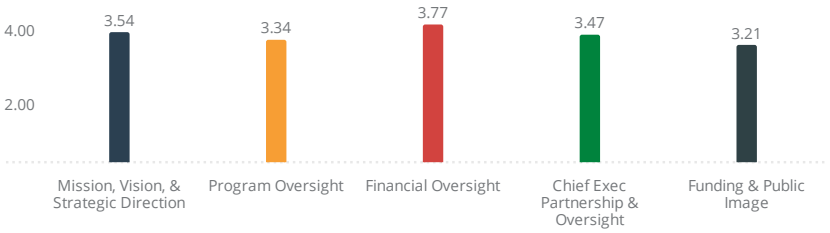
Includes:
Mission, Vision, and Strategic Direction
Program Oversight
Financial Oversight
Chief Executive Partnership and Oversight
Funding and Public Image

Boards are charged with important responsibilities. Some of these responsibilities are more fundamental, such as understanding the organization's mission and providing financial oversight. Other responsibilities are more strategic and adaptive — such as providing strategic direction and partnership with the chief executive — and still others address external leadership and ambassadorship. This section explores how well the board understands its responsibilities in each of these areas.

Your Work Score



Your role score is based on the following responsibilty scores:



Mission, Vision, and Strategic Direction | Section Detail

One of the board's primary roles is to set strategic direction. Key elements to consider when setting direction are your organization's mission, vision, and values.

- A mission statement defines your organization's fundamental purpose. A clear mission statement is inspirational yet realistic, emotional as well as informative, concise and complete. It is positive and focuses on achievable accomplishments.
- The vision statement is about long-term goals and the direction in which the organization is heading. It defines the organization's dream. Because a vision statement is created through a group process in which all boards members share their ideals for the organization, it has a team-building effect.
- Values are the principles that help mold the organization's character, tone, and working style. By articulating these principles, the board establishes guideposts that help chart direction for years ahead.

A good statement of mission and purposes serves to guide organizational planning and setting priorities among competing demands for scarce resources. To further carry out its role in setting direction, the board is actively involved in strategic planning and thinking. To do this effectively, the board must understand the organization's clients and stakeholders, as well as its internal and external operating environments. This enables the board to respond appropriately as opportunities and challenges arise. The board should focus its efforts primarily on long-term, strategic issues, rather than short-term operational and administrative matters.

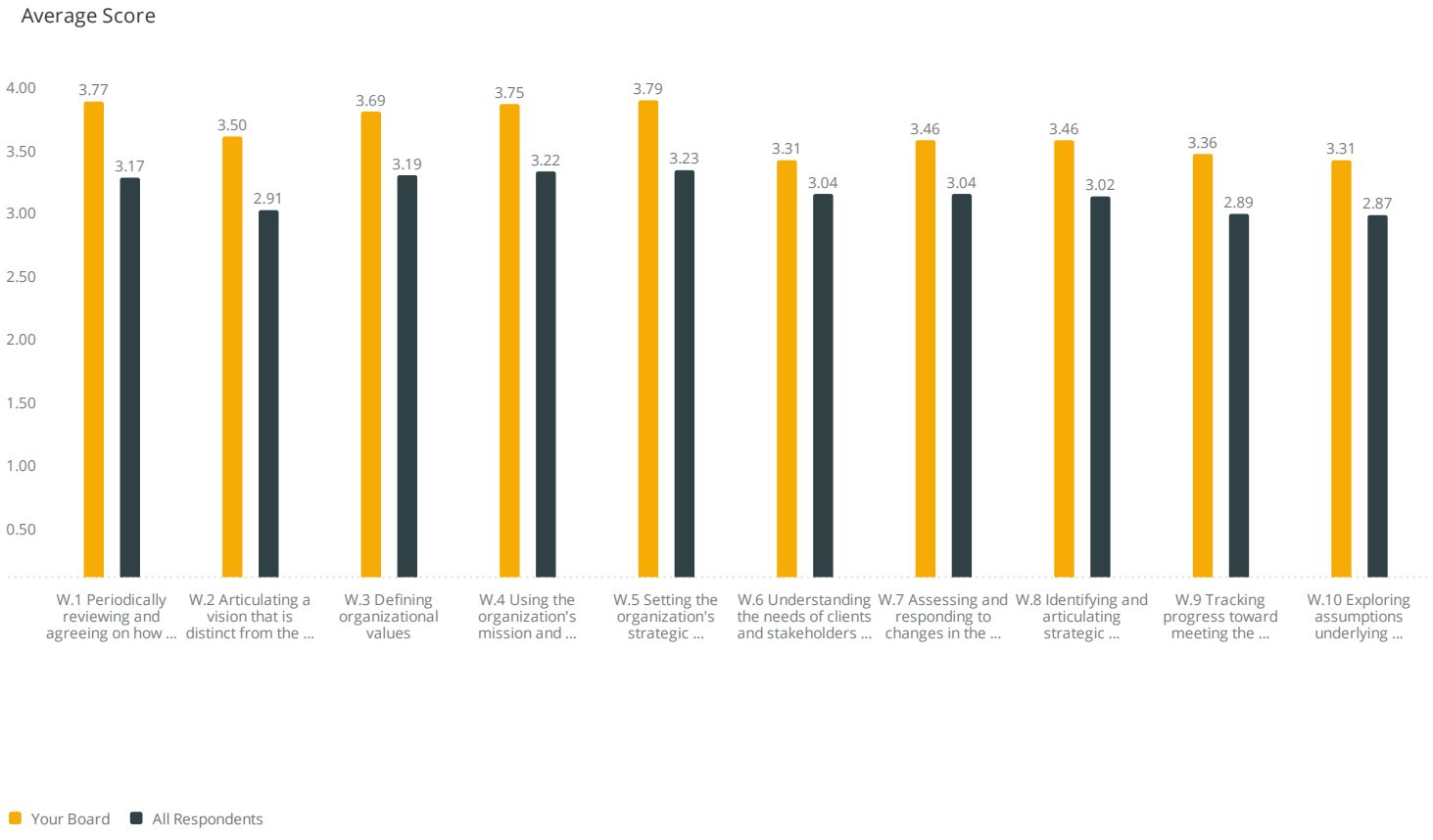
Effective and strategic boards take responsibility for identifying the issues that must be addressed to serve the organization's mission, vision, and values in the years ahead. Board members should utilize their unique talents and experience to identify these issues and to inform the organization's understanding of them.

Strengthen Performance through Action

1. Occasionally revisit the organization's mission and vision statements to ensure that the organization remains relevant.
2. Work together with the chief executive to provide guidance and input in developing the strategic planning process.
3. Elevate strategic thinking by incorporating it into every board meeting rather than relegating it to annual retreats or strategic planning processes.

Recommended Resources - Mission, Vision, and Strategic Direction

- Book: *The Nonprofit Board's Role in Mission, Planning, and Evaluation*
- Free Community Resource: Tips for Developing a Mission Statement
- Free Community Resource: Mission Statement vs. Vision Statement
- Guide: Shaping the Future of Your Organization: A Strategic Planning Guide for Nonprofit Leaders
- Free Community Resource: Nonprofit Strategy By the Numbers: Evolution and Progress
- Free Community Resource: Charting a New Path Forward: Insights & Reflections from BoardSource's Strategic Planning Efforts



Question Breakdowns

(Please rate the board's performance in the following:)

Excellent Good Ok Fair Poor NA / Don't Know

W.1 Periodically reviewing and agreeing on how the organization should fulfill its mission.

W.2 Articulating a vision that is distinct from the mission.

W.3 Defining organizational values.

W.4 Using the organization's mission and values to drive decisions.

W.5 Setting the organization's strategic direction in partnership with the chief executive.

W.6 Understanding the needs of clients and stakeholders and how they may be changing.

W.7 Assessing and responding to changes in the organization's environment.

W.8 Identifying and articulating strategic imperatives and goals for the organization through a thoughtful strategic planning process.

W.9 Tracking progress toward meeting the organization's strategic goals.

W.10 Exploring assumptions underlying proposed strategies, alternatives, and consequences before making critical decisions.

Would you like to provide any comments or context to your ratings for this section?

the strategic direction of the organization is set by the chief executive and the various regulatory mandates to which the Alliance is responsible. the board is in the back seat and not in a leadership role as related to strategic direction and organizational objectives. changes are brought before the board but generally are not subject to board approval.

This is fraught, and the impending changes in the Kaiser relationship will require the AA Board to be nimble in the year to come.

I think something that has really increased the boards effectiveness has been our compliance advisory group. The committee has really made it easy to the effectiveness in maintaining compliance which has a large impact on our mission.

Alliance does a good job on strategic planning...including its own committee plus consultants...

Strategic planning is intentional.

I think Scott and the leadership team do a good job of reminding the board of our strategic plans and organizational values guide our decisions

We just completed an updated strategic plan.

No more results to show

How can the board improve its performance in this area?

Bring the board in earlier on strategic discussions. Oftentimes decisions or plans seem almost complete by the time they get to the board.

Remaining open to adjustments as needed to allow to changes in the environment we operate in.

It might help to set aside some meeting time to have a quick refresher on the strategy and showing the progress on goals.

maybe dashboard for specific plan strategies and where we are re progress.

Dashboard metrics help track execution of strategic goals.

We need to continually review our new strategic plan and keep it in mind as we make decisions moving forward.

No more results to show

Program Oversight | Section Detail

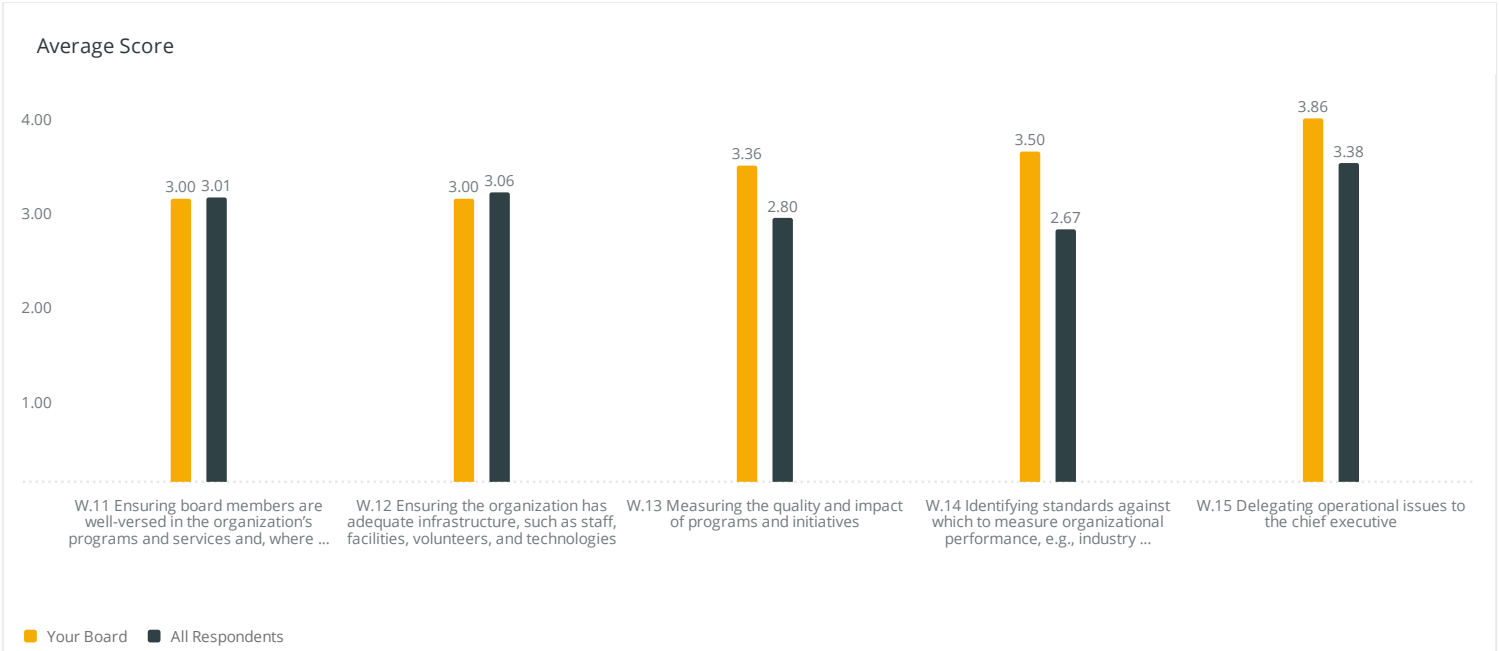
The board is responsible for program oversight and should work in collaboration with staff to understand the scope of the organization's programs and services, establish appropriate goals for quality and results, and monitor performance data. To strengthen the board's program oversight, board members should be provided with opportunities to connect with and deepen their understanding of the organization's mission and work.

Strengthen Program Oversight through Action

1. Embrace board education around programs and services as an ongoing activity.
2. Devote time to discussions of what kinds of program data are board — rather than management — related.
3. Determine how to provide the board with the information it needs to make data-driven and informed decisions while avoiding report overload at board meetings.

Recommended Resources - Program Oversight

- Book: *The Nonprofit Dashboard: Using Metrics to Drive Mission Success*
- Free Community Resource: Strengthen Your Board's Leadership by Increasing Its Understanding of Programs
- Member Resource: Identifying and Managing Risk
- Member Resource: Nonprofit Programmatic Oversight Tool



Question Breakdowns

(Please rate the board's performance in the following:)

Excellent Good Ok Fair Poor NA / Don't Know

W.11 Ensuring board members are well-versed in the organization's programs and services and, where appropriate, have an opportunity to experience the programs.

W.12 Ensuring the organization has adequate infrastructure, such as staff, facilities, volunteers, and technologies.

W.13 Measuring the quality and impact of programs and initiatives.

W.14 Identifying standards against which to measure organizational performance, e.g., industry benchmarks, competitors, or peers.

W.15 Delegating operational issues to the chief executive.

Would you like to provide any comments or context to your ratings for this section?

AAH is strongly led by the CEO and not the Board, largely due to the mandated and highly regulated nature of the mission. The CEO informs the Board about changes coming from the regulators and how he is preparing to responsibly respond.

We tend to look at benchmarks / comparisons to other plans in areas we are doing well.

I like how the dashboards are used to inform discussions and decisions.

We could hear more from our members. I also am concerned about our ability to staff many of our projects and the potential of overwhelming employees.

No more results to show

How can the board improve its performance in this area?

I believe that the board would benefit from a better general overview about the work of AAH to ensure that all are clear. Similarly the board could benefit from a conversation or training about their role as a board of a managed care plan. When a plan is in trouble, people often ask where was the board? It should be clearer to members when and how to raise concerns.

Would be helpful to have a set of indicators we are looking at related to quality and not just compliance.

no.

The board should take advantage of better pandemic conditions to have the opportunity to experience the Alliance's programs, where appropriate.

I think BOG could do a better job of delegating back to CEO.

No more results to show

Alameda Alliance for Health

W | The WORK (Continued)

Financial Oversight | Section Detail

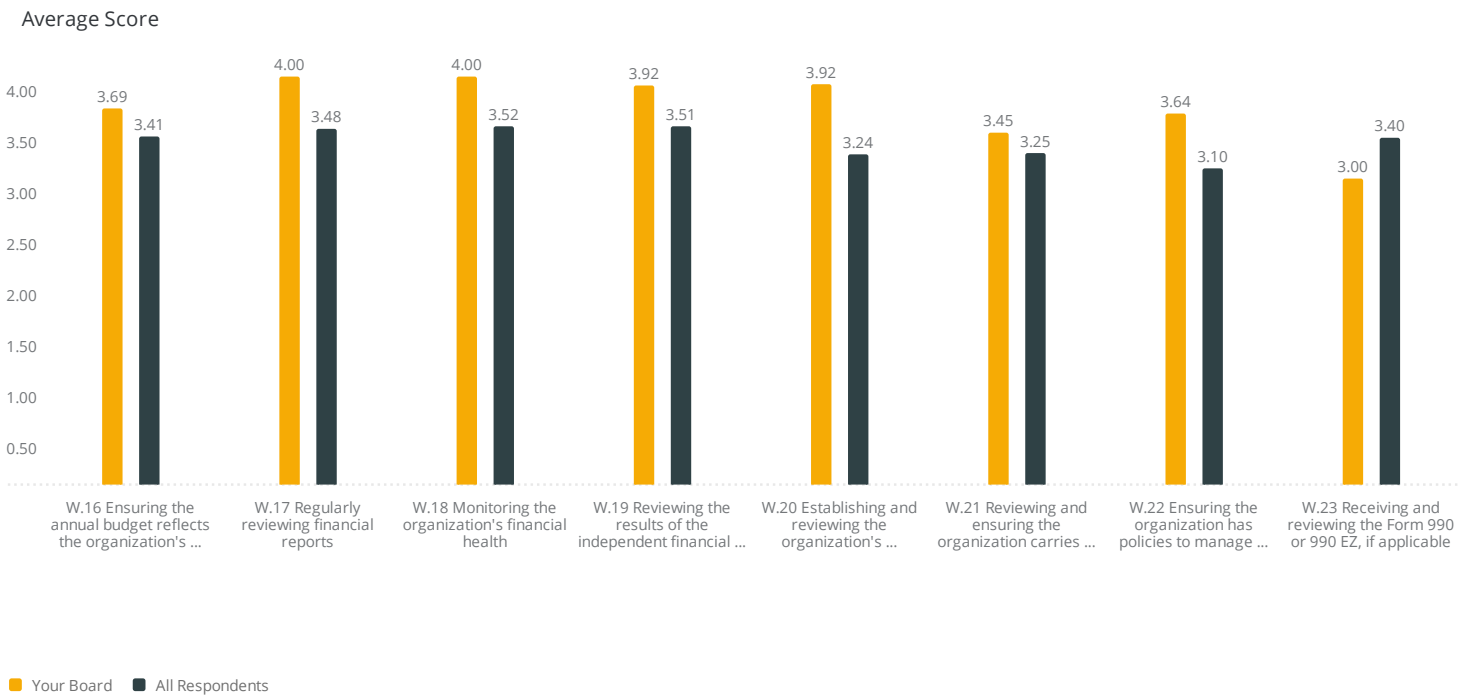
Boards are responsible for ensuring the organization has adequate resources, protecting its assets, and maintaining its legal and ethical integrity. This includes approving the annual budget and then monitoring performance against the budget throughout the year. The board also oversees the annual audit to verify that the organization is accurately reporting the sources and uses of its funds. To safeguard the organization's future, the board establishes appropriate investment and risk management policies, as needed.

Strengthen Financial Oversight through Action

1. Assist all board members in understanding nonprofit financial statements through onboarding activities and ongoing education.
2. Cultivate a climate of partnership, transparency, and rigorous ethics among board finance committee members and finance staff.
3. Encourage a culture of inquiry on the full board, recognizing that finance committee recommendations are simply that and liability for decisions rests with the full board.

Recommended Resources - Financial Oversight

- Free Community Resource: Red Flags, Yellow Flags: Are Your Financial Statements Trying to Tell You Something?
- Book: *Financial Responsibilities of Nonprofit Boards*
- Guide: Welcome to Your Financial Statements: A Primer for Nonprofit Board Members



Question Breakdowns

(Please rate the board's performance in the following:)

Excellent Good Ok Fair Poor NA / Don't Know

W.16 Ensuring the annual budget reflects the organization's priorities.

W.17 Regularly reviewing financial reports.

W.18 Monitoring the organization's financial health.

W.19 Reviewing the results of the independent financial audit and management letter.

W.20 Establishing and reviewing the organization's investment policies.

W.21 Reviewing and ensuring the organization carries adequate insurance.

W.22 Ensuring the organization has policies to manage risks, e.g., internal controls, personnel policies, emergency preparedness.

W.23 Receiving and reviewing the Form 990 or 990 EZ, if applicable.

Would you like to provide any comments or context to your ratings for this section?

The financial reporting process is thorough and regular and the Board is accustomed to having clear presentations with sufficient detail. Gil Riojas is an excellent CFO. There is not much discretion in investment policies due to public funds investment rules.

I am grateful for the recent dialogue regarding investment practices; I was impressed with the openness to reconsidering how AA invests.

I don't recall anything about a form 990 or 990 ez.

financial monitoring strong

I sit on the finance subcommittee. I think Dr. Ferguson and Gil do a great job on the above noted points.

I don't belive the board has looked into the adequacy of insurance, that function is delegated to the staff

We spend a large amount of time on the financials.

No more results to show

How can the board improve its performance in this area?

Insurance levels and types and internal controls policies are unknown to me, perhaps I missed them.

We do not review liability coverages - this may be useful. Policies to manage risks would also be helpful to review.

N/A

It may be possible to find ways to simplify some of the financial data for the general public, when the need arises.

Succession planning for finance committee.

No more results to show

Chief Executive Partnership and Oversight | Section Detail

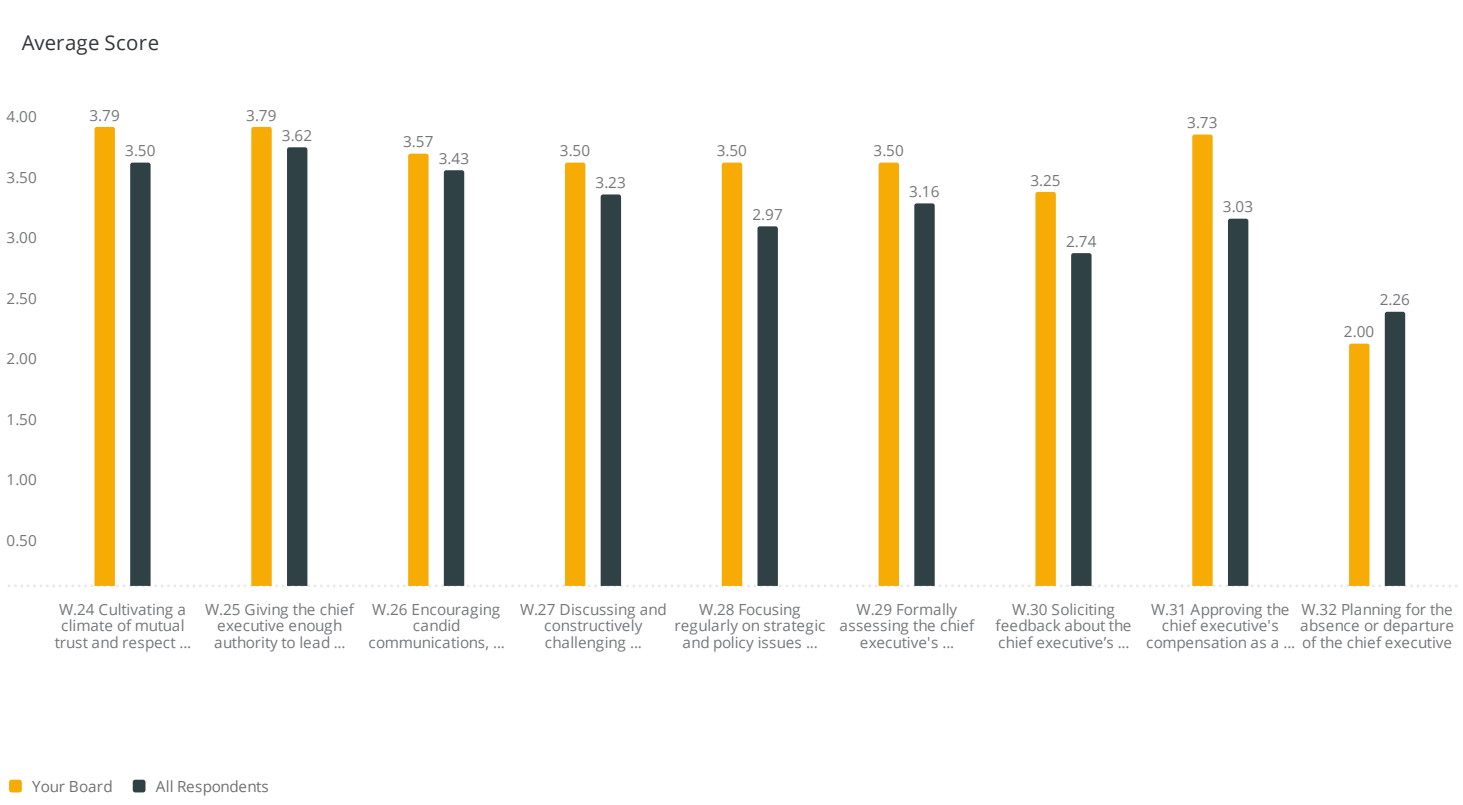
The primary board-staff relationship is between the board and the chief executive, and the quality of this relationship is of the utmost importance to the success of the organization. To be effective, the board and chief executive need a close working relationship based on mutual trust and an appreciation of their respective roles in leading the organization. As part of its responsibility for supervising the chief executive, the board ensures that a current job description outlines the duties of the role, then evaluates the chief executive annually and determines appropriate executive compensation.

Strengthen Performance through Action

1. Provide the chief executive with a clear job description and mutually agreed-upon annual expectations.
2. Recognize that effective board-chief executive partnerships, like all relationships, should be flexible in nature. Practices, communication, and assumptions may occasionally need to be recalibrated.
3. Ensure full board participation in the chief executive evaluation (feedback, final approval) even if a committee leads the process.

Recommended Resources - Chief Executive Partnership and Oversight

- Member Resource: Setting Goals for Your CEO
- Book: *Govern More, Manage Less*
- Free Community Resource: Board Chair and Chief Executive Partnership



Question Breakdowns

(Please rate the board's performance in the following:)

W.24 Cultivating a climate of mutual trust and respect between the board and chief executive.

W.25 Giving the chief executive enough authority to lead the staff and manage the organization.

W.26 Encouraging candid communications, including the sharing of challenges and issues in a timely manner.

W.27 Discussing and constructively challenging recommendations made by the chief executive.

W.28 Focusing regularly on strategic and policy issues versus operational issues.

W.29 Formally assessing the chief executive's performance annually and setting performance goals.

W.30 Soliciting feedback about the chief executive’s performance from direct reports.

W.31 Approving the chief executive's compensation as a full board, using comparable data from other organizations.

W.32 Planning for the absence or departure of the chief executive.

Would you like to provide any comments or context to your ratings for this section?

As noted in other sections, the Alliance is led by a strong CEO. The board has been timely in terms of evaluation and compensation, and has requested feedback anonymously from the CEO's subordinates. I am unaware of any succession planning or planning for the CEO's absence or departure. Succession planning is an important organizational best practice, the Board should add this to the priority list and work with the CEO to ensure that a plan for unanticipated or planned departure is in place.

Heavy reliance on the CEO and CEO reports - board meetings are often more "report outs" with Q&A rather than robust strategy discussions. One-on-one board prep with the CEO is helpful but may limit candid conversations in the meetings.

Pleased so far; there are a few items I have not delved into given my relatively brief tenure on the Board

I don't recall any meetings or plans for the absence of the CEO. Communication with the CEO has been excellent. I have been a member of other boards and the communications with the CEO prior to board meetings has been excellent.

Well done Scott! I love the montly one on one's with Scott.

No more results to show

How can the board improve its performance in this area?

The Board should work with the CEO to ensure that a plan for unanticipated or planned departure by the CEO is in place.

We can discuss succession planning

Hopefully the need never arises (other than for a vacation or another positive reason) but there should a more explicit plan for the CEO's absence or departure.

We need to review our planning for the absence or departure of the chief executive. This is something I don't recall ever doing. Hopefully this is at least discussed in the executive committee meetings.

Schedule annual review of CEO

We have not had discussion about succession planning for the CEO role or what we would do with an unexpected absence/departure. We should do this.

No more results to show

Funding and Public Image | Section Detail

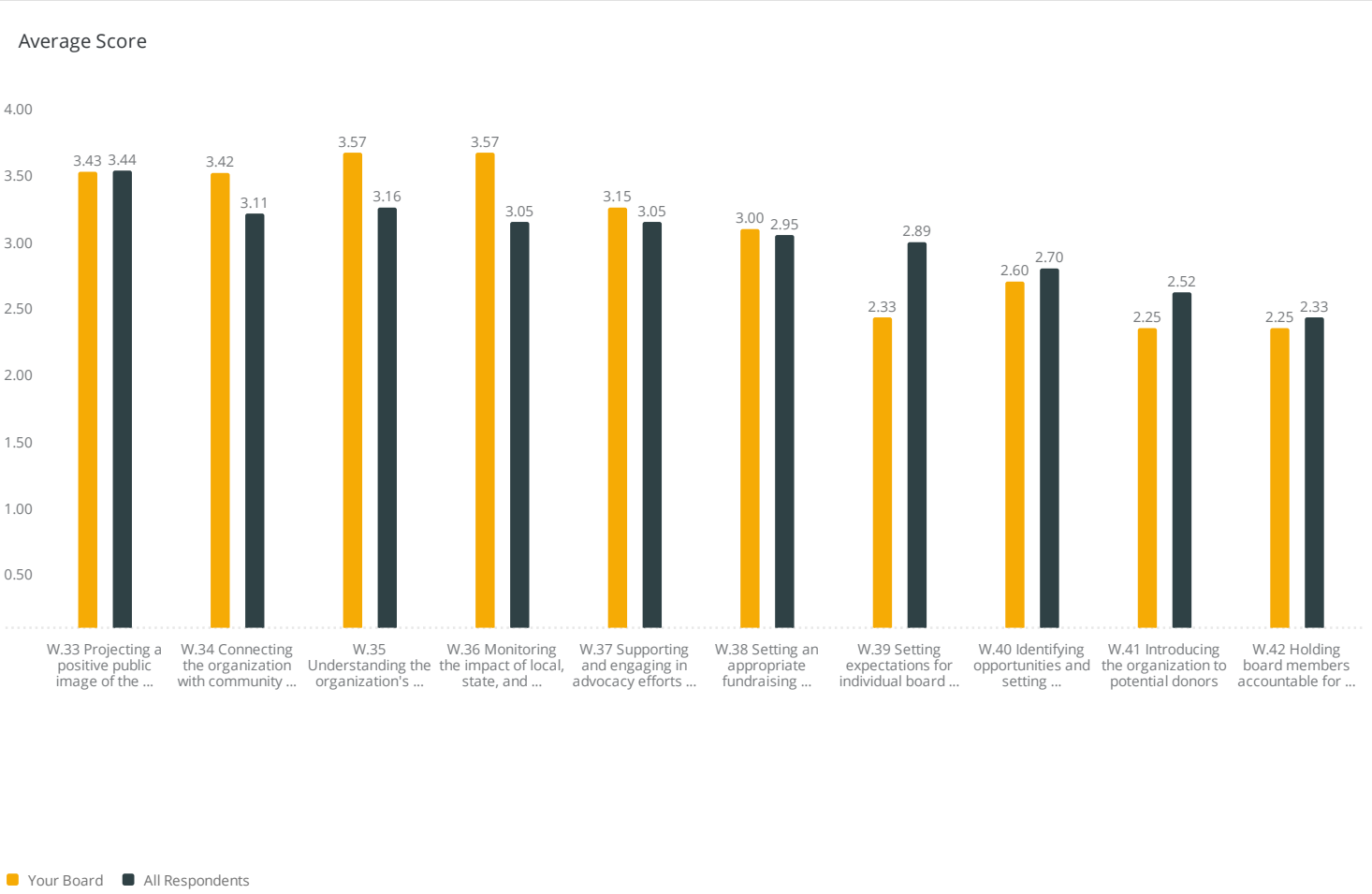
Every nonprofit requires adequate financial resources and a positive public image to accomplish its mission. To ensure the organization's financial sustainability, the board should make sure the organization has an appropriate mix of income and support the organization's fundraising strategy by participating in fundraising. Members can do this in a number of ways, including making personal contributions, connecting staff to potential donors, and soliciting friends and colleagues. The board is also responsible for building, protecting, and promoting the organization's public standing. To meet this responsibility, board members serve as ambassadors to the community and as an essential element of an organization's outreach efforts.

Strengthen Performance through Action

1. Consider the partnership climate between the board, executive, and staff as it relates to fundraising, specifically shared understanding of resource development strategies and fund development plans.
2. Embrace opportunities for board members to participate in fundraising activities that are customized/individualized, aligned with organizational strategy, and clearly communicated.
3. Evaluate the policy environment within which your organization operates.

Recommended Resources - Funding and Public Image

- Book: *Fundraising Responsibilities of Nonprofit Boards*
- Free community resource: Measuring Fundraising Effectiveness
- Free community resource: Stand for Your Mission



Question Breakdowns

(Please rate the board's performance in the following:)

W.33 Projecting a positive public image of the organization.

W.34 Connecting the organization with community leaders and potential collaboration partners.

W.35 Understanding the organization's revenue mix, e.g., government funding, charitable gifts, fees for service, and how it aligns with the business model.

W.36 Monitoring the impact of local, state, and federal policy on the organization’s mission delivery and resources.

W.37 Supporting and engaging in advocacy efforts that can help the organization achieve its mission and purposes.

W.38 Setting an appropriate fundraising strategy in conjunction with the executive and relevant staff.

W.39 Setting expectations for individual board members to make a personal financial contribution.

W.40 Identifying opportunities and setting expectations for individual board members to participate in fundraising activities and solicitations.

W.41 Introducing the organization to potential donors.

W.42 Holding board members accountable for fulfilling their fundraising responsibilities.

To what extent is the board enhancing your organization's reputation and credibility with the community your organization serves? Donors and funders to your organization? Public policy decision makers that are in a position to positively (or negatively) impact your organization's work? The general public?

The Board members represent important stakeholders in the Medi-Cal world in Alameda County. In general, Board members are not used to publicly promote the Alliance, or are they used regularly to advocate for the Alliance, and do not fundraise for the Alliance. I believe this is because AAH is a managed care plan and not a more traditional non profit. That being said, I think the Board may be under utilized in the advocacy space.

To a large extent. This role has strong synergies with my role @ AHS.

I believe the board enhances its reputation in these areas but usually when there is an Alliance need. A proactive position may be needed when the Alliance is not restricted by legal reasons as a public entity.

The composition of our board enhances our credibility. The board consists of many different stakeholders from the community. I hear of the CEO visiting many different communities that we serve and is actively participating. As a board I feel like this may be an area for improvement for myself. I am not aware of many fundraising or marketing efforts involving our board.

board represents alliance well and credibly.

This is more of a community board than a foundation board.

I believe all of us contribute to the above mentioned issues in ouir own way and do it well.

The board is largely not involved in these functions

No more results to show

Would you like to provide any comments or context to your ratings for this section?

The Board could be used more effectively as an advocate for the plan, and the increasing collaboration with the County offers the opportunity to coordinate advocacy on managed care policy with the County's.

I have more to learn in this area.

Fundraising is not relevant.

No more results to show

How can the board improve its performance in this area?

It would be helpful for the Board to clearly understand it's role with respect to public promotions and advocacy. Right now, there appears to be no role, and it would be good to have a clearly defined role.

I would be curious to know how (or if) fundraising can fit into the Alliance's budgeting. More marketing might also help with recruiting in a competitive job market.

By participating in more community and fundraising events. I haven't seen much activity in these areas since becoming a board member.

Set clear expectations at onboard.

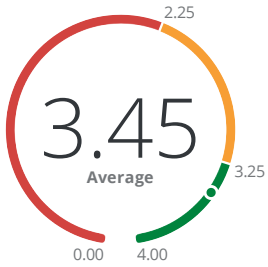
No more results to show

Alameda Alliance for Health

I | The IMPACT

This section explores the board's perception of its impact on organizational performance. The questions reflected here assess the board's connection to the organization's strategy, reputation, and overall effectiveness and the extent to whether this is a positive or negative impact.

Your Impact Score



Impact | Section Detail

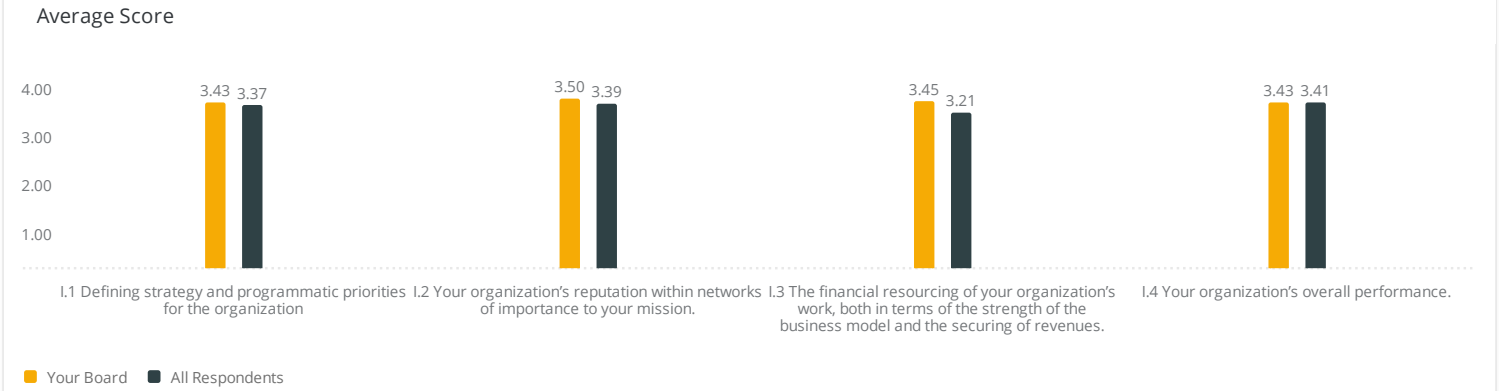
If the board has a negative or neutral impact on organizational performance, there's an opportunity to make improvements and better utilize the board's time and leadership as a vital resource. *Leading with Intent* data suggest two characteristics that both chief executives and board chairs report as having the strongest connection to board impact: understanding the board's role and responsibilities and the board's ability to work as a collaborative team.

Strengthen Board Impact through Action

1. Discuss the board's results for this section, including what information or practices would better help the board in making a positive impact.
2. Evaluate the impact results in light of your board's results in other sections of this report, looking for any potential relationships in high or low scoring areas.

Recommended Resources - Board Impact

- Book: *The Source: 12 Principles of Governance That Power Exceptional Boards*
- Free Community Resource: What Makes a Good Board Member?
- Member Resource: Eight Ways to Increase Your Board's Ability to Work as a Team



Question Breakdowns

(What impact does your board have on the following:)

Very Positive
Somewhat Positive
Neutral
Somewhat Negative
Very Negative
Don't Know/No Opinion

I.1 Defining strategy and programmatic priorities for the organization. (We asked that you assess both the quality/substance of the board's input and the clarity with which the board has defined these strategies and priorities.)

I.2 Your organization's reputation within networks of importance to your mission. (We asked that you focus specifically on the extent to which the board enhances the organization's reputation [by communicating the organization's values and priorities], rather than filtering it through the lens of fundraising or anything else.)

I.3 The financial resourcing of your organization's work, both in terms of the strength of the business model and the securing of revenues.

I.4 Your organization's overall performance.

Would you like to provide any comments or context to your ratings for this section?

The CEO leads the organization, and proposals for action are largely driven by regulatory mandates. In the few policy areas where there is discretion, the CEO develops the proposals and presents them to the Board with rationale as a vetting process. The Board does not work independently of the CEO. It appears that the Board exists as a non profit requirement, and as a mechanism to manage stakeholders, rather than a support to the organization or the CEO. The Board Chair's work on CEO evaluation and compensation is an exception, and perhaps also the work of the Compliance Committee.

Would like to see an intentional focus on eliminating disparities

I believe that prudent decisions are being made that will ensure AA's solvency and ability to meet the health needs of our constituents.

No more results to show

How can the board improve its performance in this area?

Perhaps we need to have clearer conversations about the role and value of the Board.

More public outreach and acknowledgment of the role AA plays in the health of the community.

There should be an assessment on what the staff and/or general public believe is the board's performance on these metrics.

More advertising of what they do well.

No more results to show

Taking Actions

Exceptional boards are a strategic asset to be leveraged by the organization. They add significant value and make a discernible difference in the organization's advancement of mission. Use this report as a tool to guide your board on the path to exceptional performance.

Take action. The board self-assessment establishes a platform for setting board priorities. The final step is identifying areas for growth. To help your board do this, consider the following questions:

1. What stands out? Is there anything in the report that is especially surprising, or that you'd like to understand better through conversations as a full board?
2. Does the board seem to be well aligned in terms of its assessment of its performance, or are there indications that different board members are experiencing the board's leadership performance differently? If the latter, why might that be?
3. To what extent is your board meeting its own expectations? In what ways is the board happy with its leadership performance, and where is it signaling a desire to improve? Do any natural priorities emerge from the ratings?
4. Based on what you see in the self-assessment, what are the top one to three areas where you think the board should focus its board development efforts?

Develop a board action plan. Once the board has agreed on its priorities, use a board action plan to help the board develop a clear approach to achieving its goals and staying accountable.

1. What steps can we take to ensure that information from the evaluation is used to improve the performance of the board?
2. Who or what committee is responsible for initiating and leading board development and assessment? Does it have the necessary resources and authority to fulfill its responsibilities?
3. Every board should have clearly established guidelines that outline the duties and responsibilities of individual board members. Are our board members held accountable to these standards? Do we have a process for removing nonperforming board members?

Check your progress. Only the board can hold itself accountable for its own performance. Periodically revisit the results from the self-assessment and action plan, celebrate the successes, and recommit to those areas that need further attention.

Repeat. BoardSource recommends conducting a thorough board self-assessment every two to three years and using the intervening time to work on the action plan you develop.

Additional Services

With the completion of your board self-assessment (BSA), you have joined the ranks of approximately 500 nonprofit boards that used the BoardSource BSA in the past year. Governance does not come naturally to all these leaders. BoardSource offers the following resources for those who seek additional guidance. For more information visit our website: www.boardsource.org.

The Certificate of Nonprofit Board Education

This certificate is for new and potential board members as well as staff and consultants who are new to working with a board. This program is offered through a series of webinars, an on-demand learning platform, or through a live training.

About BoardSource

About Us

BoardSource envisions a world where every social sector organization has the leadership it needs to fulfill its mission and advance the public good. Our mission is to inspire and support excellence in nonprofit governance and board and staff leadership.

Established in 1988, BoardSource's work is grounded in the fundamental belief that boards are critical to organizational success. With decades of hands-on experience working with and supporting nonprofit boards, BoardSource is the recognized leader in nonprofit governance and leadership, and a go-to resource for nonprofit board and executive leaders. BoardSource supports a broad and diverse cross-section of social sector organizations with

- leadership initiatives addressing key opportunities and issues within the nonprofit sector
- research and benchmarking of board composition, practices, and performance
- membership and board support programs
- customized diagnostics and performance assessment tools
- a comprehensive library of topic papers, publications, and downloadable infographics, tools, templates and more
- live and virtual education and training
- a biennial conference that brings together approximately 800 board leaders for two days of learning and sharing

A note to our global readers

The need for effective board leadership and governance knows no geographic boundaries, and BoardSource is committed to strong social sector board leadership and governance around the globe. While BoardSource uses United States laws and policies as the legal framework for our resources and recommendations, most of our resources do not focus on legal matters but rather on good governance practices, making them relevant to organizations working outside of the United States. We do suggest, however, that you refer to applicable laws in your country regarding financial reporting and other legal and transparency issues.

BoardSource is a 501(c)(3) organization.

For more information, please visit our website at www.boardsource.org, e-mail us at mail@boardsource.org, or call us at 800-883-6262.

ALAMEDA ALLIANCE FOR HEALTH

Board Effectiveness Assessment Summary

KEY HIGHLIGHTS –FOR DISCUSSION ONLY

1) Overall scores within each category are within the good to excellent range and slightly higher than average scores for all boards.
2) Financial Oversight (3.77) and Mission, Vision & Strategic Direction (3.54) received the highest scores. Culture (3.02) and Board Composition (2.84) received the lowest scores.
3) Satisfaction with board work and participation was high. 86% of board members report being satisfied to very satisfied with overall board effectiveness, relative to 80% for all boards. 92% of board members report being satisfied to very satisfied with their experience on the board, relative to 87% for all boards. 72% of board members are satisfied to very satisfied with the level of board member engagement, relative to 81% for all boards.

"The Alliance continues to get stronger and meets new challenges very well, due to the strong and committed staff. I would like to identify ways for the Board to contribute more to the organization's well-being."

The People

The People	**AAH**	**All Boards**
Category Average	3.22	3.01
Board Composition	2.84	2.67
Board Structure	3.43	3.18
Board Meetings	3.46	3.17

What trends emerged from the assessments?

a) Board member recruitment and building a pipeline of diverse board candidates were identified as areas of priority. Members suggested that the representative nature of board composition (seats assigned by statute) makes this difficult.

b) Planning for board officer succession was identified as a key area for improvement and it was noted that this is often left to the organizations that hold the board seat.
c) Board members expressed interest in a more robust onboarding process for new members and a desire to review board roles and responsibilities more often.
d) Suggested improvements for board meetings included reducing the length of the board packet, ensuring that meetings don't go over time and offering more opportunities for deliberation.

"We don't have a great deal of turnover on the board and also leave some of the succession planning to the individual organizations that appoint board members."

"The board meetings rarely involve deliberation, mostly the members are absorbing information and asking clarifying questions. the board packet is way too long, and the length perhaps provides an excuse for members to not read and prepare for meetings. Board members do not receive any assignments ever but staff receive assignments are always prompt about follow up. I do not know if there are enforced policies regarding attendance."

The Culture

The Culture	AAH	All Boards
Category Average	3.02	2.83

What trends emerged from the assessments?

a) There was widespread agreement that the board fosters a culture of respect, inclusion and open discussion.
b) Board members expressed interest in improving mentorship of first year members and providing more opportunities for members to get to know each other on a more personal level.
c) The lowest and most disparate scores in this section were for working proactively to address potentially negative dynamics and working proactively to address challenging board behaviors. There were a significant proportion of NA/Don't know answers for these two questions, indicating that perhaps these situations may be rare or have not been encountered.

"We have an opportunity to continue to improve the onboarding of new members. While we have an orientation and 1:1 with existing board leaders, we do not have ongoing mentoring or check-ins with new board members. We also have a relatively transparent process for selecting leaders on the board but likely can improve this to make it more inclusive. Finally, we do not have many opportunities for the board members to get to know each other, particularly in the age of teleconferences."

The Work

The Work	AAH	All Boards
Category Average	3.48	3.10
Mission, Vision & Strategic Direction	3.54	3.05
Program Oversight	3.77	2.95
Financial Oversight	3.47	3.38
Chief Executive Partnership & Oversight	3.47	3.15
Funding & Public Image	3.21	2.94

What trends emerged from the assessments?

a) Mission, Vision, and Strategic Direction received some of the highest scores, with good to excellent ratings in the high 70's to 90's.
b) With regard to program oversight, the lowest ratings were for ensuring that board members are well-versed in the organization's programs. The only poor score was (7%) was for measuring the quality and impact of programs.
c) Financial Oversight received consistently high scores. There was some commentary about the board not having reviewed insurance coverage and/or requirements.
d) There was some disparity in scores for the question of whether the board received and reviewed Form 990/990EZ on a regular basis. More than half of respondents reported NA/Don't know to this question.
e) Chief Executive Partnership and Oversight received the highest scores of all categories in the assessment.
f) Board members indicated a need to prioritize Chief Executive succession planning in the event of a sudden or unexpected departure.
g) Questions related to board member fundraising expectations and activities received mixed responses, with high percentages responding NA/Don't know. Some members commented that the nature of the board precludes individual fundraising. Others suggested that individual board member involvement in advocacy could be an effective priority.

"The financial reporting process is thorough and regular, and the Board is accustomed to having clear presentations with sufficient detail. Gil Riojas is an excellent CFO. There is not much discretion in investment policies due to public funds investment rules."

"We need to continually review our new strategic plan and keep it in mind as we make decisions moving forward."

“I believe that the board would benefit from a better general overview about the work of AAH to ensure that all are clear. Similarly, the board could benefit from a conversation or training about their role as a board of a managed care plan. When a plan is in trouble, people often ask where was the board? It should be clearer to members when and how to raise concerns.”

“It would be helpful for the Board to clearly understand it's role with respect to public promotions and advocacy. Right now, there appears to be no role, and it would be good to have a clearly defined role.”

The Impact

The Impact	AAH	All Boards
Category Average	3.35	3.34

What trends emerged from the assessments?

a) The board has a generally very positive view of its impact on the organization.
b) Some board members expressed an interest in sharing information publicly about the role and impact of the board on the organization and the communities it serves.

“Perhaps we need to have clearer conversations about the role and value of the Board.”

“Would like to see an intentional focus on eliminating disparities.”

ALAMEDA ALLIANCE FOR HEALTH
SUMMARY OF INTERVIEWS WITH BOARD MEMBERS

FOR DISCUSSON ONLY

Each member of the Board of Governors of the Alameda Alliance for Health was interviewed individually in April 2022 regarding the Board Effectiveness Assessment and other issues of interest to the Board Chair. Everyone was delightful and happy to share their perspectives.

KEY HIGHLIGHTS:

1) Members concurred with results of Board effectiveness survey generally.
2) Interest in emergency succession planning for CEO, C-suite and department heads
3) Want more time for discussion and questions at board meetings, agenda's too packed.
4) Re-think new board member orientation.
5) Mixed feelings about returning to in-person meetings; generally, most members would like a mixed approach (some in person; some all virtual).
6) Strong support for adding new seats county seats and CHCN seat to Board.
7) Most members spend between 1-2 hours each month preparing for Board meetings including 1:1 with CEO which all find extremely helpful.
8) Board retreat topics include Board composition options, single plan transition, Kaiser contract and Medicare.

DETAILED SUMMARY OF RESPONSES TO QUESTIONS:

Please Note: numbers next to each question in ( ) signify how many Board members mentioned this issue; if there is no number then 1 Board member noted the comment

1. What stands out in the assessment report and highlights? Is there anything in the report that is especially surprising or that you'd like to understand better through conversations as a full board?

a) Succession planning, especially emergency succession planning for CEO and executive team and department heads (5)
b) Diversity of board in terms of seats (4)
c) Happy to see such good results; high ratings (2)
d) Need more time at meetings for discussion and deliberations (3)
e) Seems that we are doing well compared to other surveyed organizations that we were compared to
f) I'm proud to be a member of the AAH Board
g) We should take our individual hats off and put AAH hat on at board meetings
h) Nothing like an in-person meeting
i) Good contact with executive leadership
j) Appreciate CEO leadership, use of data and his pragmatic approach to Kaiser situation
k) County health seems to be missing link on our board in the diversity question
l) Rely on staff analysis in board packet – too much to get through and understand each month

2. Is there anything you disagree with or that you think is inaccurate in the survey results? Why? Is there anything missing?

NOTE: Most people did not disagree with the assessment results

AAH Board mentioned these items as 'missing' in the assessment and think they are important to address:

a) Need more time for questions and discussion; agendas are too packed (4).
b) Succession planning for emergency situations for CEO, C-Suite and department heads (3).
c) Leadership development for key staff positions.
d) Like high-level of physician participation on AAH Board – voice of providers is very important.
e) Effectiveness of a public board.
f) Board is cohesive (2); finance reports are great; Compliance Committee is so well run by Rebecca.
g) Need more information to address proactively any negative dynamics in the environment.
h) Wondering about how we do CEO oversight. Who does CEO evaluation and what is timing of CEO evaluation?
i) Staff are available to help board members understanding issues regularly.
j) Concerned with Kaiser situation.

3. How would you define your role as a Board member?

   NOTE: Most members had a hard time with this question and responded with a variety of other related but distinct topics.

   a) Need more details on each subject; perhaps a short lecturette on topics would be helpful, even taped and sent out in advance.
   b) Unique perspective representing public hospital system.
   c) Keen interest.
   d) BH quality metrics.
   e) Attendance is a key to effectiveness of Board.
   f) Learn from other board members and how we can represent the best of AAH.
   g) Concerned about impact of decisions on members and workers.
   h) Believe in Board as 'hands off' on operations and focus on policy issues which we don't seem to do enough of.

4. Based on this assessment and on your own experience, what would help you do a better job as a board member?

   a) In-depth board orientation for new members – we have a complex organization (5).
   b) Management skills in a big organization and how a board of volunteers can be effective.
   c) Would like to learn about AAH investment policies and 'green' policies.
   d) Succession planning for senior executives.
   e) CEO prepares the Board so well with his 1:1 each month.
   f) Would have been helpful to have a board buddy as a new member; someone I could go to and ask questions; Need to add board mentoring for new members.
   g) Board packet needs to come on time – it's big and we need to set aside time to review so much material.
   h) As board, we need help with time management at our meetings.
   i) Are there things we should do more in closed versus open session?
   j) Need more time for discussion at each meeting.

5. Based on what you see in the assessment, what are the top 1-3 areas where you think the board should focus its development efforts?

   a) Succession planning for CEO and executive team, especially emergency succession (5).
   b) How to best ask relevant financial questions.
   c) Continue 1:1 prep meeting with CEO and each board member monthly.
   d) Composition of board.

e) Clear delineation of role of Board of AAH.
f) Orientation for all board members annually not just for new members – need a good reminder of our roles.
g) Workforce issues for AAH and for our provider network.
h) What opportunities do we have as an organization to reach out more effectively to our diverse membership
i) Review of vendor contracts at least annually.
j) Learn more about LA Care sanctions and what the board's role there was or wasn't.
k) Need additional dashboards to review the strategic plan impact over time.

6. Can you identify some skills or assets you can bring to the board to help address these priorities?

a) Better orientation of new members (3).
b) Aging/disability issues.
c) Homeless issues.
d) Familiar with non-profit management issues that cross over to our role on a public board.
e) Children's health expert.

7. Are you ready to go back to in person meetings? Or do you prefer hybrid meetings with some people in person and some on-line?

a) NO, prefer hybrid meetings (4).
b) YES, to in person (3) – people are not as focused on virtual platform meetings as in person.
c) NO not in person; Webex saves us all time and money (2).
d) Prefer mix of virtual and in person meetings going forward (2).
e) Quarterly meetings in person might be ok (2).
f) Remote ok; 4 won't come to in person meetings unmasked for now.
g) Quarterly meetings in person and longer than 2 hours.
h) Prefer combination of virtual and in person but not hybrid – it doesn't work.
i) In person/virtual every other month.

8. Are there gaps in the BOG composition? If so, be specific.

a) Support new seats for county and CHCN (9).
b) Bring any new members on as soon as possible and no later than January 2023 = we need them as we begin the transition work (9).
c) Board is big enough so we might have to either re-purpose current seats or use attrition to fill new seats or designations (3).
d) Re-look at designated seats.

e) Support seat for CHCN but not for another individual FQHC or community clinic.
f) Do we need a homeless representative or one from behavioral health?
g) Think we need to fill both 'member/beneficiary' seats.
h) Should we consider LGBTQIA representation on board?
i) We have not yet had enough input on the new members as proposed although I do not disagree with them.

9. How much time on average do you spend each month reading Board and committee materials?

a) 90 minutes – 2 hours (5).
b) Plus 1:1 with Scott each month.
c) Scan packet and rely on 1:1 with CEO to highlight issues.
d) Review before each meeting.
e) CEO's 1:1 meeting with us are the best!
f) Not much time; like executive summaries of each section of the packet and CEO 1:1 briefing each month.
g) 30 minutes night before.
h) 4-5 hours per month; must be done at night after regular work job.
i) Staff summaries/executive summary for each section are great, never enough time for review.

10. Do you participate in committees such as Finance or Compliance? If not, would you be open to learning more about ways to serve on existing committees?

a) Serve on Finance and Compliance (3).
b) Serve on Quality Committee.
c) Compliance (3).
d) Strategic planning committee.
e) P&T Committee.
f) Committees are the place to do the deep dive on issues.
g) Chairs of Finance and Compliance Committees are excellent (3).

11. At our next retreat, what would you like to discuss?

a) Kaiser situation – what is our shared understanding, what are the challenges to AAH (8).
b) Single plan transition – what does single plan mean with insertion of Kaiser? (5).
c) CalAIM implementation progress and new CalAIM issues ahead (2).
d) Focus on justice involved and impact of CalAIM on elderly and disabled.
e) Board composition options.
f) Team building with Board; there are many new members whom we don't know well.

g) Retrospective to show how AAH is addressing the compliance issues over time.
h) Issues impacting those that are homeless and mentally ill with wrap-around services.
i) Succession planning.
j) Workforce challenges throughout the system – both AAH and providers.
k) Financial metrics.
l) Medicare.
m) Learn more about LA Care sanctions and what the board's role there was or wasn't.
n) Impact of pandemic on the health plan.
o) How do we create a real brand for AAH.

12. What are the areas of knowledge that you would like to build in the next year?

a) Medicare and DSNP (2).
b) Regular updates on CalAIM implementation and planning.
c) Single plan transition.
d) Are we doing what we should be doing as a Board?
e) Dashboard of findings for improvement.
f) Internal investments in case management.
g) How much funding goes to CBOs?
h) Outcomes of investments and RFPs.
i) Level of board approval for vendor contracts.
j) Revenues by product line would be helpful information to have regularly.
k) Cross-system/cross-county referrals.
l) New providers needed in single plan approach.
m) CEO oversight.
n) LTSS and SNF.

13. Is there anything else you would like to add?

a) Meeting logistics
    - Board meetings every other month for 2 hours would be good (2).
    - Would prefer meetings stay at every month as we never have enough time in the 2 hours we have.
    - Could committee meeting reports be on consent calendar?
    - Need shorter reports at meetings and more time for discussion.
b) Meeting topics
    - Would like more meaningful educational presentations at each meeting.
    - Cut down on other topics that are regularly at each meeting.
    - Board officers succession plan.
    - SDOH and how it will impact AAH going forward including metrics and benchmarks.

- Need to purchase a building; continuing to lease is a bad idea.

c) Board relationships
    - Don’t really know board members for the most part as I’m new.
d) Board-staff relationships
    - Staff and Board seem to act very professionally.
    - CEO is very thorough and clear in our 1:1 meeting.

Mental Health Mild-to-Moderate and Autism Spectrum Disorder Services

CEO Update to the
Alameda Alliance Board of Governors

May 13th, 2022

Agenda

- Background
- Service Domains
- Organizational Priorities
- Mental Health & Substance Use Services
- Integrated Planning Update
- Current Activities
- Insourcing Timeline
- Updated Cost Estimates
- Cost Comparisons
- Staffing Model
- Day 1 Opportunities
- Improvement Opportunities - Day 2 and Beyond
- Next Steps

Background

- Phase One – Internal Planning *** Completed in December 2020
  - Preliminary planning with staff and industry experts to develop material for phase two.
  - Requirements gathering to identify costs, regulatory compliance, technology, and other process-related impacts and opportunities.
  - Organizational change management, best practices, core competencies, and staffing.
- Phase Two – Community Engagement *** Completed in March 2021
  - Listening Sessions with Community Partners currently engaged in mental health & autism spectrum services.
  - Feedback incorporated into the detailed planning for the insourcing of the service domains.
- In April 2021, approval to terminate contract with Beacon Health Options no later than December 2022, insourcing seven domains of service.
  - Original Implementation Costs were estimated $1.2 million to $1.7 million
  - Original Annual Administrative Costs were estimated $3.0 million to $4.5 million (excluding provider payments), resulting in the hiring of 36.5 new employees.

Service Domains

1. Care Transitions
2. Utilization Management
3. Quality Improvement
4. Provider Network
5. Credentialing
6. Customer Service
7. Claims Processing & Payment

Organizational Priorities in 2022-2023

- Insourcing of Mental Health & Autism Spectrum Services
  - Conducted an Enterprise Portfolio and Risk assessment
  - Evaluated resource capacity and regulatory demand
  - CEO & Executive Team reviewed progress report in the month of May, CEO approved to extend go-live by 30 days to November 1st, 2022. Minimizing the impact on members and providers is the highest priority.

GO LIVE November 1st, 2022

- CalAIM
  - Enhanced Care Management (ECM) – four (4) additional Populations of Focus: 1/1/2023 (3) and 7/1/2023 (1)
  - Long Term Care Carve-In: 1/1/2023
  - Population Health Management Plan: 1/1/2023
  - Justice Involved/Coordinated Re-entry: 1/1/2023
- Incentive Programs
  - Behavioral Health Integration Incentive Program (BHIIP): Commenced 1/1/2021 and continues through 12/31/2022
  - CalAIM Incentive Payment Program (IPP): Commenced 1/1/2022 and continues through 12/31/2023
  - Student Behavioral Health Incentive Program (SBHIP): Commenced 1/1/2022 and continues through 12/31/2024
  - Housing and Homelessness Incentive Program (HHIP): Commenced 1/1/2022 and continues through 12/31/2023
- Various Federal and State-mandated projects and Enterprise Portfolio
  - 20 Active Projects
  - 5 projects in the Intake phase

Mental Health & Substance Use Services

MEDI-CAL MANAGED CARE

Alameda Alliance for Health

Physical & Social health care services

- Maternity & Newborn care
- Pediatric services, including oral & vision
- Ambulatory patient services, including mental health within the PCP's scope of practice
- Prescription drugs
- Prevention & wellness services, and chronic disease management
- Enhanced Care Management
- Community Support Services

Alameda County Health Care Services

Mental Health Services

Mild to Moderate Acuity

- Individual & Group Therapy
- Psychological testing when clinically indicated to evaluate a mental health condition
- Psychiatric consultation

Severe Acuity

- Individual & group therapy
- Psychological Testing
- Medication Management
- Substance Use

Rehabilitative & habilitative services (mental health)

- Targeted case management
- Day treatment intensive programs
- Day rehabilitation
- Adult residential treatment services
- Full service partnerships

Emergency mental health services

- Crisis intervention
- Crisis stabilization
- Adult crisis residential services

Inpatient mental health hospitalization

- John George Psychiatric Hospital

School-based behavioral health services

Integrated Planning Update

- Senior Director, Behavioral Health - Hired
  - Provides industry-level expertise and knowledge of insourcing and building a Medi-Cal Behavioral Health program
- Provider Network Assessment
  - Refreshed Beacon utilization data for updated understanding of network needs
  - Utilization of consultant resources to assist with contracting Behavioral Health network
- Project Planning and Initiation
  - Detailed project plan and timeline creation – in progress
  - Identify workstreams to support “Lift and Shift” methodology – complete
  - Project kick-off – completed on April 6th
  - Update in-sourcing cost estimate – complete

Current Activities

- Internal Reassessment
  - Conduct Monthly Executive Level evaluation of project deliverables, risk and timeline
  - Begin Recruitment of New Staff
  - Building detailed Business and Technology Requirements
  - Identify Regulatory Compliance Requirements (DHCS/DMHC)
    - Regulator Notification
    - Member & Provider Notifications
    - Policy & Procedure Development

Insourcing Timeline

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Network Development	Network Adequacy – M2M / ASD Network Contracts – New contracts/negotiations				Credentialing Workflow Process & Policy Changes System Enhancements/Config				
IT Infrastructure	Data exchange capabilities evaluation Construct exchange capability gaps				Data Sharing Provider Portal Updates - Intake Forms				
Staffing		Recruitment/ Onboarding Training							
Prior Auth. (UM)		Process Updates System Enhancements/Config – new rates							
Claims			Process Updates System Enhancements/Config – new rates						
Care Management		Process Updates System Enhancements/Config – new rates							
Data Analysis / Reporting		Analysis for transitioning volumes DHCS Requirements Reporting Library							
Finance		Rates				Rates			
Training					Staff & Provider Training				
Comm/ Notifications	Member Communications - Household/Impacted Members (8/1& 9/1 Mailings) Provider Notifications - Portal / Newsletter ID Cards								
Quality			Quality Program Development Oversight of Providers/Facilities						
Compliance / P&P Approval			Policy & Procedure Approval						
Member Services		**Workflow Process & Policy Changes System Enhancements/Config (IVR, HS, TC)**							
Regulatory Filing and Approval		Notify Beacon (120 Days) DHCS Notifictation (30 Day) DMHC Notification (?)							
BH Advisory Committee									

Target Go Live 11/1/2022

Cost Estimates – Initial & Recurring

- Refreshed implementation and recurring cost data from April 2021
  - Implementation Costs: $1.2M-$1.9M *(was $1.2M-$1.7M Apr 2021)*
    - Member and provider materials
      - Increased costs for ID cards & member notifications
    - Temporary project consulting support
      - Behavioral Health Trainer
      - Contracting Specialists
  - Recurring Costs: $4.2M-$5.4M annually *(was $3.4M-$4.5M Apr 2021)*
    - Staffing – 37 FTEs *(was 36.5 FTEs)*
      - Staffing costs increased as skill sets were further defined and analyzed
    - Technology – *no material change*

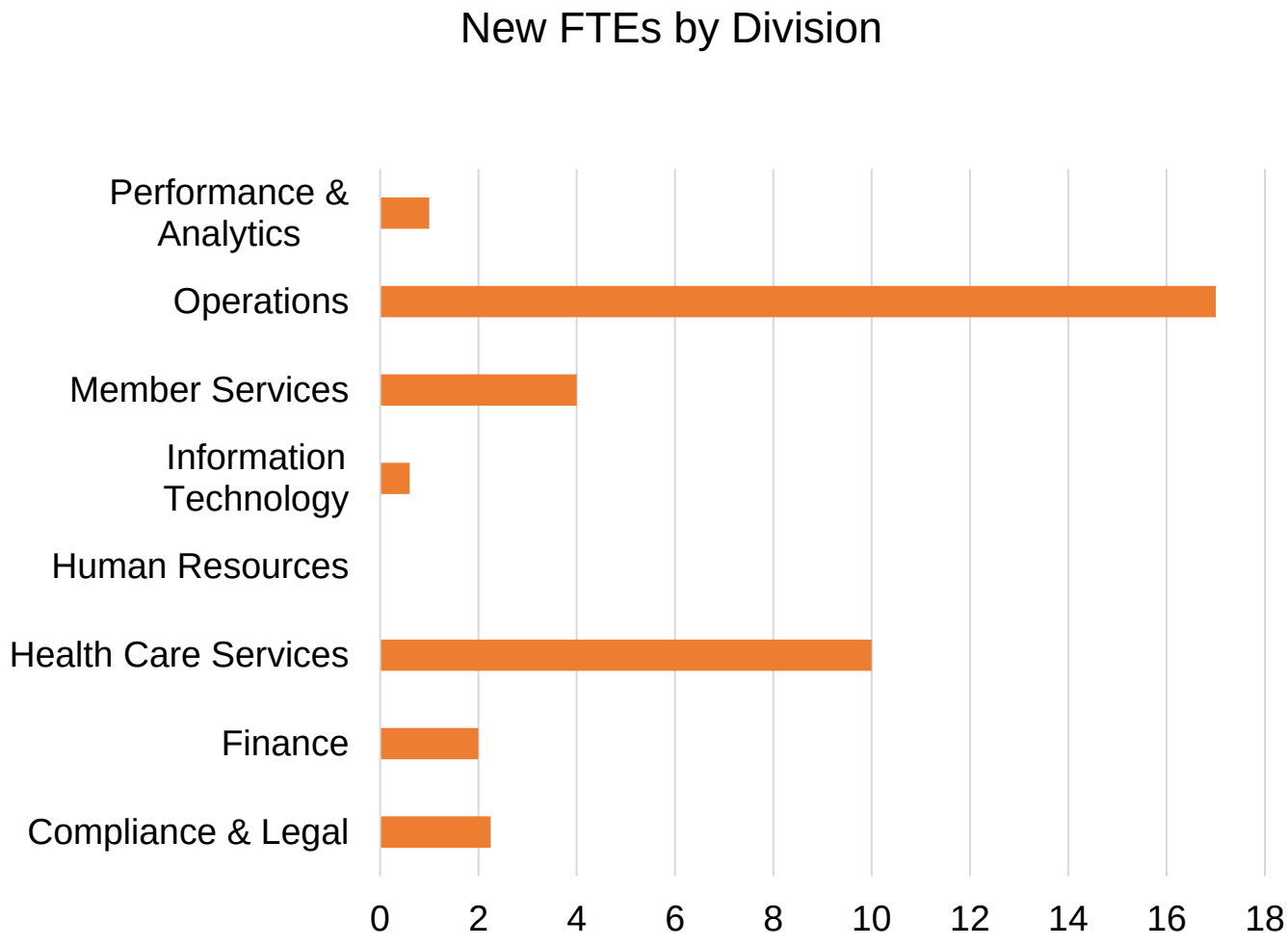
Cost Comparison: Outsource vs. Insource

	Outsource	Insource
Provider Payments	$30M	$30M
Administrative Expenses	$3.2M	$5.4M
Total	$33.2M	$35.4M

Staffing Model

- $4.2M-$5.4M annual run rate consists of 37 new FTEs, distributed across the company
  - Minimal change from 2021 in total FTEs; salary cost has increased due to the required positions

- Recruiting managed by internal HR staff & external recruiters for select positions



Lift & Shift Approach - “Day 1” Opportunities

- Regulatory Compliance / Reporting / Data Sharing
- Direct contracting will strengthen Provider relationships
- Continue Tele-Psych Program
- Leverage existing core systems and staff
- Build comprehensive internal Behavioral Health team that includes expertise in treating patients with autism
  - Creation of a new Behavioral Health Department
  - Expansion of Member Call Center to include behavioral health specialists
  - Formation of internal crisis response team (e.g. threat & potential harm assessment)
- Cohesive Medical and Behavioral Health record in Medical Management Systems (MMS)
- Access Issues / “No Wrong Door”
  - Joint workgroup with Alameda County Behavioral Health

Lift & Shift Approach - Improvement Opportunities “Day 2 & Beyond”

Areas the Alliance will evaluate:

- Warm Handoffs
- Step Up / Step Down
- Enhanced Member & Provider Portals
- Referral & Re-authorization Process
- Explore Payment Reform & Delegation Opportunities
- Primary Care Physician Engagement
- Telehealth Psych Program
- Assess Network Gaps (Linguistic/Cultural/Racial Disparities & Barriers to care)

Next Steps

- Notify Beacon of contract termination by June 30th, 2022; termination effective October 31st, 2022
- Initiate the insourcing implementation
  - Detailed Planning
  - Regulatory Notification
  - Provider Network Development (Contracting, Credentialing)
  - System Updates/Configuration
  - Recruitment
  - Space Planning
  - Member Notification
  - Mild to Moderate Mental Health / Autism Spectrum Disorder Program Cutover to AAH on November 1st, 2022

Operations

Matt Woodruff

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

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

Date: **May 13th, 2022**

Subject: **Operations Report**

Member Services

- 12-Month Trend Summary:

    - The Member Services Department received a seventeen percent (17%) decrease in calls in April 2022, totaling 11,939 compared to 14,438 in April 2021. Call volume pre-pandemic in April 2019 was 14,911, which is twenty percent (20%) higher than the current call volume.
    - April utilization for the member automated eligibility IVR system totaled one hundred sixty-nine (169).
    - The abandonment rate for April 2022 was sixteen percent (16%), compared to five percent (5%) in April 2021.
    - The Department's service level was fifty-one percent (51%) in April 2022, compared to fifteen percent (15%) in April 2021. The Department continues to recruit to fill open positions. Service levels continue to be directly impacted due to staffing challenges (unplanned callouts related to personal or family illnesses with COVID-19). Training of customer call support vendor is ongoing to augment queue support.
    - The Department is updating the Member Services IVR phone prompts to increase utilization of self-service features that enable members to access multiple plan services (i.e., transportation, pharmacy, dental, vision, behavioral health) without having to speak to an agent.
    - The average talk time (ATT) was six minutes and twenty-nine seconds (06:29) for April 2022 compared to six minutes and nineteen seconds (06:19) for April 2021.
    - The top five call reasons for April 2022 were: 1). Eligibility/Enrollment, 2). Kaiser 3). Change of PCP, 4). Benefits, 5). ID Card/Member Materials requests. The top five call reasons for April 2021 were: 1). Eligibility/Enrollment, 2). Kaiser, 3). Change of PCP 4). Benefits, 5). ID Card Requests.
    - The Department continues to service members via multiple non-contact communication channels (telephonic, email, web-based requests) while honoring the organization's policies. The Department responded to seven hundred-forty (740) web-based requests (20% increase) in April 2022

compared to five hundred ninety-five (595) in April 2021. The top three web reason requests for April 2022 were: 1). Change of PCP 2). ID Card Requests, 3). Update Contact Information.

- Training:
    - Routine and new hire training are conducted via (remote) model by the MS Leadership Team until staff returns to the office.

Claims

- 12-Month Trend Summary:
    - The Claims Department received 189,172 claims in April 2022 compared to 140,678 in April 2021.
    - The Auto Adjudication was 83.5% in April 2022 compared to 74.5% in April 2021.
    - Claims compliance for the 30-day turn-around time was 98.7% in April 2022 compared to 98.3% in April 2021. The 45-day turn-around time was 99.9% in April 2022 compared to 99.9% in April 2021.
- Training:
    - Routine and new hire training is being conducted remotely by the Claims Trainer.
- Monthly Analysis:
    - In April, we received a total of 189,172 claims in the HEALTHsuite system. This represents an increase of 1.85% from March and is higher, by 48,494 claims, than the number of claims received in April 2021.
    - We received 87% of claims via EDI and 13% of claims via paper.
    - During April, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 83.5% for April.

Provider Services

- 12-Month Trend Summary:
    - The Provider Services department's call volume in April 2022 was 5,767 calls compared to 5,501 calls in April 2021.
    - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
    - The Provider Services department completed 231 calls/visits during April 2022.
    - The Provider Services department answered 3,548 calls for April 2022 and made 640 outbound calls.

Credentialing

- 12-Month Trend Summary:
    - At the Peer Review and Credentialing (PRCC) meeting held on April 19th, 2022, there were twenty-four (24) initial providers approved; five (5) primary care providers, nine (9) specialists, two (2) ancillary providers, and eight (8) midlevel providers. Additionally, fifty-one (51) providers were re-credentialed at this meeting; thirteen (13) primary care providers, twenty-five (25) specialists, three (3) ancillary providers, and ten (10) midlevel providers.
    - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Provider Dispute Resolution

- 12-Month Trend Summary:
    - In April 2022, the Provider Dispute Resolution (PDR) team received 1081 PDRs versus 784 in April 2021.
    - The PDR team resolved 878 cases in April 2022 compared to 766 cases in April 2021.
    - In April 2022, the PDR team upheld 67% of cases versus 71% in April 2021.
    - The PDR team resolved 99.9% of cases within the compliance standard of 95% within 45 working days in April 2022 compared to 99.0% in April 2021.

- Monthly Analysis:

    - AAH received 1081 PDRs in April 2022.
    - In the month of April, 878 PDRs were resolved. Out of the 878 PDRs, 589 were upheld and 289 were overturned.
    - The overturn rate for PDRs was 33% which did not meet our goal of 25% or less.

Community Relations and Outreach

- 12-Month Trend Summary:

    - In April 2022, the Alliance completed 450-member orientation outreach calls and 102 member orientations by phone.
    - The C&O Department reached 102 people (100% identified as Alliance members) during outreach activities, compared to 217 individuals (100% self-identified as Alliance members) in April 2021.
    - The C&O Department spent a total of $0 in donations, fees, and/or sponsorships, compared to $0 in April 2022.
    - The C&O Department reached members in 12 cities/unincorporated areas throughout Alameda County, Bay Area, and the U.S., compared to 19 cities in April 2021.

- Monthly Analysis:

    - In April 2022, the C&O Department completed 450-member orientation outreach calls and 102 member orientations by phone, and 54 Alliance website inquiries.
    - Among the 102 people reached, 100% identified as Alliance members.
    - In April 2022, the C&O Department reached members in 12 locations throughout Alameda County, Bay Area, and the U.S.
    - Please see attached Addendum A.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	April 2022
Incoming Calls (R/V)	11,939
Abandoned Rate (R/V)	16%
Answered Calls (R/V)	10,383
Average Speed to Answer (ASA)	04:30
Calls Answered in 60 Seconds (R/V)	51%
Average Talk Time (ATT)	06:58
Outbound Calls	4,881

Top 5 Call Reasons (Medi-Cal and Group Care) April 2022
Eligibility/Enrollment
Kaiser
Change of PCP
Benefits
ID Card/Member/Materials Request

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) April 2022
Change of PCP
ID Card Requests
Update Contact Info

Claims Department
March 2022 Final and April 2022 Final

METRICS

Claims Compliance	Mar-22	Apr-22
90% of clean claims processed within 30 calendar days	98.8%	98.7%
95% of all claims processed within 45 working days	99.9%	99.9%

Claims Volume (Received)	Mar-22	Apr-22
Paper claims	28,901	23,865
EDI claims	156,837	165,307
Claim Volume Total	**185,738**	**189,172**

Percentage of Claims Volume by Submission Method	Mar-22	Apr-22
% Paper	15.56%	12.62%
% EDI	84.44%	87.38%

Claims Processed	Mar-22	Apr-22
HEALTHsuite Paid (original claims)	138,388	107,291
HEALTHsuite Denied (original claims)	59,276	45,904
HEALTHsuite Original Claims Sub-Total	**197,664**	**153,195**
HEALTHsuite Adjustments	3,694	1,396
HEALTHsuite Total	**201,358**	**154,591**

Claims Expense	Mar-22	Apr-22
Medical Claims Paid	$66,699,289	$56,765,361
Interest Paid	$42,308	$32,142

Auto Adjudication	Mar-22	Apr-22
Claims Auto Adjudicated	163,706	127,946
% Auto Adjudicated	82.8%	83.5%

Average Days from Receipt to Payment	Mar-22	Apr-22
HEALTHsuite	18	18

Pended Claim Age	Mar-22	Apr-22
0-29 calendar days		
HEALTHsuite	13,594	14,827
30-59 calendar days		
HEALTHsuite	152	368
Over 60 calendar days		
HEALTHsuite	0	7

Overall Denial Rate	Mar-22	Apr-22
Claims denied in HEALTHsuite	59,276	45,904
% Denied	29.4%	29.7%

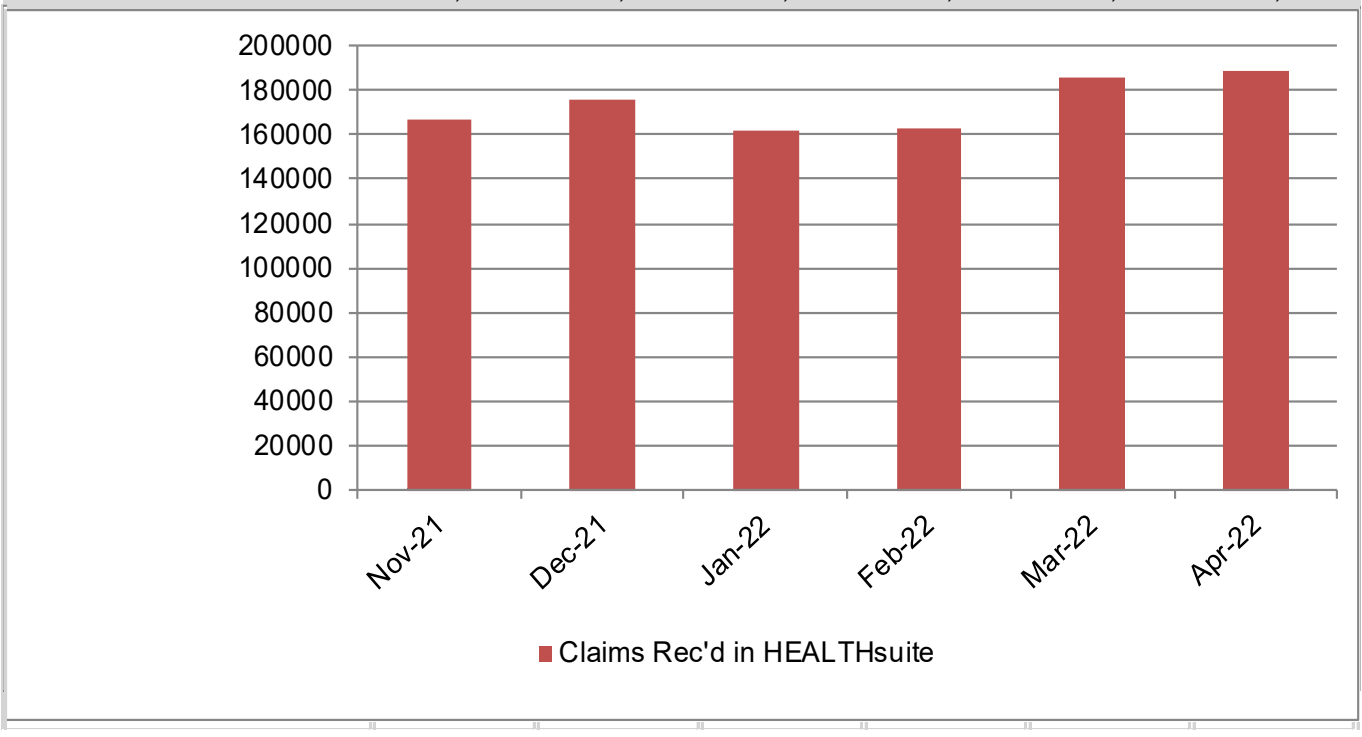
Claims Department
March 2022 Final and April 2022 Final

Apr-22

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	23%
No Benefits Found For Dates of Service	14%
Non-Covered Benefit for this Plan	10%
Duplicate Claim	10%
Please submit a copy of primary payer paper EOB	5%
% Total of all denials	**62%**

Claims Received By Month

Claims Received Through	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Claims Rec'd in HEALTHsuite	167,057	175,441	162,201	162,433	185,738	189,172



Provider Relations Dashboard April 2022

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	4810	4334	6078	5767								
Abandoned Calls	626	586	2149	2219								
Answered Calls (PR)	4184	3748	3929	3548								
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	332	373	1067	1309								
Abandoned Calls (R/V)												
Answered Calls (R/V)	332	373	1067	1309								
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	624	680	664	640								
N/A												
Outbound Calls	624	680	664	640								
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	5766	5387	7809	7716								
Abandoned Calls	626	586	2149	2219								
Total Answered Incoming, R/V, Outbound Calls	5140	4801	5660	5497								

Provider Relations Dashboard April 2022

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	3.4%	4.2%	3.4%	3.0%								
Benefits	4.1%	3.4%	3.1%	3.8%								
Claims Inquiry	40.2%	41.5%	40.8%	48.8%								
Change of PCP	2.4%	4.0%	4.8%	4.1%								
Complaint/Grievance (includes PDR's)	4.9%	5.3%	4.8%	4.2%								
Contracts	0.5%	0.7%	0.8%	0.7%								
Correspondence Question/Followup	0.0%	0.1%	0.1%	0.1%								
Demographic Change	0.1%	0.3%	0.0%	0.1%								
Eligibility - Call from Provider	25.3%	23.2%	22.6%	21.4%								
Exempt Grievance/ G&A	0.0%	0.1%	0.0%	0.1%								
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%								
Health Education	0.0%	0.0%	0.0%	0.0%								
Intrepreter Services Request	0.8%	0.4%	0.8%	0.7%								
Kaiser	0.0%	0.1%	0.1%	0.7%								
Member bill	0.0%	0.2%	0.0%	0.0%								
Mystery Shopper Call	0.0%	0.0%	0.0%	0.0%								
Provider Portal Assistance	4.5%	5.4%	4.9%	3.9%								
Pharmacy	1.2%	0.3%	0.3%	0.3%								
Provider Network Info	0.1%	0.1%	0.2%	0.1%								
Transferred Call	0.0%	0.0%	0.0%	0.0%								
All Other Calls	12.3%	10.8%	13.4%	8.2%								
TOTAL	100.0%	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	9	18	17	12								
Contracting/Credentialing	8	10	28	20								
Drop-ins	0	0	0	0								
JOM's	1	2	3	1								
New Provider Orientation	22	15	34	22								
Quarterly Visits	211	274	159	175								
UM Issues	2	4	2	1								
Total Field Visits	253	323	243	231	0	0	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS

Practitioners		AHP 413	PCP 361	SPEC 625	PCP/SPEC 15
AAH/AHS/CHCN Breakdown		AAH 399	AHS 159	CHCN 444	COMBINATION OF GROUPS 412
Facilities	**296**				

VENDOR SUMMARY
Credentialing Verification Organization, Symply CVO

	Number	Average Calendar Days in Process	Goal - Business Days	Goal - 98% Accuracy	Compliant
Initial Files in Process	22	28	25	Y	Y
Recred Files in Process	66	28	25	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**88**				

CAQH Applications Processed in April 2022

	Invoice not received
Standard Providers and Allied Health	

April 2022 Peer Review and Credentialing Committee Approvals

Initial Credentialing	Number
PCP	5
SPEC	9
ANCILLARY	2
MIDLEVEL/AHP	8
	24
Recredentialing	
PCP	13
SPEC	25
ANCILLARY	3
MIDLEVEL/AHP	10
	51
TOTAL	**75**

April 2022 Facility Approvals

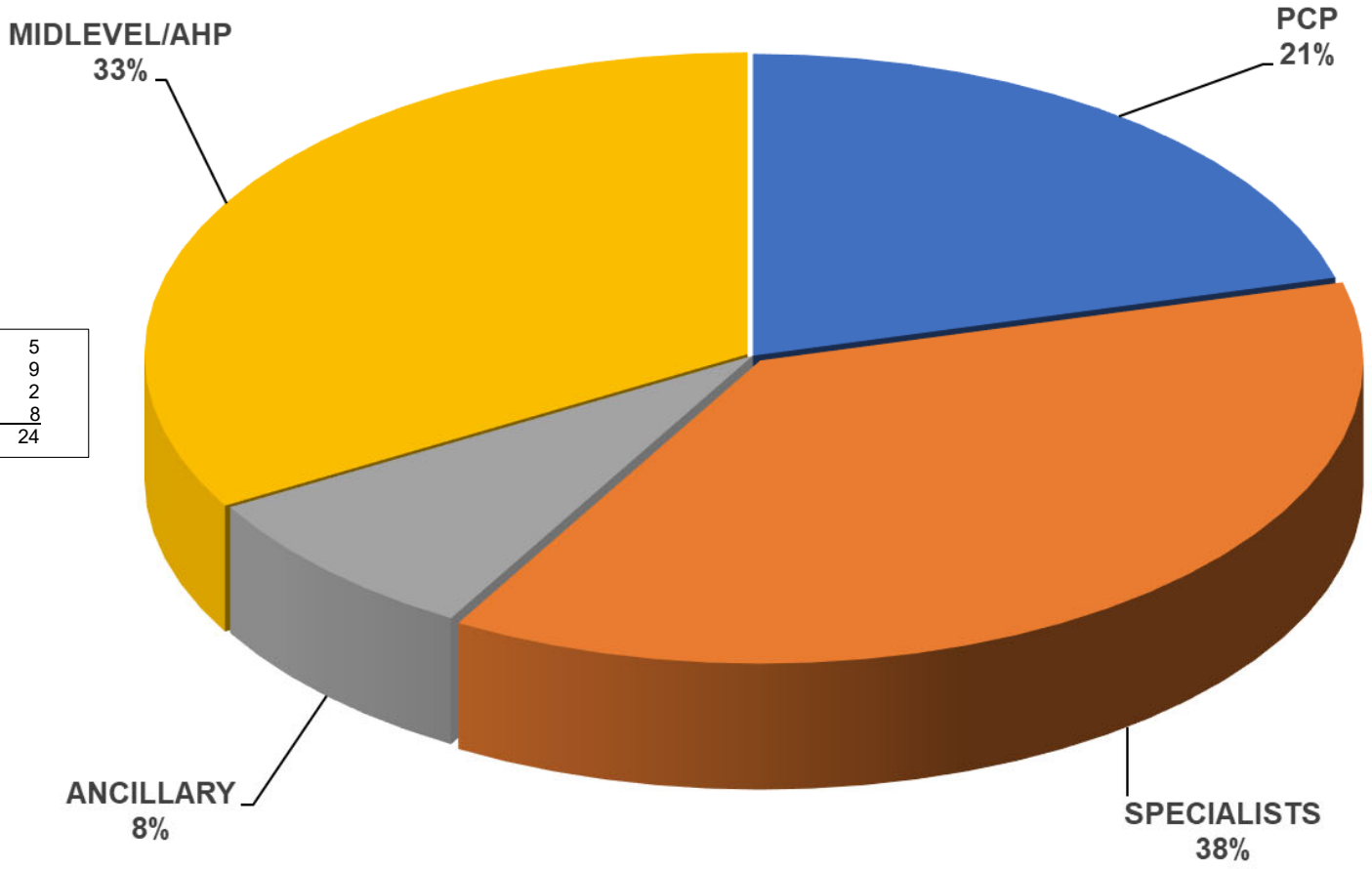
Initial Credentialing	5
Recredentialing	11
Facility Files in Process	**39**

April 2022 Employee Metrics

	4	
File Processing	Timely processing within 3 days of receipt	Y
Credentialing Accuracy	<3% error rate	Y
DHCS, DMHC, CMS, NCQA Compliant	98%	Y
MBC Monitoring	Timely processing within 3 days of receipt	Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Basu	Sanjay	Primary Care Physician	INITIAL	4/19/2022
Belsky	Larissa	Allied Health	INITIAL	4/19/2022
Charles	Alexia	Primary Care Physician	INITIAL	4/19/2022
Collins-Pallett	Thomas	Primary Care Physician	INITIAL	4/19/2022
Conderman	Christian	Specialist	INITIAL	4/19/2022
Hoang	Vay	Allied Health	INITIAL	4/19/2022
Ivey	Louis	Specialist	INITIAL	4/19/2022
Kmucha	Steven	Specialist	INITIAL	4/19/2022
Landy	Sarah	Allied Health	INITIAL	4/19/2022
Ma	Aye Moe Thu	Specialist	INITIAL	4/19/2022
Mathur	Anushka	Allied Health	INITIAL	4/19/2022
Mohiuddin	Abid	Specialist	INITIAL	4/19/2022
Moku-Paiva	Kaiulani	Ancillary	INITIAL	4/19/2022
Monroe	Lisa	Allied Health	INITIAL	4/19/2022
Morrissey	Molly	Allied Health	INITIAL	4/19/2022
Palakurthy	Prasad	Specialist	INITIAL	4/19/2022
Porwal	Nivin	Specialist	INITIAL	4/19/2022
Ring	Catherine	Allied Health	INITIAL	4/19/2022
Siani	Elena	Specialist	INITIAL	4/19/2022
Suh	Se Young	Specialist	INITIAL	4/19/2022
Suozzi	Melanie	Allied Health	INITIAL	4/19/2022
Tsang	Michelle	Primary Care Physician	INITIAL	4/19/2022
Vaghani	Drashti	Ancillary	INITIAL	4/19/2022
Valdes	Ann	Primary Care Physician	INITIAL	4/19/2022
Aarabi	Shahram	Specialist	RECRED	4/19/2022
Achanta	Kranthi	Specialist	RECRED	4/19/2022
Ally	Zahora	Specialist	RECRED	4/19/2022
Barash	Muni	Specialist	RECRED	4/19/2022
Burack	Jeffrey	Specialist	RECRED	4/19/2022
Cheifetz	Karrin	Ancillary	RECRED	4/19/2022
Chen	Xiaoshuang	Primary Care Physician	RECRED	4/19/2022
Chen	Enna	Allied Health	RECRED	4/19/2022
Cheung	Ka	Specialist	RECRED	4/19/2022
Chichili	Sudhathi	Specialist	RECRED	4/19/2022
Coleman	Dione	Allied Health	RECRED	4/19/2022
Crawford	Ana	Specialist	RECRED	4/19/2022
Daniel	Sally	Allied Health	RECRED	4/19/2022
DeBree	Olivia	Allied Health	RECRED	4/19/2022
Eapen	Jacob	Primary Care Physician	RECRED	4/19/2022
Enriquez	Christopher	Specialist	RECRED	4/19/2022
Golden	Bethany	Allied Health	RECRED	4/19/2022
Gwalani	Tulsidas	Specialist	RECRED	4/19/2022
Halio	Amy	Primary Care Physician	RECRED	4/19/2022
Hana	Anas	Primary Care Physician	RECRED	4/19/2022
Hom	Melanie	Specialist	RECRED	4/19/2022
Horoupian	Rupert	Specialist	RECRED	4/19/2022
Houser	Jennifer	Ancillary	RECRED	4/19/2022
Kao	Samuel	Specialist	RECRED	4/19/2022
Khalsa	Prabhjot	Specialist	RECRED	4/19/2022
Kwok-Oleksy	Christina	Specialist	RECRED	4/19/2022
Le	Carolyn	Primary Care Physician	RECRED	4/19/2022
Lee	Min-Wei	Specialist	RECRED	4/19/2022
Lee	Diane	Specialist	RECRED	4/19/2022
McClaughry	Corinne	Primary Care Physician	RECRED	4/19/2022
Moazed	Farzad	Specialist	RECRED	4/19/2022
Nathan	Manjari	Specialist	RECRED	4/19/2022
Paxton	Lamont	Specialist	RECRED	4/19/2022
Phung	Stephanie	Allied Health	RECRED	4/19/2022
Proddatoori	Kruthika	Primary Care Physician	RECRED	4/19/2022
Rahman	Sophia	Specialist	RECRED	4/19/2022
Reynolds	Matthew	Allied Health	RECRED	4/19/2022
Riley	Jenny	Primary Care Physician	RECRED	4/19/2022
Shah	Shaista	Primary Care Physician	RECRED	4/19/2022
Shrestha	Swechha	Allied Health	RECRED	4/19/2022
Simon-Weisberg	Deborah	Primary Care Physician	RECRED	4/19/2022
Smart	Monica	Allied Health	RECRED	4/19/2022
Smith	Kevin	Specialist	RECRED	4/19/2022
Truong	Kenneth	Primary Care Physician	RECRED	4/19/2022
Vesga	Liana	Specialist	RECRED	4/19/2022
Vu	John	Specialist	RECRED	4/19/2022
West	Jessica	Allied Health	RECRED	4/19/2022
Wu	YongYi	Ancillary	RECRED	4/19/2022
Zaka	Jamal	Specialist	RECRED	4/19/2022
Zonner	Steven	Primary Care Physician	RECRED	4/19/2022
Zorthian	Barooyr	Primary Care Physician	RECRED	4/19/2022

APRIL PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	5
Specialists	9
Ancillary	2
MIDLEVEL/AHP	8
Total	24

Provider Dispute Resolution
March 2022 and April 2022

METRICS

PDR Compliance	Mar-22	Apr-22
# of PDRs Resolved	1,028	878
# Resolved Within 45 Working Days	1,025	877
% of PDRs Resolved Within 45 Working Days	99.7%	99.9%

PDRs Received	Mar-22	Apr-22
# of PDRs Received	788	962
PDR Volume Total	**788**	**962**

PDRs Resolved	Mar-22	Apr-22
# of PDRs Upheld	729	589
% of PDRs Upheld	71%	67%
# of PDRs Overturned	299	289
% of PDRs Overturned	29%	33%
Total # of PDRs Resolved	**1,028**	**878**

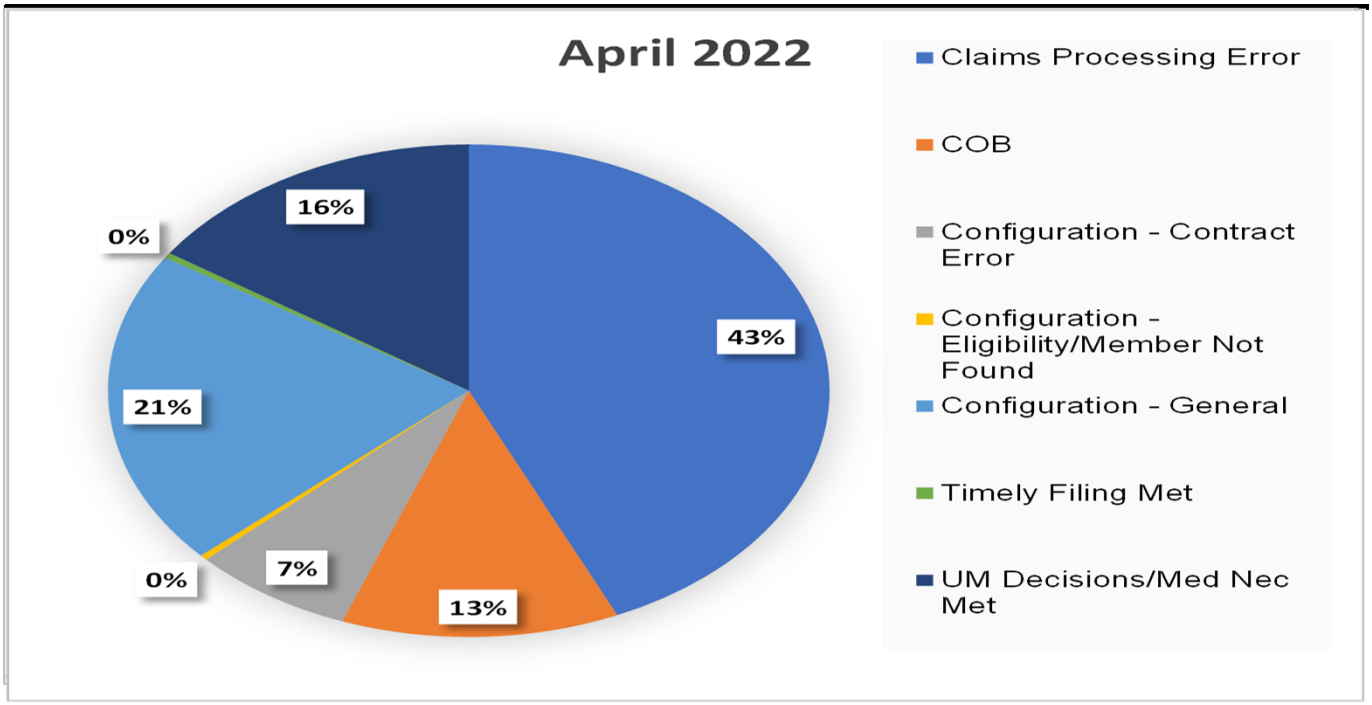
Average Turnaround Time	Mar-22	Apr-22
Average # of Days to Resolve PDRs	27	26
Oldest Unresolved PDR in Days	45	52

Unresolved PDR Age	Mar-22	Apr-22
0-45 Working Days	889	1,081
Over 45 Working Days	0	1
Total # of Unresolved PDRs	**889**	**1,082**

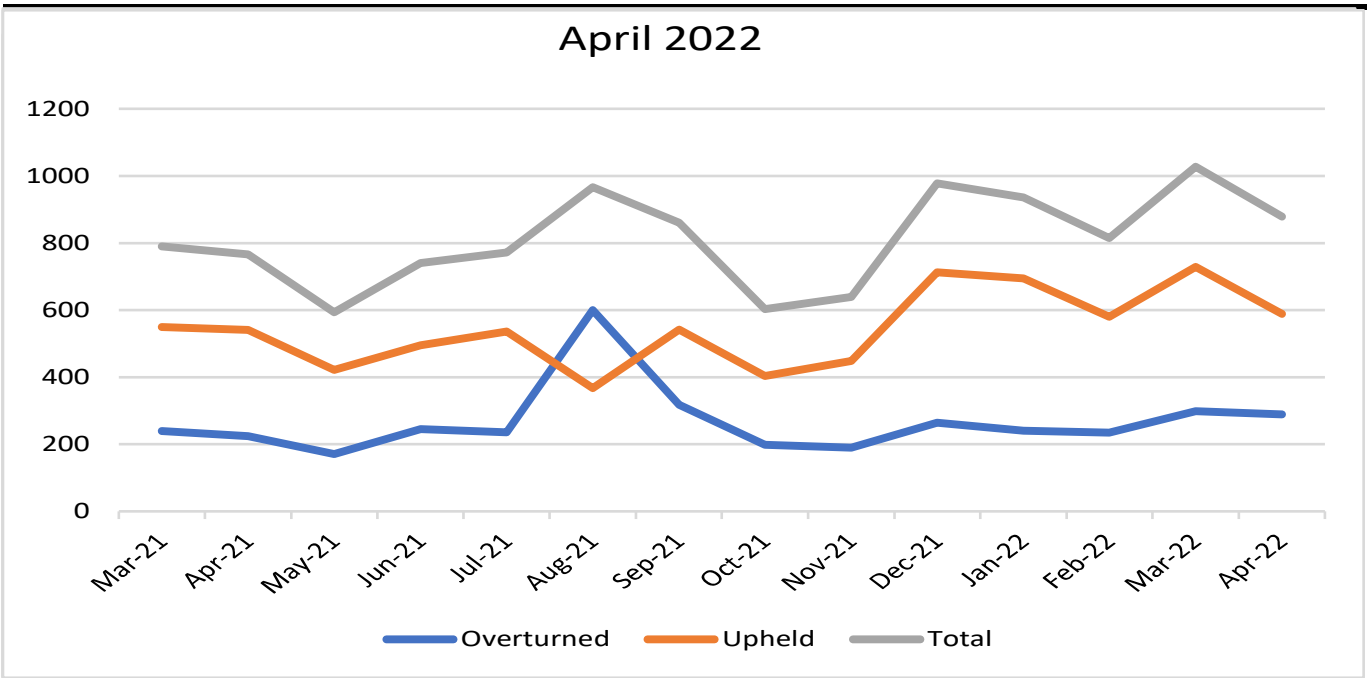
Provider Dispute Resolution
March 2022 and April 2022

Apr-22

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2021-2022 | **APRIL 2022 OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

FY 2021-2022 | APRIL 2022 OUTREACH REPORT

During April 2022, the Alliance completed **450**-member orientation outreach calls and conducted **102** member orientations (**23%-member** participation rate). In addition, in April 2022, the Outreach team completed **54** Alliance website inquiries.

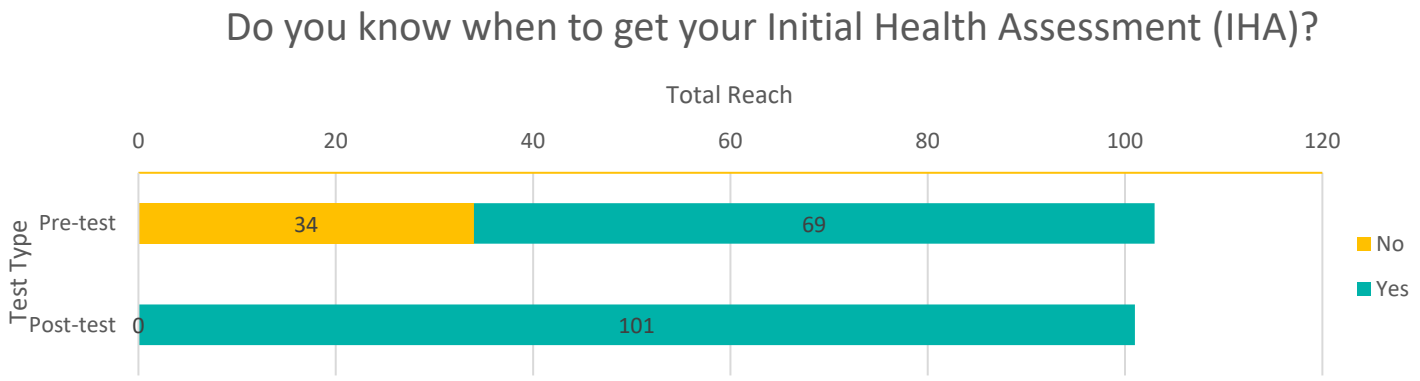
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **25,000** self-identified Alliance members have been reached during outreach activities.

On **Monday, March 16th, 2020**, the Alliance began assisting members by telephone only, following the statewide Shelter-in-Place (SIP) guidance to protect the general public from Coronavirus Disease (COVID-19). As a result, the Alliance proactively postponed all face-to-face member orientations and community events until further notice.

On **Wednesday, March 18th, 2020,** the Alliance began conducting member orientations by phone. As of April 30th, 2022, the Outreach Team completed 18,420-member orientation outreach calls and conducted 5,175 member orientations (28% member participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between April 1st, through April 30th, 2022 (21 working days) – **102** net new members completed a MO by phone.

After completing a MO **100%** of members who completed the post-test survey in April 2021 reported knowing when to get their IHA, compared to only **69%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 21-22\Q4\1. April**

ALLIANCE IN THE COMMUNITY

FY 2021-2022 | APRIL 2022 OUTREACH REPORT

FY 2020-2021 APRIL 2021 TOTALS

- 0 COMMUNITY EVENTS
- 0 MEMBER EDUCATION EVENTS
- 217 MEMBER ORIENTATIONS
- 0 MEETINGS/ PRESENTATIONS/
- 0 COMMUNITY TRAINING
- 0 TOTAL INITIATED/ INVITED EVENTS
- 217 TOTAL COMPLETED **EVENTS**

19 CITIES

Alameda
Albany
Berkeley
Brooklyn
Carson
Castro Valley
Dublin
Fremont
Hayward
Livermore
Minneapolis
Newark
Oakland
Pleasanton
Sacramento
San Leandro
San Lorenzo
Union City
Walnut Creek

- 0 TOTAL REACHED AT COMMUNITY EVENTS
- 0 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 217 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 TOTAL REACHED AT COMMUNITY TRAINING
- 217 MEMBERS REACHED AT ALL EVENTS
- 217 **TOTAL REACHED AT ALL EVENTS**

$0.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2021-2022 APRIL 2022 TOTALS

- 0 COMMUNITY EVENTS
- 0 MEMBER EDUCATION EVENTS
- 102 MEMBER ORIENTATIONS
- 0 MEETINGS/ PRESENTATIONS
- 0 COMMUNITY TRAINING
- 0 TOTAL INITIATED/ INVITED EVENTS
- 102 TOTAL COMPLETED **EVENTS**

12 CITIES*

Alameda
Berkeley
Dublin
Fremont
Hayward
Livermore
Martinez
Oakland
Pleasanton
San Leandro
San Lorenzo
Union City

- 0 TOTAL REACHED AT COMMUNITY EVENTS
- 0 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 102 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 COMMUNITY TRAINING
- 102 MEMBERS REACHED AT ALL EVENTS
- 102 **TOTAL REACHED AT ALL EVENTS**

$0.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

**Cities represent the mailing address designations for members who completed a member orientation by phone. The italicized cities are outside of Alameda County. The C&O Department started including these cities in the Q3 FY21 Outreach Report.*

Compliance

Richard Golfin III

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

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

Date: **May 13th, 2022**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2022 DHCS Routine Medical Survey:
    - The 2022 DHCS Routine Medical Survey has concluded the on-site portion of the review process. The audit began on April 4th, 2022 and was completed early on April 13th, 2022. The review period was April 1st, 2021, through March 31st, 2022, and covered the following areas:

        - Utilization Management;
        - Case Management & Care Coordination;
        - Access & Availability;
        - Member's Rights & Responsibilities;
        - Quality Improvement System; and
        - Organization and Administration.

    - To assist Staff in audit preparation, the Compliance Department conducted a series of 10 mock interview sessions, each session lasted from 1-1.5 hours. The Mock interview sessions took place from March 23rd, 2022, through March 31st, 2022. The sessions focused on the 6 DHCS areas of review bulleted above. Following each interview session, the Compliance Department distributed to Staff packets of information that contained audit tips, resources, and actual questions from the interviews. The next steps are for the Plan to complete its responses to the DHCS and resolve any remaining questions prior to issuing the preliminary report.

- 2022 DMHC Routine Financial Examination:
    - On February 25th, 2022, the DMHC sent notice to the Plan of the 2022 DMHC Routine Financial Examination beginning August 15th, 2022. The audit will review the Plan's fiscal and administrative affairs. There have been no additional updates on this audit since February.

- 2022 DMHC Behavioral Health Investigation:
    - In 2021, the DMHC began investigating full-service commercial health plans to evaluate and assess barriers providers experience in providing behavioral health services. The DMHC has announced it plans to conduct on average, 5-investigations per year with the first five plans having been investigated in 2021. Earlier this year, the DMHC announced the Plan would

be a part of the Year 2 group of Plans investigated in the reviews. At present, details on the scope of the audit are scant, however, Plans have been assured that the review will exclude Medi-Cal members.

- 2022 NCQA Re-Accreditation Survey:
  - On February 24th, 2022, the Plan received confirmation from the National Committee of Quality Assurance (NCQA) of its 2022 Re-Accreditation Survey. The Audit is scheduled to begin on June 7th, 2022, with an on-site portion to last from July 25th, 2022, through July 26th, 2022. Currently, the Plan holds active accreditation for both its Medi-Cal and Commercial Lines of Business.

- 2021 DMHC Full Medical Survey:
  - On November 13th, 2020, the DMHC sent notice to the Plan of the 2021 DMHC Routine Medical Survey beginning April 12th, 2021. DMHC conducted virtual audit interviews on April 13th, 2021, through April 16th, 2021, however no audit report has been received to date and the Department has provided no additional updates.

- 2020 DHCS Kindred Focused Audit:
  - On October 23rd, 2020, the DHCS sent notice to the Plan of a focused audit involving the Plan's delegate, CHCN, and Kindred facilities. The Plan submitted its CAP response and stated CAP milestones which involves Audits of the delegate's Concurrent Review Process and Notice of Action letters. On April 19th, 2022, the DHCS found that all CAPs and milestones were met and closed the audit.

Delegation Oversight Audit Activity Updates

- Continuing 2022 Delegation Audits, Post-Review:
  - Following the April 2022 DHCS Full-Medical Survey on-site review, the Compliance Department resumed issuing its 2021 audit findings. On May 5th, 2022, the Plan issued the final 2021 audit reports for Community Health Center Network (CHCN) and Beacon Health Options (Beacon). Per Plan Policy CMP-028 – Delegate Annual Audit, both delegates will have until mid-July 2022 to submit CAP responses.

- 2022 Kaiser Collaborative Plan Audit:
  - As part of a joint collaborative effort among Northern California Medi-Cal health plans, the Kaiser Foundation Health Plan audit is divided into sections to be completed by each Plan sponsor holding subcontracting agreements with Kaiser. For 2022, the Alliance has been assigned the Network Management portion of the audit. The remaining delegated audit functions will be distributed to other Plans.

Compliance Activity Updates

- 2022 RFP Contract Award & Review:
    - On February 9th, 2022, the DHCS released Request for Proposal (RFP) #20-10029 soliciting submissions for the 2024 Contract for the provision of managed health care services to Medi-Cal beneficiaries. The contract award is expected in August 2022, with implementation to take place through December 31st, 2023. On April 21, 2022, the Staff gave a presentation to the Local Health Plans of California (LHPC) Compliance Officer's Workgroup.
    - Staff presented on Provision 1.1.7 of the RFP Contract, which requires the Sponsor Plan to appoint a Chief Health Equity Officer (CHEO). The CHEO appointment is a new requirement for Plans aimed at addressing potential system-wide inequities and social determinants in Medi-Cal delivery. As part of a larger effort by Plans to strategize an effective implementation of the 2024 DHCS Contract, Alliance Staff are poised to continue presenting various sections of the RFP Contract at LHPC Workgroups.

- 2022 Corporate Compliance Training:
    - In accordance with the Annual Anti-Fraud Plan filed with the DMHC in Q1 each year, and in compliance with requirements from the DHCS State Sponsored contract on Fraud, Waste and Abuse, the Plan maintains an annual training and education program to ensure employees understand all relevant laws, regulations, and internal policies covering specific subject matter. The 2022 Annual Corporate Compliance Training will be distributed this coming September 2022. Per Plan Policy, CMP-026 – Compliance Training and Education, all impacted staff will have ninety (90) days to complete assigned trainings.

    - The Annual Staff Training includes the following:
        - Health Insurance Portability and Accountability Act (HIPAA)
        - Fraud Waste and Abuse
        - Cultural Sensitivity Training

    - The Board of Governors Compliance Training will be assigned in August and should follow the same ninety (90) day completion schedule as proscribed to Plan Staff. 2022 Annual Board Training includes:
        - Health Insurance Portability and Accountability Act (HIPAA)
        - Fraud Waste and Abuse

Compliance

Supporting Documents

2022 APL/PL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
1	DMHC	22-001	1/4/2022	LARGE GROUP RENEWAL NOTICE REQUIREMENTS	MEDI-CAL	California Health and Safety Code (HSC) section 1374.21, subdivision (a)(2) requires all commercial full-service health care service plans ("plans") to comply with disclosure requirements relating to large group renewal notices. Specifically, no change in premium rates or changes in coverage stated in a large group health care service plan contract shall become effective unless the plan has delivered in writing a notice indicating the change or changes at least 120 days prior to the contract renewal effective date.
2	DHCS	22-001	1/11/2022	2022-2023 MEDI-CAL MANAGED CARE HEALTH PLAN MEDS/834 CUTOFF AND PROCESSING SCHEDULE	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with the 2022-2023 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.
3	DMHC	22-002	1/19/2022	HOSPITAL BLOCK TRANSFER FILINGS FOR PPO ENROLLEES	MEDI-CAL	The Department of Managed Health Care is reminding health care service plans to comply with the Block Transfer filing and notice requirements applicable to hospital contract terminations affecting PPO enrollees. The block transfer statute and regulation is not limited in applicability to a particular product type and therefore applies to PPO products. Accordingly, health plans shall submit a Block Transfer filing for hospital contract terminations that will result in the redirection of 2,000 or more PPO enrollees (or PPO combined with other lines of business).
4	DMHC	22-003	1/21/2022	ASSEMBLY BILL 457 PROTECTION OF PATIENT CHOICE IN TELEHEALTH PROVIDER ACT	GROUP CARE	On October 1, 2021, Governor Gavin Newsom signed AB 457, which amends Section 1374.14 and adds Section 1374.141. Section 1374.141 requires a plan to meet certain conditions if it offers telehealth services to an enrollee through a third-party corporate telehealth provider. AB 457 also requires a plan that provides services to an enrollee through a third-party corporate telehealth provider to (a) notify the enrollee of their right to access their medical records, (b) share the records of any telehealth services provided with the enrollee's PCP, (c) ensure such records are shared with the enrollee's PCP unless the enrollee objects, and (d) notify the enrollee that all services received through the thirdparty corporate telehealth provider are available at in-network cost-sharing and all costsharing shall accrue to the out-of-pocket maximum and deductible (if any).
5	DMHC	22-004	1/21/2022	ASSEMBLY BILL 347 STEP THERAPY EXCEPTION COVERAGE GUIDANCE	MEDI-CAL & GROUP CARE	On October 9, 2021, Governor Gavin Newsom signed Assembly Bill (AB) 347. AB 347 requires health care service plans (health plans or plans), effective January 1, 2022, to expeditiously grant step therapy exceptions within specified time periods when use of the prescription drug required under step therapy is inconsistent with good professional practice. AB 347 also permits providers to appeal a health plan's denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request.
6	DMHC	22-005	1/25/2022	FEDERAL REQUIREMENT TO COVER AT-HOME COVID-19 TESTS PURCHASED OVER-THE COUNTER	GROUP CARE	On January 10, 2022, the federal Departments of Labor, Health and Human Services,and the Treasury issued guidance regarding commercial health plan coverage of athome, over-the-counter COVID-19 tests (OTC COVID-19 tests) authorized by the U.S. Food and Drug Administration.
7	DMHC	22-006	2/1/2022	PLAN YEAR 2023 QHP AND QDP FILING REQUIREMENTS	MEDI-CAL & GROUP CARE	The DMHC offers current and prospective Qualified Health and Dentla Plans, Covered California for Small Business Issuers, and health plans offering non-grandfathered Individual and Small Group product(s) outside of the California Health Benefit Exchange (Covered Calfornia), guidance to assist in the preparation of Plan Year 2023 regulatory submissions, in compliance with Knox-Keene Act at California Health and Safety Code Sections 1340.
8	DMHC	22-007	3/4/2022	DPN MONITORING AND ANNUAL REPORTING CHANGES	MEDI-CAL & GROUP CARE	This All Plan Letter (APL) provides an overview of the changes to monitoring and annual reporting of the Timely Access Compliance Report and the Annual Network Report, as required under the Knox-Keene Act.
9	DMHC	22-008	3/9/2022	2022 ANNUAL ASSESSMENTS	MEDI-CAL & GROUP CARE	The Report of Enrollment Plan, as required by Health and Safety Code section 1356 and the California Code of Regulations, title 28, section 1300.84.6(a) must be filed with DMHC no later than May 15, 2022.
10	DHCS	22-002	3/14/2022	ALTERNATIVE FORMAT SELECTION FOR MEMBERS WITH VISUAL IMPAIRMENTS	MEDI-CAL & GROUP CARE	The purpose of this All Plan Letter (APL) is to provide information about the Department of Health Care Services' (DHCS) processes to ensure effective communication with members with visual impairments or other disabilities requiring the provision of written materials in alternative formats, by tracking members' alternative format selections (AFS).

2022 APL/PL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
11	DMHC	22-009	3/16/2022	PROVIDER DIRECTORY ANNUAL FILING REQUIREMENTS	MEDI-CAL & GROUP CARE	California Health and Safety Code section 1367.27, subdivision (m), requires health care service plans to annually submit provider directory policies and procedures to the Department of Managed Health Care (Department).
12	DMHC	22-010	3/17/2022	GUIDANCE REGARDING AB 1184 - CONFIDENTIALITY OF MEDICAL INFORMATION	MEDI-CAL & GROUP CARE	On September 22, 2021, Governor Gavin Newsom signed AB 1184, which amends the Confidentiality of Medical Information Act to require plans to take specified steps to protect the confidentiality of a subscriber's or enrollee's medical information.
13	DHCS	22-003	3/17/2022	MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITY TO PROVIDE SERVICES TO MEMBERS WITH EATING DISORDERS	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with clarification and guidance regarding their responsibility to coordinate and provide medically necessary services for members who are diagnosed with feeding and eating disorders and are currently receiving Specialty Mental Health Services (SMHS) from a county Mental Health Plan (MHP). Corresponding guidance to MHPs is contained in Behavioral Health Information Notice (BHIN) 22-009.
14	DHCS	22-004	3/17/2022	STRATEGIC APPROACHES FOR USE BY MANAGED CARE PLANS TO MAXIMIZE CONTINUTIY OF COVERAGE AS NORMAL ELIGIBILITY AND ENROLLMENT OPERATIONS RESUME	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide instruction to Medi-Cal managed care health plans (MCPs) about strategies that must be used by MCPs in collaboration with counties to help ensure eligible beneficiaries retain coverage in Medi-Cal and ease transitions for individuals eligible for coverage through Covered California as the Department of Health Care Services (DHCS) prepares for the resumption of normal operations after the end of the COVID-19 Public Health Emergency (PHE).
15	DMHC	22-011	3/21/2022	NO SURPRISES ACT (NSA) GUIDANCE	GROUP CARE	Effective for plan years beginning on or after January 1, 2022, the NSA prohibits surprise balance billing, as specified, and establishes other consumer protections. To date, the federal government has issued four rulemaking packages, issued guidance, and established a dedicated web page, No Surprises to implement the NSA.
16	DMHC	22-012	3/24/2022	SECTION 1357.503 COMPLIANCE AND MEWA REGISTRATION	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to inform health care service plans (Plans) and association of employers defined as multiple employer welfare arrangement (MEWA) of the requirements of SB 255 (Portantino, Ch. 725, Stats. 2021) and SB 718 (Bates, Ch. 736, Stats. 2021), including California Health and Safety Code section 1357.503. This APL discusses the requirements of Section 1357.503, including requirements of Plans, registration of MEWAs, and other requirements.
17	DHCS	22-005	3/30/2022	NO WRONG DOOR FOR MENTAL HEALTH SERVICES POLICY	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCP) with guidance and clarification regarding the No Wrong Door for Mental Health Services policy. This policy ensures that members receive timely mental health services without delay regardless of the delivery system where they seek care and that members are able to maintain treatment relationships with trusted providers without interruption.
18	DMHC	22-013	4/6/2022	COMPLIANCE WITH SENATE BILL 368	GROUP CARE	On October 6, 2021, Governor Gavin Newsom signed Senate Bill (SB) 368. SB 368 requires individual or group health care service plan (health plans or plans) contracts, issued, amended, or renewed on or after July 1, 2022, to provide enrollees with their up-to-date accrual towards their annual deductible and out-of-pocket maximum for every month benefits were used until the accrual balances are met. SB 368 also requires plans to notify enrollees of their rights to such accrual information and the ability to opt in to receiving the accrual information electronically instead of via mail. Delegated entities with claims payment functions must also comply with the provisions of SB 368.
19	DHCS	22-006	4/8/2022	MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITIES FOR NON-SPECIALTY MENTAL HEALTH SERVICES	MEDI-CAL	The purpose of this All Plan Letter (APL) is to explain the responsibilities of Medi-Cal managed care health plans (MCPs) for the provision or arrangement of clinically appropriate and covered non-specialty mental health services (NSMHS) and the regulatory requirements for the Medicaid Mental Health Parity Final Rule (CMS-2333-F). This APL also delineates MCP responsibilities for referring to, and coordinating with, County Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS).
20	DMHC	22-014	4/25/2022	SENATE BILL 510 COVID-19 TESTING AND VACCINATION COVERAGE GUIDANCE	MEDI-CAL & GROUP CARE	SB 510 requires health care service plans (health plans) to cover, among other things, the costs associated with COVID-19 diagnostic and screening testing and immunization against COVID-19 without cost-sharing, prior authorization, utilization management, or in-network requirements.

ALAMEDA Alliance FOR HEALTH

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

Health Care Services

Steve O'Brien, MD

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

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

Date: **May 13th, 2022**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

- DHCS 2021: Action Plans on UM findings from the DHCS audit are being monitored and reported at UM Committee and are demonstrating sustained compliance with the requirements. This includes ensuring requests for Dental Anesthesia are being evaluated by a clinician and ensuring that Speech Therapy visits for members under 21 are not limited.

- The carve in of Major Organ Transplant/Bone Marrow Transplant (MOT/BMT) went live on 1/1/2022. So far, 116 members in various stages of the Transplant process are being managed, and the systems developed to coordinate care are working well. UCSF has the bulk of cases with 97 (primarily kidney and liver); Stanford 7; Out of network (Sutter) 6; (cornea specialists) 2.

- NCQA 2022: UM team continues to gather documents that address the NCQA UM standards for submission to NCQA in June 2022.

- Progress continues with UM/Claims/Configuration alignment. Standardization improves accuracy and timeliness of claims payment through appropriate data integration between the authorization process and the claims processing. This results in fewer instances of accrued interest because of claim payment delays. This project is also supporting accurate reporting of data to the state for a variety of initiatives.

- Enhancements to our processes of interacting with CCS are underway to integrate into the larger EPSDT strategy. Reports on shared members and workflows are being refined and will be used to enhance the coordination of care between AAH and CCS on our mutual members under age 21. There is also coordination of effort to assist hospitals not currently paneled with CCS to become paneled.

- Turn Around Times and Denial Rates have remained steady over the past months, ensuring that members received their authorizations timely, typically 97+% and are approved 95% of the time.

Outpatient Authorization Denial Rates			
Denial Rate Type	**Feb 2022**	**March 2022**	**April 2022**
Overall Denial Rate	4.5%	4.1%	3.9%
Denial Rate Excluding Partial Denials	4.0%	3.5%	3.3%
Partial Denial Rate	0.5%	0.6%	0.6%

Turn Around Time Compliance			
Line of Business	**Feb 2022**	**March 2022**	**April 2022**
Overall	98%	98%	98%
Medi-Cal	98%	98%	98%
IHSS	100%	100%	99%
Benchmark	***95%***	***95%***	***95%***

Utilization Management: Inpatient

- The IP team has developed workflows, standard work, and reports to manage members with catastrophic illness or injury, to ensure that they receive high quality, timely care in the right setting. Reports are discussed at Utilization Management Committee and Medical Expense committee. Part of the workflow includes communication to Finance for more refined forecasting of medical expense.

- DHCS 2021: Action Plans on UM findings from the DHCS audit and the LTACH focused audit are being monitored and reported at UM Committee and are demonstrating sustained compliance with the requirements. After sustained compliance is demonstrated, the LTACH focused audit may be closed.

- Inpatient UM team continues to track COVID admissions: COVID admissions continue to remain low, consistent with Alameda County data, and this pattern is continuing. There are also fewer Intensive Care days than in the earlier time periods, and shorter average length of stay.

- Weekly complex/long stay patient rounds continue with partner hospitals and CHCN with a goal of removing barriers to discharge. The focus of these rounds is on members with catastrophic injury or illness, longer lengths of stay, and patients with challenging barriers to placement. Case Management also attends rounds to provide referral recommendations for post hospital care and identify referrals to CM early in the process.

- Readmission reduction: CM continuing to collaborate with hospital partners and with their community-based Transitions of Care (TOC) programs to focus on readmission reduction, aligning with their readmission reduction goals. There has been CM leadership changes at AHS, and AAH is re-establishing the partnership. Data on readmission drivers is being refined to focus efforts.

- AAH has engaged with CHCN to fund the Care Transition RN (CTRN) program to facilitate access to follow up care with the FQHC clinics and referrals for ongoing care after hospitalization. This initiative extends the reach of the TOC program to more hospitals and strengthens the relationship with AAH's largest delegate, CHCN.

Inpatient Med-Surg Utilization Total All Aid Categories **Actuals (excludes Maternity)**			
Metric	**January 2022**	**February 2022**	**March 2022**
Authorized LOS	5.3	5.1	4.8
Admits/1,000	51.9	51.5	55.8
Days/1,000	274.7	264.3	266.4

Pharmacy

- Pharmacy Services process outpatient pharmacy claim, and pharmacy prior authorization (PA) has met turn-around time compliance for all lines of business.

Decisions	**Number of PAs Processed**
Approved	19
Denied	33
Closed	67
Total	**119**

Line of Business	**Turn Around Rate compliance (%)**
GroupCare	100

- Medications for asthma, acne, diabetes, chest pain, hepatitis B, hypogonadism, migraine, and hypertension are top 10 categories for denials.

Rank	Drug Name	Common Use	Common Denial Reason
1	NUCALA 100 MG/ML SYRINGE	Asthma	Criteria for approval not met
2	ISOTRETINOIN 20 MG CAPSULE	Acne	Criteria for approval not met
3	BASAGLAR 100 UNIT/ML KWIKPEN	Diabetes	Criteria for approval not met
4	JARDIANCE 10 MG TABLET	Diabetes	Criteria for approval not met
5	RANEXA ER 500 MG TABLET	Chest pain	Criteria for approval not met
6	VEMLIDY 25MG TABLET	Hepatitis B	Criteria for approval not met
7	TESTOSTERONE 1% (25MG/2.5G) PK	Hypogonadism	Criteria for approval not met
8	AJOVY 225 MG/1.5 ML AUTOINJECT	Migraine	Criteria for approval not met
9	BYSTOLIC 5 MG TABLET	Hypertension	Criteria for approval not met
10	JANUVIA 100 MG TABLET	Diabetes	Criteria for approval not met

- The Alameda Alliance for Health (AAH) Pharmacy Department has successfully carried out Medi-Cal RX go-live as of 1/1/2022 and continues to serve its members with the same high standards of care.
- As of April 15, 2022, Medi-Cal Rx has:
    - Processed more than 34.93 million point-of-sale pharmacy paid claims with a sub second response time to participating pharmacies totaling more than $4.1 billion in payments
    - Processed more than 176,783 prior authorizations. PA continues to decline (i.e., 4,444 per 4/15 weekly data).
    - Answered 199,170 calls and 100 percent of virtual hold calls and voicemails have been returned. Call volume continues to decline (i.e., 10,025 per 4/15 weekly data).
    - The most edits/PA/limitations have been removed/lifted with no definite date until the DHCS decides otherwise.

- As we approach mid-year, Medi-Cal RX's 180-Day Transition Plan is nearing a close as per the original planned date of 7/1/2022. AAH has been successfully keeping its members and providers up to date with pertinent changes via fax blast, quarterly packets and through its provider portal to help ensure that they have the most updated information as things evolve with the pharmacy Carve Out.

- We are also in close communication with Magellan and Department of Health Care Services (DHCS) on resolving any recurring or outstanding issues that arise when dealing with this transition, which are on the Pharmacy Benefit Administrator's side thus far (i.e., Magellan) to help echo any concerns that are trending within our provider and member community to resolve things as quickly as possible.

- We have closed submitted Medi-Cal PAs and informing doctor offices to submitted to Medi-Cal RX:

Month	Number of Total PA Closed
January 2022	169
February 2022	44
March 2022	31
April 2022	25

- Pharmacy Services continues to collaborate with other Health Care Services teams for member on use of opioids and/or benzodiazepines.
    - There was an 8.9 % increase in 50 MME users and 23.1 % increase in 200 MME users. This increase happened after the carveout.
    - 90 MME & 120 MMGE groups had a 16.7% decrease and a 40.1% decrease.
    - 300, 400 milligram equivalents (MME) remained around the same.

MME	IHSS	MCAL	Total
January			**372**
50	8	283	291
90	2	16	18
120	1	25	26
200	1	21	22
300	0	2	2
400	0	13	13
February			**324**
50	7	250	257
90	2	13	15
120	1	26	27
200	0	12	12
300	1	4	5
400	0	8	8
March			**391**
50	11	306	317
90	3	12	15
120	1	31	32
200	0	13	13
300	1	3	4
400	0	10	10

- We had 19 members on chronic concurrent use of opioids, benzodiazepines, and antipsychotics.

- It was observed that 160 Medi-Cal children use antipsychotics chronically. 7 children used antipsychotics for schizophrenia. Most prescriptions were prescribed by psychiatrist/neurologist.

- The AAH Pharmacy Department is working with its Inpatient Department and Case Management Disease Management (CMDM) Department.
    - This is to help expand and optimize Transition of Care (TOC) program to help reduce the number of re-admissions after members are discharged from hospitals through education to the members as well as filling potential gaps between providers and their patients.
    - This not only increases the quality of life of our members, but also provides great cost-benefit to the Alliance as well.
    - The Pharmacy Department is also beginning to work with the IT Department to improve metrics and outcomes tracking to ensure effective data-driven optimization of the program, which not only improves cost-benefit to the plan but helps us better serve our members as well.

- As a result of an AAH population needs assessment, Pharmacy Services, QI, HealthEd and Case Management worked together to improve drug adherence for 200 Black adults with asthma between 21 to 44 years of age with asthma medication possession rate of 50% or below.
    - Our poster was presented at the 2022 Centers for Medicare & Medicaid Services (CMS) Quality Conference Virtual Gallery Walk and supported by MAC QI TA team as a part of CMS Asthma Affinity Group project.
    - Third member outreach calls are complete. Asthma survey is available as a TruCare assessment. Smoking cessation questionnaire is available in TruCare pharmacy consultation assessment

- Pharmacy is leading initiatives on PAD focused internal and external partnership and biosimilar optimization (from July 2021 to February 2022).
    - Biosimilar utilization average was 68.8%.
    - Fiscal year savings $1.1million.
    - Percentage of savings per drug type Oncology ($627k), Immunology ($387k) drugs and White Blood Cell Stimulator ($145k).

- Pharmacy Services and Operations continue to collaborate to drive up COVID-19 vaccination rates.

Case and Disease Management

- Population health-driven, disease-specific case management bundles (standard sets of actions developed to address the specific needs of members with significant diseases,) continue development. Major Organ Transplant (MOT) CM bundle was deployed, and the volume is higher than anticipated, (116 cases YTD) The processes to support the members is working well across CM, UM, and the Centers of Excellence.

- Dialysis CM bundle work has begun with the DaVita Shared Patient Care Coordination, (SPCC) program. CM works with DaVita on very high-risk members to ensure wrap around support so that the member can successfully manage their dialysis needs. Regular high-risk rounds have launched with DaVita SPCC to coordinate interventions and support to these highest risk members who require dialysis.

- Disease Management collaboration continues with AAH Health Education to optimize and enhance the Diabetes and Asthma Disease Management programs. Collaborative efforts also include incorporating the Asthma Remediation CS services into the care continuum.

- DHCS audit: Action Plans on CM findings from the DHCS audit is being monitored and continues to demonstrate consistent compliance with requirements. The CM team is fielding questions on the Annual DHCS audit on CM or HRA processes to help them understand the processes and how AAH monitors them.

- NCQA 2022: CM team has gathered documents that address the NCQA PHM standards for submission to NCQA in June 2022, and now documents related to care coordination for members Out of Net, and readmissions work being done with multiple departments across AAH and community partners.

Case Type	New Cases Opened in Feb 2022	Total Open Cases as of Feb 2022	New Cases Opened in March 2022	Total Open Cases as of March 2022
Care Coordination	277	539	320	611
Complex Case Management	28	63	23	55
Transitions of Care (TOC)	254	490	287	565

Enhanced Case Management and Community Supports Services

- Enhanced Case Management (ECM): ECM is fully launched with the initial populations of focus, including those receiving HHP/WPC. Final work to close out the HHP/WPC programs has been completed. Members being "grandfathered" from HHP will be re-evaluated by 6/30/2022 to see if they meet criteria for ECM or are ready for step down to other CM services.

- Work continues to launch ACBH as an ECM provider by 07/01/22.

- Work with PPD team continues for next POFs (formerly incarcerated adults/youth/children; LTC to home; LTC diversion) to launch 01/01/23.

- Revised MOC Parts 1 & 2 on the new Populations of Focus are in development, for submission by 07/01/22.

- Community Supports: CS services are focused on reducing unnecessary hospitalizations and ED visits. The six initial CS services launched on 1/1/2022 were:
    - Housing Navigation
    - Housing Deposits
    - Tenancy Sustaining Services
    - Medical Respite
    - Medically Tailored/Supportive meals
    - Asthma Remediation

- CalAIM Community Supports (CS): The planned staff for the CS program have been hired and are working at authorizing members for programs and program tracking.

- Close collaboration with the various CS provides is ongoing, with weekly meetings with each provider to work through logistical issues as they arise. Members are receiving care from all the CS provider types.

Community Supports	Services Started in Feb 2021	Services Started in March 2021
Housing Navigation	15	20
Housing Deposits	1	2
Housing Tenancy	19	24
Asthma Remediation	5	5
Meals	11	11
Medical Respite	9	11

Grievances & Appeals

- All cases were resolved within the goal of 95% within regulatory timeframes; however, expedited grievances were not resolved within our goal of 95%.
- Expedited Grievances:
    - 1 out of the 10 cases were out of compliance.
        - One case was changed from expedited to standard in error by one of our G&A Department staff. Action: A change was made in our G&A system, Quality Suite, to only allow access to update the priority of a case to certain level of employees in the G&A Department.
    - During the month of April, the G&A Department received 144 complaints that were originally logged as expedited and de-expedited within the required timeframe.

- Total grievances resolved in March were 6.33 complaints per 1,000 members.

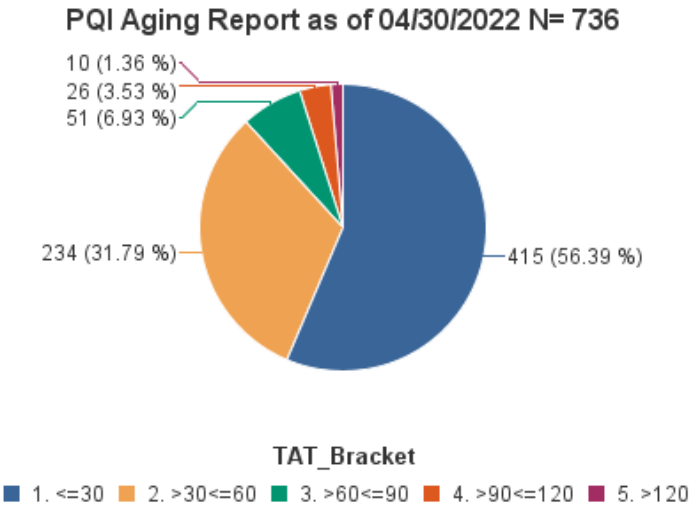
- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of April 2022; we did meet our goal at 15% overturn rate.

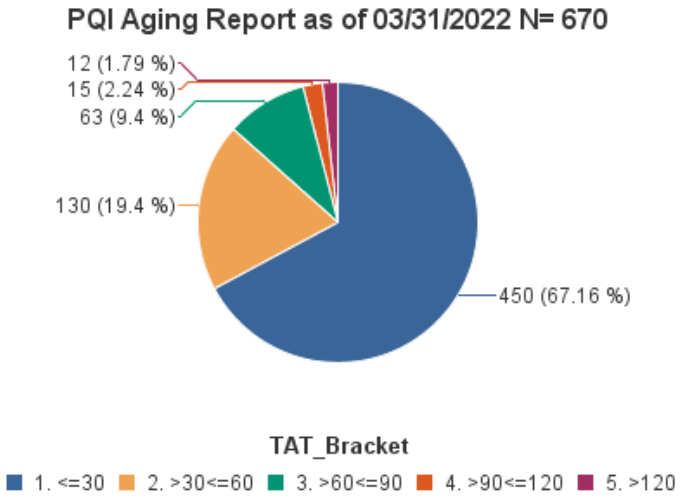
April 2022 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	670	30 Calendar Days	95% compliance within standard	637	95.1%	2.17
Expedited Grievance	10	72 Hours	95% compliance within standard	9	90.0%	0.03
Exempt Grievance	1,254	Next Business Day	95% compliance within standard	1,253	99.9%	4.06
Standard Appeal	20	30 Calendar Days	95% compliance within standard	20	100.0%	0.06
Expedited Appeal	0	72 Hours	95% compliance within standard	NA	NA	NA
Total Cases:	1,954		95% compliance within standard	1,919	98.2%	6.33

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

Quality

- Potential Quality Issues: Quality continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our aging report month to month goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records. PQI cases open > 120 days made up 1.36% of total cases for April with a noted increase of 66 cases in April when compared to March. Cases open for >120 days are primarily related to delay in submission of medical records by specific providers. Medical record procurement TAT greatly improved month over month due to increase staff outreach and return response by providers. Quality continues to work with providers to identify operations barriers in medical record procurement to maintain a TAT goal of < 5% for cases open >120 days. April also noted that TAT for cases open >90 days increased slightly by 1.29% from 2.24% in March to 3.53% in April.





Continuity and Coordination of Medical Report – 2022

- Performance Measure Scope and Focus

- The organization annually identifies opportunities to improve coordination of medical care by:
    - Collecting data on member movement between practitioners includes the inception or cessation of patient care by a practitioner and coordination of care across practitioners who are concurrently or intermittently providing ongoing care for members.
    - Collecting data on member movement across settings usually occurs as a member's health status changes (e.g., moving from home to hospital, moving from the hospital to a rehabilitation facility).

Measure No.	Name of Measure	Movement		Measurement Years		
		Across Settings	Between Practitioners	Baseline	Remeasure #1	Remeasure #2
1	Practitioner Satisfaction w/ Continuity and Coordination of Care		X	2019	2020	2021
2	HEDIS Diabetic Eye Exam		X	2018	2019	2020
3	HEDIS Readmissions After Discharge	X		2018	2019	2020
4	HEDIS Use of Opioids from Multiple Providers	X		2019	2020	2021

- Performance Measure #1 -Timeliness of feedback/reports from specialists in the health plan's provider network
    - Data Source: Annual Provider Satisfaction Survey
    - Time of Fielding: ~ Q4 each year
    - Lead for Improvement: Quality
    - Most Recent Workgroup Meeting: April 21st, 2022

- Next Steps
  - As AAH performance goal has been exceeded for three years (based on SPHA's Aggregated Book of Business Goal), AAH has set 35% as goal for the 2022 fielding.
  - AAH has also determined the need to have greater specificity in the question detail regarding behavioral health and specialty care provider feedback, so the addition of two questions is being pursued with SPHA.

- Data Trend

Q. 11C The timeliness of feedback/reports from specialists in the health plan's provider network	Numerator: No. ranking in top two box scores	Denominator: No. of question respondents	Rate	Performance Goal	Goal Met? (Y/N)
Measurement Y1 2019	40	120	33.3%	26.5%	Y
Measurement Y2 2020	48	124	38.7%	29.0%	Y
Measurement Y3 2021	30	86	34.9%	29.9%	Y

- Performance Measure #2 –Rate of Diabetic Retinal Exam (DRE)
  - Data Source: Annual HEDIS data collection
  - Time of Fielding: March-May each year
  - Lead for Improvement: Quality
  - Most Recent Workgroup Meeting: December 15th, 2021
  - Key Partners: MARCH Vision

- Next Steps
  - As annual goals for performance have been largely not met, the goals noted below will remain for assessment of MY 2021 results to be received later this year.
  - In partnership with MARCH VISION, interventions year over year stemming from qualitative analysis have been robust, with focus on PCP communication, eye care provider notification via practice support, and member education regarding the importance of this exam. These efforts will continue, and new initiatives will be contemplated in 2Q2022.

- Data Trend – Medicaid

HEDIS: Diabetic Eye Exams	Numerator	Denominator	Rate	Performance Goal	Goal Met? (Y/N)
Measurement Y1 2018	252	411	61.31%	65%	N
Measurement Y2 2019	262	411	63.75%	65%	N
Measurement Y3 2020	201	398	50.5%	65%	N

- Data Trend – Commercial

HEDIS: Diabetic Eye Exams	Numerator	Denominator	Rate	Performance Goal	Goal Met? (Y/N)
Measurement Y1 2018	229	411	55.72%	55%	Y
Measurement Y2 2019	225	411	54.74%	55%	N
Measurement Y3 2020	207	411	50.36%	55%	N

- Noted decrease in MY2020 believed to be a factor of COVID-19.

- Performance Measure #3 –Plan All Cause Readmissions:
    - Data Source: Annual HEDIS data collection
    - Time of Fielding: March-May each year
    - Lead for Improvement: Health Services
    - Most Recent Workgroup Meeting: February 14th, 2022
    - Key Partners: AHS and Sutter Health

- Next Steps:
    - As the annual goal of < 10% was not met in MY 2020, this goal will remain for assessment of MY 2021 results.
    - The partnerships with AHS and Sutter Health will continue, as well as the process to notify the PCP of hospitalization and provide access to the discharge summary.
    - While AAH has had success in managing member's post-discharge needs, it is dependent upon being able to reach the member. To address this barrier/opportunity, AAH plans to develop a process and pilot a team of two nurses in 2022 to confirm contact information prior to discharge.

- Data Trend – Medicaid

HEDIS: Readmissions in 30 days After Discharge	Count of Index Stays	Count of Observed 30-day Readmits	Observed Rate	Performance Goal	Goal Met? (Y/N)
Measurement Y1 2018	5,553	955	17.20%	≤ 15%	N
Measurement Y2 2019	4,653	509	10.94%	≤ 15%	Y
Measurement Y3 2020	4,319	471	10.91%	≤ 10%	N

- Noted decrease in MY 2019 believed to be a factor of the level of collaboration with AHS in deploying joint improvement actions.

- Performance Measure #4 –Use of Opioids from Multiple Providers:
  - Data Source: Annual HEDIS data collection.
  - Time of Fielding: March-May each year.
  - Lead for Improvement: Co-led by Quality and Pharmacy.
  - Most Recent Workgroup Meeting: April 26th, 2022.

- Next Steps:
  - The annual goal for both products was set at the HEDIS 25th percentile, which has been exceeded by the Commercial population for all three measurement years. As a result, AAH will set the 10th percentile as the goal for assessment of MY 2022 results for the Commercial product when received in CY 2023.
  - All current member and practitioner communication/education initiatives will continue. In addition, given the lack of interest in practitioner application for the X Waiver, and the increase in ER use due to the need for a controlled setting when initiating Buprenorphine therapy, AAH is planning to hire Substance Use Navigators to address this barrier.

- Data Trend – Medicaid

Use of Opioids	Numerator	Denominator	Rate	Performance Goal	Goal Met? (Y/N)
Measurement Y1 2019	862	4,815	20.60%	≤ 18.2%	No
Measurement Y2 2020	740	3,702	19.99%	≤ 16.58%	No
Measurement Y3 2021*	706	3,482	20.28%	≤ 16.58%	No

- Data Trend – Commercial

Use of Opioids	Numerator	Denominator	Rate	Performance Goal	Goal Met? (Y/N)
Measurement Y1 2019	27	252	10.96%	≤ 11.32%	Yes
Measurement Y2 2020	25	239	10.56%	≤ 12.07%	Yes
Measurement Y3 2021*	18	161	11.18%	≤ 12.07%	Yes

- *Note: Due to the timing of the AAH NCQA accreditation submission, Measurement Y3 data were collected via administrative refresh prior to the HEDIS 2022 data collection cycle. The HEDIS specification s for this measure were followed without exception.

ALAMEDA Alliance FOR HEALTH

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

Information Technology

Sasikumar Karaiyan

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

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

Date: **May 13th, 2022**

Subject: **Information Technology Report**

Call Center System Availability

- AAH phone systems and call center applications performed at 100% availability during the month of April despite supporting 97% of staff working remotely.

Office 365 Initiative

- The Alliance continues to enhance and expand the Microsoft Office 365 platform to the maximum potential as part of the cloud migration strategy. One of our goals is to move away from the silo operated platform to a consolidated shared services platform which will allow technology team to manage and maintain efficiently.

- Microsoft Teams training and deployment phase has been successfully completed as planned. Microsoft Teams is now deployed to the entire organization and all employees have participated in training.

- We plan to disable the chat feature within the Jabber client by May 13th, 2022, and WebEx meetings by the end of June 2022. Part of our ongoing campaign is to encourage our staff to use Microsoft Teams as the primary application for chat and meetings. Email communications has been sent out weekly as a reminder to staff.

    - **A chat function:** The basic chat function is commonly found within most collaboration apps and can take place between teams, groups, and individuals.

    - **Online video calling and screen sharing:** Enjoy seamless and fast video calls to employees within the Alliance.

    - **Online meetings**: This feature can help enhance your communications, company-wide meetings, and even training with an online meetings function that can host up to 10,000 users.

    - **Conversations within channels and teams:** All team members can view and add to different conversations in the General channel and can use an @ function to invite other members to different conversations.

- **Apps Integration:** The tool shall help directly integrate with applications like Webex, Power Business Intelligence (BI), Smartsheet etc.

- **Full telephony:** Microsoft TEAMS will be integrated with our existing Cisco VOIP to allow for flexible voice communications without the use of physical phones.

Disaster Recovery and Business Continuity

- One of the Alliance primary objectives for the fiscal year 2022 is the implementation of enterprise IT Disaster Recovery and Business Recovery to enable our core business areas to restore and continue when there is any disaster.

- IT Disaster Recovery involves a set of policies, tools, and procedures to enable the recovery or continuation of vital technology infrastructure and systems following a natural or human-induced disaster. IT Disaster Recovery focuses on technology systems supporting critical business functions, which involve keeping all essential aspects of the business functioning, despite significant disruptive events.

- We have concluded our initial discovery meetings and have provided documents for all tier 1 applications and compiled a list of essential reports to our vendor to review.

IT Security Program

- IT Security 2.0 initiative is one of the Alliance's top priorities for fiscal year 2022 and 2023. Our goal is to elevate and further improve our security posture, ensure that our network perimeter is secure from threats and vulnerabilities, and to improve and strengthen our security policies and procedures.

- This program will include multiple phases and remediation efforts are now in progress.

- Cyber Security is at 40% complete, M365 is at 83% complete (on-hold pending professional services contract), Azure 75% and overall, 62% complete for high-severity items.

- Protecting shared cloud applications with Multi-Factor Authentication and Single Sign-On has been included in the overall project.

- As part of this program, our team has completed the evaluation of security solutions and services based on the key initiatives below and are now in the process procurement.

- **Key initiatives include:**
    - Remediating issues from security assessments. (e.g., Cyber, Microsoft Office 365, & Azure Cloud).
    - Create, update, and implement policies and procedures to operationalize and maintain security level after remediation.
    - Set up extended support for monitoring, alerting and supplementary support in cases of security issues.
    - Implement Security Information and Event Management (SIEM) tool for the enterprise to provide real-time visibility across the organization's information security systems.

Encounter Data

- In the month of April 2022, the Alliance submitted 164 encounter files to the Department of Health Care Services (DHCS) with a total of 313,080 encounters.

Enrollment

- The Medi-Cal Enrollment file for the month of April 2022 was received and processed on time.

HealthSuite

- A total of 153,195 claims were processed in the month of April 2022 out of which 127,946 claims auto adjudicated. This sets the auto-adjudication rate for this period to 83.5%.

TruCare

- A total of 13,142 authorizations were loaded and processed in the TruCare application.
- TruCare application continues to operate with an uptime of 99.99%.
- The Alliance has started the process of upgrade to TruCare Clinical Management platform 9.1 version. This upgrade is expected to go-live before end of June 2022. This version has additional features and is also compatible with Milliman Care Guideline v25. However, the plan is also to have the latest version of Milliman Care Guideline v26 by August 2022. Support for this version is being released by the vendor in July 2022.

Consumer and the Alliance Public Portal

- The provider and member consumer portal utilization for the month of March 2022 remains consistent with prior months.

Data Warehouse

- The Data Warehouse project is aimed at bringing all critical health care data domains to the Data Warehouse and enabling the Data Warehouse to be the single source of truth for all reporting needs and requirements.

- In the month of April 2022, we made progress per plan to add the Case Management data domain to the Data and the project is expected to complete in May 2022.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of April 2022”.
- Summary of Primary Care Physician (PCP) Auto-assignment in the month of April 2022”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of April 2022”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal and Group Care Member enrollment in the month of April 2022

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
April	302,878	4,341	2,468	5,829	100	119

1. MC – Medi-Cal Member 2. GC – Group Care Member

Table 1-2 Summary of Primary Care Physician (PCP) Auto-Assignment For the Month of April 2022

Auto-Assignments	Member Count
Auto-assignments MC	1,624
Auto-assignments Expansion	1,532
Auto-assignments GC	51
PCP Changes (PCP Change Tool) Total	2,366

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of April 2022”.
- There were 13,142 authorizations processed into TruCare application.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of April 2022

Transaction Type	Inbound EDI Auths	Errored	Total Auths Loaded in TruCare
EDI	3,835	386	3,719
Paper to EDI	3,546	2.382	1,219
Provider Portal	2,268	395	2,178
Manual Entry	N/A	N/A	1,890
Total			9,006

Key: EDI – Electronic Data Interchange

Web Portal Consumer Platform

- The following table 3-1 is a supporting document from the Web Portal summary section.

Table 3-1 Web Portal Usage for the Month of March 2022

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	5,632	3,515	168,666	442
MCAL	82,313	3,012	7,453	1,272
IHSS	3,070	140	350	47
AAH Staff	170	55	997	14
Total	**91,185**	**6,722**	**177,466**	**1,775**

Table 3-2 Top Pages Viewed for the Month of March 2022

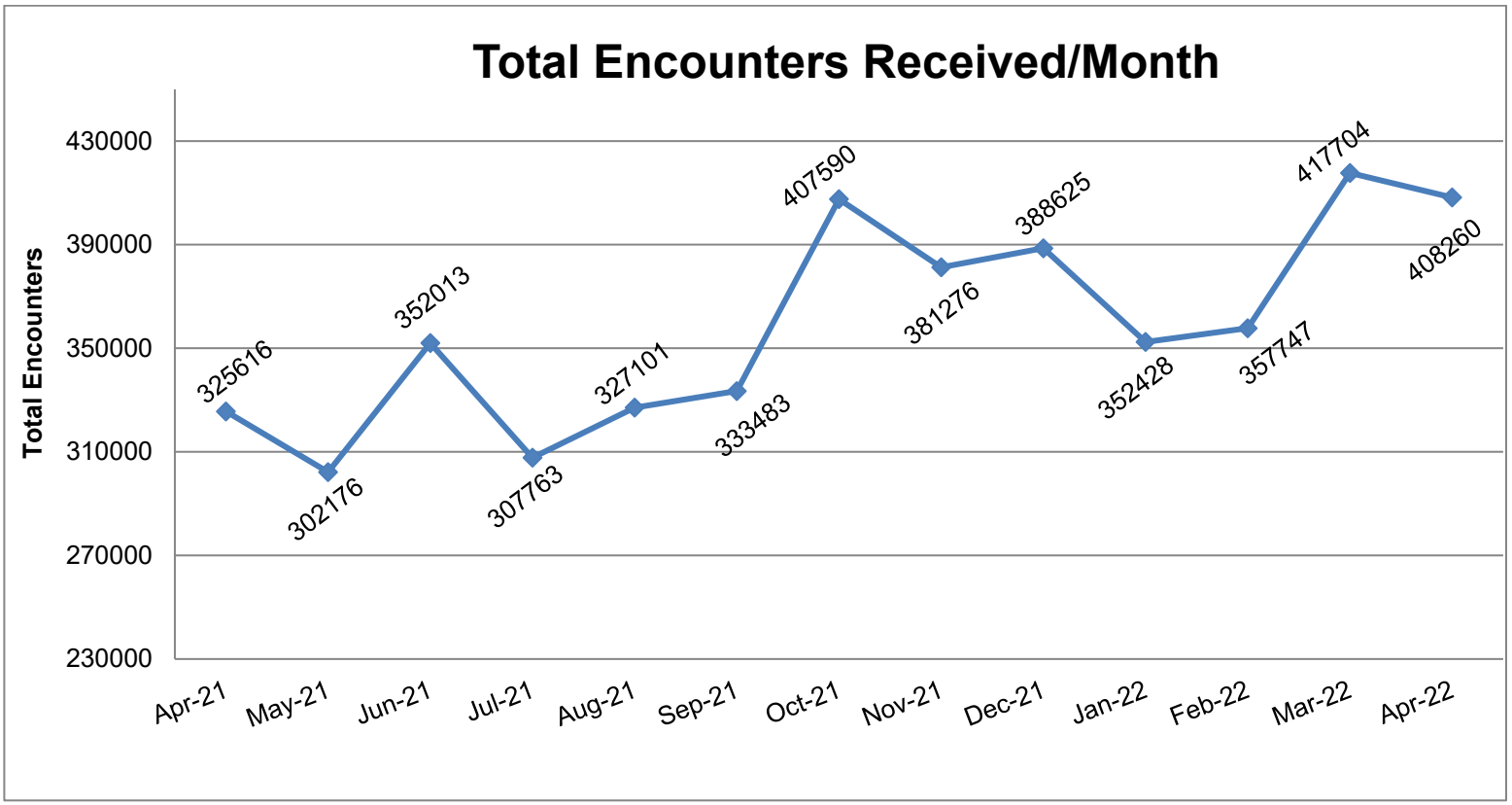
Top 25 Pages Viewed		
Category	**Page Name**	**March - 22**
Provider	Member Eligibility	752,265
Provider	Claim Status	167,574
Provider - Authorizations	Auth Submit	8,959
Provider	Member Roster	5,946
Member My Care	Member Eligibility	4,030
Provider - Authorizations	Auth Search	3,894
Member Help Resources	Find a Doctor or Hospital	2,181
Member Help Resources	ID Card	2,145
Member Help Resources	Select or Change Your PCP	1,516
Member My Care	MC ID Card	1,145
Member Help Resources	Request Kaiser as my Provider	930
Member My Care	My Claims Services	891
Provider - Provider Directory	Provider Directory	815
Member My Care	Authorization	481
Provider - Home	Forms	403
Member My Care	My Pharmacy Medication Benefits	397
Provider	Pharmacy	322
Member Help Resources	FAQs	280
Member Help Resources	Forms Resources	269
Member Help Resources	Contact Us	241
Provider - Provider Directory	Instruction Guide	238
Member My Care	Member Benefits Materials	236
Member Help Resources	Authorizations Referrals	198
Provider - Provider Directory	Manual	176
Member Help Resources	Kaiser ID Card	121

Encounter Data from Trading Partners 2022

- **AHS**: April weekly files (7,717 records) were received on time.
- **BAC**: April monthly file (45 records) were received on time.
- **Beacon**: April weekly files (14,303 records) were received on time
- **CHCN**: April weekly files (74,683 records) were received on time.
- **CHME**: April monthly file (4,955 records) were received on time.
- **CFMG**: April weekly files (10,943 records) were received on time.
- **Docustream**: April monthly files (2,220 records) were received on time.
- **HCSA**: April monthly files (2,029 records) were received on time.
- **PerformRx**: April monthly files (5,358 records) were received on time.
- **Magellan**: April monthly files (279,337 records) were received on time.
- **Kaiser**: April bi-weekly files (69,174 records) were received on time.
- **LogistiCare**: April weekly files (16,232 records) were received on time.
- **March Vision**: April monthly file (3,425 records) were received on time.
- **Quest Diagnostics**: April weekly files (13,330 records) were received on time.
- **Teladoc**: April monthly files (32 records) were received on time.

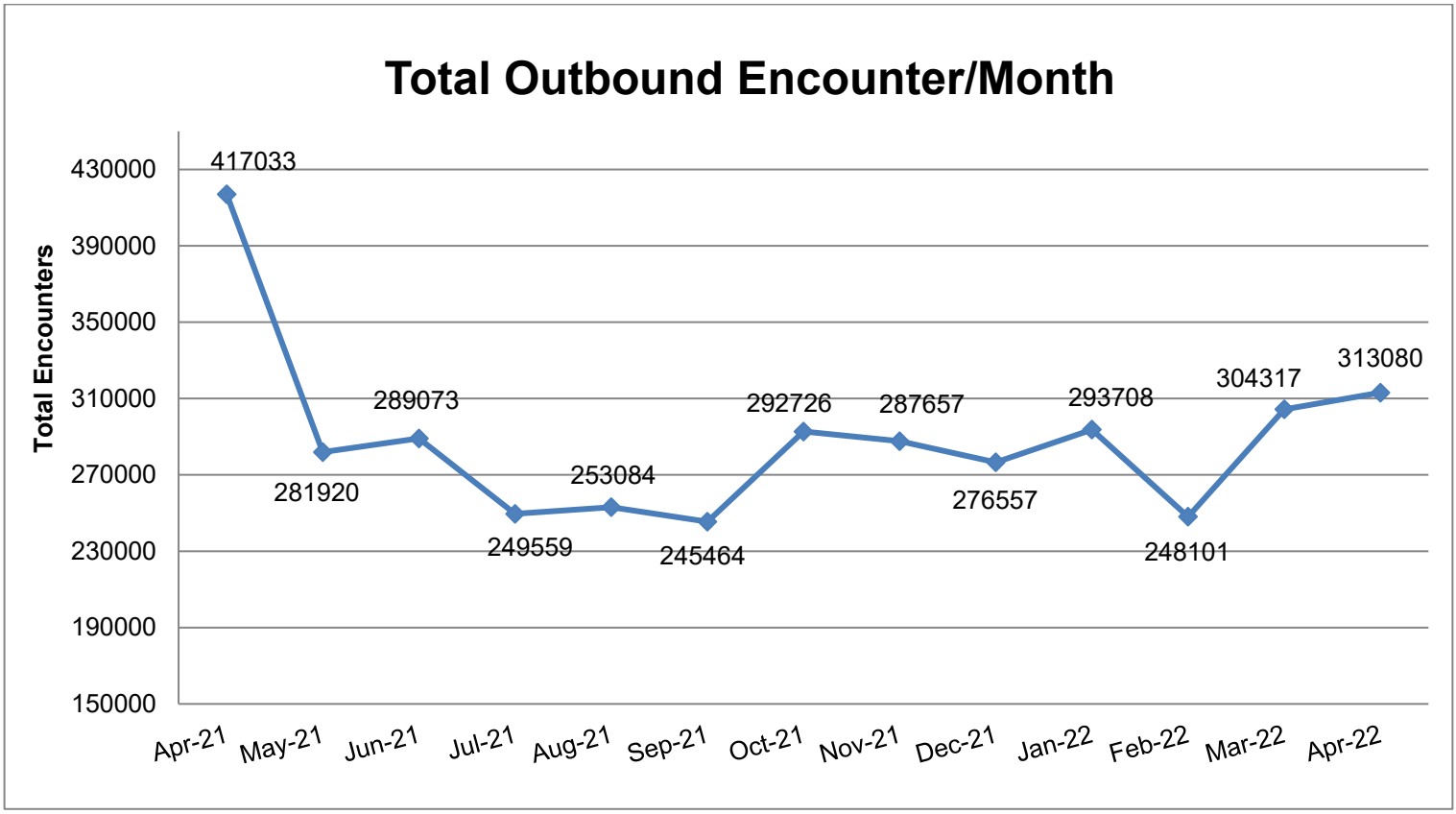
Trading Partner Medical Encounter Inbound Submission History

Trading Partners	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
HealthSuite	140678	129847	136687	133958	139079	159558	177483	167057	175441	162201	162433	185738	189172
AHS	11166	9074	10138	8913	7869	7640	10625	8791	9314	6944	5630	6215	7717
BAC											34	12	45
Beacon	19247	14951	17079	15236	13320	14618	13693	12456	14899	9796	10966	16088	14303
CHCN	69080	66260	82211	63905	80862	60227	71581	99117	73269	75302	77276	79363	74683
CHME	5497	4885	4700	4960	4926	5393	4814	5003	4908	9254	4706	4778	4955
Claimsnet	8835	10834	8129	9774	7712	9880	15598	11032	12410	8643	13228	13522	10943
Docustream	1166	1445	1218	1296	1568	1594	1474	1185	1586	1703	1304	2130	2220
HCSA												3630	2029
Kaiser	39632	30039	60081	39398	35165	44366	75112	38085	63939	46458	52179	68530	69174
Logisticare	12945	14399	15473	14415	17306	13803	16977	22403	17125	16536	16393	19841	16232
March Vision	3156	3708	3306	3303	3531	3297	3377	3584	3220	2872	1445	3559	3425
Quest	14203	16718	12979	12563	15746	13084	16841	12542	12494	12696	12121	14268	13330
Teladoc	11	16	12	42	17	23	15	21	20	23	32	30	32
Total	325616	302176	352013	307763	327101	333483	407590	381276	388625	352428	357747	417704	408260


Total Encounters Received/Month
Total Encounters
430000
390000
350000
310000
270000
230000
325616
302176
352013
307763
327101
333483
407590
381276
388625
352428
357747
417704
408260
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22

Outbound Medical Encounter Submission

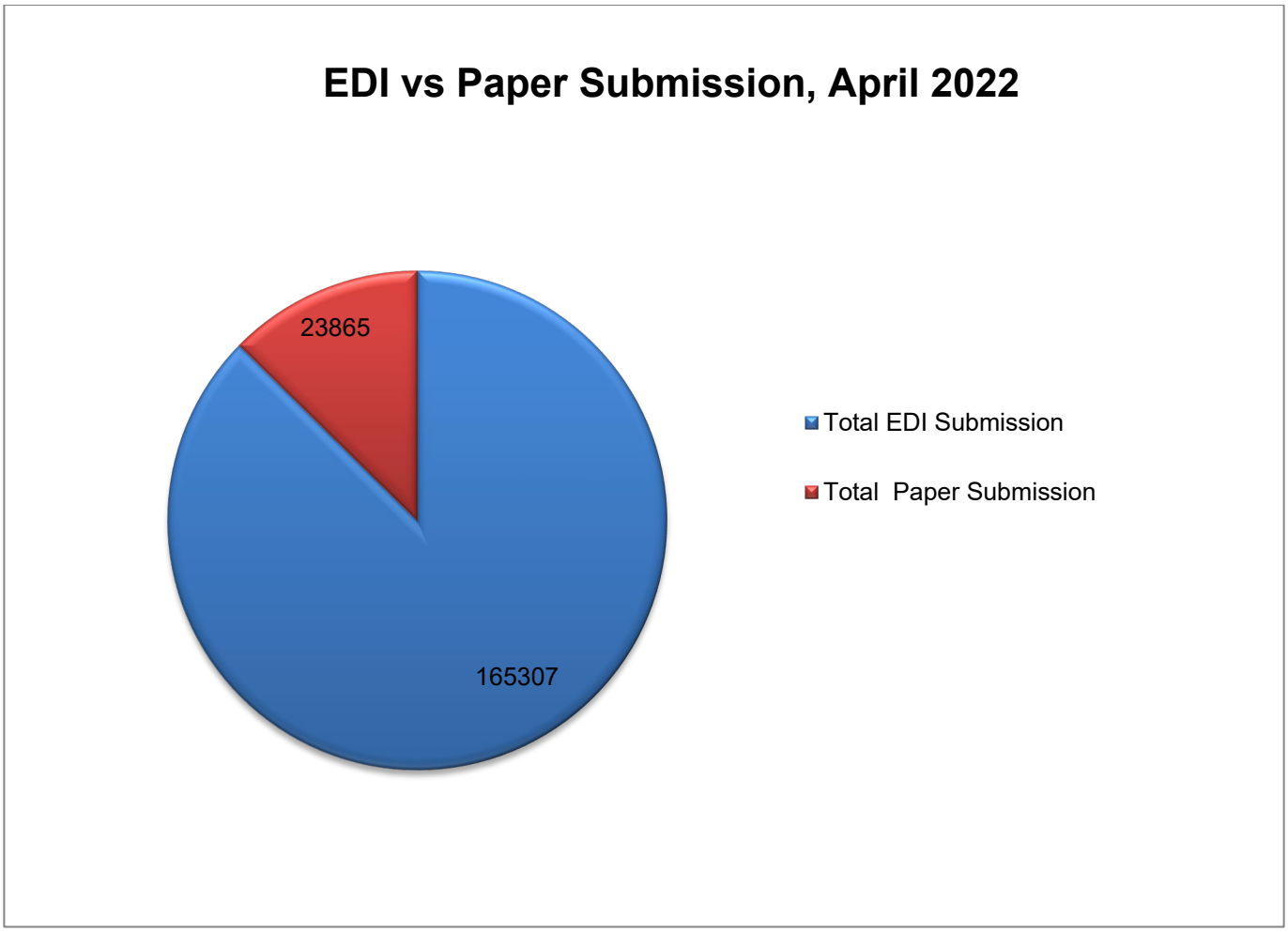
Trading Partners	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
HealthSuite	216640	130885	128980	85346	109070	83690	100925	114507	95489	139452	97141	103843	133252
AHS	8812	10762	9912	7163	9172	7476	10176	8541	7728	7943	5524	6142	6251
BAC											34	12	45
Beacon	14881	12347	11746	12684	10959	9355	11423	9969	12659	7566	8140	12332	11273
CHCN	49446	48573	58519	45338	46573	54958	49171	67383	49080	52531	44745	58795	49365
CHME	5136	4767	4586	4753	4820	5280	4587	4849	4691	4496	4585	4702	4686
Claimsnet	6489	8110	5993	5625	7335	7452	10829	7406	8465	6114	9917	9677	8100
Docustream	1070	1286	1016	1120	1273	1209	1094	981	1185	1176	66	72	14
HCSA												3112	1810
Kaiser	89295	29570	38443	59215	33798	43779	73264	37473	63433	44248	51831	67559	67177
Logisticare	9705	17299	15178	14008	12751	17657	16231	19240	19787	16309	16242	19700	16123
March Vision	2455	2850	2624	2596	2665	2483	2608	2831	2490	2175	1072	2724	2575
Quest	13093	15455	12066	11711	14632	12102	12403	14457	11531	11676	8774	15620	12378
Teladoc	11	16	10	0	36	23	15	20	19	22	30	27	31
Total	417033	281920	289073	249559	253084	245464	292726	287657	276557	293708	248101	304317	313080



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
22-Apr	165307	23865	189172

Key: EDI – Electronic Data Interchange

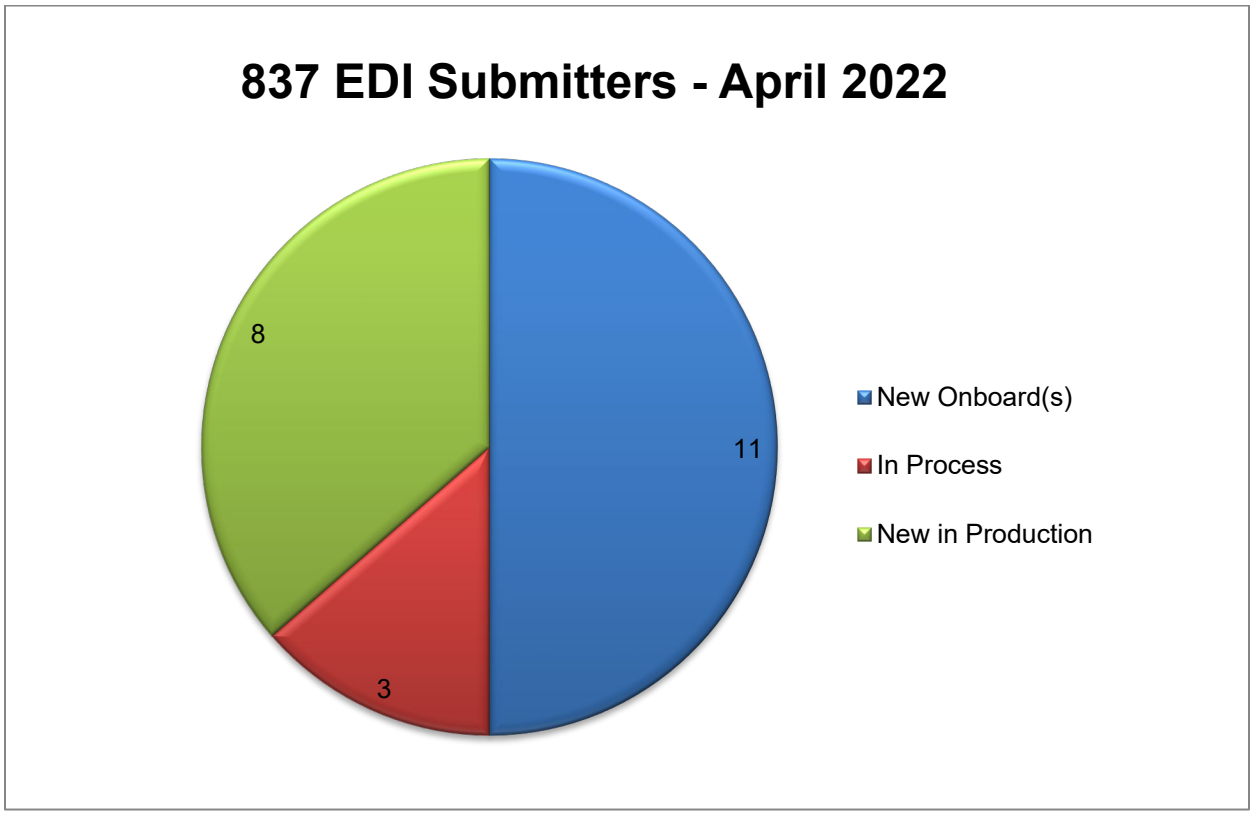


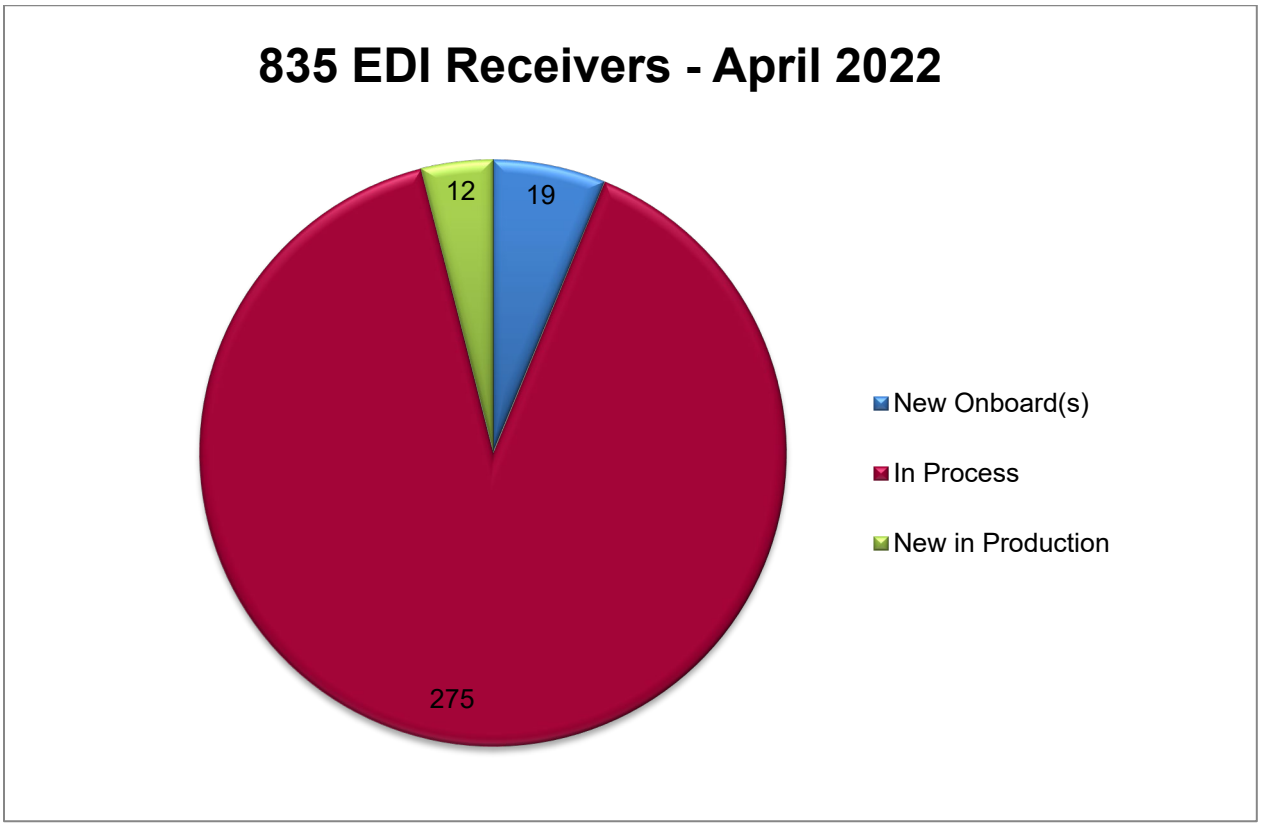
Onboarding EDI Providers - Updates

- April 2022 EDI Claims:
  - A total of 1325 new EDI submitters have been added since October 2015, with 8 added in April 2022.
  - The total number of EDI submitters is 2065 providers.

- April 2022 EDI Remittances (ERA):
  - A total of 426 new ERA receivers have been added since October 2015, with 12 added in April 2022.
  - The total number of ERA receivers is 453 providers.

	837				835			
	New On Boards	In Process	New In Production	Total In Production	New On Boards	In Process	New In Production	Total In Production
May-21	32	0	32	1862	20	134	12	329
Jun-21	13	0	13	1875	17	136	15	344
Jul-21	30	3	27	1902	14	138	12	356
Aug-21	17	0	17	1919	47	178	7	363
Sep-21	21	1	20	1939	15	193	0	363
Oct-21	17	0	17	1956	30	205	18	381
Nov-21	14	0	14	1970	19	210	14	395
Dec-21	8	0	8	1978	18	223	5	400
Jan-22	29	1	28	2006	44	253	14	414
Feb-22	17	2	15	2021	20	258	15	429
Mar-22	36	0	36	2057	22	268	12	441
Apr-22	11	3	8	2065	19	275	12	453


837 EDI Submitters - April 2022
8
11
3
New Onboard(s)
In Process
New in Production


835 EDI Receivers - April 2022
12
19
275
New Onboard(s)
In Process
New in Production

Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

- EDSRF Submission: Below is the total number of encounter files that AAH submitted in the month of April 2022.

File Type	Apr-22
837 I Files	39
837 P Files	125
NCPDP	1
Total Files	165

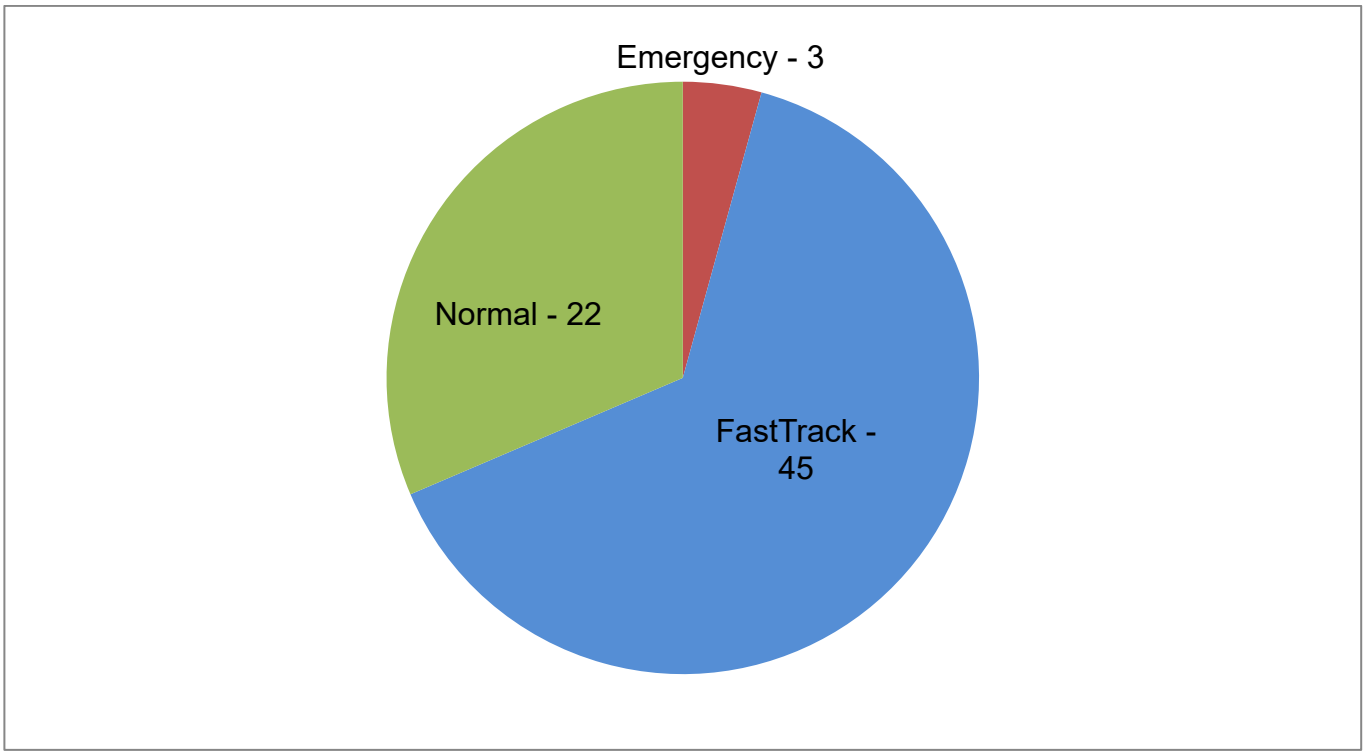
Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Apr-22	Target
Timeliness-% Within Lag Time – Institutional 0-90 days	73%	60%
Timeliness-% Within Lag Time – Institutional 0-180 days	77%	80%
Timeliness-% Within Lag Time – Professional 0-90 days	89%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	96%	80%

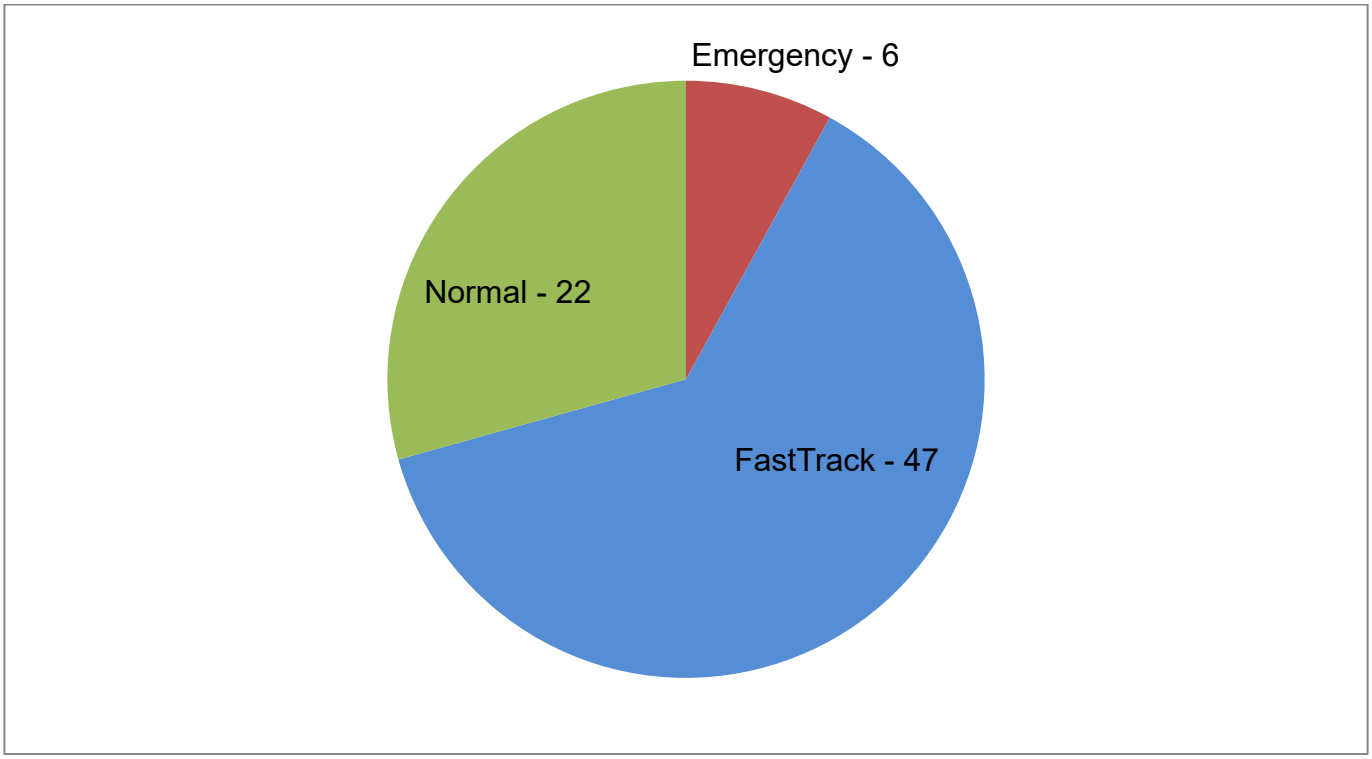
Change Management Key Performance Indicator (KPI)

- Change Request Overall Summary in the month of April 2022 KPI:
  - 70 Changes Submitted.
  - 75 Changes Completed and Closed.
  - 125 Active Change Requests in pipeline.
  - 4 Change Request Cancelled or Rejected.

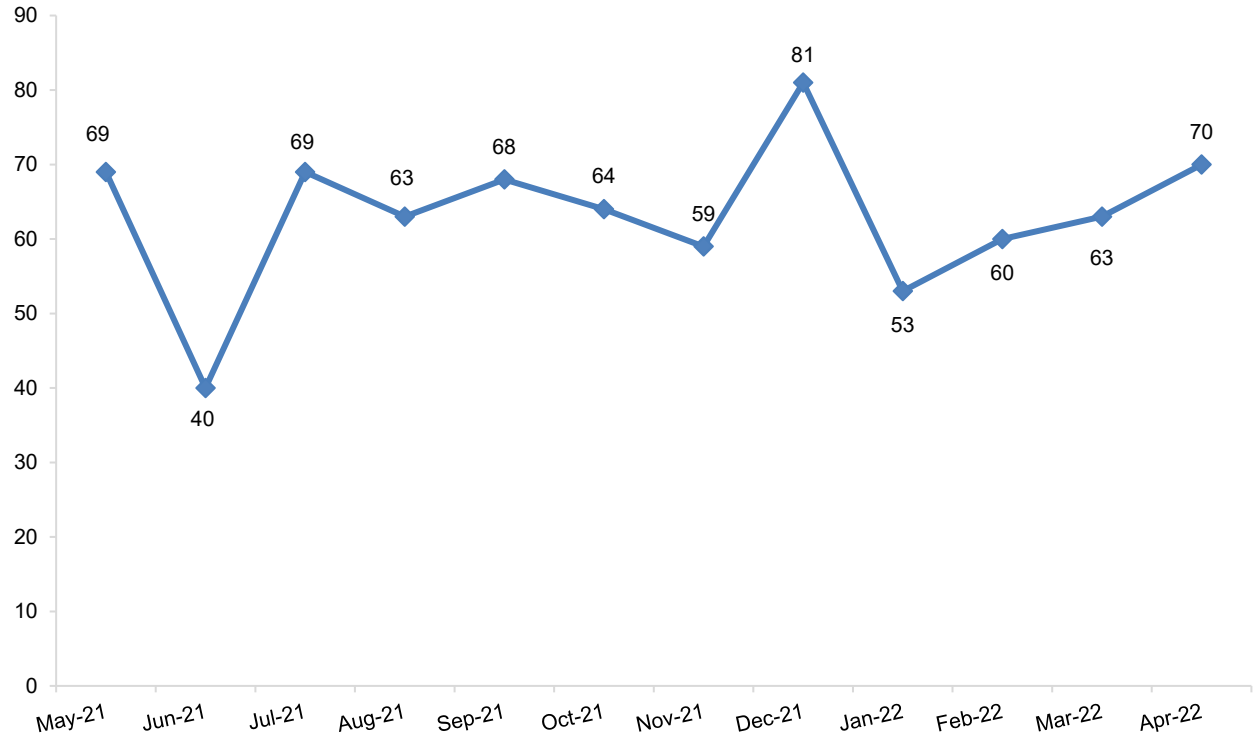
- 70 Change Requests Submitted/Logged in the month of April 2022



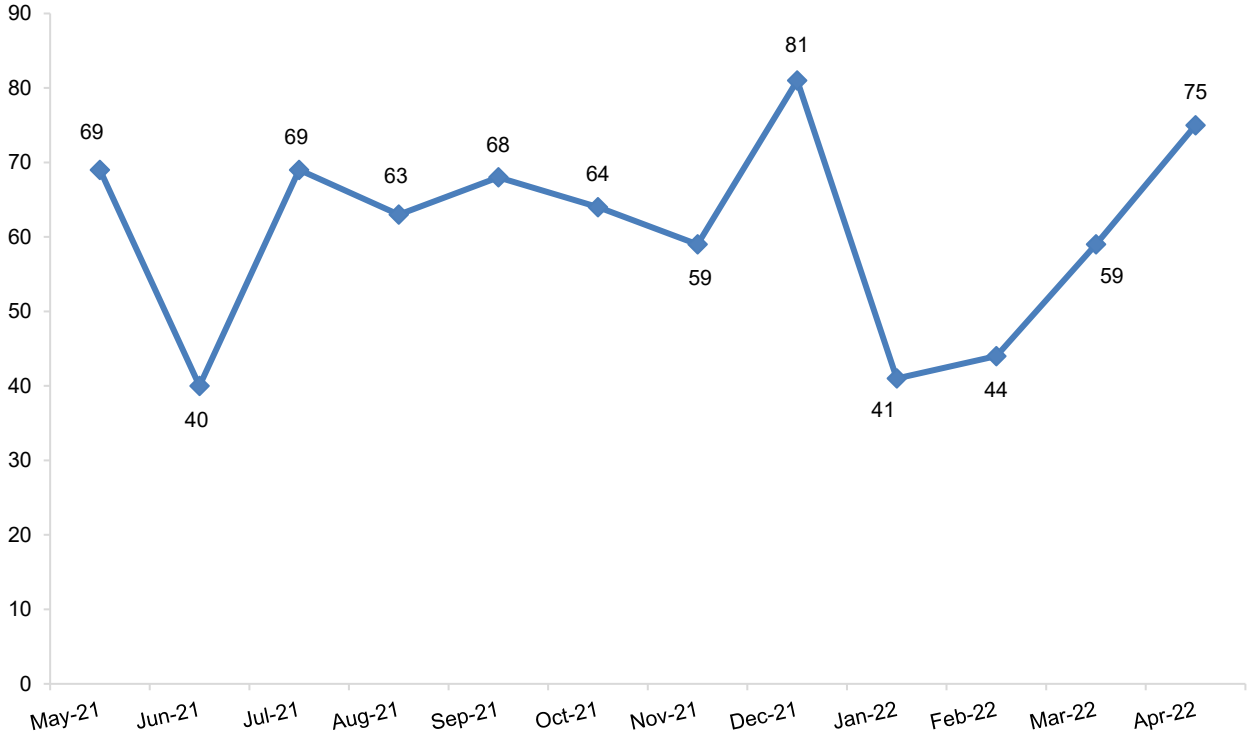
- 75 Change Requests Closed in the month of April 2022



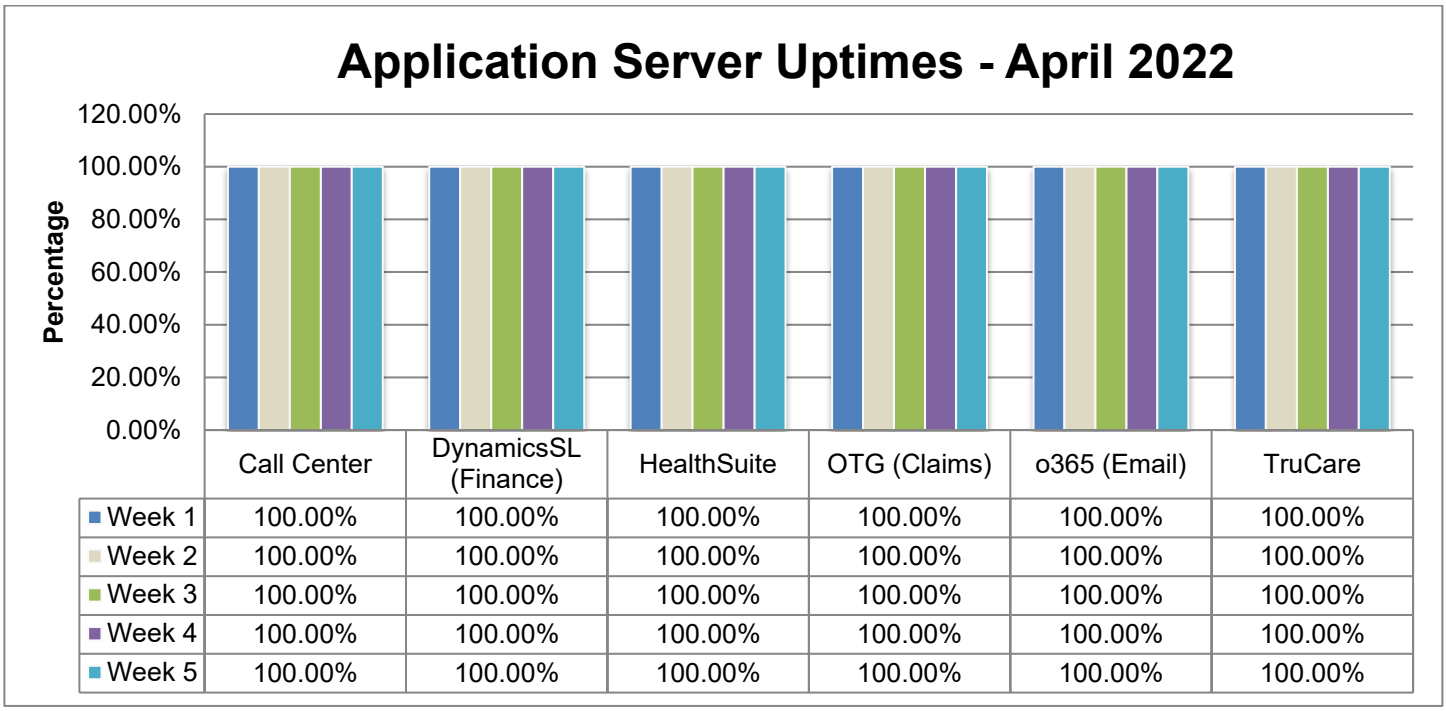
- Change Requests Submitted: Monthly Trend



- Change Requests Closed: Monthly Trend



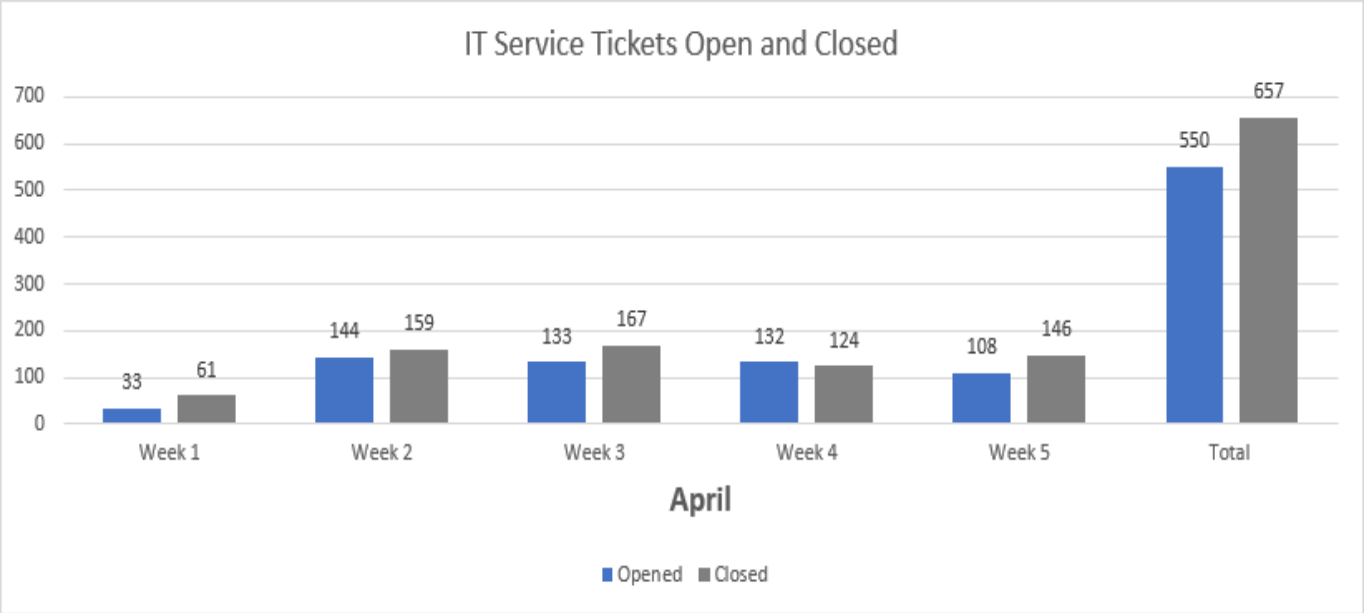
IT Stats: Infrastructure



	Call Center	DynamicsSL (Finance)	HealthSuite	OTG (Claims)	o365 (Email)	TruCare
Week 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 2	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 3	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 4	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- All mission critical applications are monitored and managed thoroughly.
- There were no major outages experienced in the month of April 2022 despite supporting 97% of staff working remotely.

- 550 Service Desk tickets were opened in the month of April 2022, which is 32.9% lower than the previous month and 657 Service Desk tickets were closed, which is 32.1% lower than the previous month.

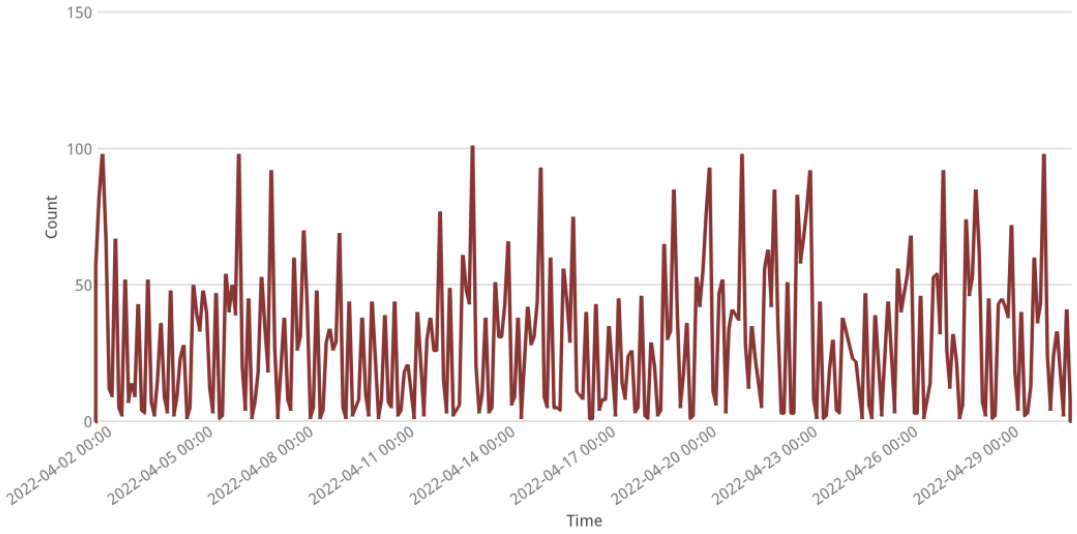


- The open ticket count for the month of April is lower than the previous 3-month average of 750.

- There were 14 new hires and 8 off boards for the month of April 2022.

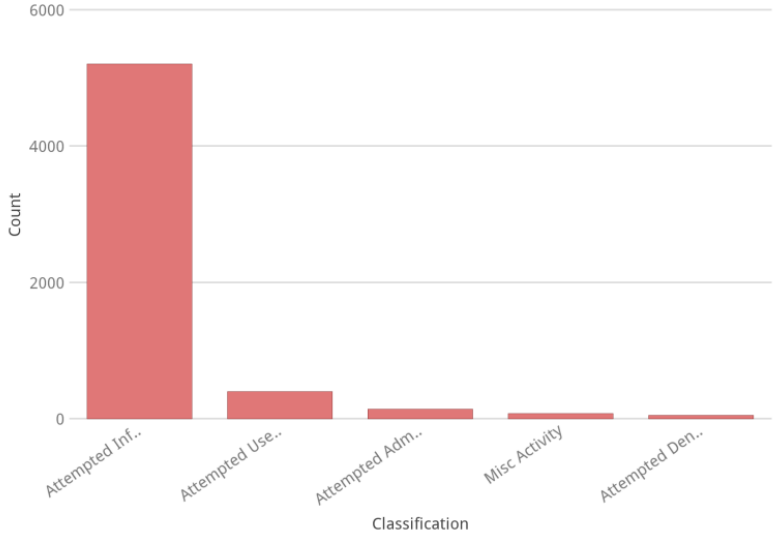
All Intrusion Events

Time Window: *2022-04-01 09:29:00 - 2022-04-30 09:29:00*



Dropped Intrusion Events

Time Window: *2022-04-01 09:30:00 - 2022-04-30 09:30:00*
Constraints: *Inline Result = dropped*

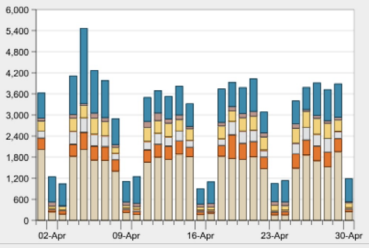


Classification	Count
Attempted Information Leak	5,207
Attempted User Privilege Gain	401
Attempted Administrator Privilege Gain	143
Misc Activity	78
Attempted Denial of Service	50

IronPort Email Security Gateways
Email Filters

MX4

Overview > Incoming Mail Graph



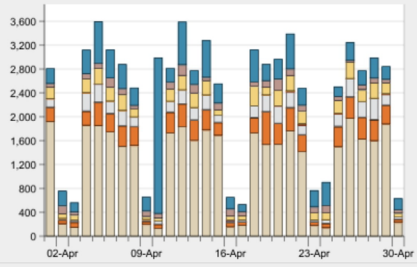
Export...

Overview > Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	26.6%	23.8k
Stopped by Domain Reputation Filtering	3.4%	3,051
Stopped as Invalid Recipients	0.1%	57
Spam Detected	9.5%	8,484
Virus Detected	0.0%	1
Detected by Advanced Malware Protection	0.0%	1
Messages with Malicious URLs	0.1%	83
Stopped by Content Filter	0.1%	54
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**39.7%**	**35.5k**
Marketing Messages	7.1%	6,318
Social Networking Messages	0.4%	363
Bulk Messages	9.7%	8,706
Total Graymails:	**17.2%**	**15.4k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	43.1%	38.6k
Total Attempted Messages:		**89.5k**

MX9

Overview > Incoming Mail Graph



Export...

Overview > Incoming Mail Summary

Stopped by IP Reputation Filtering	17.4%	12.2k
Stopped by Domain Reputation Filtering	4.1%	2,859
Stopped as Invalid Recipients	0.1%	60
Spam Detected	7.5%	5,273
Virus Detected	0.0%	3
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.1%	76
Stopped by Content Filter	0.1%	61
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**29.2%**	**20.6k**
Marketing Messages	7.2%	5,076
Social Networking Messages	0.5%	348
Bulk Messages	10.4%	7,356
Total Graymails:	**18.1%**	**12.8k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	52.7%	37.2k
Total Attempted Messages:		**70.6k**

Item / Date	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	***Apr-22***
Stopped By Reputation	79.9k	65.4	78.8k	62.7k	43.1k	41.5k	24.3k	39.3k	69.7k	42.4k	329.9k	52.8k	***36k***
Invalid Recipients	1,776	99	1,982	742	185	132	82	92	153	185	69	389	***117***
Spam Detected	19.2k	18	17.4k	27	12.8k	10.8k	5.6k	9,684	13.2k	10.3k	10.3k	15k	***13.7k***
Virus Detected	5	2	2	9	14	14	0	1	1	5	13	1	***4***
Advanced Malware	6	6	0	1	3	2	0	0	9	0	4	2	***1***
Malicious URLs	0	264	30	12	9	7	6	43	39	16	89	41	***159***
Content Filter	151	264	167	78	58	89	27	27	8	371	54	39	***115***
Marketing Messages	6,707	6,366	6,357	6,256	6,710	7,383	4,489	9,221	6,147	8,864	9,588	8,864	***11.3k***
Attempted Admin Privilege Gain	96	95	109	101	129	157	128	124	116	103	116	132	***143***
Attempted User Privilege Gain	10	1	0	3	7	6	6	13	49	117	663	789	***401***
Attempted Information Leak	20	18	38	15	32	3,700	7,782	9,376	13.7k	13.7k	5,813	5,192	***5,207***
Potential Corp Policy Violation	0	0	0	0	0	0	0	0	0	0	0	0	***0***
Network Scans Detected	0	0	0	0	0	0	0	0	0	0	0	0	***0***
Web Application Attack	11	0	3	1	0	0	0	0	0	0	1	0	***0***
Attempted Denial of Service	1	0	0	0	0	0	0	0	0	0	0	0	***50***
Misc. Attack	4,395	3,851	1,516	975	446	5,733	8,550	76	161	275	626	308	***78***

- All security activity data is based on the current month's metrics as a percentage. This is compared to the previous three month's average, except as noted.
- Email based metrics currently monitored have increased with a return to a reputation-based block for a total of 36k.
- Attempted information leaks detected and blocked at the firewall is at 5,207 for the month of April 2022.
- Network scans returned a value of 0, which is in line with previous month's data.
- Attempted User Privilege Gain is lower at 401 from a previous six-month average of 272.

Projects and Programs

Ruth Watson

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

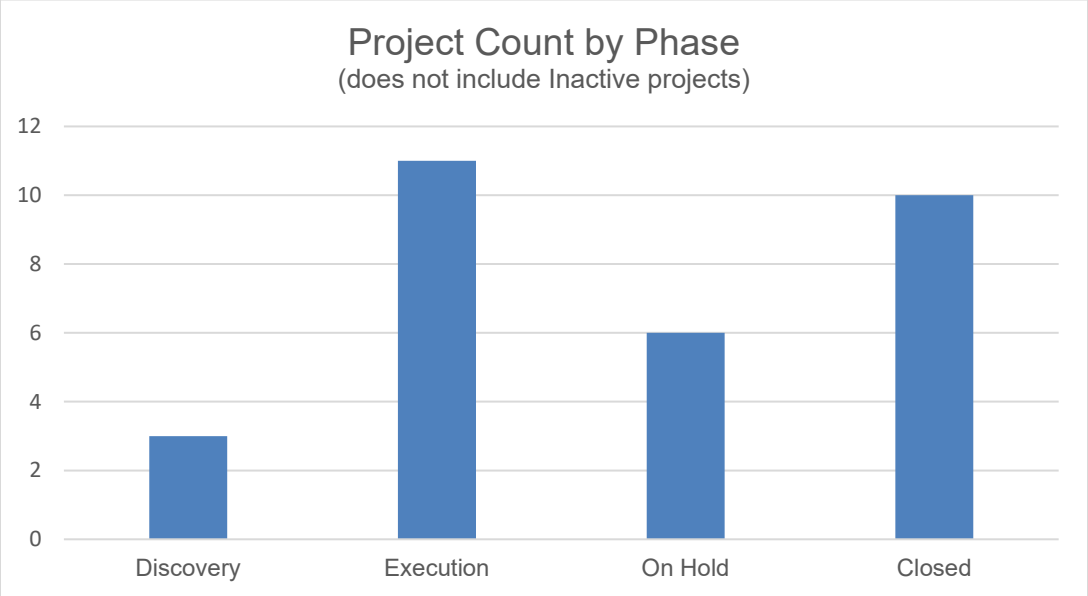
From: **Ruth Watson, Chief Projects and Programs Officer**

Date: **May 13th, 2022**

Subject: **Projects & Programs Report**

Project Management Office

- 37 projects currently on the Alliance enterprise-wide portfolio
  - 14 Active projects (discovery, initiation, planning, execution, warranty)
  - 6 On Hold projects
  - 10 Closed projects
  - 7 Inactive projects (not included on chart as Inactive is not a phase)



Integrated Planning

- CalAIM Enhanced Care Management (ECM) and Community Supports (CS):
  - Launched three (3) ECM Populations of Focus (PoFs) and six (6) CS on January 1st.
  - ECM portion of the Model of Care (MOC) fully approved by DHCS on March 8th.
  - Implementation of additional ECM PoFs effective January 2023 (3) and July 2023 (1).
    - Updated MOC Parts 1 & 2 for the January PoFs due to DHCS on July 1st, 2022.
    - Updated MOC for Part 3 for the January PoFs due to DHCS on September 1st, 2022.

        - Updated MOC Parts 1 & 2 for the July PoF due to DHCS on January 1st, 2023.
        - Updated MOC for Part 3 for the July PoF due to DHCS on March 1st, 2023.
    - CS portion of the MOC fully approved for Parts 1 and 2 and conditionally approved for Part 3.
        - DHCS requested additional information to previous responses on March 15th; AAH responded to DHCS on March 22nd and is still awaiting final approval.
    - AAH has notified DHCS that it intends to offer two (2) additional CS services by January 2024.
        - Environmental Accessibility Adaptations (Home Modifications).
        - Sobering Centers (Cherry Hill facility only).
    - Operational Readiness Activities – Day 2 work continues in two-week increments to complete post-go live identified activities.
    - Planning activities underway for the following January 2023 CalAIM initiatives:
        - Long Term Care Carve-In
        - Justice-Involved/Coordinated Re-Entry
        - Population Health Management Plan

- CalAIM Major Organ Transplants (MOT):
    - Submitted response to DHCS on January 7th regarding the Corrective Action Plan (CAP) received on December 10th for lack of a certified MOT network; CAP will remain in place until AAH has an executed contract with a transplant program that is a Center of Excellence (COE) for adult kidney-pancreas transplants.
        - AAH only contracted with UCSF and Stanford for transplants and Stanford is not a COE for kidney-pancreas transplants.
        - Still waiting for DHCS to issue rate guidance so we can execute a formal contract with UCSF for kidney-pancreas transplants.

- CalAIM Incentive Payment Program – three-year DHCS program to provide funding for the support of ECM and CS in the following areas:
    - 1) Delivery System Infrastructure
    - 2) ECM Provider Capacity Building
    - 3) Community Supports Provider Capacity Building and Community Supports Take-Up
    - Received approval from DHCS on March 29th for all 1,000 points
    - Program Year 1 (PY1), Payment 1 (50% of PY1 funding) released by DHCS on April 27th.
    - Provider funding application being developed jointly with Anthem and will be released shortly.

- Mental Health (Mild to Moderate/Autism Spectrum Disorder) Insourcing – services currently performed by Beacon Health Options will be brought in-house as of November 1st, 2022.
    - Conducted an Enterprise Portfolio and Risk assessment.
        - Assessment will continue to be conducted monthly.

    - Evaluated resource capacity and regulatory programs demand.
    - Senior Leadership Team met and made the decision to extend implementation through the end of October with a target go live by November 1st to mitigate the risk and ensure seamless transition for members and providers.

- Behavioral Health Integration (BHI) Incentive Program – DHCS pilot program commenced January 1st, 2021 and continues through December 31st, 2022:
    - PY1Q3 Milestone payments sent to Grantees on April 15th.
    - PY2Q1 Milestone reports received from Grantees on April 29th; consolidated report due to DHCS on May 30th.

- Student Behavioral Health Incentive Program (SBHIP) – DHCS program commenced January 1st, 2021 and continued through December 31st, 2023:
    - Received DHCS approval for the first funding milestone (50% of Needs Assessment allocation) on April 22nd; funding expected to be released late May.
    - Individual meetings with identified Partners were held during April.
    - First stakeholder meeting with all Partners scheduled for May 6th.

- Housing and Homelessness Incentive Program (HHIP):
    - Submitted HHIP Letter of Intent (LOI) to DHCS on April 4th.
    - Awaiting final program guidance from DHCS.
    - Contracting with consultant to assist with project, including preparation and submission of Local Homelessness Plan (LHP) to DHCS by June 30th.

- Justice-Involved/Coordinated Re-Entry:
    - Awaiting additional program guidance from DHCS.
    - Contracting with consultant to assist with project.

Recruiting and Staffing

- Project Management Open position(s):
    - Recruitment to commence/continue for the following positions:
        - Manager, Project Management Office (PMO)
        - Senior Business Analyst
        - Project Manager

Projects and Programs

Supporting Documents

Project Descriptions

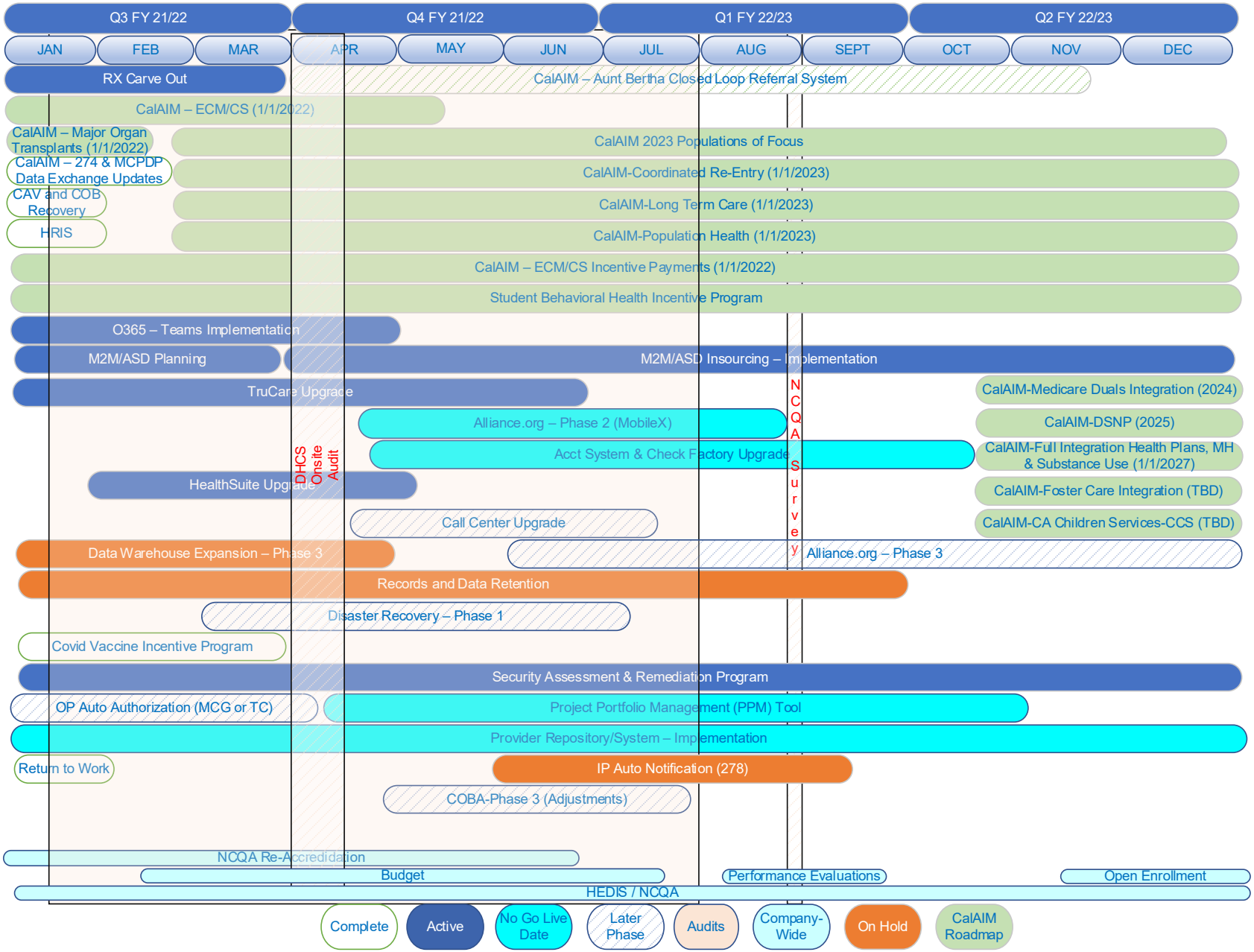
Key projects currently in-flight:

- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs.
    - Enhanced Care Management (ECM) – ECM will target seven (7) specific populations of vulnerable and high-risk children and adults.
        - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022.
        - Three (3) additional PoFs will become effective on January 1st, 2023.
        - Final PoF will become effective on July 1st, 2023.
    - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays.
        - Six (6) Community Supports were implemented on January 1st, 2022
        - Two (2) additional CS services are targeted for implementation by January 1st, 2024.
    - Major Organ Transplants (MOT) – currently not within the scope of many Medi-Cal managed care plans (MCPs); carved into all MCPs effective January 1st, 2022.
        - Applicable to all adults as well as children if the transplant is not covered by California Children's Services.
    - CalAIM Incentive Payment Program (IPP) – The CalAIM ECM and CS programs will require significant new investments in care management capabilities, ECM and CS infrastructure, information technology (IT) and data exchange, and workforce capacity across MCPs, city and county agencies, providers and other community-based organizations. CalAIM incentive payments are intended to:
        - Build appropriate and sustainable ECM and ILOS capacity.
        - Drive MCP investment in necessary delivery system infrastructure.
        - Incentivize MCP take-up of ILOS.
        - Bridge current silos across physical and behavioral health care service delivery.
        - Reduce health disparities and promote health equity.
        - Achieve improvements in quality performance.
    - Long Term Care - currently not within the scope of many Medi-Cal managed care plans (MCPs); will be carved into all MCPs effective January 1st, 2023
    - Justice Involved/Coordinated Re-Entry – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release effective January 1st, 2023
    - Population Health Management (PHM) – all Medi-Cal managed care plans will be required to develop and maintain a whole system, person-centered population health management strategy effective January 1st, 2023

        - PHM is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes.
- Return to Work – assessment of current state work environment and recommendations for future configurations (remote/onsite/hybrid).
- Project Portfolio Management (PPM) Tool – vendor demonstrations complete; target implementation in FY 2022-23.
- APL 20-017 Managed Care Program Data Improvement.
    - DHCS will require Managed Care Plans (MCPs) to report program data using new, standardized reporting formats.
        - Additional requirements for data reporting related to grievances, appeals, monthly Medical Exemption Requests (MER) and other continuity of care requests, out-of-Network requests, and Primary Care Provider (PCP) assignments for all MCPs.
        - MCPs are required to meet all requirements in this APL no later than July 1st, 2021.
- Accounting & Enterprise Resource Planning (ERP) System Upgrade – upgrade current system to supported platform.
- Student Behavioral Health Incentive Program (SBHIP) – program launched in January 2022 to support new investments in behavioral health services, infrastructure, information technology and data exchange, and workforce capacity for school-based and school-affiliated behavioral health providers. Incentive payments will be paid to Medi-Cal managed care plans (MCPs) to build infrastructure, partnerships and capacity, statewide, for school behavioral health services.
    - Letter of Intent submitted to DHCS on January 27th.
    - Partners Form submitted to DHCS on March 15th.
    - Meetings completed with Alameda County Office of Education (ACOE), Center for Healthy Schools and Communities (CHSC) and interested Local Education Agencies (LEAs) to begin work on Needs Assessment which will identify which of the fourteen (14) targeted interventions are a priority for Alameda County.
- Housing and Homelessness Incentive Program (HHIP) – program launched in January 2022 and is part of the Home and Community-Based (HCBS) Spending Plan.
    - Enables Managed Care Plans (MCPs) to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health.
    - MCPs must collaborate with local homeless Continuums of Care (CoCs) and submit a Local Homelessness Plan (LHP) to be eligible for HHIP funding.
    - LHP is expected to be in alignment with local Homeless Housing, Assistance and Prevention (HHAP) grant application.
    - In counties with more than one MCP, MCPs need to work together to submit one LHP per county.

Key Projects on Hold:

- In Patient (IP) Auto Notification (278 Data File) – pilot hospitals are not ready to start implementation.
- Records and Data Retention – on hold due to internal resource constraints re-directed to regulatory required projects.


Q3 FY 21/22
Q4 FY 21/22
Q1 FY 22/23
Q2 FY 22/23
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEPT
OCT
NOV
DEC
RX Carve Out
CalAIM – Aunt Bertha Closed Loop Referral System
CalAIM – ECM/CS (1/1/2022)
CalAIM – Major Organ Transplants (1/1/2022)
CalAIM 2023 Populations of Focus
CalAIM – 274 & MCPDP Data Exchange Updates
CalAIM-Coordinated Re-Entry (1/1/2023)
CAV and COB Recovery
CalAIM-Long Term Care (1/1/2023)
HRIS
CalAIM-Population Health (1/1/2023)
CalAIM – ECM/CS Incentive Payments (1/1/2022)
Student Behavioral Health Incentive Program
O365 – Teams Implementation
M2M/ASD Planning
M2M/ASD Insourcing – Implementation
TruCare Upgrade
CalAIM-Medicare Duals Integration (2024)
Alliance.org – Phase 2 (MobileX)
CalAIM-DSNP (2025)
Acct System & Check Factory Upgrade
CalAIM-Full Integration Health Plans, MH & Substance Use (1/1/2027)
DHCS Onsite Audit
NCQA Survey
HealthSuite Upgrade
CalAIM-Foster Care Integration (TBD)
Call Center Upgrade
CalAIM-CA Children Services-CCS (TBD)
Data Warehouse Expansion – Phase 3
Alliance.org – Phase 3
Records and Data Retention
Disaster Recovery – Phase 1
Covid Vaccine Incentive Program
Security Assessment & Remediation Program
OP Auto Authorization (MCG or TC)
Project Portfolio Management (PPM) Tool
Provider Repository/System – Implementation
Return to Work
IP Auto Notification (278)
COBA-Phase 3 (Adjustments)
NCQA Re-Accreditation
Budget
Performance Evaluations
Open Enrollment
HEDIS / NCQA
Complete
Active
No Go Live Date
Later Phase
Audits
Company-Wide
On Hold
CalAIM Roadmap

Analytics

Tiffany Cheang

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

From: **Tiffany Cheang, Chief Analytics Officer**

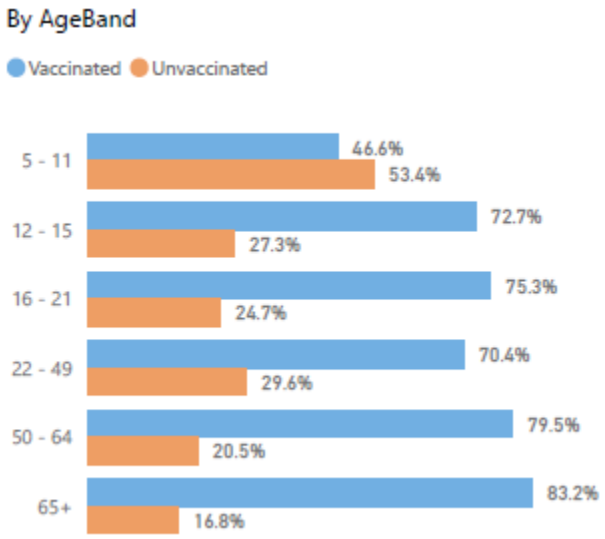
Date: **May 13th, 2022**

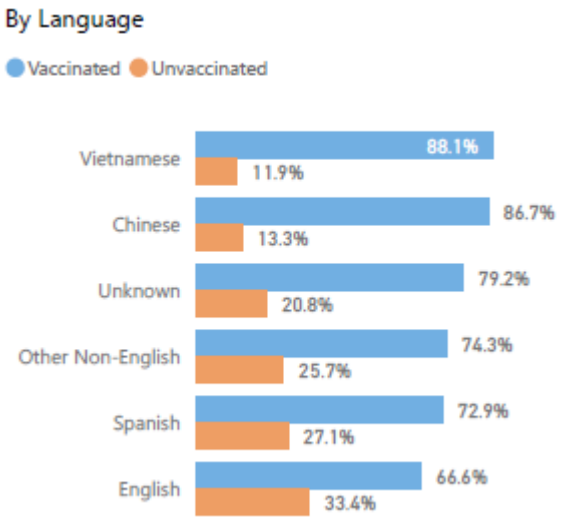
Subject: **Performance & Analytics Report**

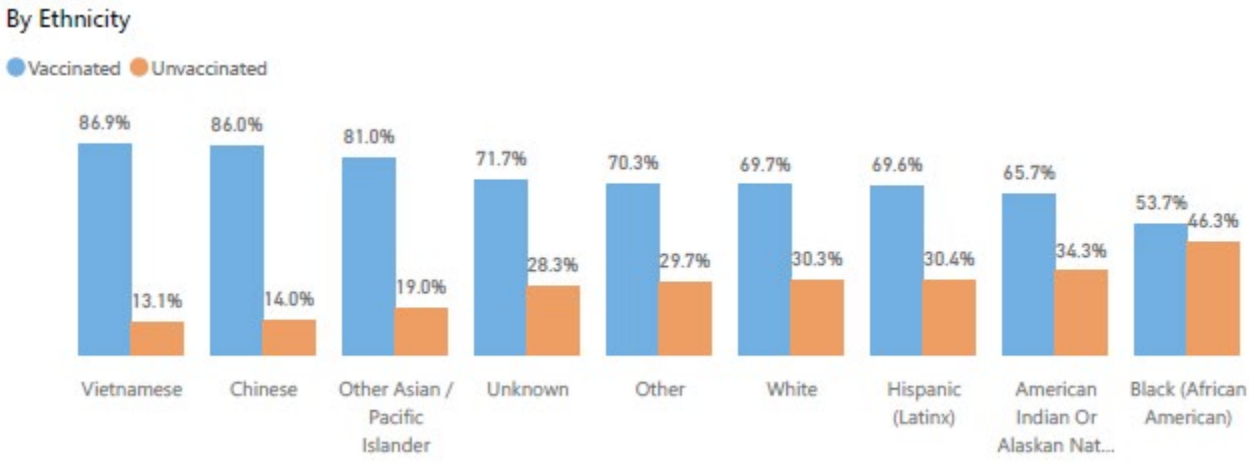
COVID-19 Vaccination Rate

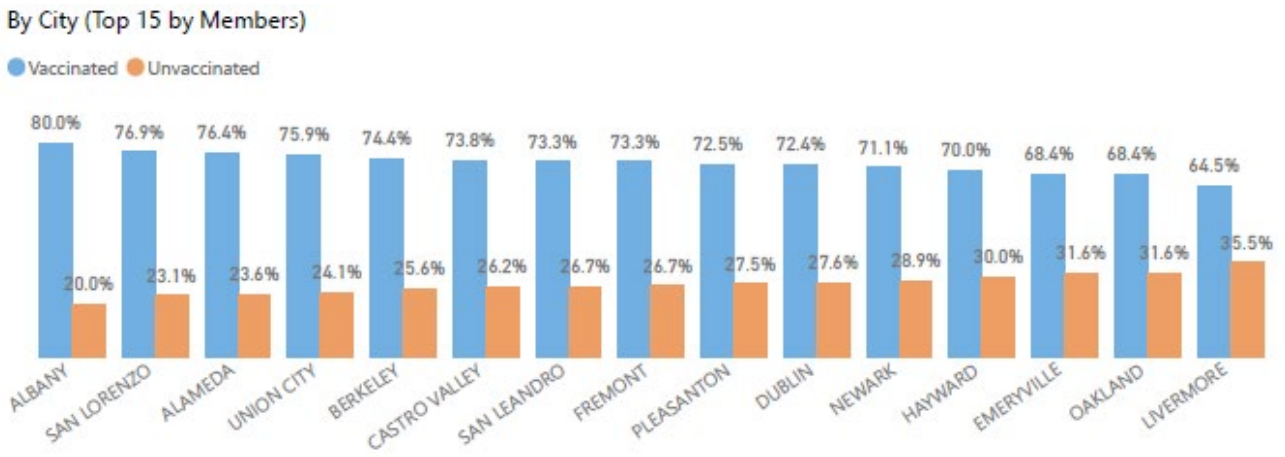
- The Alliance COVID-19 Vaccination rate is 70.9% for fully and partially vaccinated members aged **5** years and older.
  - 66.8% are fully vaccinated
  - 4.1% are partially vaccinated

A comparison of the Alliance's vaccinated vs unvaccinated members (29.1%) shows the following demographic results:









Member Cost Analysis

- The Member Cost Analysis below is based on the following 12 month rolling periods:
  Current reporting period: Feb 2021 – Jan 2022 dates of service
  Prior reporting period: Feb 2020 – Jan 2021 dates of service
  (Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 8.7% of members account for 83.8% of total costs.

- In comparison, the Prior reporting period was lower at 7.9% of members accounting for 83.6% of total costs.

- Characteristics of the top utilizing population remained consistent between the reporting periods:

    - The SPD (non-duals) and ACA OE categories of aid saw no change to account for 60.3% of the members, with SPDs accounting for 27.0% and ACA OE's at 33.3%.
    - The percent of members with costs >= $30K slightly increased from 1.7% to 1.9%.
    - Of those members with costs >= $100K, the percentage of total members remained consistent at 0.4%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 49.5%.

- Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.

- However, the age distribution of the top 8.7% is more concentrated in the 45-66-year-old category (40.3%) compared to the overall population (20.3%).

Analytics

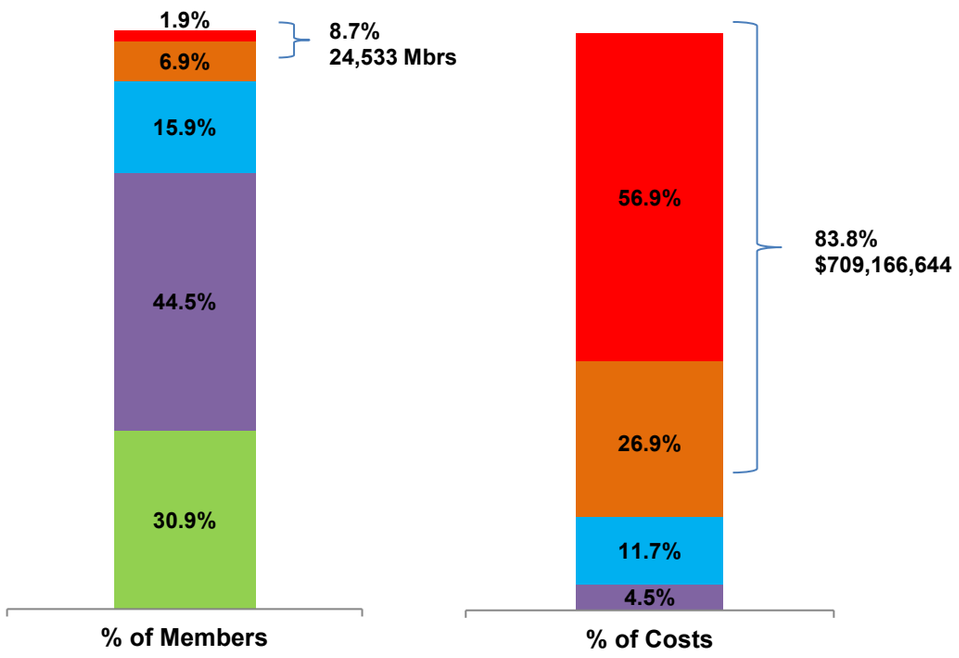
Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Feb 2021 - Jan 2022

Note: Data incomplete due to claims lag

Run Date: 04/29/2022

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	5,232	1.9%	$ 481,398,379	56.9%
$5K - $30K	19,301	6.9%	$ 227,768,266	26.9%
$1K - $5K	44,447	15.9%	$ 98,975,081	11.7%
< $1K	124,865	44.5%	$ 38,142,638	4.5%
$0	86,568	30.9%	$ -	0.0%
Totals	**280,413**	**100.0%**	**$ 846,284,364**	**100.0%**

Top 8.7% of Members = 83.8% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	1,226	0.4%	$ 266,454,563	31.5%
$75K to $100K	674	0.2%	$ 57,944,221	6.8%
$50K to $75K	1,270	0.5%	$ 77,852,642	9.2%
$40K to $50K	799	0.3%	$ 35,624,965	4.2%
$30K to $40K	1,263	0.5%	$ 43,521,989	5.1%
SubTotal	***5,232***	***1.9%***	***$ 481,398,379***	***56.9%***
$20K to $30K	2,532	0.9%	$ 61,533,703	7.3%
$10K to $20K	6,974	2.5%	$ 96,804,556	11.4%
$5K to $10K	9,795	3.5%	$ 69,430,006	8.2%
SubTotal	***19,301***	***6.9%***	***$ 227,768,266***	***26.9%***
Total	**24,533**	***8.7%***	**$ 709,166,644**	***83.8%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Jan 2022	258,085	$ 750,152,726
Dis-Enrolled During Year	22,328	$ 96,131,638
Totals	**280,413**	**$ 846,284,364**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
8.7% of Members = 83.8% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Feb 2021 - Jan 2022
Note: Data incomplete due to claims lag
Run Date: 04/29/2022

8.7% of Members = 83.8% of Costs
27.0% of members are SPDs and account for 32.4% of costs.
33.3% of members are ACA OE and account for 32.8% of costs.
6.7% of members disenrolled as of Jan 2022 and account for 12.8% of costs.

Highest Cost Members; Cost Per Member >= $100K
36.1% of members are SPDs and account for 35.4% of costs.
31.1% of members are ACA OE and account for 33.0% of costs.
19.7% of members disenrolled as of Jan 2022 and account for 20.4% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	140	601	741	3.0%
MCAL	MCAL - ADULT	583	3,651	4,234	17.3%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	218	1,592	1,810	7.4%
	MCAL - ACA OE	1,687	6,491	8,178	33.3%
	MCAL - SPD	1,834	4,783	6,617	27.0%
	MCAL - DUALS	107	1,208	1,315	5.4%
Not Eligible	Not Eligible	663	975	1,638	6.7%
Total		**5,232**	**19,301**	**24,533**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	25	2.0%
MCAL	MCAL - ADULT	110	9.0%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	6	0.5%
	MCAL - ACA OE	381	31.1%
	MCAL - SPD	442	36.1%
	MCAL - DUALS	21	1.7%
Not Eligible	Not Eligible	241	19.7%
Total		**1,226**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 10,003,194	$ 6,804,185	$ 16,807,379	2.4%
MCAL	MCAL - ADULT	$ 44,991,665	$ 42,477,972	$ 87,469,637	12.3%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 10,315,985	$ 18,476,611	$ 28,792,596	4.1%
	MCAL - ACA OE	$ 158,122,135	$ 74,728,061	$ 232,850,196	32.8%
	MCAL - SPD	$ 171,956,834	$ 58,166,985	$ 230,123,819	32.4%
	MCAL - DUALS	$ 7,876,750	$ 14,767,249	$ 22,643,999	3.2%
Not Eligible	Not Eligible	$ 78,131,815	$ 12,347,202	$ 90,479,017	12.8%
Total		**$ 481,398,379**	**$ 227,768,266**	**$ 709,166,644**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 4,466,502	1.7%
MCAL	MCAL - ADULT	$ 20,886,782	7.8%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 1,117,175	0.4%
	MCAL - ACA OE	$ 87,818,768	33.0%
	MCAL - SPD	$ 94,364,057	35.4%
	MCAL - DUALS	$ 3,567,924	1.3%
Not Eligible	Not Eligible	$ 54,233,356	20.4%
Total		**$ 266,454,563**	**100.0%**

% of Total Costs By Service Type

Breakout by Service Type/Location

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	8%	0%	0%	11%	57%	1%	14%	5%	2%	7%
$75K to $100K	7%	0%	1%	16%	45%	3%	8%	5%	8%	13%
$50K to $75K	7%	0%	1%	15%	43%	4%	7%	7%	8%	14%
$40K to $50K	7%	0%	1%	15%	45%	6%	9%	6%	2%	16%
$30K to $40K	14%	1%	1%	13%	38%	14%	7%	6%	1%	19%
$20K to $30K	7%	2%	1%	17%	34%	11%	10%	7%	1%	18%
$10K to $20K	1%	0%	1%	19%	32%	6%	12%	10%	1%	16%
$5K to $10K	0%	0%	0%	21%	18%	9%	13%	15%	0%	19%
Total	**6%**	**0%**	**1%**	**15%**	**44%**	**5%**	**12%**	**7%**	**3%**	**13%**

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

Human Resources

Anastacia Swift

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

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

Date: **May 13th, 2022**

Subject: **Human Resources Report**

Staffing

- As of May 1st, 2022, the Alliance had 374 full time employees and 1-part time employees.

- On May 1st, 2022, the Alliance had 47 open positions in which 7 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 40 positions open to date. The Alliance is actively recruiting for the remaining 40 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by department:

Department	Open Positions May 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	13	2	11
Operations	16	3	13
Healthcare Analytics	3	0	3
Information Technology	4	1	3
Finance	2	0	2
Regulatory Compliance	4	1	3
Human Resources	4	0	4
Projects & Programs	1	0	1
Total	47	7	40

- Our current recruitment rate is 11%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in March 2022 included:
    - 5 years:
        - Rita Ng (Quality Improvement)
        - Angelica Glasco-Olivares (Complaints & Resolutions)
        - Sivilay Sisombat (Provider Relation)
        - Pritika Kumar (Claims)
    - 6 years:
        - Jamisha Jefferson (Quality Improvement)
        - Sylvia Marquez (Member Services)
        - Darryl Crowder (Provider Relation)
    - 7 years:
        - Ed Fugaban (IT Development)
        - Daniel Primus (IT Development)
        - Shiuwen Fu (IT Development)
    - 8 years:
        - Lisa Calvo (Utilization Management)
    - 10 years:
        - Jeffrey McKenzie (IT Development)
    - 17 years:
        - Crista Tran (IT Apps Mgmt., IT Quality & Process Improvement)
    - 21 years:
        - Anet Quiambao (Claims)
    - 26 years:
        - Donna Ceccanti (Credentialing)

- Employees reaching major milestones in their length of service at the Alliance in April 2022 included:
    - 5 years:
        - Ramon Tran Tang (Pharmacy Services)
    - 6 years:
        - Sonia Spears (Quality Analytics)
        - Kristel Rusiana (Utilization Management)
        - Maria Radona (Utilization Management)
        - Tanisha Lipscomb-Shepard (Regulatory Affairs & Compliance)
        - Junaid Godil (IT Operations & Quality Apps Management)
        - Remy Sagayo (Finance)

- 7 years:
  - Paris Hawkins (Claims)
  - Janese Jacques-Davis (Projects & Programs)
  - Christine Marie Rosal (Utilization Management)
- 10 years:
  - Christine Rattray (Quality Improvement)
  - Elsa Guzman (Case & Disease Management)
- 12 years:
  - Marlowe West (Claims)
  - Latrina Brodnax (Claims)
- 13 years:
  - Tyisha Pierce (Claims)
- 14 years:
  - Ed Sanares (IT Infrastructure)
- 20 years:
  - Mandy Gutierrez (Community Relations)
- 21 years:
  - Teresa Corral (Claims)