Board of Governors

Regular Meeting

Friday, November 11th 2022
12:00 p.m. – 2:30 p.m.

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

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, November 11th, 2022
12:00 p.m. – 2:30 p.m.

Video Conference Call or

1240 S. Loop Road

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: Click here to join the meeting OR MAY LISTEN TO THE MEETING BY CALLING IN TO THE FOLLOWING TELEPHONE NUMBER: 1-510-210-0967 Conference ID 8650745#. 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 COMMENTS 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 November 11h, 2022, at 12:00 p.m. in Alameda County, California, by Rebecca Gebhart, Presiding Officer. This meeting is hybrid and is to take place by video conference call or in person.)

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) OCTOBER 14th, 2022, BOARD OF GOVERNORS MEETING MINUTES

b) NOVEMBER 8th, 2022, FINANCE COMMITTEE MEETING MINUTES

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

b) FINANCE COMMITTEE

7. CEO UPDATE

8. BOARD BUSINESS

a) REVIEW AND APPROVE SEPTEMBER 2022 MONTHLY FINANCIAL STATEMENTS

b) ALLIANCE OPERATIONS UPDATE

c) REVIEW AND APPROVE PROVISIONAL VOTE ON ADDITIONAL BOARD SEATS TO TAKE EFFECT UPON COUNTY ORDINANCE CHANGE.

d) REVIEW AND APPROVE RESOLUTION #2022-04 JODY MOORE, ALLIANCE CONSUMER MEMBER ADVISORY COMMITTEE SEAT

e) BOARD CHAIR ANNOUNCEMENT

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. CLOSED SESSION

a) **DISCUSSION AND DELIBERATION REGARDING TRADE SECRETS (WELFARE & INSTITUTIONS CODE SECTION 14087.35). DISCUSSION WILL CONCERN A NEW LINE OF BUSINESS; PROTECTION OF ECONOMIC BENEFIT TO THE HEALTH AUTHORITY. ESTIMATED PUBLIC DISCLOSURE WILL OCCUR IN THE MONTH OF JANUARY 2025.**

15. ADJOURNMENT

NOTICE TO THE PUBLIC

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

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

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 2:30 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 2:30 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.

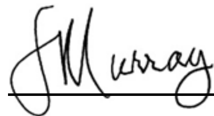
Public Input: If you are interested in addressing the Board, you may submit comments on any agenda item or on any item not on the agenda, in writing via mail to "Attn: Alliance Board," 1240 S. Loop Road, Alameda, CA 94502; or through e-comment at jmurray@alamedaalliance.org. You may also provide comments 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 by November 7th, 2022.



Clerk of the Board – Jeanette Murray

Consent Calendar

Board of Governors Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING
October 14th, 2022
12:00 pm – 2:00 pm
1240 S. Loop Road and
Video Conference Call
Alameda, CA

SUMMARY OF PROCEEDINGS

Board of Governors on Conference Call and/or in person: Dr. Evan Seevak (Chair), Rebecca Gebhart (Vice-Chair), Dr. Marty Lynch, Byron Lopez, Dr. Rollington Ferguson, James Jackson, Dr. Noha Aboelata, Dr. Michael Marchiano, Aarondeep Basrai, Supervisor Dave Brown

Alliance Staff Present on Conference Call and/or in person: Scott Coffin, Dr. Steve O'Brien, Gil Riojas, Anastacia Swift, Ruth Watson, Matt Woodruff, Tiffany Cheang

Guests Present on Conference Call:

Excused: Natalie Williams, Dr. Kelley Meade, Andrea Schwab-Galindo, Yeon Park

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 12:04 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

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 July 8th, 2022, Consent Calendar. a) July 8th, 2022, Board of Governors Meeting Minutes b) September 29th, 2022, Board of Governors Retreat Minutes c) September 6th, 2022, Finance Committee Meeting Minutes d) October 11th, 2022, Finance Committee Meeting Minutes Motion to Approve October 14th, 2022, Board of Governors Consent Calendar. A roll call vote was taken, and the motion passed.	Motion to Approve October 14th, 2022, Board of Governors Consent Calendar. Motion: Dr. Marty Lynch Second: Byron Lopez Vote: Yes No opposed or abstained.	None

6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY COMMITTEE			
Rebecca Gebhart	The Compliance Advisory Committee (CAC) was held telephonically on October 14th, 2022, at 10:30 am. Rebecca Gebhart gave the following Compliance Advisory Committee updates from the September 9th, 2022, and October 14th, 2022, Compliance Advisory Committee meetings. 2022 Medical Survey: • On September 9th, 2022, we reviewed the 2022 Medical Survey, which had fifteen (15) preliminary findings, nine (9) were repeats. As of September, the State had thirty (30) days to respond. We were notified today that the State issued its final report, and the fifteen (15) preliminary findings are now final. We reviewed ten (10) of the fifteen (15), and the other five (5) findings will be reviewed in November. • Some are repeat findings – for example, in Grievances and Appeals, the appeals acknowledgments were not sent out on time due to several months of backup from last year, which has been corrected. In Grievances and Appeals due to COVID, there was an oversight concerning updating materials, which has also been corrected. • Our focus regarding the findings is determining whether it is a simple fix, or whether there is an issue within our system that requires resources to resolve. Most of these findings were easily corrected. For example, a member rights issue related to failure to send acknowledge letters timely or in threshold languages; was easily corrected. • There was another finding that we did not report unauthorized disclosures of PHI in the reporting timeframes – during that timeframe, we were reporting to the DHCS mailbox, but they were not going through. Compliance Activity Dashboard: • The Kindred Audit has gone through an internal review of all the services of the first quarter (Q1) of 2022, and there were no findings with respect to these services, and this audit may be closed.	Informational update to the Board of Governors. Vote not required.	

	• The audit related to dental anesthesia that was discussed prior has also been closed. DMHC 2022 Behavioral Health Investigation: • Over one thousand (1,000) documents have been submitted due to legislation requesting that behavioral health parity be looked at. All teams across the organization participated in this audit, which only focused on our commercial line. The other audited entities include Kaiser, Health Net, and Blue Cross. The Medi-Cal line of business is held accountable to all requirements. • The investigation reinforced that we do not want to create siloed processes and policies for behavioral health – we want to integrate them into our existing policies and procedures. • In our insourcing work, the staff is looking for discrepancies in how we manage medical and behavioral health, and ensuring we integrate behavioral health into our existing processes. • In the investigation, Beacon was present, as well as all their subject matter experts. Some of the questions from the investigators were related to utilization management, and how we are handling urgent crisis issues in medical cases as well as in behavioral health, and what happens when members are hospitalized. The investigators were interested in which medical criteria were used, and why they were used. Additionally, there is new legislation related to training, which needs to be fulfilled and reflected. • For grievances and appeals, the investigators were interested in how we are tracking that. Additionally, they wanted to ensure our behavioral health network meets adequacy requirements. There are also new requirements for follow-up care. • Regarding member services, the emphasis was placed on whether the same workflows are used for both medical and behavioral health without any additional requirements. • For claims, the focus was whether we are paying claims as quickly on the behavioral health side that we do on the medical side. • All organization departments were analyzed in this investigation and will continue to be looked at. Question: Do we have data on access and how long it takes to get someone a visit for behavioral health?		

Answer: In almost all areas, we can get timely access to a visit. The only area we have had questions about access is psychiatry, however, a significant improvement has been made in the network for this. For ABA services/autism services, a lot of families want treatment after school and before the evening. We struggle with this specific time availability, but we continue to have plenty of availability to meet the timely standard. Beacon has done a reasonably good job at reporting access, and standards, and doing it in a way that matches our procedure for tracking access. From an audit perspective, we were able to demonstrate that we have accurate oversight.

Question: Do we have any responsibility for psychiatry for the Duals population?
Answer: Psychiatry is in high demand, and therefore, they are often not interested in payer mixes due to fees. Our contracting team has strategically contracted with psychiatrists at a higher rate of pay, so our rates are higher than standard Medicare for our Duals. As a Plan, we are being proactive in contracting with psychiatry to ensure we have an adequate network. We are also adding Teladoc, which is new to the Plan to add psychiatry services, and this should be in place by the time we go live. This will give us a broader network capacity.

Single Plan Model Transition:

- The State extended our deliverable submission requirements from two-hundred-forty-five (245) deliverables to a total of four-hundred-seventy-one (471) deliverables.
- The deliverables are submitted to the State in phases. Thus far, we have made two (2) submissions. Our third submission will be due on November 28th, 2022. The largest number of deliverables will be submitted in Spring-Summer 2023.
- There are two-hundred-thirty-three (233) deliverables that are still not yet identified by the State.
- The new Medi-Cal contract will go into effect on January 1st, 2024, when we transition to the Single Plan Model. All deliverables are associated with Operational Readiness.

Medi-Cal Pharmacy Transition:

- Dr. Lee spoke about the Medi-Cal Pharmacy Transition and reminded us that it commenced in January. The pharmacy benefit moved to State

	administration, and the State is serving ten million (10M) beneficiaries, with a quarter of a million authorizations. • There was a massive cost for many drugs that did not require a prior authorization. The State is now phasing in prior authorization requirements for certain drugs. 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, September 6th, 2022, and Tuesday, October 11th, 2022. Since Dr. Ferguson was not present for the meeting, Dr. Marchiano provided the following updates: Highlights: • Our enrollment has increased by over six thousand (6,000) members since June 2022, and growth has been reported in all categories of aid. • For the fiscal year-to-date (YTD) ending May 31st, 2022, revenue was topped at about $1.2B, and expenses grew to $1.1B. • The administrative loss ratio (ALR) and medical loss ratio (MLR) remain favorable – the MLR was reported to be ninety-two-point-four percent (92.4%). The MLR is instructed to be between ninety percent (90%) and ninety-five percent (95%). • The TNE is also very healthy – overall, an excellent report and a testament to the hard work of the Alliance. Dr. Ferguson provided the following update: • We had predicted a thirteen-million-dollar loss ($13M) for the fiscal year, and we have turned it around; therefore, it will be an eight-million-dollar profit ($8M) for the fiscal year.	Informational update to the Board of Governors. Vote not required.	None

	Informational update to the Board of Governors. Vote not required.		
7. CEO UPDATE			
Scott Coffin	Scott Coffin, Chief Executive Officer, presented the following updates: Today, we are reporting three (3) months of financial statements, for the months of June, July, and August of 2022. The reporting consolidation is due to the Board recess in August, and the strategic Board Retreat in the month of September. Financials: • The Alliance implemented a system configuration change in the month of June 2022 that resulted in five-hundred-sixty-seven (567) claims being denied inappropriately over a ninety (90) day period. In the month of September, the claims were correctly processed and paid, totaling approximately three-point-five million dollars ($3.5M). • There was an interest incurred of about forty-one-hundred-dollars ($4100) that was also paid. The paid amount will be recognized in the September 2022 financial report and presented as an adjustment in the financial report presented next month. This is being called out because it is an unusual adjustment and different than previous adjustments that have been presented to the Board. • The public health emergency is still in effect and is tentatively scheduled to continue through January 31st, 2023. This is tied into two important programs occurring right now: (1) The Department of Health Care Services Ambassador Program, which was created to minimize the impact of individuals that would be disenrolled as a result of the public health emergency unwinding. The public health emergency is going to delay some of these plans. The Board will continue to see growth – we have been averaging anywhere from thirteen hundred to fifteen hundred (1,300 – 1,500) in the Medi-Cal program each month. Today, we have about three-hundred-twenty-four thousand (324,000) members, demonstrating	Informational update to the Board of Governors. Vote not required.	None

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<tr><td></td><td>growth from our August report which showed three-hundred-nineteen thousand (319,000) members. Next year around April is when re-determinations will start; that is when the membership will begin to balance.

Final Budget – Fiscal Year (FY) 2023:
• The final budget for FY2023 is in process and will be presented to the Board of Governors in December 2022. This will follow the delivery of the Medi-Cal rates that will be issued by the Department of Health Care Services, which we are anticipating will be received in November.

CalAIM Incentives:
• Long-Term Care Initiative: Ruth Watson, our Chief of Integrated Planning will present with the team on the milestones of long-term care.
• Mild-to-Moderate Autism Spectrum Disorder: The transition of insourcing of these services from Beacon to Alameda Alliance is set for March 2023.
• We’ve reached a critical milestone with the Housing and Homelessness Incentive Plan (HHIP) – in total, forty-four-point-three million dollars ($44.3M) was allocated to Alameda Alliance as part of this incentive program. This was to cover two-calendar years: nineteen-point-nine million dollars ($19.9M) for calendar year 2022 and twenty-four-point-four million dollars ($24.4M) for calendar year 2023.
• For this initiative, the State will issue payments for eligible expenses in three-year periods: September 2022, June 2023, and March 2024. It is important to note that the Department of Health Care Services requires that we obtain performance results using very specific measures by October 2023. The outcomes and performance measures must be obtained in about twelve (12) months. Due to the reimbursement criteria, approximately twenty-six-point-five million dollars ($26.5M) which is sixty percent (60%) of the total allocation was identified. A small portion of that – about six percent (6%) is reserved for administrative expenses that we will incur as part of administering this investment plan. The investment plan was submitted to the Department of Health Care Services on September 30th, 2022. This is a non-binding document that allows us to make necessary changes as we begin implementation.
• In this Housing and Homelessness Incentive Plan initiative, the amount at risk is twenty-six-point-five million dollars ($26.5M). There are</td><td></td><td></td></tr>
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	performance measures that must be achieved in this program. We are unlikely to be accountable for the full amount because of the performance measures. However, we must demonstrate results to earn the money back. This initiative is in partnership with Alameda County and many of its community-based organizations that are involved. Question: For Calendar Year 2022, what has happened to the nineteen-point-nine million dollars ($19.9M) allotted? Answer: Thus far, we have submitted the Incentive Plan, and we are waiting to receive approval from the Department of Health Care Services. Depending on the timing of the approval, we may begin some of the investment activities. Question: Have there been any updates on the phasing of the re-determination process regarding the ending of the public health emergency? Answer: Assuming the public health emergency carries over through January 2023, there is a sixty (60) day pause after the public health emergency ends before the re-determination process begins. The re-determination process would be created on the anniversary date for the Medi-Cal beneficiary. For example, if enrolled in June 2022, their anniversary date would be triggered in June 2023 which is when they would be re-determined. The impact will be divided over twelve (12) months. Secondly, there is a follow-up plan that the Department of Health Care Services has released – the Unwinding Plan, which is tied into the Ambassador Program. The purpose of this plan is to minimize the potential for people falling out of Medi-Cal managed care and losing coverage. Informational update to the Board of Governors. Vote not required.		
8. a. BOARD BUSINESS – REVIEW AND APPROVE MOSS ADAMS FISCAL YEAR 2022 AUDIT RESULTS			
Chris Pritchard	2022 Audit Results: Alameda Alliance for Health 2022 Audit Objectives:	Motion to Approve the Moss Adams Fiscal Year 2022 Audit Results as presented.	None

Rianne Suico	• Opinion on whether the financial statements are reasonably stated and free of material misstatement in accordance with generally accepted accounting principles. • Part of that process involves the consideration of internal controls and compliance. Report of Independent Auditors: • We are issuing an unmodified audit opinion, which is the highest level of assurance an audit firm can provide; this means that the financial statements are presented fairly and in accordance with generally accepted accounting principles, and free of material misstatements. Assets and Deferred Outflows of Resources Composition: • For cash and cash equivalents, we tested the back reconciliations, including any reconciling items as needed. We also confirmed the balances with the bank. • For premiums receivable, we obtained and tested account receivable details. We also looked at cash receipts to test for the collectability of the year-end balances and noted no issues there. • The largest item on the balance sheet is the Alliance's investments. For investments, we obtained and tested the investments and confirmed the investments balance with City National Bank and reviewed the investment footnotes in the financial statements to ensure they were properly stated and presented. • For the other asset accounts, we reviewed the various supporting documents, including the actuary reports for net pension assets, and noted that the balances appeared reasonable. • For capital assets, we tested the capital assets roll forward and tested any additions and disposals as needed above our scope. Liabilities, Deferred Inflows of Resources, and Net Position Balance: • For accounts payable and accrued liabilities and other liabilities, this balance represents the liabilities accrued before year-end but have not been paid before year-end. • For claims payable, we reviewed the Alliance's model to calculate claim liability and performed certain of our own procedures to come up with our estimate of claims payable and compare it to the balance.	Motion: Dr. Marty Lynch Second: Dr. Rollington Ferguson Vote: Yes No opposed or abstained.	

- We also reviewed the actual report, including the assumptions, and determined that the claims payable balance materially agreed with the actuary report.
- For payable to other governmental agencies and hospital fees payable, we tested the different payable reconciliations and gained an understanding of the fluctuation of the balances, and also reviewed the subsequent payments made after year-end.
- Lastly, the change in net position is driven by the results of revenues and expenses. We performed various analytical procedures over these balances based on rates, ratios, trends, etc. We deemed these balances to be reasonable.

Operating Expenses:

- Medical services are the biggest expense. The other operating expense categories, such as marketing, general, and administrative expenses; depreciation and amortization expense; and premium tax expense are consistent each year.

Historic Estimated Claims Liability and Historic Actual Claims Liability:

- Over the past few years, the Alliance has been close to their estimations in terms of claims liability. This is categorized as more conservative, due to the estimates being higher than the actual claims liability.
- In 2020 and 2021, there was a lot of volatility in utilization that typically historical claims experience is what is used to estimate the balance. Due to COVID, there was a lot of volatility which made making estimates more difficult. However, the staff has done a great job with estimating to the best of their ability using the information they had at the time.

Historic Actual Claims Liability as a % of Capitation and Premium Revenues:

- In the past few years, the percentage has been around seven (7%) to nine (9%) percent of capitation and premium revenues.
- In 2020 and 2021, although there’s been an increase in membership, the claims have remained fairly consistent at seven percent (7%), which also demonstrates there’s lower utilization due to COVID, and utilization not going back to its usual, pre-COVID levels.

	Tangible Net Equity (TNE): • There is a required Tangible Net Equity (TNE) the Alliance has to maintain in accordance with the Department of Managed Health Care (DMHC) Contract, and the Alliance is in a health financial position. • For each fiscal year end the past few years 2017 to 2022, the Alliance has maintained a Tangible Net Equity five (5) to eight (8) times over the requirement. • This is a good indication of the management's ability to have reserves in place, as all of these more complex compliance items and new programs increase. Important Board Communications: • There are significant accounting policies in the financial statements, listed in note two (2). We read the policies that were adopted by management and found that they were in compliance with generally accepted accounting principles that we are aware of today. • There are accounting estimates in the financial statements; the management also has to make an estimate on collectability of your accounts receivable from the State, as well as the fair market value of your investments. • Based on the procedures we performed, we found that management's accounting estimate process is reasonable and based on the best available information they have. • There were no audit adjustments as a result of audit procedures. The Alliance's management provided us with a fully set up and adjusted trial balance and financial statement that we were able to provide our opinion on and perform our audit procedures based on. The audit went very smoothly, and there were no disagreements. We were also not aware of any instances of fraud or noncompliance with applicable laws and regulations. Question: Is the claims liability of seven-point-one percent (7.13%) typical, and what does it represent? Answer: This represents the percentage of claims activity, and how much claims you are paying as a percentage of your capitation and premium revenues. This is not indicative of all medical expenses; this is the unpaid portion. What we		

	typically like to see is this trend going in the same direction as your revenue. As your revenue is getting bigger, your claims payments and liability is getting bigger. The percentage has been consistent with a drop in 2021, which is expected due to lower utilization from COVID. Motion to Approve Moss Adams Fiscal Year 2022 Audit Results as presented. A roll call vote was taken, and the motion passed.		

8. b. BOARD BUSINESS – REVIEW AND APPROVE JUNE 2022 MONTHLY FINANCIAL STATEMENTS			
Gil Riojas	Enrollment: • For the month ending June 30th, 2022, the Alliance had an enrollment over 313,000 members, a net income of $3.3M, and the Tangible Net Equity (TNE) was 601% of the required amount. • Our enrollment has increased by nearly 2,300 members since May 2022, and on a fiscal YTD, we gained over 24,000 members since June 2021. This is primarily due to the Public Health Emergency and the extension of it. • Our seniors and persons with disabilities enrollment continues to grow, as well as our Medi-Cal Duals. Group care remains flat, with a slight decline since June 2022. • Enrollment will continue to grow up until the end of the Public Health Emergency, and likely a few months beyond that. After that, it will likely decline, until members are renewed. Net Operating Results: • For the fiscal YTD ending June 30th, 2022, the actual net income was $23.7M. Our budgeted net income was $3.5M. Revenue: • For the month ending June 30th, 2022, the actual revenue was $96.5M vs. the budgeted revenue of $95.9M. • For the fiscal year ending June 30th, 2022, the actual revenue was $1.2B vs. the budgeted revenue of $1.2B. • We have continued to see growth in our revenue over the past couple of years and are expected to continue growing. Medical Expense: • For the month ending June 30th, 2022, the actual medical expense was $87.6M, and the budgeted medical expense was $86.1M. • For the fiscal year ending June 30th, 2022, the actual medical expense was $1.1B vs. the budgeted medical expense of $1.1B.	Motion to Approve June 2022 Monthly Financial Statements Motion: Dr. Rollington Ferguson Second: Dr. Michael Marchiano Vote: Yes No opposed or abstained.	None

- In terms of actual budget, we were about 1.3% unfavorable with what we had budgeted in total dollar medical expenses versus what we had reported. This primarily is due to the increase in volume above what we had expected for our enrollment. As our enrollment increased above our budget, this increased not only our revenue, but also our medical expenses.
- On a PMPM basis, we were closer in terms of budget to the actual; medical expense is 1.1% favorable to the budget.
- Overall, for the end of FY2022, the team did a great job analyzing and understanding the trends in our medical expenses and our final budget to actual reflects that in our small percentage change.

Medical Loss Ratio (MLR):

- For the month ending June 30th, 2022, the MLR was 90.8% and 92.5% for the fiscal year-to-date.
- Ideally, we would like to maintain our MLR between 90.0% and 95.0%.
- Our budget for the end of the fiscal year was at 92.7%.

Administrative Expense:

- For the month ending June 30th, 2022, the actual administrative expense was $5.4M vs. the budgeted administrative expense of $7.5M.
- For the fiscal YTD ending June 30th, 2022, the actual administrative expense was $64.5M vs. the budgeted administrative expense $82.0M.

Other Income / (Expense):

- As of June 30th, 2022, our fiscal year-to-date net investment revenue reported a small net loss of one-hundred-sixty-two thousand dollars ($162,000). In July and August, we have a reversible trend as interest rates have increased – we have seen some positive results for our investment income, but we did end the fiscal year at a small loss.

	• Fiscal-year-to-date claims interest expense is three-hundred-ninety-six thousand dollars ($396,000). Tangible Net Equity (TNE): • The Department of Managed Health Care (DMHC) requires TNE to be thirty-eight million dollars ($38.0M). • We reported actual TNE of two-hundred-twenty-nine-million-dollars ($229.1M), and excess TNE of one-hundred-ninety-one-million-dollars ($191.0M). • Of the required TNE, we have six-hundred-and-one percent (601%). Cash Position and Assets: • For the month ending June 30th, 2022, the Alliance reported $307.4M in cash; $192.7M in uncommitted cash. Our current ratio is above the minimum required at 1.72 compared to the regulatory minimum of 1.0. Capital Investment: • Fiscal year-to-date capital assets acquired: $421,000. • Annual capital budget: $1.4M. Motion to Approve June 2022 Monthly Financial Statements as presented. A roll call vote was taken, and the motion passed.		
8. c. BOARD BUSINESS – REVIEW AND APPROVE JULY 2022 MONTHLY FINANCIAL STATEMENTS			
Gil Riojas	Enrollment: • For the month ending July 30th, 2022, the Alliance had an enrollment over 317,000 members, a net income of $5.7M, and the Tangible Net Equity (TNE) was 625% of the required amount. • Our enrollment has increased by over 4,500 members since June 2022. We saw increases in consistent categories; there was also a rise in our	Motion to Approve July 2022 Monthly Financial Statements Motion: Dr. Michael Marchiano	None

	optional expansions beyond normal and in our SPD's. The reason for these increases is related to the transition for adults over fifty (50) that happened in May, which reflected in our July results. The biggest increase was in SPD's and Optional Expansion (OE) related to the older adults coming into our population. • Our Medi-Cal Duals continue to grow as well as our Group Care was flat from June to July. • There continues to be a consistent increase in enrollment, with a significant increase from June to July due to the increase in adult members fifty and older. Net Operating Results: • For the fiscal YTD ending July 31st, 2022, the actual net income was $5.7M. Our budgeted net loss was $3.4M. • What we are planning for our final budget involves looking at the results of the first few months of this fiscal year and adjusting based on actual results. • There was a favorable variance of $9.1M in the month of July due to lower than anticipated medical expenses, and lower than anticipated administrative expenses. Revenue: • For the month ending July 31st, 2022, the actual revenue was $100.8M vs. the budgeted revenue of $101.8M. • We have continued to see growth in our revenue over the past couple of years and are expected to continue growing. • DHCS made an acuity adjustment to our rates related to our membership and the acuity level of our members. It was determined that the acuity level of our members is lower than the rate paid to us. This has resulted in an adjustment to our calendar year 2022 rates, which will be about four million dollars ($4.0M) negative to our revenue. This is being factored in monthly basis. Medical Expense:	Second: Dr. Marty Lynch Vote: Yes No opposed or abstained.	

- For the month ending July 31st, 2022, the actual medical expense was $90.9M, and the budgeted medical expense was $98.8M.
- We also had some adjustments that were favorable to our Incurred-But-Not-Paid (IBNP) claims; as we looked at some of the factors, we reduced the estimate for our IBNP by two-point-five million dollars ($2.5M).

Medical Loss Ratio (MLR):

- For the month ending July 31st, 2022, the MLR was 90.1% and 90.1% for the fiscal year-to-date.
- Our budgeted MLR for FY2023 is 94.5%, so we are currently below our budgeted number. We anticipate changing this budgeted number based on the results we see in the first couple of months of the fiscal year.

Administrative Expense:

- For the month ending July 31st, 2022, the actual administrative expense was $4.7M vs. the budgeted administrative expense of $6.5M.
- Our administrative loss ratio (ALR) represented 4.7% of net revenue for the month and year-to-date. Our preliminary budget was about 6.6%, so we are below our target for administrative expenses.

Other Income / (Expense):

- Our investments are demonstrating positive results. As of July 31st, 2022, our fiscal year-to-date net investment revenue reported a four-hundred-sixty-six thousand dollars ($466,000).
- Fiscal-year-to-date claims interest expense due to delayed payment of certain claims or re-calculated interest on previously paid claims is twenty-four thousand dollars ($24,000).

Tangible Net Equity (TNE):

- The Department of Managed Health Care (DMHC) requires TNE to be about thirty-eight million dollars ($38.0M).

	• We reported actual TNE of two-hundred-thirty-six-point-four million dollars ($236.4M), and excess TNE of one-hundred-ninety-eight-point-six million dollars ($198.6M). • Of the required TNE, we reported (625%). • In June, starting in July, the Department of Managed Health Care increased the requirement for monthly reporting from one-hundred thirty percent (130%) of Tangible Net Equity to one-hundred-and-fifty percent (150%) of Tangible Net Equity. This means that if our Tangible Net Equity falls below 150% of the required amount, we would be required to report monthly financials to the Department of Managed Health Care. This will not impact us because our Tangible Net Equity is high. Cash Position and Assets: • For the month ending July 31st, 2022, the Alliance reported $300.8M in cash; $204.8M in uncommitted cash. Our current ratio is above the minimum required at 1.72 compared to the regulatory minimum of 1.0. Capital Investment: • Fiscal year-to-date capital assets acquired: $0. • Annual capital budget: $979,000. Motion to Approve July 2022 Monthly Financial Statements as presented. A roll call vote was taken, and the motion passed.		
8.d. BOARD BUSINESS – REVIEW AND APPROVE AUGUST 2022 MONTHLY FINANCIAL STATEMENTS			
Gil Riojas	Enrollment: • For the month ending August 31st, 2022, the Alliance had an enrollment over 319,000 members, a net income of $2.3M, and the Tangible Net Equity (TNE) was 627% of the required amount.	Motion to Approve August 2022 Monthly Financial Statements Motion: Dr. Rollington Ferguson	None

	• One of the significant factors we look at for our final budget is the rates the State provides us – the State has delayed providing the rates to us, and so we have preliminary draft rates to anticipate until we receive them. We do not anticipate receiving the final rates until January 2023. • Our enrollment has increased by over 1,600 members since July 2022, and by 6,200 members since June 2022. Net Operating Results: • For the fiscal YTD ending August 31st, 2022, the actual net income was $8.0M. Our budgeted net loss was $5.5M. • We also saw an increase in our claims payment that will be reflected in our September results. Revenue: • For the month ending August 31st, 2022, the actual revenue was $101.0M vs. the budgeted revenue of $102.3M. • For the fiscal YTD ending August 31st, 2022, the actual revenue was $201.8M vs. the budgeted revenue of $204.1M. Medical Expense: • For the month ending August 31st, 2022, the actual medical expense was $93.3M, and the budgeted medical expense was $97.4M. • We also had a decrease in our Incurred-But-Not-Paid (IBNP) claims by one-point-six million dollars ($1.6M). • Our budgeted total numbers PMPM were about three percent (3%) variance between our budget to actuals in terms of full dollars, which equates to about five-point-eight-million-dollar ($5.8M) variance. Question: Please tell us more about the other benefits and services category? Answer: The bulk of what we categorize as other benefits and services is related to our clinical, administrative expenses, and that equates to our FTEs; our clinical FTEs are included in those expenses. For example, if we have budgeted for FTEs in our clinical departments to be hired and they are not hired, we would have savings in that department. These constitute clinical expenses and are included	Second: Dr. Marty Lynch Vote: Yes No opposed or abstained.	

as medical expenses. It is to our benefit to ensure this is reflected in our medical expense.

Medical Loss Ratio (MLR):

- For the month ending August 31st, 2022, the MLR was 92.4% and 91.3% for the fiscal year-to-date.
- Our budgeted MLR for FY2023 is 94.5%, so we are currently below our budgeted number.

Administrative Expense:

- For the month ending August 31st, 2022, the actual administrative expense was $5.7M vs. the budgeted administrative expense of $7.0M.
- For the fiscal YTD ending August 31st, 2022, the actual administrative expense was $10.4M vs. the budgeted administrative expense of $13.5M.
- On both the monthly and year-to-date basis, which equates to about a three million dollar ($3.0M) variance. The bulk of this is related to the delayed timing of new project start-dates for Consultants, Computer Support Services and Purchased Services, as well as the delayed hiring of new employees.
- Administrative loss ratio (ALR) represented five-point-six percent (5.6%) of net revenue for the month and five-point-two percent (5.2%) of net revenue year-to-date. Our budgeted administrative loss percent is six-point-six percent (6.6%), so we are below our budgeted number.

Other Income / (Expense):

- We are continuing to see growth in our investments. As of August 31st, 2022, our fiscal year-to-date net investment revenue reported eight-hundred-fifty-nine thousand dollars ($859,000).
- Fiscal-year-to-date claims interest expense due to delayed payment of certain claims or re-calculated interest on previously paid claims is fifty-two thousand dollars ($52,000).

Tangible Net Equity (TNE):

- The Department of Managed Health Care (DMHC) requires TNE to be about thirty-eight million dollars ($38.0M).
- We reported actual TNE of two-hundred-thirty-eight-point-seven million dollars ($238.7M), and excess TNE of two-hundred-point-six million dollars ($200.6M).
- Of the required TNE, we reported a growth of two percent (2%) from last month to six-hundred-twenty-seven percent (627%).
- It is important we continue to maintain a healthy reserve amount with all the new projects we are implementing.
- Compared to other plans, we fall somewhere in the middle in terms of Tangible Net Equity. However, our TNE trend is similar to our sister plans.

Cash Position and Assets:

- For the month ending August 31st, 2022, the Alliance reported $322.4M in cash; $147.9M in uncommitted cash. Our current ratio is above the minimum required at 1.55 compared to the regulatory minimum of 1.0.

Capital Investment:

- Fiscal year-to-date capital assets acquired: $24,000.
- Annual capital budget: $1.0 million.

Motion to Approve August 2022 Monthly Financial Statements as presented.

A roll call vote was taken, and the motion passed.

8. e. BOARD BUSINESS – REVIEW AND APPROVE RESOLUTION #2022-03 AD HOC EXECUTIVE SEARCH			
Dr. Evan Seevak	Staff Report & Resolution: • Alameda Alliance for Health CEO Scott Coffin has informed the Board of Governors of his retirement, effective May 31st, 2023. • The Subcommittees intend to take on the task of the hiring process. Resolution No. 2022-03 will create an Ad Hoc Executive Search Subcommittee, as an advisory subcommittee of the standing Executive Committee, to advise as necessary on the search, selection, and hiring of a new Alliance CEO. • Resolution No. 2022-03 nominates the following six (6) Alliance Board members to the Ad Hoc Executive Search: Dr. Evan Seevak, Ms. Rebecca Gebhart, Dr. Rollington Ferguson, Ms. Andrea Schwab-Galindo, Dr. Marty Lynch, and Mr. James Jackson. Motion to Approve Resolution #2022-03 Ad Hoc Executive Search Subcommittee as presented. A roll call vote was taken, and the motion passed.	Motion to Approve Resolution #2022-03 Ad Hoc Executive Search Subcommittee Motion: Dr. Rollington Ferguson Second: Aaron Basrai Vote: Yes No opposed or abstained.	None
8. f. BOARD BUSINESS – REVIEW THE CURRENT BOARD OF GOVERNORS COMPOSITION & DISCUSS FOUR (4) ADDED			
Dr. Evan Seevak	BOG Composition & 4 Additional Seats: • Based on the discussion at the Board retreat, the Long-Term Support Services Seat will focus on long-term services and supports LTSF. • We discussed whether this person will be someone with expertise in nursing or broader expertise. Initially, it may make sense to have someone with skilled expertise in nursing; in the long-term, it may be beneficial to have someone with broader experience. • The four new Board seats are: (1) The Alameda County Health Care Services Agency, Agency Director Seat; (2) The Alameda County Social Services Agency, Agency Director Seat; (3) Community Health Center Network (CHCN) Executive Director Seat; and (4) The Long-Term Support Services (LTSS) Seat.	Informational update to the Board of Governors. Vote not required.	None

	Informational update to the Board of Governors. Vote not required.		
8. g. BOARD BUSINESS – CALAIM IMPLEMENTATION UPDATE			
Ruth Watson Lily Hunter	Agenda: • Under CalAIM: Enhanced Care Management; Community Supports; Long-Term Care Carve-In, which will be effective January 1st, 2023. • Mental Health Insourcing • Incentive Programs: CalAIM Incentive Payment Program (IPP); Student Behavioral Health Incentive Program (SBHIP); and Housing and Homelessness Incentive Program (HHIP). CalAIM – Enhanced Care Management (ECM): • We currently have over nine-thousand members eligible for ECM, and approximately one-thousand enrolled in ECM across our eight (8) ECM Providers. • In January 2023, we will be taking on two (2) more populations of Focus: (1) Members Eligible for Long-Term Care and At-Risk of Institutionalization; and (2) Nursing Home Residents Transitioning to Community. To assist these members, the work will center around finding housing. • DHCS is also looking to strengthen our transitions of care programming for members leaving facilities. To better serve these populations of focus, there are two (2) community supports services that are under consideration for a self-funded pilot. CalAIM – Community Supports: • We currently offer six (6) Community Supports (CS) services. Through August of this year, we have served over eleven hundred (1,135) members across the six (6) CS services through our six (6) CS Providers. Most of our authorizations have been around housing.	Informational update to the Board of Governors. Vote not required.	None

Annjanette Dixon	• Our CS are in lieu of services; we are seeing a decline in hospital utilization with admissions, bed days, and average length of stay. • This data is preliminary and not finalized, but this is moving in the right direction. CalAIM – Long Term Care Carve-In: • Long-Term Care Benefits for Members: Effective January 1st, 2023. • We have submitted our Skilled Nursing Facility (SNF) Network Readiness Template on September 1st, 2022. The resubmission took place on October 12th, 2022, with minor edits. • The DHCS Network Goal is sixty percent (60%), and we are currently at sixty-point-two percent (60.2%). Matthew Woodruff provided the following comment: We received a couple of contracts in the mail yesterday which were immediately signed. This reflects a growth in our percentage to sixty-seven percent (67%). • The Long-Term Care Member Materials have been submitted and approved by DHCS. • DHCS released the final APL for Long-Term-Care Carve In on September 28th, 2022. Additional DHCS Deliverables will be submitted November 28th, 2022, and will include new Policies and Procedures (P&Ps) for the Alliance, revisions of existing P&Ps, and Program Description for the Long-Term Care Benefits. • Contracting and Credentialing: We have contracted with fifty-seven (57) facilities, specifically for the Custodial Level of Care. Thirty-four (34) of the fifty-seven have been credentialed by our Credentialing department. Sixty-four (64) Primary Care Providers (PCPs) have been identified, and twenty-three (23) contracts have been signed. We have a total of forty-five (45) out-of-area facilities. • We will begin conducting Long-Term Care Provider Town Halls beginning in late October. This will include training for all long-term care providers and facilities on specific submissions of claims and how to contact		

	Alameda Alliance for Health representatives and further strength our partnership with providers. • DHCS should be providing updated Member Data in November 2022 regarding the members that will be part of this carve-in. We are developing a contingency plan on how we will absorb these members prior to going live to ensure we are aligned with DHCS requirements and the APL. We will also be receiving existing authorizations data which will impact continuity of care. • Long-Term Care Staffing Resources: The RN Manager position has been accepted by a candidate; we have two RN Positions open and have offered one position; the Social Worker will be posted; and we are interviewing for the Non-Clinical Navigator position. Question: Whether the work involving the nursing homes will be taken up under the new Long-Term Care manager position, or whether it will stay on the ECM side? Answer: We just hired Long-Term Care managers who are building the team; these resources with Community Supports, ECM, and Long-Term Care benefit need to be very closely working together. The getting people out or keeping people out is primarily focused on housing supports, and it is going to be a defined set of services. The ECM Community Support team will have oversight with significant connectivity to Long-Term Care. However, this may evolve as we bring more staff on board.		
Ruth Watson	CalAIM – LTC and Managed Long-Term Services and Supports (MLTSS): • In January 2023, the Mandatory Managed Care Enrollment – LTC Transition from Medi-Cal FFS into Managed Care will go live. • In July 2023, the Mandatory Managed Care Enrollment for Medi-Cal members residing in Sub-acute or Pediatric Subacutes, Intermediate Care Facilities (ICF) and Institutions for Mental Disease (IMD) will transition to MCPs. • In January 2025 or by 2026, (the State has not officially decided), the Transition to Dual Eligible Special Needs Plan (D-SNP), all Medi-Cal MCPs will be required to operate Medicare Dual Eligible Special Needs		

	Plans (D-SNPs), unless determined otherwise by 2022 D-SNP Feasibility Study. • Additionally, exclusivity aligned enrollment (EAE) will be required in all counties. This means that you must have Medicare and Medicaid within the same organization for purposes of coordinating care. • By January 2026 or 2027 (the State has not officially decided), the Transition to Statewide Managed Long-Term Support Service (MLTSS) will go live. Informational update to the Board of Governors. Vote not required.		
8. h. BOARD BUSINESS – INSOURCING OF MENTAL HEALTH AND AUTISM SPECTRUM			
Corry Keenan	Mental Health Insourcing: • We are currently working on Material Modification – it is required and must be approved by the Department of Managed Health Care (DMHC). • Based on the work in our pre-filing meetings, we decided to break it up into three (3) submissions. • The first submission involved the Narrative of what we included in all three submissions; in that, we included our Evidence of Coverage (EOC) for Medi-Cal and Group Care, our Member and Provider Notices, and Medi-Cal and Group Care Notifications. Also, part of Submission #1 was our Behavioral Health Contract Template – submitted on September 2nd, 2022. • Submission #2 was submitted on September 30th, 2022, and included an update to the Narrative submitted in Submission #1, all Policies and Procedures that were either modified to incorporate Behavioral Health or were created for the new benefit, and our Financial Assumptions. • Submission #3 we targeted for internal review on October 12th, 2022, was a Narrative to DMHC around a full network analysis that we are completing for Provider Services.	Informational update to the Board of Governors. Vote not required.	None

Matthew Woodruff Tami Lewis	• The following are also part of our DMHC submissions: (1) DMHC BH Filing Comment Table, which is due October 18th, 2022; (2) ASAs – submitted October 5th, 2022. Provider Services: • We have one-hundred-twenty-seven (127) providers that are under contract as of Wednesday – that breaks down to five-hundred-eighty (580) which includes medical doctors, psychologists, ABA providers, and all other providers falling under behavioral health. • Another two-hundred-forty-seven (247) were telehealth only; the five-hundred-eight (580) mentioned could also have telehealth services, but they also have offices. CalAIM Incentive Payment Program (IPP): • The CalAIM Incentive Payment Program is intended to support ECM and CS, enhance capacity building, and system infrastructure. • We have received ten (10) applications for IPP Funding to date. As of September, initial payments totaling over four-point-sixty-nine million dollars ($4.69M) have been distributed to the applicants who received awards for IPP Funding. • As of this week, we have reviewed all the applicants' Status Reports, and everyone who has submitted so far has been approved for the second half of their incentive amount; those payments are being processed. • On September 1st, 2022, we submitted our documents to DHCS for our second payment, which will determine how much of our remaining fifty percent (50%) we will earn – we will most likely be informed in December 2022. Question: From the providers that were mentioned, are they all aware of the transition? Have they agreed to stay with us? Answer: Yes, I cannot say they are all Beacon providers – some are new providers. There are five-hundred-eighty non-telehealth-only providers, and two-hundred-forty-seven (247) are telehealth providers. They have agreed contractually, but not all have gone through credentialing. Incentive Programs – Student Behavioral Health Incentive Program (SBHIP):		

	• This is a three (3) year program that started in January 2022 and will conclude in December 2024. There are two (2) phases – The Needs Assessment Phase and the Targeted Interventions Phase. • We are currently concluding the Needs Assessment Phase; each of the partnering school districts are required to complete a Needs Assessment, and those are due to us Monday, October 17th, 2022. We will then look at those and work with our SBHIP partners to identify Targeted Interventions for Alameda County – we must have a minimum of four (4). We want to identify those by the end of November 2022. In the month of December, we will consolidate the eleven (11) separate Needs Assessment into one document, and create project plans for the targeted interventions that we will identify, all of which must be submitted to DHCS by December 31st, 2022. • Starting in January, we will begin implementing the various Targeted Interventions. Incentive Programs – Housing and Homelessness Incentive Program: • We expect to receive the first payment from DHCS this month, which is tied to the initial five percent (5%) of earnable dollars for submission of our Local Homelessness Plan. Informational update to the Board of Governors. Vote not required.		

9. STANDING COMMITTEE UPDATES			
Dr. Steve O'Brien	**The Health Care Quality Committee (HCQC) was held September 16th, 2022.** Dr. Steve O'Brien provided the following Committee updates: • We reviewed the Kaiser QI Program Evaluation and Workplan, and the 2022 Patient Needs Assessment. The Patient Needs Assessment is a cornerstone document for the Plan; it describes our members, what our population looks like, as well as a variety of demographic and equity issues. This report helps feed our Population Health strategy. • We also looked at our 2021 HEDIS results and 2022 HEDIS Roadmap. We got an update on PQI's, facility site reviews, and the Pause Survey. **The Peer Review & Credentialing Committee (PRRC) was held on July 19th, 2022, and September 20th, 2022.** Dr. Steve O'Brien provided the following Committee updates: • In July, we had ten (10) initial providers credentialed, and forty-one (41) providers were re-credentialed. • In September, we had ninety-six (96) initial providers credentialed of which seventy-six (76) were the first batch of credentialed behavioral health providers. The next Credentialing Committee is next Tuesday, October 18th, 2022, and there is another equally large batch of behavioral health providers in line to be credentialed. We also re-credentialed twenty-seven (27) providers. **The Pharmacy & Therapeutics Committee (P&T) was held on September 20th, 2022.**	None	None

Scott Coffin	Dr. Steve O'Brien provided the following Committee updates: • The Committee reviewed the Efficacy Safety Cost and Utilization profiles of ten (10) therapeutic categories and drug monographs, four (4) formulary modifications, and thirty-five (35) prior authorization guidelines, nineteen (19) of which were reviewed with no updates. Question: How was the HEDIS data? Answer: It is good compared to previous years; there was significant improvement. **The Member Advisory Committee (MAC) was held on September 15th, 2022.** CEO Scott Coffin provided the following Committee updates: • There was an update from the CEO on the operations and financial performance followed by an update by the Chief Medical Officer on COVID-19 and Monkeypox. • Reports were given by the Grievance and Appeals team, an Operations report, and a Community Outreach report. The meeting closed with a Cultural and Linguistics presentation on the second part of the annual report. • The 2022 Population Means Assessment and Action Plan was presented, and we welcomed two (2) new MAC members – Warren Cushman and Jody Moore. We also have two (2) new candidates that were introduced for consideration for membership to MAC. • Our next MAC meeting is scheduled for December 15th, 2022. Informational update to the Board of Governors. Vote not required.		

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			
Dr. Evan Seevak	None	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 2:01 pm.	None	None

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

Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

November 8th, 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, Gil Riojas

Board of Governor members on Conference Call: Yeon Park

Alliance Staff on Conference Call: Scott Coffin, Tiffany Cheang, Richard Golfin, III, Sasi Karaiyan, Dr. Steve O'Brien, Ruth Watson, Matthew Woodruff, Carol van Oosterwijk, Shulin Lin, Danube Serri, Christine Corpus

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
CALL TO ORDER			
Dr. Rollington Ferguson	Dr. Rollington Ferguson called the 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.		
INTRODUCTIONS			
Scott Coffin	Scott Coffin introduced Yeon Park, our newly appointed member to the Board of Governors, currently in attendance at today's Finance Committee Meeting. Ms. Park is the Vice-President of the SEIU local 1021, serving as the East Bay Ethics Liaison.		

CONSENT CALENDAR			
Dr. Rollington Ferguson	Dr. Ferguson presented the Consent Calendar. October 11th, 2022, Finance Committee Minutes were approved at the Board of Governors meeting October 14th, 2022, and not presented today.	There were no modifications to the Consent Calendar, and no items to approve.	
a.) CEO Update			
Scott Coffin	Scott Coffin provided updates to the Committee on the following: **Final Budget Update** – The Final Budget for Fiscal Year 2023 will be presented at the December Finance Committee and Board of Governor's meetings. The Department of Health Care Services (DHCS) will not deliver final Medi-Cal Base Rates until late in the month of December and therefore final base rates will not be included in the Final Budget. We will include the final rates in our February 2023 Q3 Forecast. **Alternative Payment Methodology** – DHCS has introduced a new payment program affecting Federally Qualified Health Centers (FQHC). The program is scheduled begin in calendar year 2024. We are in the early stages with both the DHCS and local FQHCs on the formation of what this program *could* look like in Alameda County. On November 1st, several local health centers filed a Letter of Intent to DHCS to participate in this optional program. Details will be shared at future Finance Committee and Board of Governors meetings as they become available from the State. **Question:** Dr. Ferguson asked if there is any additional information available to share regarding the potential payment structure changes. Gil Riojas answered that currently FQHCs get paid directly from the DHCS through a specific program (PPS) that may be changing, giving them an opportunity to retain the rate that the State was paying them with potential to earn more, based on Quality scores and other measures. This would put the plan in the middle of the funding arrangement between the State and the FQHC, providing an element of potential risk to the Plan, while providing a lot of opportunity for FQHC. **Quality Component added to Base Rates Calculation** – Starting in calendar year 2023, the DHCS will be factoring HEDIS scores into Medi-Cal Base Rates and the County-wide Averaging Process, as the Quality Component. DHCS will use the Plan's 2021 HEDIS score for year-one. A	Informational update to the Finance Committee Vote not required	

	presentation will be delivered to the Finance Committee in December or January. **Public Health Emergency (PHE) Unwinding Initiative** – The PHE is currently set to continue through January 2023. Alameda County Social Services will begin the process of Medi-Cal Enrollee Redetermination 60-days after the end of the PHE. It is expected that this process will remove individuals who are no longer eligible for Medi-Cal services. We do not yet have an estimate of the impact to our enrollment at the Alliance. DHCS has asked us to partner with local agencies to help minimize the impact to individuals who are no longer eligible for Medi-Cal but need to find another source of health coverage. The Alliance will be investing funds in early 2023 that support outreach programs purposed to help people connect with health insurance.		
b.) Review September 2022 Monthly Financial Statements			
Gil Riojas	**September 2022 Financial Statement Summary** As a reminder, we are on a Fiscal Year that begins on July 1st and goes to June 30th of the following year. This is the third month of the fiscal year and represents our first quarter of the fiscal year. **Enrollment:** Current enrollment is 321,333 and continues to trend upward, Total enrollment has increased by 2,077 members from August 2022, and 8,277 members since June 2022. Consistent increases were primarily in the Child, Adult, and Optional Expansion categories of aid, and include slight increases in the Duals, SPD, and Group Care categories of aid. Monthly enrollment trends are projected to increase as the Public Health Emergency (PHE) is currently extended through January 2023. The disenrollment process is scheduled to start 90-days later. **Net Income:** For the month ending September 30th, 2022, the Alliance reported a Net Income of $4.0 million (versus budgeted Net Loss of $230,000). For the year-to-date, the Alliance recorded a Net Income of $12.0 million versus a budgeted Net Income of $5.7 million. The favorable variance is primarily due		

	to lower than anticipated Medical Expense and lower than anticipated Administrative Expense. This is further explained on page 9. **Revenue:** For the month ending September 30th, 2022, actual Revenue was $100.9 million vs. our budgeted amount of $102.7 million. The slight unfavorable Revenue variance is mainly due to the previously discussed acuity adjustment by DHCS. **Medical Expense:** Actual Medical Expenses for the month were $91.2 million vs. our budgeted amount of $95.8 million. Medical Expense for the year-to-date were $275.4 versus a budgeted $292.0 million. Drivers leading to the favorable variance can be seen on the tables on page 11, with further explanation on pages 11 and 12. **Medical Loss Ratio:** Our MLR ratio for this month was reported at 90.4%. Year-to-date MLR was at 91.0%. **Question:** Dr. Marchiano asked if there has ever been an instance where our MLR was below 85%, and further asked what you would look at and how you would fix it. Gil Riojas answered that it has not happened during his tenure. He further explained that MLR represents the percentage of Revenue dollars that are spent on Medical Expenses. We may have an odd month here or there where we spent less than anticipated (below 85%) but the State is interested when it is below 85% annualized. Dr. Ferguson added that he recalled a time when there was discussion of the State recouping the excess funds. Shulin Lin confirmed Dr. Ferguson's recollection, explaining that in Fiscal Years 2014/15, and 2015/16, when the Optional Expansion population was first brought in to Medi-Cal, the State was paying the Alliance at a higher rate than our expenses justified. After reviewing claims data, the State discovered the discrepancy and in addition to adjusting our rate, they recouped monies from the Alliance. **Administrative Expense:** Actual Administrative Expenses for the month ending September 30th, 2022 were $5.7 million vs. our budgeted amount of $7.2 million. Our Administrative Expense represents 5.7% of our Revenue for the month, and 5.3% of Net Revenue for year-to-date. Reasons for the favorable month-end variances, as	**Dr. Ferguson asked for comparison of September 2021 fiscal YTD Pharmacy Expense to September 2022 fiscal YTD Gil to prepare for BOG**	

	well as the favorable year-to-date variances are outlined on page 13 of the presentation. **Other Income / (Expense):** As of September 30th, 2022, our YTD interest income from investments was $930,000. YTD claims interest expense is $82,000. **Tangible Net Equity (TNE):** We reported a TNE of 639%, with an excess of $204.7 million. This remains a healthy number in terms of our reserves. **Cash and Cash Equivalents:** We reported $399.6 million in cash; $212.6 million is uncommitted. Our current ratio is above the minimum required at 1.57 compared to regulatory minimum of 1.0. **Capital Investments:** For the month ending September 30th, 2022, we added $24,000 in Capital Assets. Our annual capital budget is $1.0 million.	Motion to accept **September 2022 Financial Statements** Motion: Dr. Marchiano Seconded: Gil Riojas Motion Carried No opposed or abstained	
ADJOURNMENT			
Dr. Rollington Ferguson	The meeting adjourned at 8:45 am.		

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

CEO Update

Scott Coffin

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

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

Date: **November 11th, 2022**

Subject: **CEO Report**

- **Financials:**

  - Fiscal Year 2023: Net Operating Performance by Line of Business for the month of September 2022 and Year-To-Date (YTD):

	September	YTD
Medi-Cal.....................	$3.8M	$10.7M
Group Care	$184K	$1.35M
Totals	$4.0M	$12.0M

  - The net income for September includes a $3.5 million adjustment that was reported to the Board of Governors last month, related to 567 claims being denied inappropriately over a 90-day period. The claims were correctly processed and paid in the month of September, including $4,105 in interest expense.

  - Revenue $100.9 million in September 2022, and $302.7 million Year-to-Date (YTD).

    - Medical expenses $91.2 million in September, and $275.4 million year-to-date (three months); medical loss ratio is 90.4% for the month, and averages 91.0% for the first three months of the fiscal year.
    - Administrative expenses $5.7 million in September, and $16.1 million year-to-date; 5.7% of revenue for the month, and averages 5.3% for the first three months in the fiscal year.

  - Tangible Net Equity (TNE): Financial reserves are 639% above the regulatory requirement, representing $204.7 million in excess TNE.

  - Total enrollment 321,333 in September 2022, increasing by more than 1,850 Medi-Cal members as compared to August. Preliminary enrollment in

the month of November exceeds 326,000 members, led by Medi-Cal growth due to the public health emergency.

- The public health emergency is approved through the month of November and is anticipated to be extended to January 31st, 2023. During the public health emergency, the Medi-Cal re-determination process is suspended, and will resume 60 days after the termination of the public health emergency.

- **Final Budget – Fiscal Year (FY) 2023:**
  - Fiscal Year 2023 preliminary budget approved by the Board of Governors on June 10th, 2022.
  - DHCS has announced that final Medi-Cal rates will be issued by December 31st, 2022.
  - The final budget for FY2023 will be presented to the Finance Committee and Board of Governors in December 2022 and will exclude the final Medi-Cal base rates. The final rates will be incorporated into the third quarter forecast that is scheduled for presentation to the Finance Committee and Board of Governors in February 2023.

- **Key Performance Indicators:**
  - Regulatory Metrics:
    - All regulatory metrics were met in the month of October.
  - Non-Regulatory Metrics:
    - The Member Services call center reported an abandonment rate of 19%, and a 46% service level, for the month of October. The results are 13% and 24% below the internal thresholds respectively. Call volumes continue to remain above 13,000 per month as membership grows. Additional support staff are being hired and trained to support the inbound member calls.
    - The Human Resources Division is reporting 15% vacancy rate in the month of October due to the high volume of open positions related to projects and operations initiatives funded in the fiscal year 2023 budget.

- **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:
        - Insourcing of mental health & autism spectrum services on 3/31/2023.

    - Medi-Cal Only:
        - CalAIM: ECM and Community Supports launched in January 2022; Additional Community Support (Recipe4Health) launched in September 2022.
        - CalAIM: Behavioral health in schools begins 12/31/22.
        - CalAIM: Additional ECM Populations of Focus in 2023.
        - CalAIM: Long-Term Care begins 1/1/23.
        - CalAIM: Population health begins 1/1/23.
        - CalAIM: Justice Involved begins 1/1/24; pilot is being planned to begin Q3-2023 (policy changes announced by the DHCS).

- **CalAIM Incentives:**

    - Housing **& Homelessness Incentive Plan (HHIP)**: The HHIP investment plan was submitted by Alameda Alliance to the DHCS on September 30th, 2022. In total, $44.3M was allocated to the Alameda Alliance for Health for a two-year period.
        - $19.9 million is allotted for calendar year 2022.
        - $24.4 million is allotted for calendar year 2023.
        - Payments issued for eligible expenses will be issued by the DHCS in September 2022, June 2023, and March 2024.
    - As a result of the DHCS' reimbursement criteria, approximately $26.5M (60%) of the available $44.3M was identified as the targeted spending for initiatives relating to local housing & homeless initiatives in calendar years 2022-2023.
    - The investment plan is a non-binding document to the State of California that includes an estimated spend of $26.5M by the Alameda Alliance in the next 12 months. The Alliance will release funds into the community and the DHCS will determine the eligibility for reimbursements as outlined above. The initiatives are measured by goals and outcomes, and the benefits must be demonstrated by October 2023. The HHIP does not cover investments in housing solutions that result in outcomes beyond October 2023.

Therefore, the Alliance is at risk for investing in housing and homeless initiatives in 2022 and 2023, up to the specified amount of $26.5M.

- **As of November 9th, 2022, the DHCS has not provided written approval on the HHIP investment plan, and the CEO has approved to proceed with releasing of funds as defined in the timeline.**

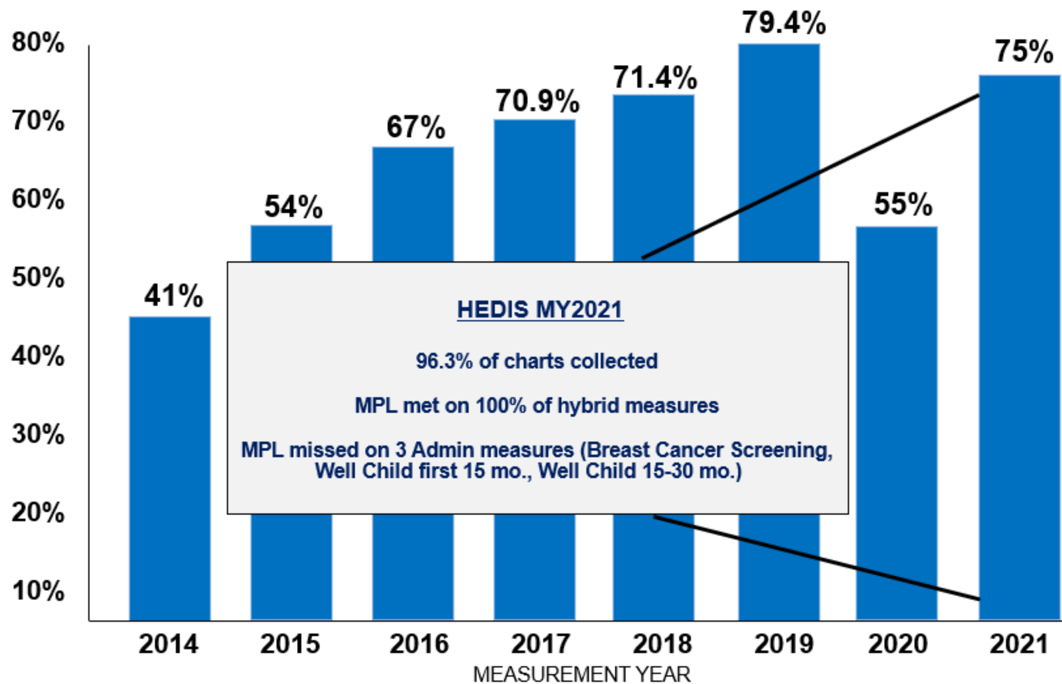
- HHAP: The intersections of housing services funded through the Homeless Housing, Assistance and Prevention (HHAP) grant program are considered by the DHCS, as well as the alignment to the overall housing strategy. Recently Governor Newsom rejected the HHAP grant applications and has requested additional information on performance outcomes.

- CalAIM IPP: The second payment for the CalAIM Incentive Program (Program Year 1, or calendar year 2022) has been delayed by six months to June 2023; in addition, DHCS changed the requirements to mandate reaching outcomes before payments will be issued.

- **Quality Improvement, HEDIS, and Medi-Cal Rate Development:**

  - DHCS announced a Medi-Cal "quality component" is being added in calendar year 2023 that compares HEDIS scores between Alameda Alliance and Anthem Blue Cross.
  - The quality component is based on a proposed set of 10-15 HEDIS measures, and uses actual HEDIS scores from calendar year 2021.
  - Weightings for each measure are applied to the calculation, and includes achievement and improvement as part of the scoring component. This function is referred to as the risk adjustment and results in more or less of the dollars being awarded to the Alliance, based on the quality scoring results.

- The DHCS has not issued the final HEDIS rates for calendar year 2021. The following graph illustrates the Alliance's actual HEDIS scores for calendar years 2014 through 2020, and the projected HEDIS score for calendar year 2021:



*MPL is the minimum performance level for a HEDIS measure, defined by NCQA.

- **Single Plan Model:**
  - The California DHCS has issued a single plan transition timeline for calendar years 2022 and 2023.
  - The first set of deliverables were submitted on August 12th, and a second set on September 12th.
  - The next regulatory submission to the DHCS is scheduled for November 28th.
  - The Alliance's Integrated Planning & Compliance Divisions are coordinating resources to meet the regulatory timelines.
  - Alameda County begins the single plan model for Medi-Cal managed care on January 1st, 2024. Please refer to the Compliance Report below for more information.

Executive Dashboard

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Financials

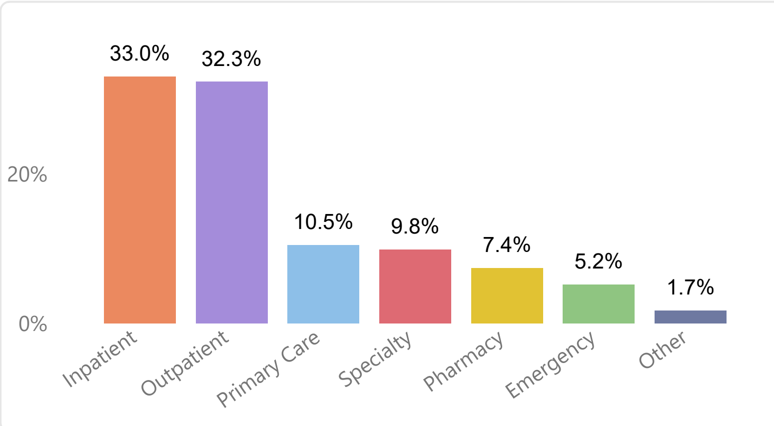
Income & Expenses

	SEPTEMBER 2022	FISCAL YTD
REVENUE	$ 100.9 M	$ 302.7 M
MEDICAL EXPENSE	$ (91.2) M	$ (275.4) M
ADMIN EXPENSE	$ (5.7) M	$ (16.1) M
OTHER	$ (11) K	$ 848 K
NET INCOME	$ 4.0 M	$ 12.0 M

Gross Margin %

9.0%

Medical Expenses



Liquid Reserves

MLR Net %

91.0%

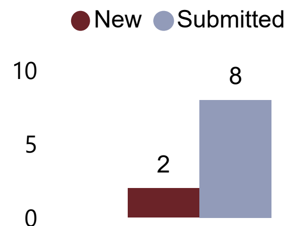
TNE %

639.0%

TNE $

$242.7M

Reinsurance Cases



Balance Sheet

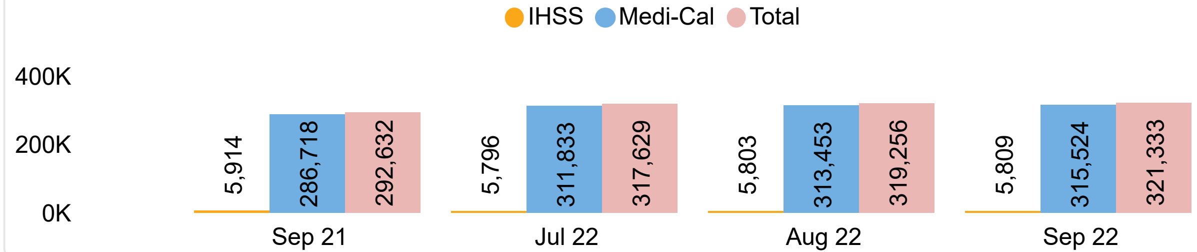
Cash Equivalents	$399.6M
Pass-Through Liabilities	$187.0M
Uncommitted Cash	$212.6M
Working Capital	$201.8M

Current Ratio

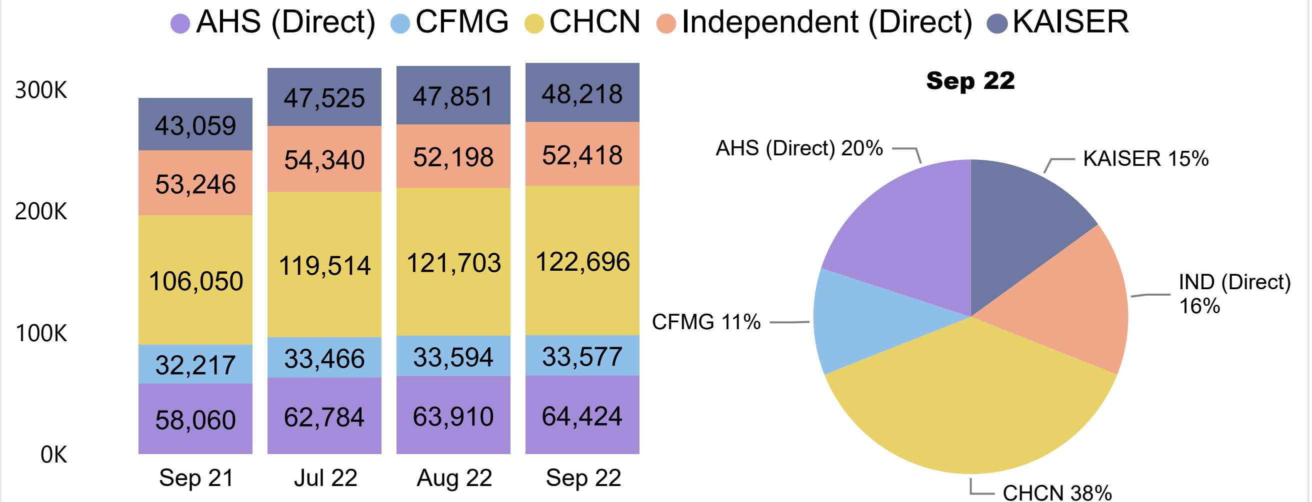
1.57

Membership

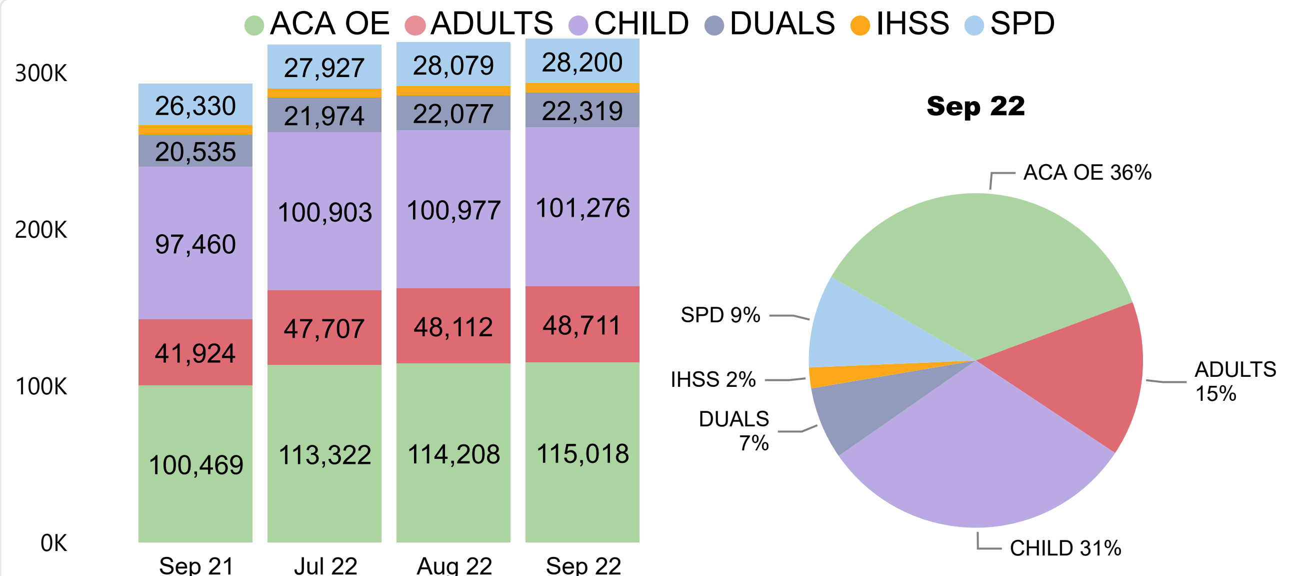
By Plan



By Network

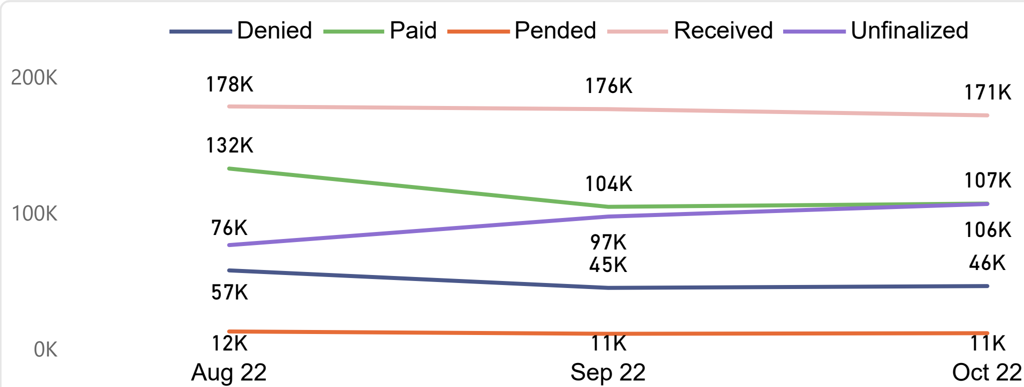


By Category

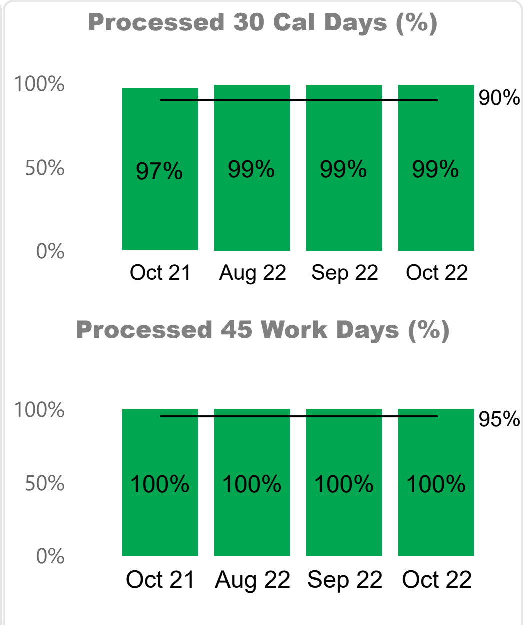


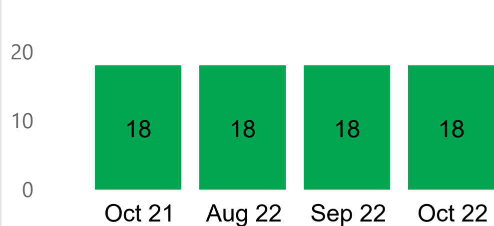
Claims

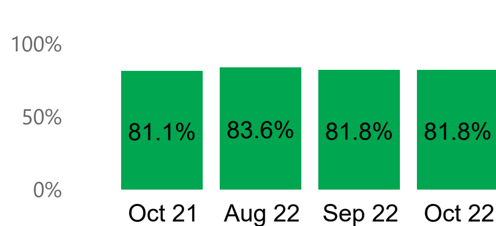
Claims Processing

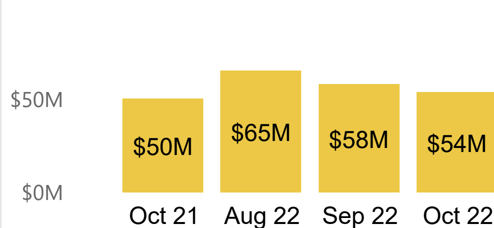


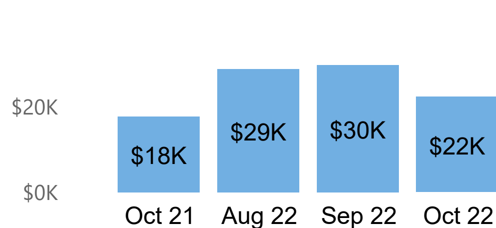
Claims Compliance



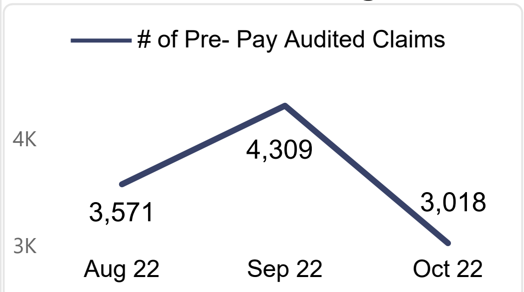




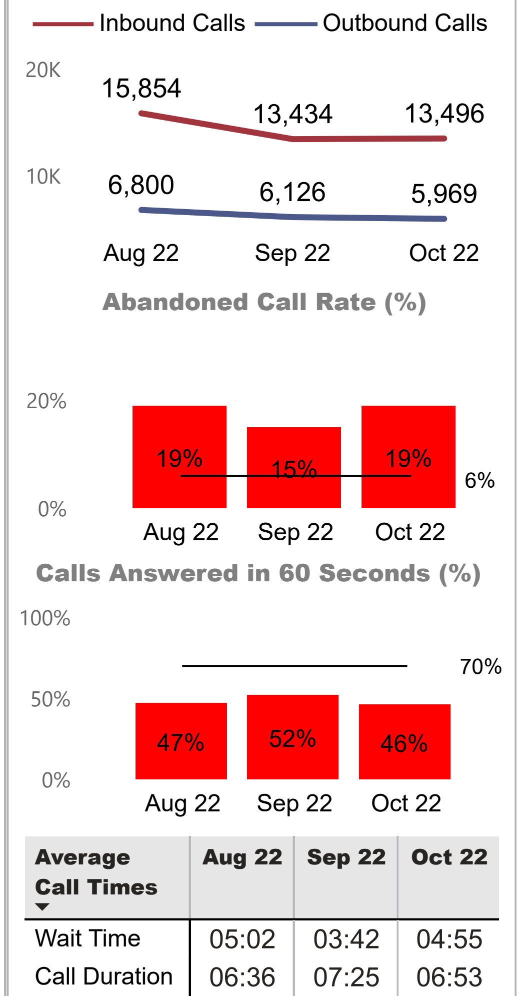




Claims Auditing

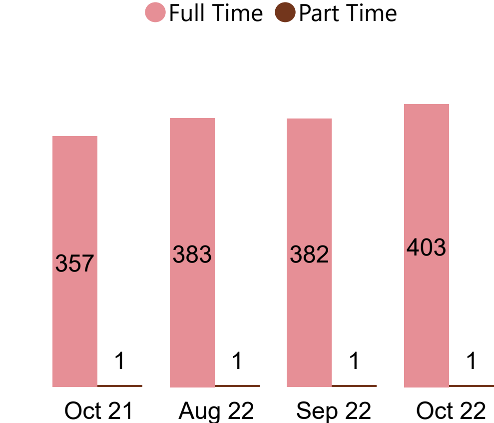


Member Services

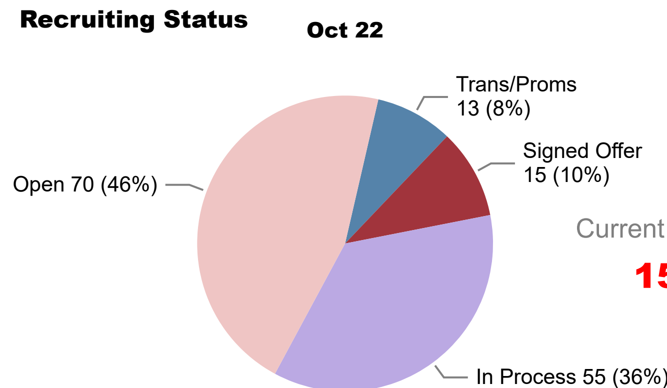


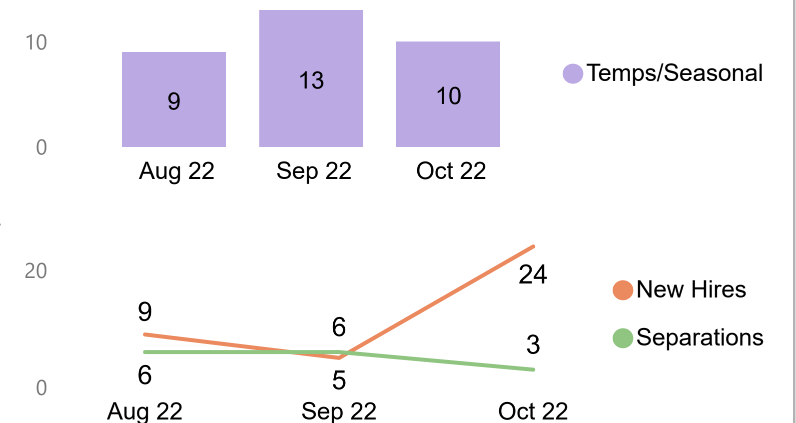
Average Call Times	Aug 22	Sep 22	Oct 22
Wait Time	05:02	03:42	04:55
Call Duration	06:36	07:25	06:53

Human Resources



Recruiting Status **Oct 22**





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Provider Services

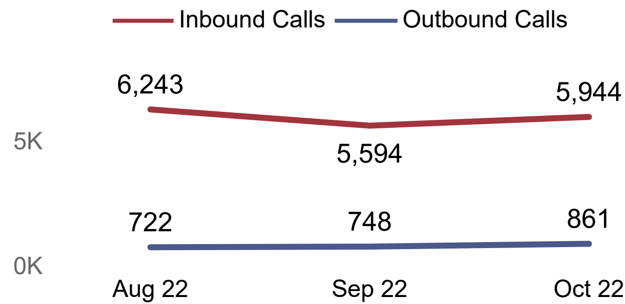
Provider Network

Hospital	17
Specialist	9,222
Primary Care Physician	741
Skilled Nursing Facility	66
Urgent Care	8
Health Centers (FQHCs and Non-FQHCs)	67
Transportation	380
TOTAL	**10,501**

Provider Credentialing

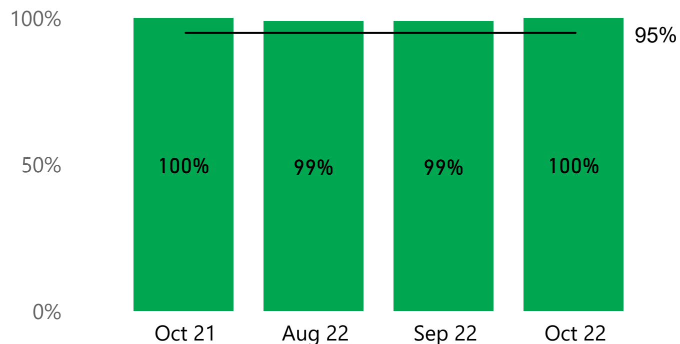
1,504

Provider Call Center



Provider Disputes & Resolutions

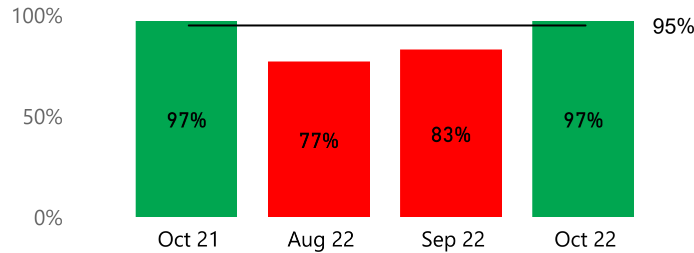
Turnaround Compliance (45 business days)



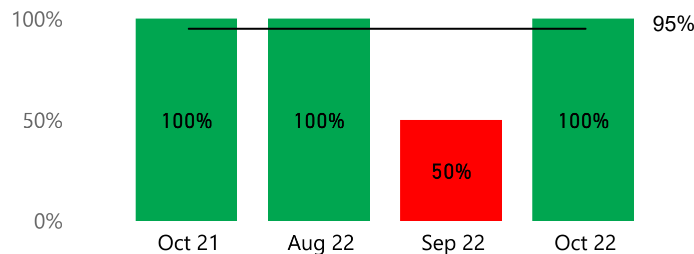
Compliance

Member Grievances

Standard (30 calendar days)

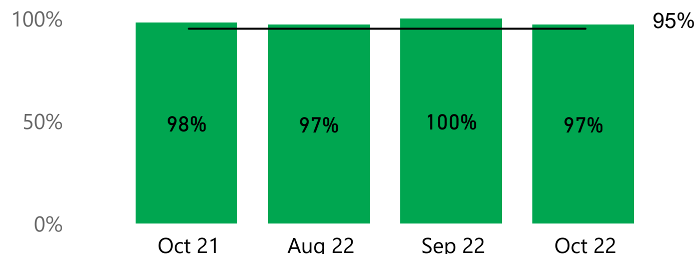


Expedited (3 calendar days)

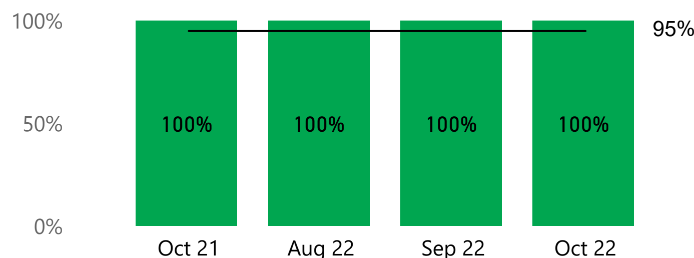


Member Appeals

Standard (30 calendar days)

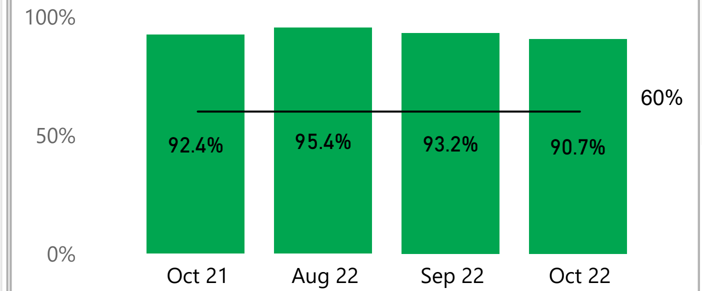


Expedited (3 calendar days)

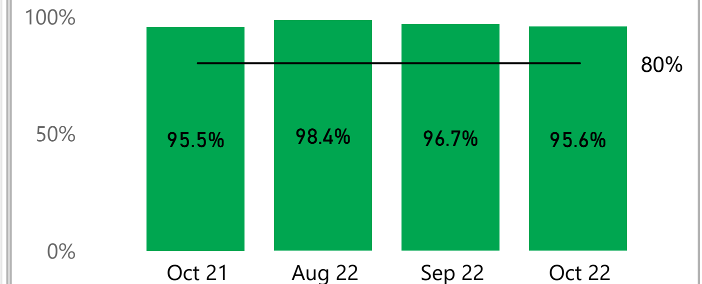


Encounter Data

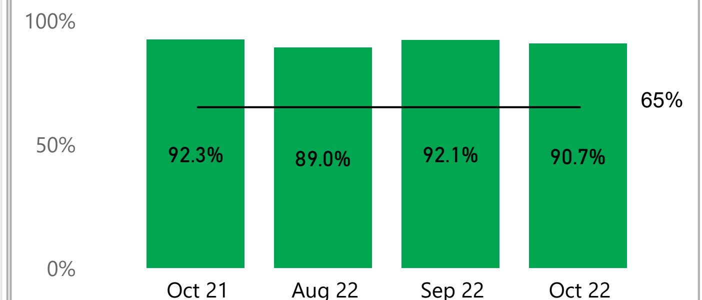
Institutional 0-90 days



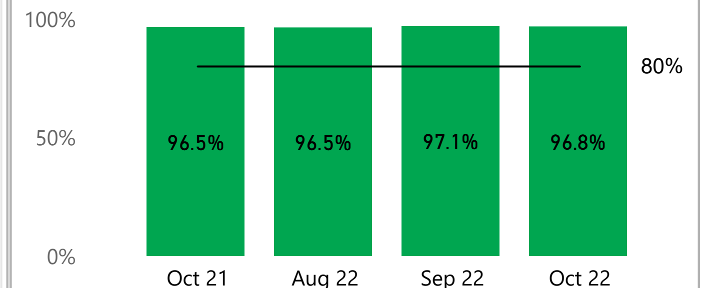
Institutional 0-180 days



Professional 0-90 days

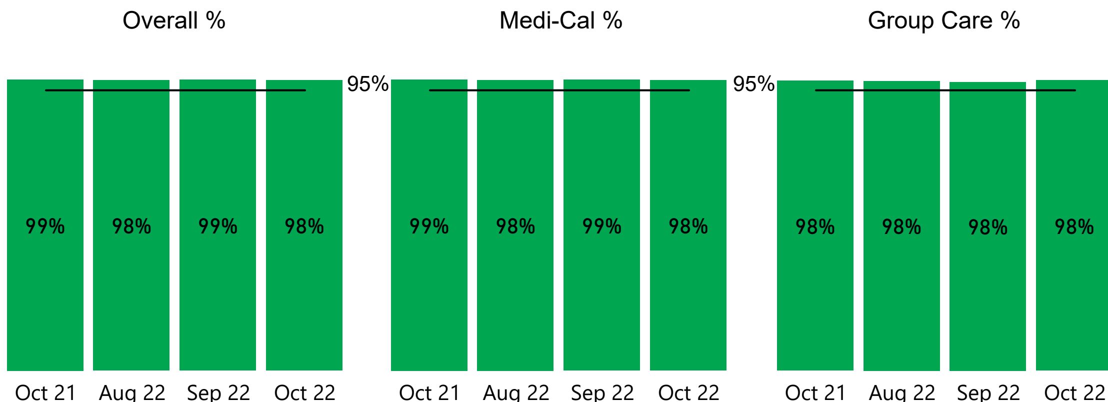


Professional 0-180 days

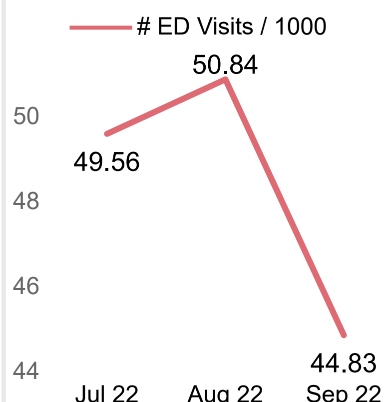


Health Care Services

Authorization Turnaround

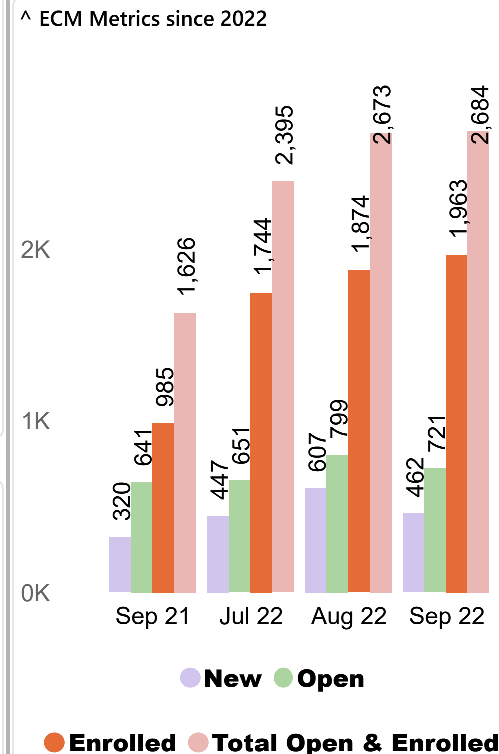


ED Utilization

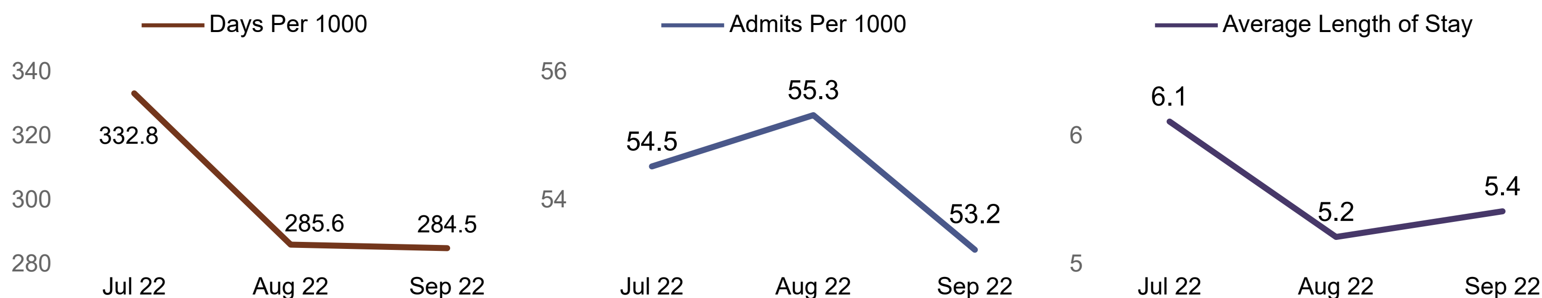


Case Management

Total Cases^



Inpatient Utilization

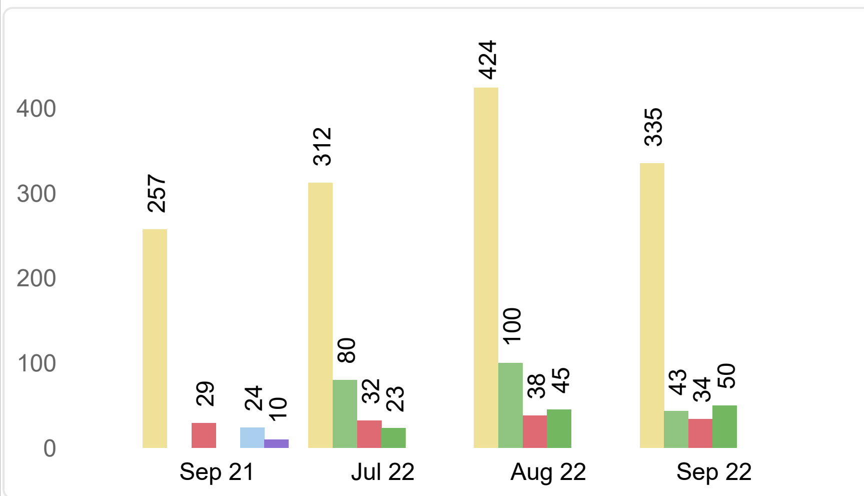


Case Management^

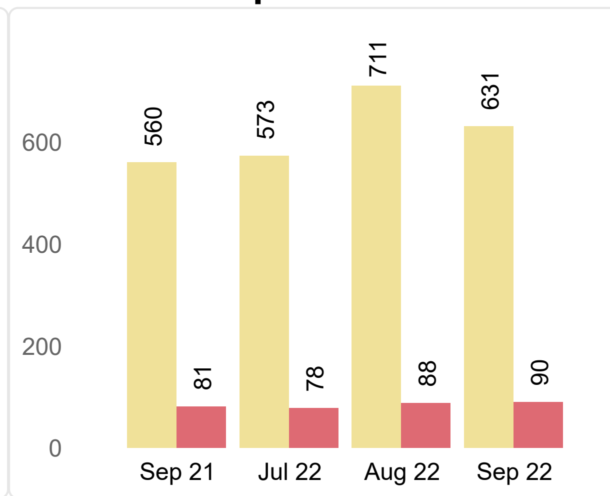
Care Coordination · Complex Cases · Health Homes · Whole Person Care · Community Supports · Enhanced Case Management

^ ECM Metrics since 2022

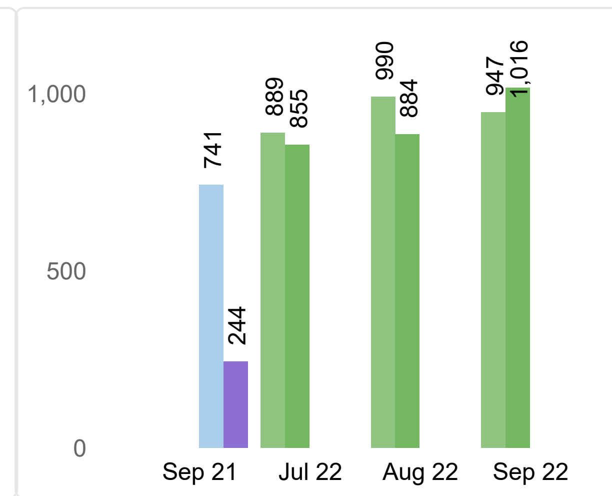
New Cases



Open Cases



Enrolled Cases



Technology (Business Availability)

Applications	Oct 21	Aug 22	Sep 22	Oct 22
HEALTHsuite System	100.0%	100.0%	100.0%	100.0%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Oct 21	Aug 22	Sep 22	Oct 22
Denial Rate Excluding Partial Denials (%)	4.0%	3.9%	3.6%	2.7%
Overall Denial Rate (%)	4.6%	4.2%	4.2%	2.9%
Partial Denial Rate (%)	0.7%	0.3%	0.6%	0.3%

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

Pharmacy Authorizations

Authorizations	Oct 21	Aug 22	Sep 22	Oct 22
Approved Prior Authorizations	879	33	35	25
Closed Prior Authorizations	808	78	110	116
Denied Prior Authorizations	673	39	29	38
Total Prior Authorizations	2,360	150	174	179

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 11/4/2022.**

On August 31st, the state legislature officially adjourned the 2021-2022 session. All bills that made it through the legislative process went to the Governor's desk and were either signed or vetoed by the Governor as of September 30th.

A legislative summary of tracked bills that were signed by the Governor will be included in the Board of Governor's December 2022 packet.

Medi-Cal (Medicaid)

- **AB 32 (Aguilar-Curry – D) Telehealth**
  - **Introduced:** 12/07/2020
  - **Status:** 9/25/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 515, Statues of 2022.
  - **Summary:** Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, Medi-Cal services may be provided pursuant to contracts with various types of managed care health plans, including through a county organized health system. Under existing law, in-person contact between a healthcare provider and a patient is not required under the Medi-Cal program for services appropriately provided through telehealth. Current law provides that neither face-to-face contact nor a patient's physical presence on the premises of an enrolled community clinic is required for services provided by the clinic to a Medi-Cal beneficiary during or immediately following a proclamation declaring a state of emergency. Current law defines "immediately following" for this purpose to mean up to 90 days following the termination of the proclaimed state of emergency, unless there are extraordinary circumstances. This bill would authorize the department to authorize an FQHC or RHC to establish a new patient relationship using an audio-only synchronous interaction when the visit is related to sensitive services, as defined, and authorize an FQHC or RHC to establish a new patient relationship using an audio-only synchronous interaction when the patient requests an audio-only modality or attests they do not have access to video.

- **AB 1355 (Levine – D) Medi-Cal: Independent medical review system**
  - **Introduced:** 2/19/2021
  - **Status:** 9/30/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 944, Statues of 2022.
  - **Summary:** Current law establishes hearing procedures for an applicant for, or recipient of, public social services who is dissatisfied with certain actions regarding those services to request a hearing from the State Department of Social Services or the State Department of Health Care Services, as applicable, under specified circumstances. After an administrative law judge has held

a hearing and issued a proposed decision, within 30 days after the department has received a copy of the administrative law judge's proposed decision, or within the 3 business days for an expedited resolution of an appeal of an adverse benefit determination for a Medi-Cal managed care plan beneficiary, as specified, current law authorizes the director to take specified action under prescribed timeframes. These actions include adopting the decision in its entirety, deciding the matter themselves on the record, including the transcript, with or without taking additional evidence, or ordering a further hearing to be conducted by the director or another administrative law judge on their behalf. Under current law, failure of the director to take certain actions is deemed an affirmation of the proposed decision. This bill would instead authorize the director to adopt the decision in its entirety, decide the matter on the record after reviewing the transcript or recording of the hearing without taking additional evidence, or order a further hearing to be conducted by the director or another administrative law judge on their behalf that affords the parties the opportunity to present and respond to additional evidence. The bill would clarify that a proposed decision would be deemed affirmed and adopted if the director fails to take prescribed action and would require the director's alternated decision to contain a statement of the facts and evidence, including references to the applicable provisions of law and regulations, and the analysis that supports their decision.

- **AB 1859 (Levine – D) Mental health and substance use disorder treatment**
  - **Introduced:** 2/8/2022
  - **Status:** 9/9/2022 Vetoed by Governor
  - **Summary:** Would require a health care service plan or a health insurer, for a health care service plan contract or a health insurance policy issued, amended, or renewed on or after July 1sy, 2023, that includes coverage for mental health services to, among other things, approve the provision of medically necessary treatment of a mental health or substance use disorder for persons who are screened, evaluated, and detained for treatment and evaluation under the Lanterman-Petris-Short Act. The bill would prohibit a noncontracting provider of covered mental health or substance use disorder treatment 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 that treatment. Under the bill, if an enrolled or insured is referred for a follow-up appointment for mental health services on a voluntary basis pursuant to the Lanterman-Petris-Short Act, the bill would require the health care service plan or health insurer to process the referral as a request for an appointment and offer appointments within specified timeframes, and if an appointment is not available in network that meets the geographic and timely access standards set by law, arrange coverage to ensure the delivery of medically necessary out-of-network services, to the extent possible, to meet those geographic and timely access standards. Because a willful violation of the bill's requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **AB 1880 (Arambula – D) Prior authorization and step therapy**
  - **Introduced:** 1/24/2022
  - **Status:** 9/25/2022 Vetoed by Governor
  - **Summary:** 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. The bill would define the term “clinical peer” for these purposes.

- **AB 1892 (Flora - R) Medi-Cal: orthotic and prosthetic appliances**
  - **Introduced:** 2/9/2022
  - **Status:** 8/12/2022-Failed Deadline pursuant to Rule 61(b)(15). (Last location was APPR. SUSPENSE FILE on 6/20/2022)
  - **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:** 8/12/2022-Failed Deadline pursuant to Rule 61(b)(15). (Last location was APPR. SUSPENSE FILE on 6/27/2022)
  - **Summary:** Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, and under which qualified low-income individuals receive health care services. Current law requires the department 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 current 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. To the extent that any necessary federal authorization is obtained, and effective no sooner than January 1, 2024, this bill 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. The bill would require the department to seek any necessary federal authorization for maintaining that income level for maintenance and would make conforming changes to related provisions. The bill would authorize the department to implement those provisions by various means, including all-county letters, and would require the department to implement those changes by regulatory action within 2 years of the operation of the above-described increase.

- **AB 1929 (Gabriel - D) Medi-Cal: violence preventive services**
  - **Introduced:** 2/10/2022
  - **Status:** 8/22/2022-Approved by the Governor. Chaptered by Secretary of State - Chapter 154, Statutes of 2022.
  - **Summary:** Current law establishes a schedule of benefits under the Medi-Cal program, including various mental health services. Current federal law authorizes, at the option of the state, preventive services, as defined, that are recommended by a physician or other licensed practitioner of the healing arts. This bill would add violence prevention services, as defined, as a covered benefit under Medi-Cal, subject to medical necessity and utilization controls. The bill

would authorize the department to implement, interpret, or make specific that provision by means of all-county letters, plan letters, or plan or provider bulletins, or similar instructions until regulations are adopted. The bill would limit its implementation only to the extent that any necessary federal approvals are obtained, and federal financial participation is not otherwise jeopardized. The bill would require the department to post on its internet website the date upon which violence prevention services may be provided and billed.

- **AB 1930 (Arambula - D) Medi-Cal: comprehensive perinatal services**
  - **Introduced:** 2/10/2022
  - **Status:** 9/27/2022 Vetoed by Governor
  - **Summary:** 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:** 7/5/2022-Failed Deadline pursuant to Rule 61(b)(14). (Last location was S. GOV. & F. on 6/8/2022)
  - **Summary:** The Ralph M. Brown Act requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act contains specified provisions regarding the timelines for posting an agenda and providing for the ability of the public to observe and

provide comment. The 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. 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, contributions or copayments**
  - **Introduced:** 1/24/2022
  - **Status:** 8/12/2022-Failed Deadline pursuant to Rule 61(b)(15). (Last location was APPR. SUSPENSE FILE on 6/27/2022
  - **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:** 8/12/2022-Failed Deadline pursuant to Rule 61(b)(15). (Last location was APPR. SUSPENSE FILE on 8/8/2022)
  - **Summary:** Would require a health care service plan contract, health insurance policy, or self-insured employee welfare benefit plan 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, health

insurance policy, or self-insured employee welfare benefit plan 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:** 5/20/2022-Failed Deadline pursuant to Rule 61(b)(8). (Last location was A. APPR. SUSPENSE FILE on 5/18/2022)
  - **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, which 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:** 9/27/2022 Vetoed by Governor
  - **Summary:** Qualified individuals under the Medi-Cal program include medically needy persons and medically needy family persons who meet the required eligibility criteria, including applicable income requirements. Current law requires the State Department of Health Care Services to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Current law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $80, commencing on July 1st, 2024, or on the date that any necessary federal approvals are obtained, whichever is later.

- **AB 2117 (Gipson – D) Mobile stroke units**
  - **Introduced:** 2/14/2022
  - **Status:** 9/29/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 772, Statues of 2022.
  - **Summary:** The Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (act) establishes the Emergency Medical Services Authority, which is responsible for the coordination of various state activities concerning emergency medical services

(EMS), including development of planning and implementation guidelines for EMS systems. The act authorizes a county to develop an EMS program by designating a local EMS agency. This bill would define, under the act, “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 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 healthcare 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:** 5/6/22 Failed Deadline pursuant to Rule 61(b)(6). (Last location was A. PRINT on 2/16/2022)
  - **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:** 9/27/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 590, Statues of 2022.
  - **Summary:** Would require a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1st, 2023, 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, administering, or ordering a lower cost or clinically appropriate alternative drug. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **AB 2402 (Rubio, Blanca - D) Medi-Cal: continuous eligibility**
  - **Introduced:** 2/17/2022
  - **Status:** 8/31/2022-Failed Deadline pursuant to Rule 61(b)(18). (Last location was INACTIVE FILE on 8/30/2022)
  - **Summary:** 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, Blanca – D) Open meetings: local agencies: teleconferences**
  - **Introduced:** 1/24/2022
  - **Status:** 9/13/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 285, Statues of 2022.
  - **Summary:** Current law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act generally requires posting an agenda at least 72 hours before a regular meeting that contains a brief general description of each item of business to be transacted or discussed at the meeting and prohibits any action or discussion from being undertaken on any item not appearing on the posted agenda. This bill would revise and recast those teleconferencing provisions and, until January 1, 2026, would authorize a local agency to use teleconferencing without complying with the teleconferencing requirements that each teleconference location be identified in the notice and agenda and that each teleconference location be accessible to the public if at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda that is open to the public and situated within the local agency's jurisdiction.

- **AB 2458 (Weber – D) California Children's Services: reimbursement rates.**
  - **Introduced:** 2/17/2022
  - **Status:** 5/20/22 Failed Deadline pursuant to Rule 61(b)(8). (Last location was A. APPR. SUSPENSE FILE on 4/6/2022)
  - **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 2516 (Aguiar-Curry - D) Health care coverage: human papillomavirus**
  - **Introduced:** 2/17/2022
  - **Status:** 9/25/2022 Vetoed by Governor

- **Summary:** 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. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The bill would also expand comprehensive clinical family planning services under the Family PACT Program to include the HPV vaccine for persons for whom it is FDA approved. This bill contains other related provisions and other existing laws.

- **AB 2539 (Choi - R) Public health: COVID-19 vaccination: proof of status**
  - **Introduced:** 2/17/2022
  - **Status:** 4/29/22 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:** 9/25/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 533, Statues of 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 also provides for the regulation of disability insurers by the Department of Insurance. Current law requires a health care service plan contract or disability 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. For provider contracts issued, amended, or renewed on and after January 1st, 2023, this bill would require a health care service plan or disability insurer 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 or disability insurer's networks, to assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application.

- **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:** 8/31/2022-Failed Deadline pursuant to Rule 61(b)(18). (Last location was INACTIVE FILE on 8/23/2022)
  - **Summary:** Would, commencing January 1st, 2023, 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 authorize the department to contract with one or more private foundations to assist the department with administering 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 facilitation of quarterly meetings on enrollment and access barriers and solutions, among other requirements. The bill would become operative only upon an express appropriation in the annual Budget Act or another statute for the purposes of the bill.

- **AB 2697 (Aguilar-Curry – D) Medi-Cal: Community health worker services**
  - **Introduced:** 2/18/2022
  - **Status:** 6/30/2022 Approved by the Governor. Chaptered by Secretary of State- Chapter 488, Statutes of 2022
  - **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under federal law, covered services include "preventive services," which are defined as, services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under state law to prevent disease, disability, and other health conditions or their progression, prolong life, and promote physical and mental health and efficiency. On July 26th, 2022, the federal Centers for Medicare and Medicaid Services approved the department's Medicaid State Plan Amendment to add community health workers as a preventive service. This bill would codify the requirement that community health worker services be a covered Medi-Cal benefit. The bill would require a Medi-Cal managed care plan to engage in outreach and education efforts to enrollees, as determined by the department, but that would include, at a minimum, specified information to enrollees, including, among other things, a description of the community health worker services benefit and a list of providers that are authorized to refer an enrollee to community health worker services. The bill would require the department, through existing and regular stakeholder processes, to inform stakeholders about, and accept input from stakeholders on, implementation of the community health worker services benefit. The bill would be implemented only to the extent that federal financial participation is available and not otherwise jeopardized. The bill would authorize the department to implement,

interpret, or make specific this bill by means of policy letters, provider bulletins, or other similar instructions, without taking any further regulatory action.

- **AB 2724 (Arambula – D) Medi-Cal: alternate health care service plan**
  - **Introduced:** 2/18/2022
  - **Status:** 6/30/2022-Chaptered by Secretary of State- Chapter 73, Statutes of 2022
  - **Summary:** Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would authorize the department 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 certain eligible beneficiaries in geographic regions designated by the department, as specified. The bill would authorize the department to contract with an AHCSP as a Medi-Cal managed care plan in any geographic region of the state for which federal approval is available, for which the AHCSP maintains appropriate licensure or an approved exemption from the Department of Managed Health Care, and in which the AHCSP already provides commercial coverage in the individual, small group, or large group market.

- **AB 2727 (Wood – D) Medi-Cal: Eligibility**
  - **Introduced:** 1/24/2022
  - **Status:** 9/13/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 291, Statues of 2022.
  - **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 their communicating that determination in writing to the Department of Finance, no sooner than January 1st, 2024. Current 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 the date that the resource disregards are implemented, 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:** 7/5/22 Failed Deadline pursuant to Rule 61(b)(14). (Last location was S. HEALTH on 6/1/2022)
  - **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.

- **SB 184 Health Trailor Bill**
  - **Introduced:** 1/08/2022
  - **Status:** 6/30/2022 Chaptered by Secretary of State – Chapter 47, Statues of 2022
  - **Summary:** SB 184 is an omnibus health trailer bill that makes statutory revisions affecting health programs necessary to implement the Budget Act of 2022. ***See addendum for a complete summary on this bill.***

- **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.

- **SB 281 (Dodd – D) Medi-Cal: Short-Term Community Transitions program**
    - **Introduced:**
    - **Status:** 9/30/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 898, Statutes of 2022
    - **Summary:** Current federal law establishes the Money Follows the Person Rebalancing Demonstration, which is designed to achieve various objectives with respect to institutional and home- and community-based long-term care services provided under state Medicaid programs. Under the Money Follows the Person Rebalancing Demonstration, an eligible individual is required to meet prescribed qualifications, including that they have resided in an inpatient facility for at least 60 consecutive days. Current law requires the State Department of Health Care Services to provide services consistent with the Money Follows the Person Rebalancing Demonstration for transitioning eligible individuals out of an inpatient facility who have resided in that setting for fewer than 60 days. Current law requires the department to cease to enroll beneficiaries under these provisions commencing January 1st, 2023, and to cease providing these services commencing January 1st, 2024. Current law repeals these provisions on January 1, 2025. This bill would instead require the department to cease to enroll beneficiaries commencing January 1st, 2026, and to cease providing those services commencing January 1st, 2027. The bill would extend the repeal date of those provisions to January 1st, 2028.

- **SB 853 (Wiener – D) Prescription drug coverage**
    - **Introduced:** 1/19/2022
    - **Status:** 8/12/2022-Failed Deadline pursuant to Rule 61(b)(15). (Last location was APPR. SUSPENSE FILE on 8/3/2022)
    - **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 drug, dose, or dosage form, and would apply the prohibition to blanket disability insurance policies and certificates. The bill would prohibit a health care service plan or disability insurer that provides coverage for prescription drugs from limiting or declining to cover a drug or dose of a drug as prescribed or imposing additional cost sharing for covering a drug as prescribed, if specified criteria apply.

- **SB 858 (Wiener – D) Health care service plans: discipline: civil penalties.**
    - **Introduced:** 1/19/2022
    - **Status:** 9/30/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 291, Statues of 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. 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 more than $25,000 per violation, and would authorize a lower, proportionate penalty for specialized dental and vision health care service plans. Under the bill, the civil penalty base amount would be adjusted annually commencing January 1st, 2028, and every 5 years thereafter, as specified.

- **SB 871 (Pan – D) Public Health: Immunization**
    - **Introduced:** 4/29/22 Failed Deadline pursuant to Rule 61(b)(5). (Last location was JUD. on 2/24/2022)
    - **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:** 9/29/2022 Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
    - **Summary:** Current law applies the provisions relating to biomarker testing to Medi-Cal managed care plans, as prescribed. This bill 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. The bill would specify

that it does not require a health care service plan or health insurer to cover biomarker testing for screening purposes unless otherwise required by law. The bill would subject restricted use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of a medical condition to state and federal grievance and appeal processes. 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:** 9/29/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 822, Statues of 2022.
  - **Summary:** Would require a Medi-Cal managed care plan, a PACE organization, a health care service plan, or a health insurer, and delegated entities, 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 transgender, gender diverse, or intersex (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:** 7/5/2022-Failed Deadline pursuant to Rule 61(b)(14). (Last location was A. HEALTH on 5/27/2022)
  - **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:** 9/27/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 607, Statues of 2022.
  - **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, to the extent that federal financial participation is available, federally qualified health center (FQHC) services and rural health clinic (RHC) services are reimbursed on a per-visit basis, as specified. This bill would require the State Department of Health Care Services to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when certain requirements are met, including that the visit is billed under the supervising licensed behavioral health practitioner of the FQHC or RHC.

- **SB 974 (Portantino - D) Health care coverage: diagnostic imaging**
  - **Introduced:** 2/10/2022
  - **Status:** 9/27/2022 Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
  - **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. Under current law, mammography performed pursuant to those requirements or that meets the current recommendations of the United States Preventive Services Task Force is provided to an enrollee or an insured without cost sharing. This bill would require a health care service plan contract, a 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, 2024, to provide coverage without imposing cost sharing for, among other things, 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, except as specified.

- **SB 987 (Portantino – D) California Cancer Care Equity Act**
  - **Introduced:** 2/14/2022
  - **Status:** 9/27/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 608, Statues of 2022.
  - **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various health care delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would, for covered benefits under its contract, require a Medi-Cal managed care plan to, among other things, make a good faith effort to contract with at least one National Cancer Institute (NCI)-designated comprehensive cancer center, site affiliated with the NCI Community Oncology Research Program (NCORP), or qualifying academic cancer center, as specified within each county in which the Medi-Cal managed care plan operates, and authorize any eligible enrollee diagnosed with a complex cancer diagnosis to request a referral to any of those centers to receive medically necessary services unless the enrollee chooses a different cancer treatment provider. The bill would require a Medi-Cal managed care plan to notify all enrollees of their right to request a referral to access to care through any of those centers. This bill contains other related provisions.

- **SB 1019 (Gonzalez – D) Medi-Cal managed care plans: mental health benefits**
  - **Introduced:** 2/14/2022
  - **Status:** 9/30/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 879, Statues of 2022.
  - **Summary:** 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. Under current law, non specialty mental health services covered by a Medi-Cal managed care plan include, among other things, individual and group mental health evaluation and treatment, psychological testing, and psychiatric consultation, as specified. This bill would require a Medi-Cal managed care plan, no later than January 1st, 2025, to conduct annual outreach and education for its enrollees, based on a plan that the Medi-Cal managed care plan develops and submits to the State Department of Health Care Services, as specified, regarding the mental health benefits that are covered by the Medi-Cal managed care plan. The bill would require a Medi-Cal managed care plan to also conduct annual outreach and

education, based on a plan that it develops, to inform primary care providers regarding those mental health benefits.

- **SB 1033 (Pan – D) Health care coverage**
  - **Introduced:** 2/15/2022
  - **Status:** 8/12/2022-Failed Deadline pursuant to Rule 61(b)(15). (Last location was APPR. SUSPENSE FILE on 8/10/2022)
  - **Summary:** Current law requires the Department of Managed Health Care and the commissioner to develop and adopt regulations establishing standards and requirements to provide enrollees and insureds with appropriate access to language assistance in obtaining health care services and covered benefits. Current law requires the Department of Managed Health Care and the 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. This bill would require the Department of Managed Health Care and the commissioner to revise these regulations and develop and adopt regulations establishing demographic data collection standards, no later than July 1st, 2024. The bill would require health care service plans and health insurers to assess the individual cultural, linguistic, and health-related social needs of enrollees and insureds for the purpose of identifying and addressing health disparities, improving health care quality and outcomes, and addressing population health.

- **SB 1180 (Pan – D) Medi-Cal: time and distance standards for managed care services**
  - **Introduced:** 2/17/2022
  - **Status:** 8/31/2022-Failed Deadline pursuant to Rule 61(b)(18). (Last location was INACTIVE FILE on 8/25/2022)
  - **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:** 9/30/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 993, Statues of 2022.
  - **Summary:** The Confidentiality of Medical Information Act prohibits a provider of health care, a health care service plan, or 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.

- **SB 1207 (Portantino – D) Health care coverage: maternal and pandemic-related mental health conditions**
  - **Introduced:** 2/17/2022
  - **Status:** 9/27/2022 Approved by the Governor. Chaptered by Secretary of State – Chapter 618, Statues of 2022.
  - **Summary:** 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. The bill would revise the requirements of the program to include quality measures to encourage screening, diagnosis, treatment, and referral. The bill also would encourage health care service plans and health insurers to improve screening, treatment, and referral to maternal mental health services, include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and educate enrollees and insureds about the program. The bill would define "health care service plan" to include specified Medi-Cal managed health care plans, as specified, and would require those plans to continue to comply with any quality measures required or adopted by the State Department of Health Care Services, notwithstanding the requirements of the bill. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **SB 1298 (Ochoa Bogh - R) Behavioral Health Continuum Infrastructure Program**
  - **Introduced:** 2/18/2022
  - **Status:** 58/31/22 Failed Deadline pursuant to Rule 61(b)(18). (Last location was APPR. SUSPENSE FILE on 5/2/2022)
  - **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:** 5/20/2022-Failed Deadline pursuant to Rule 61(b)(8). (Last location was S. APPR. SUSPENSE FILE on 5/16/2022)
  - **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.

Board Business

Finance

Gil Riojas

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

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

Date: **November 11th, 2022**

Subject: **Finance Report – September 2022**

Executive Summary

- For the month ended September 30th, 2022, the Alliance had enrollment of 321,333 members, a Net Income of $4.0 million and 639% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$100,878	$302,688
Medical Expense	91,159	275,360
Admin. Expense	5,713	16,139
Other Inc. / (Exp.)	(11)	848
Net Income	**$3,995**	**$12,038**

Net Income by Program:

	Month	YTD
Medi-Cal	$3,811	$10,689
Group Care	184	1,349
	$3,995	**$12,038**

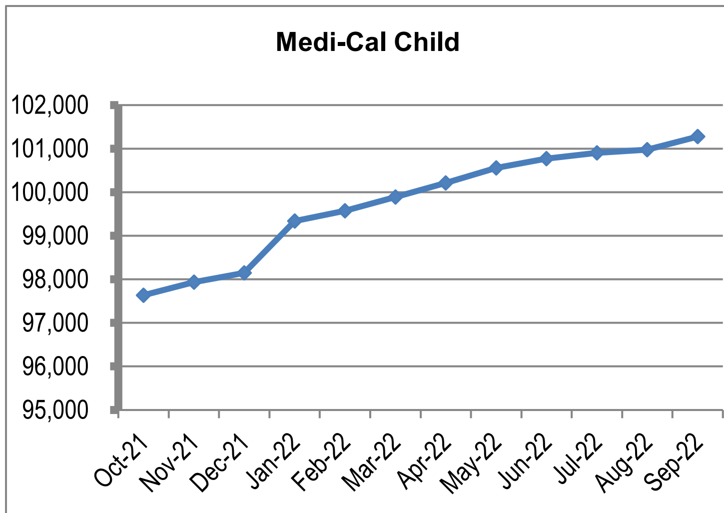
Enrollment

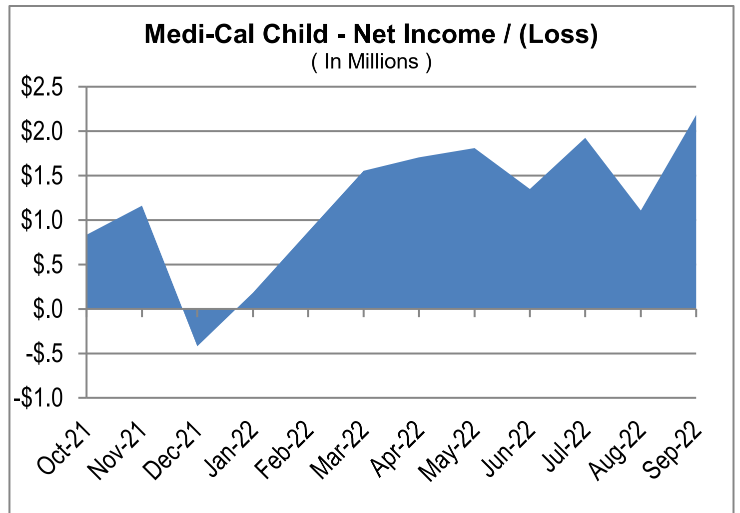
- Total enrollment increased by 2,077 members since August 2022.
- Total enrollment increased by 8,277 members since June 2022.

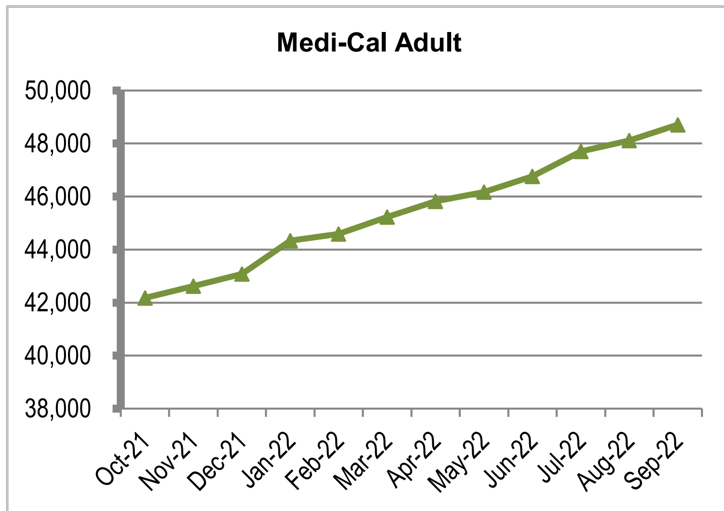
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

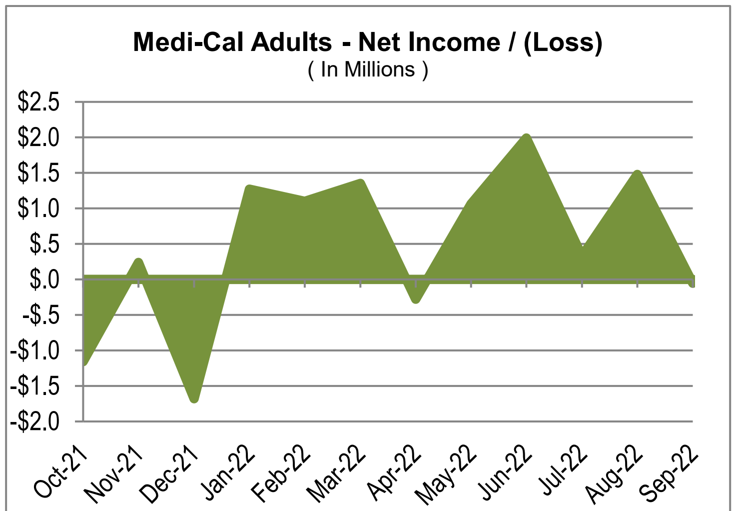
Enrollment September-2022 Actual	Budget	Variance	Variance %		Member Months Year-to-Date Actual	Budget	Variance	Variance %
				Medi-Cal:				
48,711	47,359	1,352	2.9%	Adult	144,530	141,092	3,438	2.4%
101,276	101,727	(451)	-0.4%	Child	303,156	304,270	(1,114)	-0.4%
28,200	28,453	(253)	-0.9%	SPD	84,270	85,104	(834)	-1.0%
22,319	21,780	539	2.5%	Duals	66,306	65,145	1,161	1.8%
115,018	114,700	318	0.3%	ACA OE	342,548	342,390	158	0.0%
315,524	**314,019**	**1,505**	**0.5%**	**Medi-Cal Total**	**940,810**	**938,001**	**2,809**	**0.3%**
5,809	5,828	(19)	-0.3%	Group Care	17,408	17,484	(76)	-0.4%
321,333	**319,847**	**1,486**	**0.5%**	**Total**	**958,218**	**955,485**	**2,733**	**0.3%**

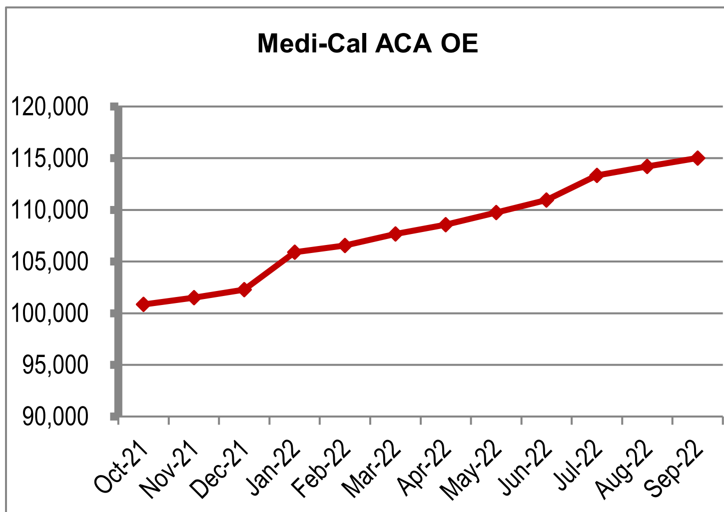
Enrollment and Profitability by Program and Category of Aid

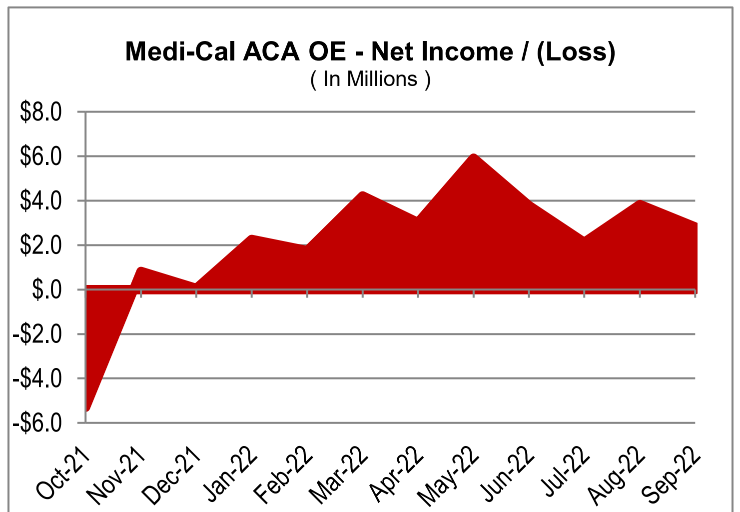




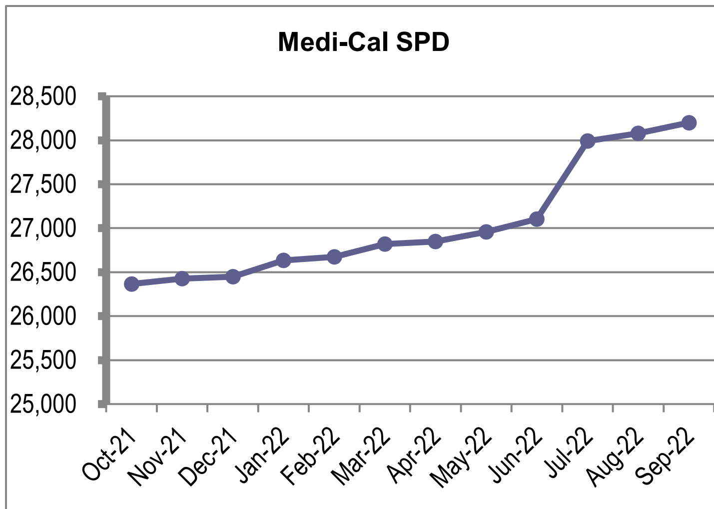


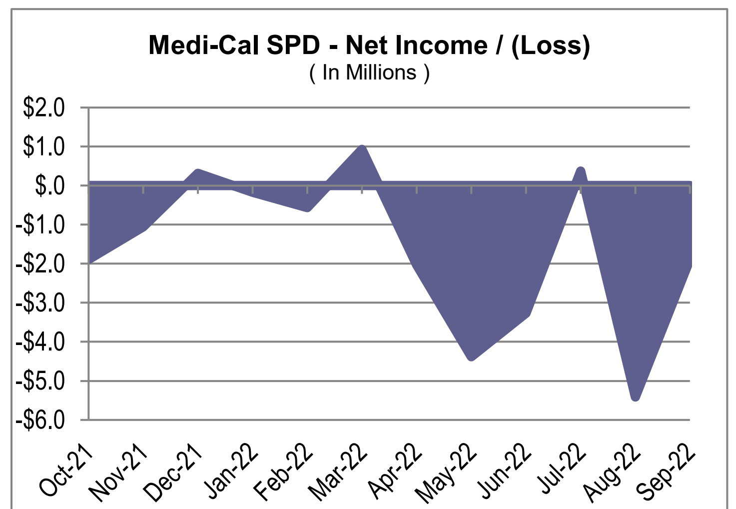


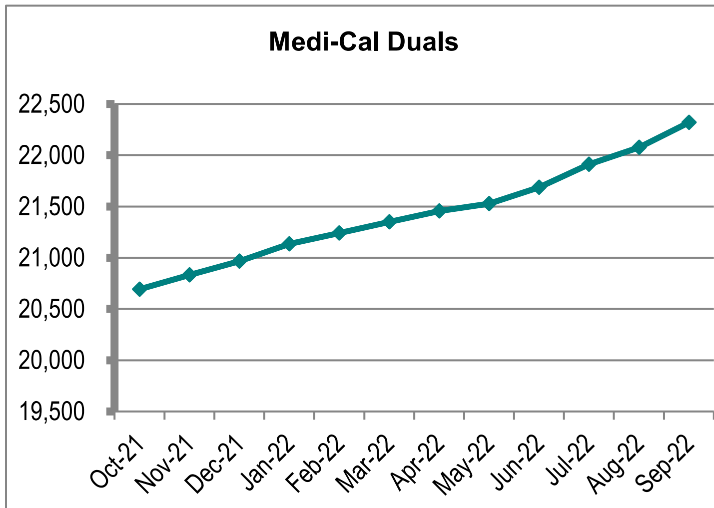


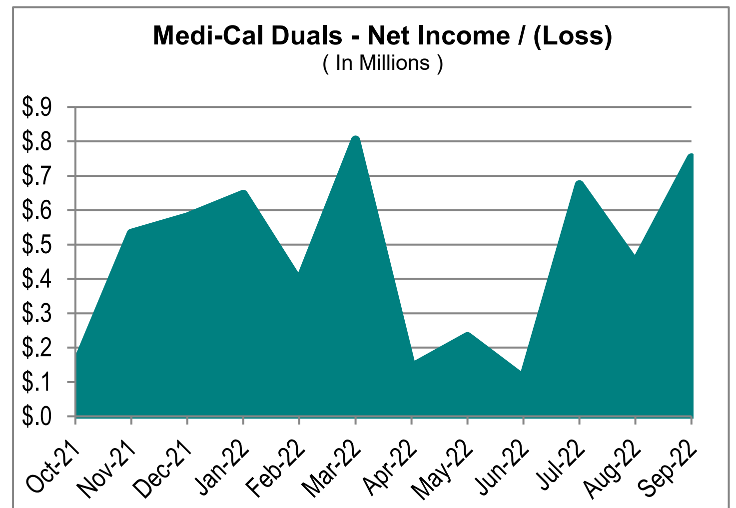


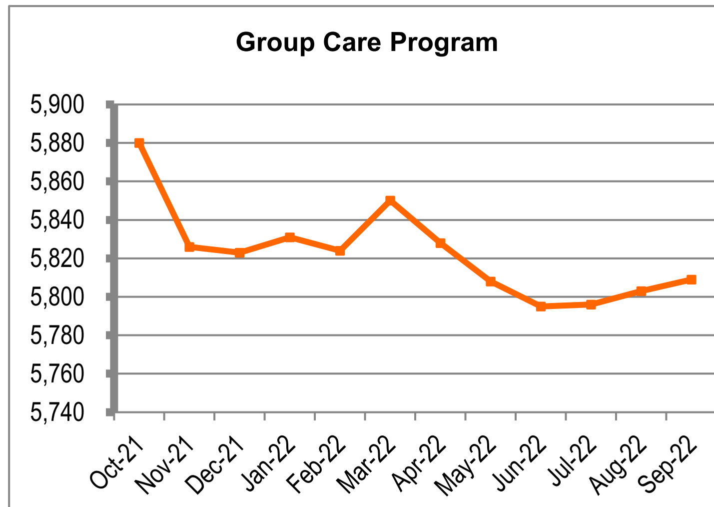
Enrollment and Profitability by Program and Category of Aid

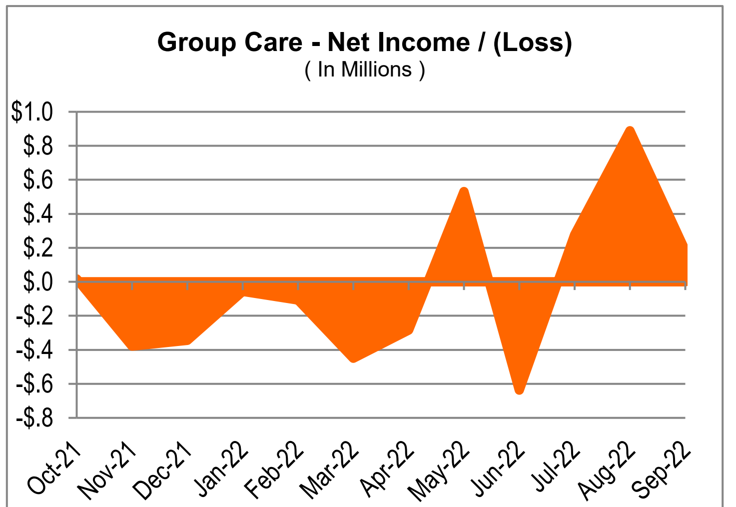




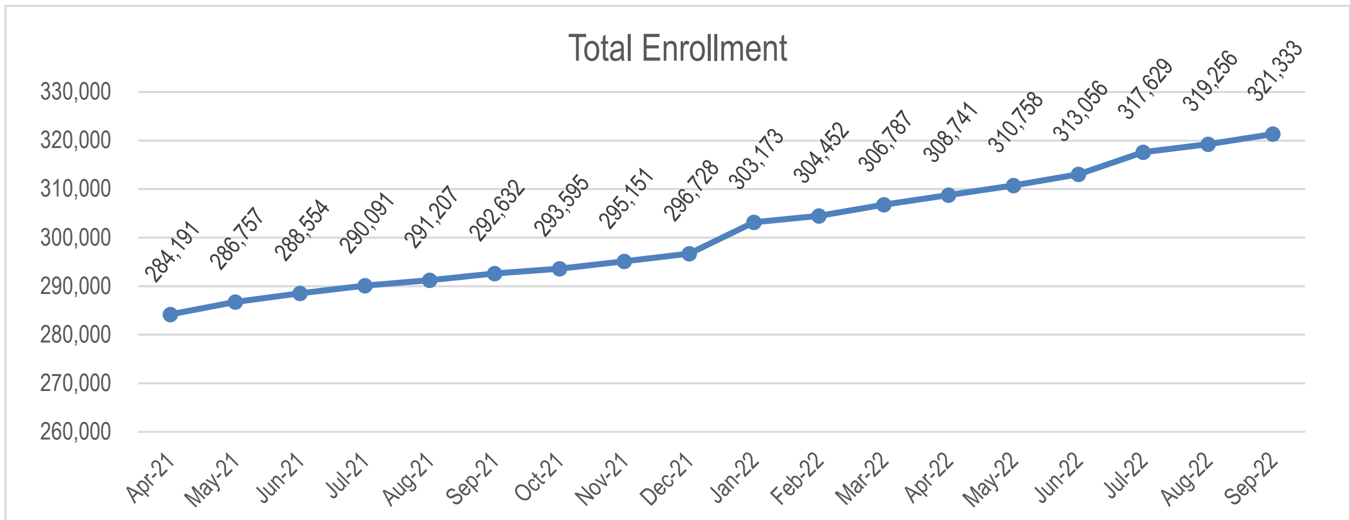


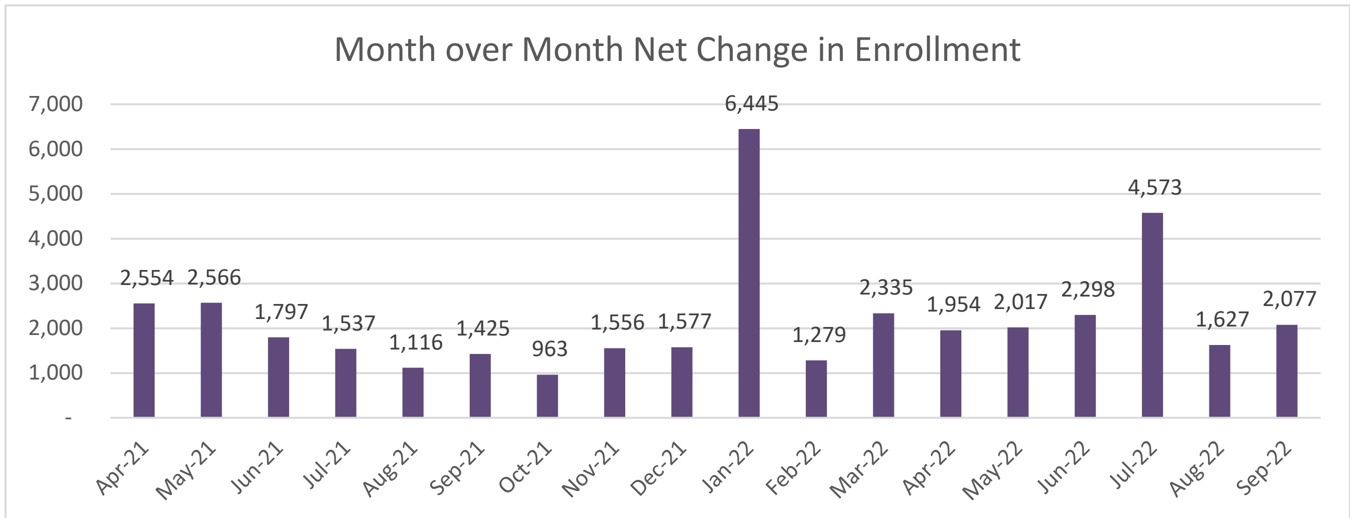






Net Change in Enrollment



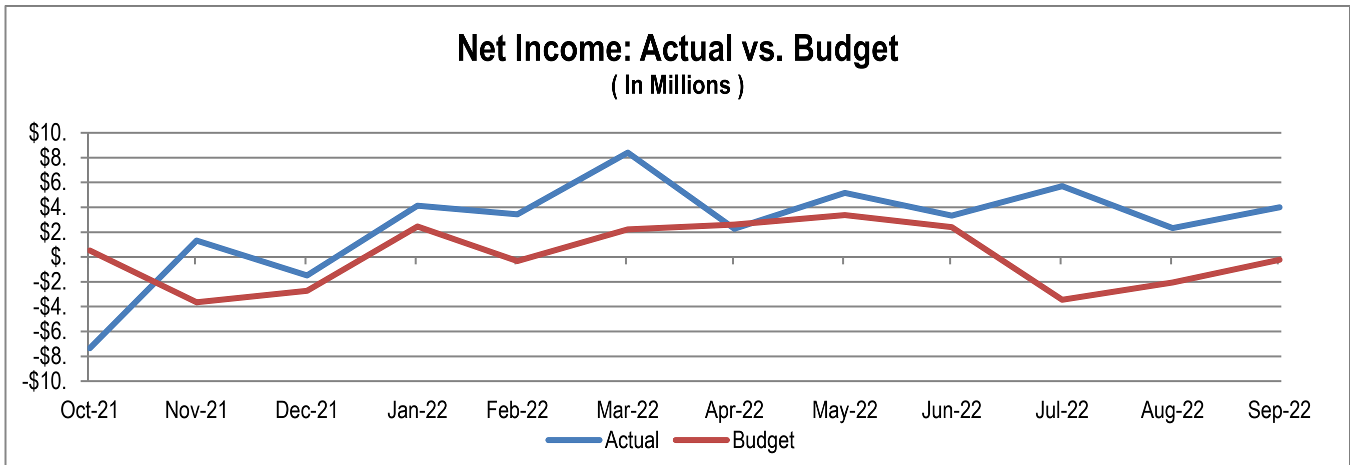


- The disenrollment process associated with the Public Health Emergency (PHE) is projected to restart in May 2023.

Net Income

- For the month ended September 30th, 2022:
  - Actual Net Income: $4.0 million.
  - Budgeted Net Loss: $230,000.

- For the fiscal YTD ended September 30th, 2022:
  - Actual Net Income: $12.0 million.
  - Budgeted Net Loss: $5.7 million.

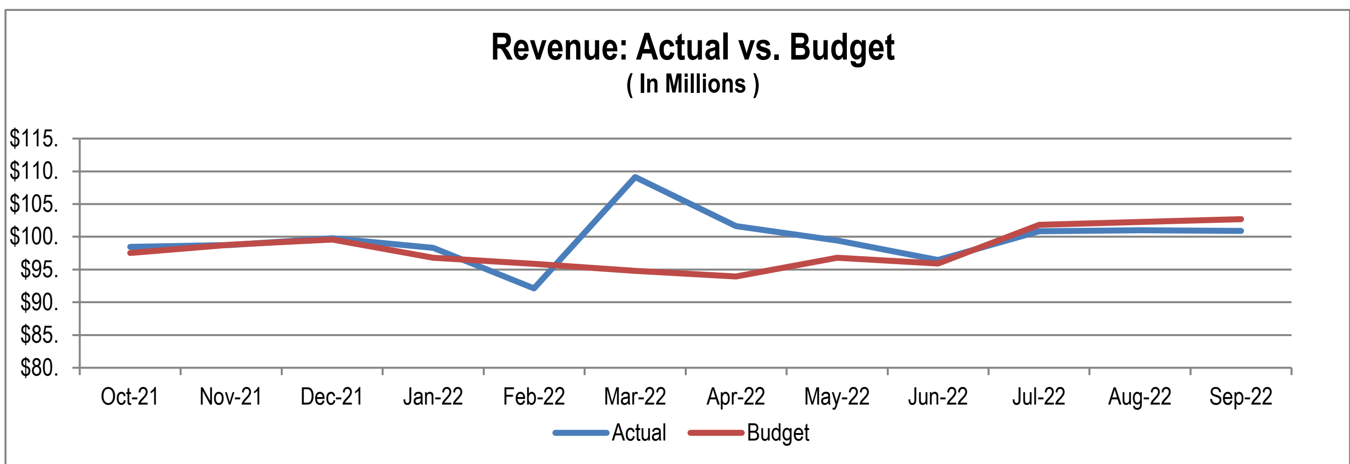


- The favorable variance of $4.4 million in the current month is primarily due to:
  - Unfavorable $1.8 million lower than anticipated Revenue.
  - Favorable $4.6 million lower than anticipated Medical Expense.
  - Favorable $1.5 million lower than anticipated Administrative Expense.
  - Unfavorable $60,000 lower than anticipated Total Other Income.

Revenue

- For the month ended September 30th, 2022:
  - Actual Revenue: $100.9 million.
  - Budgeted Revenue: $102.7 million.

- For the fiscal YTD ended September 30th, 2022:
  - Actual Revenue: $302.7 million.
  - Budgeted Revenue: $306.8 million.



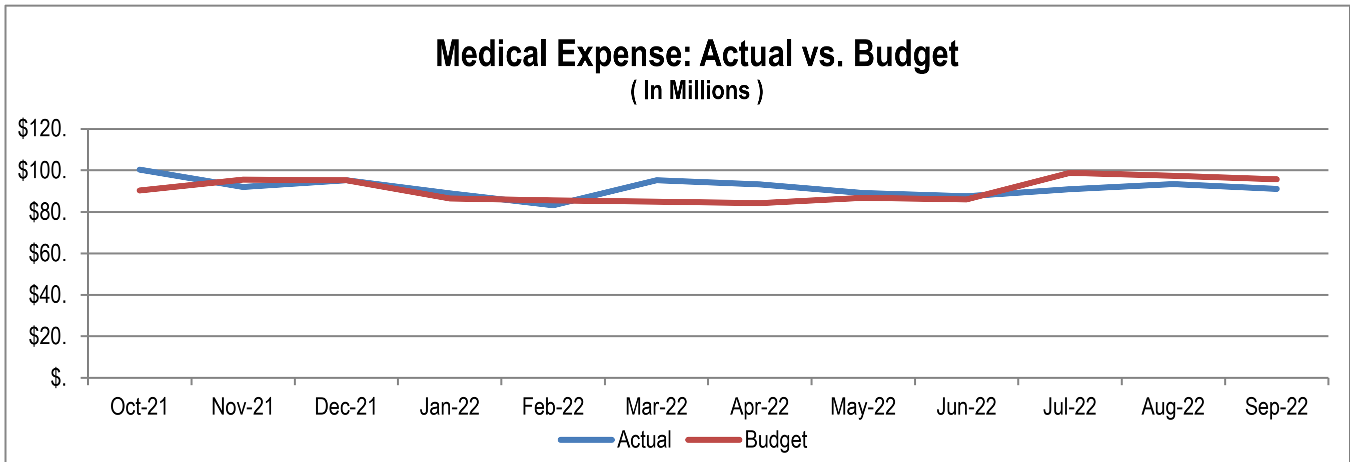
- For the month ended September 30th, 2022, the unfavorable revenue variance of $1.8 million is primarily due to an unfavorable $700,000 accrual to Medi-Cal Base Capitation Revenue for an anticipated member health acuity adjustment by DHCS,

unfavorable Prop 56 Revenue, and unfavorable Supplemental Maternity and Behavioral Health Revenue.

Medical Expense

- For the month ended September 30th, 2022:
    - Actual Medical Expense: $91.2 million.
    - Budgeted Medical Expense: $95.8 million.

- For the fiscal YTD ended September 30th, 2022:
    - Actual Medical Expense: $275.4 million.
    - Budgeted Medical Expense: $292.0 million.



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

- For September, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $1.0 million. The estimate for prior years decreased by $8.7 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)

Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$72,112,286	$0	$72,112,286	$71,926,565	($185,721)	-0.3%
Primary Care FFS	12,875,773	$22,964	$12,898,737	12,569,361	($306,412)	-2.4%
Specialty Care FFS	15,365,919	$241,083	$15,607,002	15,390,167	$24,247	0.2%
Outpatient FFS	25,326,805	($985,837)	$24,340,969	26,790,201	$1,463,395	5.5%
Ancillary FFS	21,055,483	($951,119)	$20,104,364	21,746,088	$690,605	3.2%
Pharmacy FFS	20,468,925	($82,140)	$20,386,786	19,319,916	($1,149,009)	-5.9%
ER Services FFS	14,430,554	($71,815)	$14,358,739	16,351,125	$1,920,571	11.7%
Inpatient Hospital & SNF FFS	97,754,719	($6,874,048)	$90,880,670	98,405,168	$650,449	0.7%
Other Benefits & Services	5,551,720	$0	$5,551,720	8,844,674	$3,292,954	37.2%
Net Reinsurance	(881,527)	$0	($881,527)	654,147	$1,535,674	234.8%
	$284,060,658	**($8,700,912)**	**$275,359,746**	**$291,997,412**	**$7,936,754**	**2.7%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

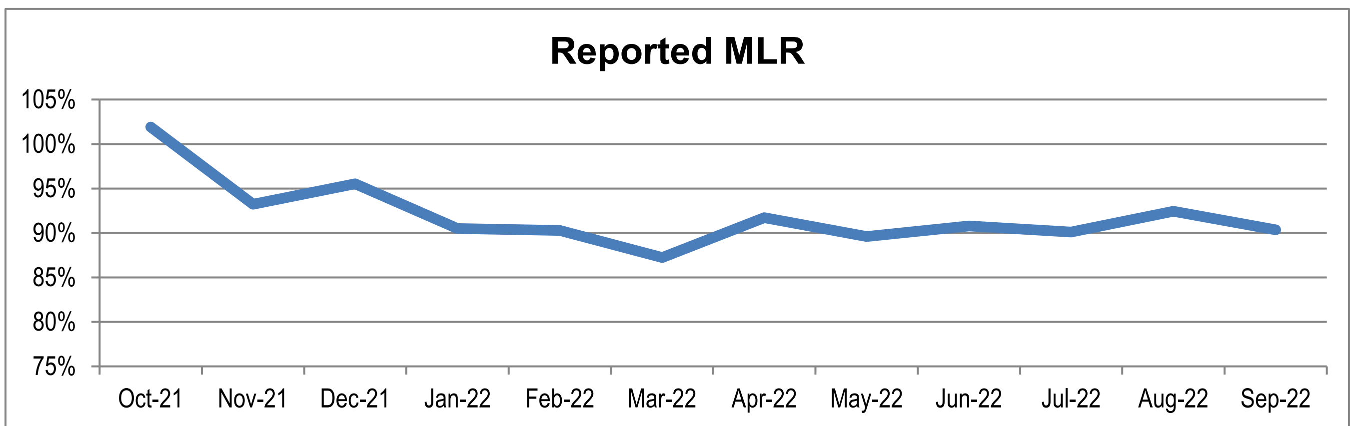
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$75.26	$0.00	$75.26	$75.28	$0.02	0.0%
Primary Care FFS	$13.44	$0.02	$13.46	$13.15	($0.28)	-2.1%
Specialty Care FFS	$16.04	$0.25	$16.29	$16.11	$0.07	0.4%
Outpatient FFS	$26.43	($1.03)	$25.40	$28.04	$1.61	5.7%
Ancillary FFS	$21.97	($0.99)	$20.98	$22.76	$0.79	3.5%
Pharmacy FFS	$21.36	($0.09)	$21.28	$20.22	($1.14)	-5.6%
ER Services FFS	$15.06	($0.07)	$14.98	$17.11	$2.05	12.0%
Inpatient Hospital & SNF FFS	$102.02	($7.17)	$94.84	$102.99	$0.97	0.9%
Other Benefits & Services	$5.79	$0.00	$5.79	$9.26	$3.46	37.4%
Net Reinsurance	($0.92)	$0.00	($0.92)	$0.68	$1.60	234.4%
	$296.45	**($9.08)**	**$287.37**	**$305.60**	**$9.15**	**3.0%**

- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $7.9 million favorable to final budget, primarily due to higher enrollment. On a PMPM basis, medical expense is 3.0% favorable to budget. For per-member-per-month expense:
  - Capitated Expense overall is virtually at budget.
  - Primary Care Expense is unfavorable compared to budget, driven by unfavorable utilization in the Adult, ACA OE and SPD Categories of Aid, unfavorable unit cost in the Child and Group Care Categories of Aid, offset by favorable utilization and unit cost for the Duals.

- Specialty Care Expense is slightly higher than budget, generally driven by favorable utilization in the ACA OE, Adult, Child, and Dual COAs, offset by unfavorable utilization in the SPD and Group Care populations.
- Outpatient Expense is under budget, driven by favorable utilization, offset by unfavorable unit cost.
- Ancillary Expense is favorable to budget due to higher Other Medical Professional, Lab and Radiology, Hospice, CBAS and Transplant Wrap Around expense offset by unfavorable HHA, DME and other Medical Supplies, Non-Emergency Transportation, Ambulance and ECM expense. Unit cost is favorable, offset by unfavorable utilization.
- Pharmacy Expense is over budget due to unfavorable Non-PBM expense, driven by unfavorable unit cost in the ACA OE and Adult COAs, both unfavorable unit cost and utilization in the Group Care population offset by favorable utilization in the remaining aid code groups.
- Emergency Room Expense is under budget driven by favorable unit cost across all populations.
- Inpatient Expense is under budget, driven by favorable utilization in all populations except SPD, where unfavorable expense is driven by unit cost.
- Other Benefits & Services are under budget, primarily due to favorable purchased and professional, printing/postage/promotion and employee expense, and the timing of CalAIM incentive expense.
- Net Reinsurance year-to-date is favorable because more recoveries were received than budgeted.

Medical Loss Ratio (MLR)

- The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 90.4% for the month and 91.0% for the fiscal year-to-date.



Administrative Expense

- For the month ended September 30th, 2022:
    - Actual Administrative Expense: $5.7 million.
    - Budgeted Administrative Expense: $7.2 million.
- For the fiscal YTD ended September 30th, 2022:
    - Actual Administrative Expense: $16.1 million.
    - Budgeted Administrative Expense: $20.6 million.

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

Month					Year-to-Date			
Actual	**Budget**	**Variance $**	**Variance %**		**Actual**	**Budget**	**Variance $**	**Variance %**
$3,373,774	$4,056,801	$683,027	16.8%	Employee Expense	$10,215,210	$11,657,149	$ 1,441,939	12.4%
357,427	320,356	(37,071)	-11.6%	Medical Benefits Admin Expense	976,843	950,857	(25,986)	-2.7%
917,109	1,492,520	575,411	38.6%	Purchased & Professional Services	2,247,303	4,457,776	2,210,473	49.6%
1,064,570	1,324,968	260,398	19.7%	Other Admin Expense	2,699,402	3,581,029	881,627	24.6%
$5,712,880	$7,194,645	$1,481,765	20.6%	Total Administrative Expense	$16,138,757	$20,646,811	$ 4,508,053	21.8%

The year-to-date variances include:

- 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 5.7% of net revenue for the month and 5.3% of net revenue year-to-date.

Other Income / (Expense)

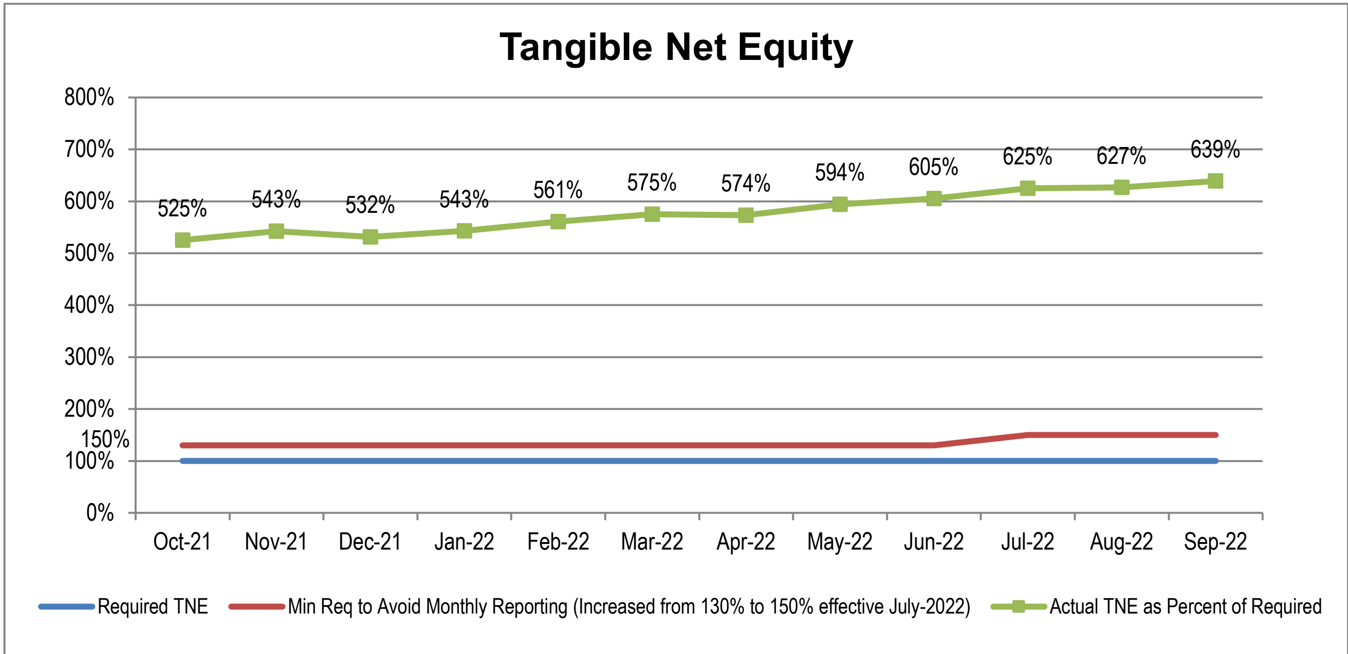
Other Income & Expense is comprised of investment income and claims interest.

- Fiscal year-to-date net investments show a gain of $930,000.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $82,000.

Tangible Net Equity (TNE)

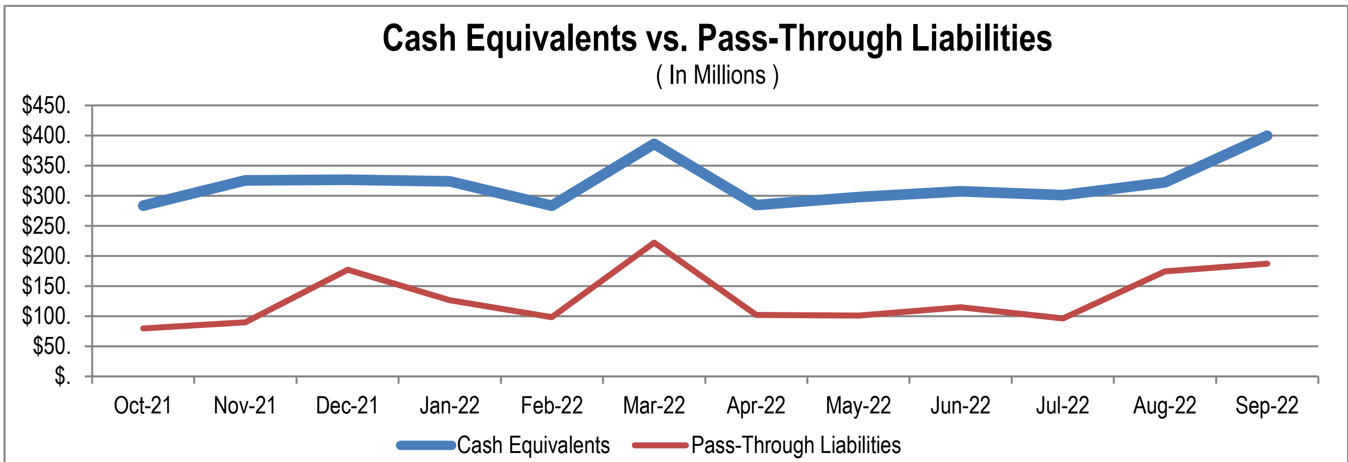
- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to consumers. TNE is a calculation of a company's total tangible assets minus the company's total liabilities. The Alliance exceeds DMHC's required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

- Required TNE $38.0 million
- Actual TNE $242.7 million
- Excess TNE $204.7 million
- TNE % of Required TNE 639%



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

- Key Metrics
  - Cash & Cash Equivalents $399.6 million
  - Pass-Through Liabilities $187.0 million
  - Uncommitted Cash $212.6 million
  - Working Capital $201.8 million
  - Current Ratio 1.57 (regulatory minimum is 1.0)



Capital Investment

- Fiscal year-to-date capital assets acquired: $24,000.
- Annual capital budget: $1.0 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 September 30, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
315,524	314,019	1,505	0.5%	1 - Medi-Cal	940,810	938,001	2,809	0.3%
5,809	5,828	(19)	(0.3%)	2 - Group Care	17,408	17,484	(76)	(0.4%)
321,333	**319,847**	**1,486**	**0.5%**	**3 - TOTAL MEMBER MONTHS**	**958,218**	**955,485**	**2,733**	**0.3%**
				REVENUE				
$100,878,054	**$102,692,237**	**($1,814,183)**	**(1.8%)**	**4 - TOTAL REVENUE**	**$302,688,156**	**$306,757,999**	**($4,069,843)**	**(1.3%)**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$23,904,711	$24,080,603	$175,892	0.7%	5 - Capitated Medical Expense	$72,112,286	$71,926,564	($185,722)	(0.3%)
				Fee for Service Medical Expenses:				
$29,766,836	$32,262,851	$2,496,015	7.7%	6 - Inpatient Hospital & SNF FFS Expense	$90,880,670	$98,405,170	$7,524,500	7.6%
$4,476,091	$4,180,746	($295,345)	(7.1%)	7 - Primary Care Physician FFS Expense	$12,898,737	$12,569,362	($329,375)	(2.6%)
$5,211,670	$5,047,632	($164,038)	(3.2%)	8 - Specialty Care Physician Expense	$15,607,002	$15,390,163	($216,839)	(1.4%)
$6,420,008	$7,170,884	$750,876	10.5%	9 - Ancillary Medical Expense	$20,104,364	$21,746,076	$1,641,712	7.5%
$8,219,712	$8,746,108	$526,396	6.0%	10 - Outpatient Medical Expense	$24,340,969	$26,790,201	$2,449,232	9.1%
$4,756,776	$5,357,812	$601,036	11.2%	11 - Emergency Expense	$14,358,739	$16,351,124	$1,992,385	12.2%
$7,774,805	$6,345,624	($1,429,181)	(22.5%)	12 - Pharmacy Expense	$20,386,786	$19,319,915	($1,066,871)	(5.5%)
$66,625,898	**$69,111,657**	**$2,485,760**	**3.6%**	**13 - Total Fee for Service Expense**	**$198,577,267**	**$210,572,011**	**$11,994,744**	**5.7%**
$1,770,314	$2,364,916	$594,602	25.1%	14 - Other Benefits & Services	$5,551,720	$8,844,651	$3,292,931	37.2%
($1,141,731)	$218,881	$1,360,612	621.6%	15 - Reinsurance Expense	($881,527)	$654,148	$1,535,675	234.8%
$91,159,192	**$95,776,057**	**$4,616,865**	**4.8%**	**17 - TOTAL MEDICAL EXPENSES**	**$275,359,746**	**$291,997,374**	**$16,637,628**	**5.7%**
9,718,863	**6,916,180**	**2,802,683**	**40.5%**	**18 - GROSS MARGIN**	**27,328,411**	**14,760,625**	**12,567,786**	**85.1%**
				ADMINISTRATIVE EXPENSES				
$3,373,774	$4,056,801	$683,027	16.8%	19 - Personnel Expense	$10,215,210	$11,657,149	$1,441,939	12.4%
$357,427	$320,356	($37,071)	(11.6%)	20 - Benefits Administration Expense	$976,843	$950,857	($25,986)	(2.7%)
$917,109	$1,492,520	$575,411	38.6%	21 - Purchased & Professional Services	$2,247,303	$4,457,776	$2,210,473	49.6%
$1,064,570	$1,324,968	$260,398	19.7%	22 - Other Administrative Expense	$2,699,402	$3,581,029	$881,627	24.6%
$5,712,880	**$7,194,645**	**$1,481,765**	**20.6%**	**23 - TOTAL ADMINISTRATIVE EXPENSE**	**$16,138,757**	**$20,646,811**	**$4,508,054**	**21.8%**
$4,005,983	**($278,465)**	**$4,284,448**	**1,538.6%**	**24 - NET OPERATING INCOME / (LOSS)**	**$11,189,653**	**($5,886,186)**	**$17,075,839**	**290.1%**
				OTHER INCOME / EXPENSE				
($10,922)	**$48,750**	**($59,672)**	**(122.4%)**	**25 - TOTAL OTHER INCOME / (EXPENSE)**	**$848,210**	**$146,250**	**$701,960**	**480%**
$3,995,061	**($229,715)**	**$4,224,776**	**1,839.1%**	**26 - NET INCOME / (LOSS)**	**$12,037,863**	**($5,739,936)**	**$17,777,799**	**309.7%**
5.7%	**7.0%**	**1.3%**	**18.6%**	**27 - Admin Exp % of Revenue**	**5.3%**	**6.7%**	**1.4%**	**20.9%**

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED September 30, 2022

	September	August	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$18,674,387	$24,597,319	($5,922,932)	-24.08%
Short-Term Investments	380,926,536	297,760,158	83,166,379	27.93%
Interest Receivable	284,688	305,785	(21,097)	-6.90%
Other Receivables - Net	139,020,422	210,740,990	(71,720,568)	-34.03%
Prepaid Expenses	5,148,160	5,822,225	(674,065)	-11.58%
Prepaid Inventoried Items	1,810	5,385	(3,575)	-66.39%
CalPERS Net Pension Asset	6,930,703	6,930,703	0	0.00%
Deferred CalPERS Outflow	3,802,239	3,802,239	0	0.00%
TOTAL CURRENT ASSETS	**$554,788,946**	**$549,964,804**	**$4,824,142**	**0.88%**
OTHER ASSETS:				
Long-Term Investments	34,449,795	37,306,236	(2,856,441)	-7.66%
Restricted Assets	350,000	350,000	0	0.00%
Lease Asset - Office Space (Net)	2,004,431	2,067,070	(62,638)	-3.03%
Lease Asset - Office Equipment (Net)	233,878	238,174	(4,296)	-1.80%
TOTAL OTHER ASSETS	**$37,038,104**	**$39,961,480**	**($2,923,376)**	**-7.32%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,113,570	10,113,570	0	0.00%
Furniture And Equipment	11,540,223	11,540,223	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally-Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	37,380,242	37,380,242	0	0.00%
Less: Accumulated Depreciation	(31,887,694)	(31,819,830)	(67,864)	0.21%
NET PROPERTY AND EQUIPMENT	**$5,492,548**	**$5,560,412**	**($67,864)**	**-1.22%**
TOTAL ASSETS	**$597,319,598**	**$595,486,695**	**$1,832,903**	**0.31%**
CURRENT LIABILITIES:				
Accounts Payable	1,469,429	769,298	700,131	91.01%
Other Accrued Expenses	443,835	903,442	(459,608)	-50.87%
Interest Payable	11,588	11,871	(282)	-2.38%
Pass-Through Liabilities	186,963,740	174,549,300	12,414,439	7.11%
Claims Payable	26,407,817	40,160,356	(13,752,539)	-34.24%
IBNP Reserves	118,673,164	118,007,599	665,565	0.56%
Payroll Liabilities	5,690,046	5,559,420	130,626	2.35%
CalPERS Deferred Inflow	6,781,898	6,781,898	0	0.00%
Risk Sharing	5,591,939	7,374,932	(1,782,993)	-24.18%
Provider Grants/ New Health Program	191,151	203,381	(12,229)	-6.01%
ST Lease Liability - Office Space	763,968	758,526	5,442	0.72%
ST Lease Liability - Office Equipment	49,191	49,027	164	0.34%
TOTAL CURRENT LIABILITIES	**$353,037,765**	**$355,129,049**	**($2,091,284)**	**-0.59%**
LONG TERM LIABILITIES:				
LT Lease Liability - Office Space	1,428,326	1,495,153	(66,827)	-4.47%
LT Lease Liability - Office Equipment	191,343	195,389	(4,046)	-2.07%
TOTAL LONG TERM LIABILITIES	**$1,619,669**	**$1,690,543**	**($70,873)**	**-4.19%**
TOTAL LIABILITIES	**$354,657,434**	**$356,819,591**	**($2,162,158)**	**-0.61%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	229,784,068	229,784,068	0	0.00%
Year-to Date Net Income / (Loss)	12,037,863	8,042,802	3,995,061	49.67%
TOTAL NET WORTH	**$242,662,164**	**$238,667,104**	**$3,995,061**	**1.67%**
TOTAL LIABILITIES AND NET WORTH	**$597,319,598**	**$595,486,695**	**$1,832,903**	**0.31%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 9/30/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$170,277,495	$354,849,298	$593,180,746	$354,849,300
Commercial Premium Revenue	2,648,781	7,951,312	14,502,502	7,951,313
Other Income	(1,597)	(9,997)	(2,610)	(9,998)
Investment Income	53,202	966,235	1,149,675	966,235
Cash Paid To:				
Medical Expenses	(106,369,115)	(263,562,033)	(529,172,960)	(263,562,033)
Vendor & Employee Expenses	(4,636,200)	(15,661,081)	(34,445,088)	(15,661,080)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	61,972,566	84,533,734	45,212,265	84,533,737
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	0	(23,992)	(211,108)	(23,992)
Net Cash Provided By (Used In) Financing Activities	0	(23,992)	(211,108)	(23,992)
Cash Flows from Investing Activities:				
Changes in Investments	2,856,441	619,055	3,537,824	619,055
Restricted Cash	12,414,440	7,061,773	(35,154,491)	7,061,773
Net Cash Provided By (Used In) Investing Activities	15,270,881	7,680,828	(31,616,667)	7,680,828
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**77,243,447**	**92,190,570**	**13,384,490**	**92,190,573**
Cash @ Beginning of Period	322,357,476	307,410,350	386,216,432	307,410,350
Subtotal	$399,600,923	$399,600,920	$399,600,922	$399,600,923
Rounding	0	3	1	0
Cash @ End of Period	**$399,600,923**	**$399,600,923**	**$399,600,923**	**$399,600,923**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$3,995,060	$12,037,865	$24,343,715	$12,037,864
Depreciation	67,863	204,675	471,619	204,675
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	71,741,666	61,334,835	11,284,092	61,334,835
Prepaid Expenses	677,640	197,225	(7,889,975)	197,225
Trade Payables	240,522	(792,494)	(1,786,160)	(792,494)
Claims payable & IBNP	(14,869,967)	10,604,891	12,498,128	10,604,892
Deferred Revenue	0	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	119,782	946,740	6,290,847	946,740
Subtotal	61,972,566	84,533,737	45,212,266	84,533,737
Rounding	0	(3)	(1)	0
Cash Flows from Operating Activities	**$61,972,566**	**$84,533,734**	**$45,212,265**	**$84,533,737**
Rounding Difference	0	(3)	(1)	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 9/30/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,648,781	$7,951,312	$14,502,502	$7,951,313
Total	2,648,781	7,951,312	14,502,502	7,951,313
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	98,229,200	294,736,554	585,515,074	294,736,556
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	0	0	0	0
Premium Receivable	72,048,295	60,112,744	7,665,672	60,112,744
Total	170,277,495	354,849,298	593,180,746	354,849,300
Investment & Other Income Cash Flows				
Other Revenue (Grants)	(1,597)	(9,997)	(2,610)	(9,998)
Investment Income	32,105	972,487	1,142,195	972,487
Interest Receivable	21,097	(6,252)	7,480	(6,252)
Total	51,605	956,238	1,147,065	956,237
Medical & Hospital Cash Flows				
Total Medical Expenses	(91,159,193)	(275,359,746)	(545,212,673)	(275,359,747)
Other Receivable	(327,726)	1,228,343	3,610,940	1,228,343
Claims Payable	(13,752,539)	6,819,095	5,427,090	6,819,095
IBNP Payable	665,565	5,568,790	9,604,032	5,568,790
Risk Share Payable	(1,782,993)	(1,782,993)	(2,532,993)	(1,782,993)
Health Program	(12,229)	(35,521)	(69,355)	(35,521)
Other Liabilities	0	(1)	(1)	0
Total	(106,369,115)	(263,562,033)	(529,172,960)	(263,562,033)
Administrative Cash Flows				
Total Administrative Expenses	(5,754,236)	(16,252,748)	(31,600,774)	(16,252,747)
Prepaid Expenses	677,640	197,225	(7,889,975)	197,225
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	240,522	(792,494)	(1,786,160)	(792,494)
Other Accrued Liabilities	(282)	(929)	11,588	(929)
Payroll Liabilities	130,626	982,611	6,154,095	982,611
Net Lease Assets/Liabilities (Short term & Long term)	1,667	579	194,519	579
Depreciation Expense	67,863	204,675	471,619	204,675
Total	(4,636,200)	(15,661,081)	(34,445,088)	(15,661,080)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**61,972,566**	**84,533,734**	**45,212,265**	**84,533,737**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 9/30/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	2,856,441	619,055	3,537,824	619,055
	2,856,441	619,055	3,537,824	619,055
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	12,414,440	7,061,773	(35,154,491)	7,061,773
Restricted Cash	0	0	0	0
	12,414,440	7,061,773	(35,154,491)	7,061,773
Fixed Asset Cash Flows				
Depreciation expense	67,863	204,675	471,619	204,675
Fixed Asset Acquisitions	0	(23,992)	(211,108)	(23,992)
Change in A/D	(67,863)	(204,675)	(471,619)	(204,675)
	0	(23,992)	(211,108)	(23,992)
Total Cash Flows from Investing Activities	**15,270,881**	**7,656,836**	**(31,827,775)**	**7,656,836**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**77,243,447**	**92,190,570**	**13,384,490**	**92,190,573**
Rounding	0	3	1	0
Cash @ Beginning of Period	322,357,476	307,410,350	386,216,432	307,410,350
Cash @ End of Period	**$399,600,923**	**$399,600,923**	**$399,600,923**	**$399,600,923**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 9/30/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$3,995,060	$12,037,865	$24,343,715	$12,037,864
Add back: Depreciation	67,863	204,675	471,619	204,675
Receivables				
Premiums Receivable	72,048,295	60,112,744	7,665,672	60,112,744
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	21,097	(6,252)	7,480	(6,252)
Other Receivable	(327,726)	1,228,343	3,610,940	1,228,343
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	71,741,666	61,334,835	11,284,092	61,334,835
Prepaid Expenses	677,640	197,225	(7,889,975)	197,225
Trade Payables	240,522	(792,494)	(1,786,160)	(792,494)
Claims Payable, IBNR & Risk Share				
IBNP	665,565	5,568,790	9,604,032	5,568,790
Claims Payable	(13,752,539)	6,819,095	5,427,090	6,819,095
Risk Share Payable	(1,782,993)	(1,782,993)	(2,532,993)	(1,782,993)
Other Liabilities	0	(1)	(1)	0
Total	(14,869,967)	10,604,891	12,498,128	10,604,892
Unearned Revenue				
Total	0	0	0	0
Other Liabilities				
Accrued Expenses	(282)	(929)	11,588	(929)
Payroll Liabilities	130,626	982,611	6,154,095	982,611
Net Lease Assets/Liabilities (Short term & Long term)	1,667	579	194,519	579
Health Program	(12,229)	(35,521)	(69,355)	(35,521)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	119,782	946,740	6,290,847	946,740
Cash Flows from Operating Activities	**$61,972,566**	**$84,533,737**	**$45,212,266**	**$84,533,737**
Difference (rounding)	0	3	1	0

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF SEPTEMBER 2022

	Child	Adult	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	101,276	48,711	28,200	115,018	22,319	315,524	5,809	321,333
Net Revenue	$12,752,785	$14,688,016	$26,253,779	$40,321,069	$4,213,625	$98,229,274	$2,648,780	$100,878,054
Medical Expense	$10,116,975	$13,961,410	$26,258,675	$35,282,513	$3,276,531	$88,896,103	$2,263,088	$91,159,192
Gross Margin	$2,635,810	$726,606	($4,895)	$5,038,556	$937,094	$9,333,171	$385,692	$9,718,863
Administrative Expense	$453,780	$781,185	$1,879,166	$2,212,049	$184,297	$5,510,477	$202,403	$5,712,880
Operating Income / (Expense)	$2,182,030	($54,579)	($1,884,062)	$2,826,507	$752,798	$3,822,694	$183,289	$4,005,983
Other Income / (Expense)	$673	$699	($3,641)	($7,655)	($1,270)	($11,194)	$272	($10,922)
Net Income / (Loss)	$2,182,703	($53,880)	($1,887,703)	$2,818,852	$751,528	$3,811,499	$183,561	$3,995,061
Revenue PMPM	$125.92	$301.53	$930.99	$350.56	$188.79	$311.32	$455.98	$313.94
Medical Expense PMPM	$99.90	$286.62	$931.16	$306.76	$146.80	$281.74	$389.58	$283.69
Gross Margin PMPM	$26.03	$14.92	($0.17)	$43.81	$41.99	$29.58	$66.40	$30.25
Administrative Expense PMPM	$4.48	$16.04	$66.64	$19.23	$8.26	$17.46	$34.84	$17.78
Operating Income / (Expense) PMPM	$21.55	($1.12)	($66.81)	$24.57	$33.73	$12.12	$31.55	$12.47
Other Income / (Expense) PMPM	$0.01	$0.01	($0.13)	($0.07)	($0.06)	($0.04)	$0.05	($0.03)
Net Income / (Loss) PMPM	$21.55	($1.11)	($66.94)	$24.51	$33.67	$12.08	$31.60	$12.43
Medical Loss Ratio	79.3%	95.1%	100.0%	87.5%	77.8%	90.5%	85.4%	90.4%
Gross Margin Ratio	20.7%	4.9%	0.0%	12.5%	22.2%	9.5%	14.6%	9.6%
Administrative Expense Ratio	3.6%	5.3%	7.2%	5.5%	4.4%	5.6%	7.6%	5.7%
Net Income Ratio	17.1%	-0.4%	-7.2%	7.0%	17.8%	3.9%	6.9%	4.0%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE - SEPTEMBER 2022

	Child	Adult	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Member Months	303,156	144,530	84,270	342,548	66,306	940,810	17,408	958,218
Net Revenue	$37,918,812	$45,072,500	$78,106,279	$121,137,569	$12,501,684	$294,736,844	$7,951,312	$302,688,156
Medical Expense	$31,445,918	$41,215,236	$80,027,692	$106,420,339	$10,130,289	$269,239,474	$6,120,272	$275,359,746
Gross Margin	$6,472,894	$3,857,264	($1,921,413)	$14,717,229	$2,371,396	$25,497,370	$1,831,040	$27,328,411
Administrative Expense	$1,304,882	$2,218,690	$5,303,152	$6,279,754	$525,616	$15,632,094	$506,663	$16,138,757
Operating Income / (Expense)	$5,168,012	$1,638,574	($7,224,565)	$8,437,475	$1,845,780	$9,865,276	$1,324,378	$11,189,653
Other Income / (Expense)	$50,042	$118,869	$296,152	$336,184	$22,697	$823,944	$24,265	$848,210
Net Income / (Loss)	$5,218,054	$1,757,443	($6,928,413)	$8,773,659	$1,868,476	$10,689,220	$1,348,643	$12,037,863
Revenue PMPM	$125.08	$311.86	$926.86	$353.64	$188.55	$313.28	$456.76	$315.89
Medical Expense PMPM	$103.73	$285.17	$949.66	$310.67	$152.78	$286.18	$351.58	$287.37
Gross Margin PMPM	$21.35	$26.69	($22.80)	$42.96	$35.76	$27.10	$105.18	$28.52
Administrative Expense PMPM	$4.30	$15.35	$62.93	$18.33	$7.93	$16.62	$29.11	$16.84
Operating Income / (Expense) PMPM	$17.05	$11.34	($85.73)	$24.63	$27.84	$10.49	$76.08	$11.68
Other Income / (Expense) PMPM	$0.17	$0.82	$3.51	$0.98	$0.34	$0.88	$1.39	$0.89
Net Income / (Loss) PMPM	$17.21	$12.16	($82.22)	$25.61	$28.18	$11.36	$77.47	$12.56
Medical Loss Ratio	82.9%	91.4%	102.5%	87.9%	81.0%	91.3%	77.0%	91.0%
Gross Margin Ratio	17.1%	8.6%	-2.5%	12.1%	19.0%	8.7%	23.0%	9.0%
Administrative Expense Ratio	3.4%	4.9%	6.8%	5.2%	4.2%	5.3%	6.4%	5.3%
Net Income Ratio	13.8%	3.9%	-8.9%	7.2%	14.9%	3.6%	17.0%	4.0%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED September 30, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$3,373,774	$4,056,801	$683,027	16.8%	Personnel Expenses	$10,215,210	$11,657,149	$1,441,939	12.4%
357,427	320,356	(37,071)	(11.6%)	Benefits Administration Expense	976,843	950,857	(25,986)	(2.7%)
917,109	1,492,520	575,411	38.6%	Purchased & Professional Services	2,247,303	4,457,776	2,210,473	49.6%
283,975	288,266	4,291	1.5%	Occupancy	770,584	825,003	54,419	6.6%
244,354	201,507	(42,847)	(21.3%)	Printing Postage & Promotion	338,530	456,586	118,056	25.9%
511,140	802,776	291,636	36.3%	Licenses Insurance & Fees	1,553,785	2,199,387	645,602	29.4%
25,101	32,419	7,318	22.6%	Supplies & Other Expenses	36,503	100,053	63,550	63.5%
$2,339,106	$3,137,844	$798,738	25.5%	Total Other Administrative Expense	$5,923,547	$8,989,662	$3,066,115	34.1%
$5,712,880	$7,194,645	$1,481,765	20.6%	Total Administrative Expenses	$16,138,757	$20,646,811	$4,508,054	21.8%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED September 30, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
2,275,162	2,389,681	114,519	4.8%	Salaries & Wages	6,760,969	6,893,541	132,572	1.9%
194,872	266,365	71,493	26.8%	Paid Time Off	812,722	760,069	(52,653)	(6.9%)
50	2,899	2,849	98.3%	Incentives	3,662	9,044	5,382	59.5%
0	23,077	23,077	100.0%	Severance Pay	0	75,000	75,000	100.0%
35,111	41,672	6,561	15.7%	Payroll Taxes	108,198	197,720	89,522	45.3%
7,485	17,945	10,460	58.3%	Overtime	74,602	51,761	(22,841)	(44.1%)
161,945	202,953	41,008	20.2%	CalPERS ER Match	509,122	584,823	75,701	12.9%
517,713	718,317	200,604	27.9%	Employee Benefits	1,618,661	2,035,337	416,676	20.5%
65	0	(65)	0.0%	Personal Floating Holiday	1,897	0	(1,897)	0.0%
2,391	16,346	13,955	85.4%	Employee Relations	28,589	73,357	44,768	61.0%
12,770	16,907	4,137	24.5%	Work from Home Stipend	28,490	47,913	19,423	40.5%
451	3,069	2,618	85.3%	Transportation Reimbursement	1,240	7,956	6,716	84.4%
3,745	18,662	14,917	79.9%	Travel & Lodging	11,791	43,519	31,728	72.9%
63,459	117,022	53,564	45.8%	Temporary Help Services	128,763	333,349	204,586	61.4%
10,385	73,602	63,217	85.9%	Staff Development/Training	22,023	178,908	156,885	87.7%
88,169	148,284	60,115	40.5%	Staff Recruitment/Advertising	104,482	364,852	260,370	71.4%
$3,373,774	**$4,056,801**	**$683,027**	**16.8%**	**Total Employee Expenses**	**$10,215,210**	**$11,657,149**	**$1,441,939**	**12.4%**
				Benefit Administration Expense				
25,066	16,415	(8,651)	(52.7%)	RX Administration Expense	40,223	42,813	2,590	6.0%
284,626	284,889	263	0.1%	Behavioral Hlth Administration Fees	851,007	851,127	120	0.0%
19,035	19,052	17	0.1%	Telemedicine Admin Fees	56,912	56,917	5	0.0%
28,700	0	(28,700)	0.0%	Housing & Homelessness Incentive Program (HHIP) Expense	28,700	0	(28,700)	0.0%
$357,427	**$320,356**	**($37,071)**	**(11.6%)**	**Total Employee Expenses**	**$976,843**	**$950,857**	**($25,986)**	**(2.7%)**
				Purchased & Professional Services				
451,269	633,498	182,229	28.8%	Consulting Services	926,615	2,118,370	1,191,755	56.3%
275,482	438,862	163,380	37.2%	Computer Support Services	821,804	1,133,601	311,797	27.5%
9,916	9,915	(1)	0.0%	Professional Fees-Accounting	29,748	29,745	(3)	0.0%
276	17	(259)	(1,522.1%)	Professional Fees-Medical	276	51	(225)	(440.7%)
39,158	155,145	115,987	74.8%	Other Purchased Services	124,775	443,256	318,481	71.9%
0	1,400	1,400	100.0%	Maint.& Repair-Office Equipment	628	4,200	3,572	85.0%
78,423	87,688	9,265	10.6%	HMS Recovery Fees	222,588	242,568	19,980	8.2%
14,982	21,194	6,212	29.3%	Hardware (Non-Capital)	23,891	63,582	39,691	62.4%
21,420	31,467	10,047	31.9%	Provider Relations-Credentialing	56,947	94,401	37,454	39.7%
26,184	113,334	87,151	76.9%	Legal Fees	40,032	328,002	287,970	87.8%
$917,109	**$1,492,520**	**$575,411**	**38.6%**	**Total Purchased & Professional Services**	**$2,247,303**	**$4,457,776**	**$2,210,473**	**49.6%**
				Occupancy				
67,864	63,650	(4,214)	(6.6%)	Depreciation	204,675	190,500	(14,175)	(7.4%)
62,225	72,717	10,492	14.4%	Building Lease	185,342	216,848	31,506	14.5%
4,567	5,916	1,349	22.8%	Leased and Rented Office Equipment	13,465	17,748	4,283	24.1%
12,294	20,393	8,099	39.7%	Utilities	38,344	54,177	15,833	29.2%
83,268	79,700	(3,568)	(4.5%)	Telephone	231,100	239,100	8,000	3.3%
53,758	45,890	(7,868)	(17.1%)	Building Maintenance	97,658	106,630	8,972	8.4%
$283,975	**$288,266**	**$4,291**	**1.5%**	**Total Occupancy**	**$770,584**	**$825,003**	**$54,419**	**6.6%**
				Printing Postage & Promotion				
59,218	68,492	9,274	13.5%	Postage	70,522	164,786	94,264	57.2%
5,280	5,501	221	4.0%	Design & Layout	14,570	17,429	2,859	16.4%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED September 30, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
144,557	65,778	(78,779)	(119.8%)	Printing Services	169,707	171,113	1,406	0.8%
16,397	2,500	(13,897)	(555.9%)	Mailing Services	22,897	7,500	(15,397)	(205.3%)
5,892	5,203	(689)	(13.2%)	Courier/Delivery Service	15,840	15,357	(483)	(3.1%)
0	2,217	2,217	100.0%	Pre-Printed Materials and Publications	0	3,951	3,951	100.0%
0	1,999	1,999	100.0%	Promotional Products	0	1,999	1,999	100.0%
0	150	150	100.0%	Promotional Services	0	450	450	100.0%
5,070	41,500	36,430	87.8%	Community Relations	16,670	49,500	32,830	66.3%
7,940	8,167	227	2.8%	Translation - Non-Clinical	28,324	24,501	(3,823)	(15.6%)
$244,354	**$201,507**	**($42,847)**	**(21.3%)**	**Total Printing Postage & Promotion**	**$338,530**	**$456,586**	**$118,056**	**25.9%**
				Licenses Insurance & Fees				
0	100,000	100,000	100.0%	Regulatory Penalties	0	100,000	100,000	100.0%
24,083	26,350	2,267	8.6%	Bank Fees	70,432	79,050	8,618	10.9%
67,775	94,366	26,591	28.2%	Insurance	222,957	283,098	60,141	21.2%
347,540	496,138	148,598	30.0%	Licenses, Permits and Fees	1,041,640	1,472,958	431,318	29.3%
71,742	85,922	14,180	16.5%	Subscriptions & Dues	218,756	264,281	45,525	17.2%
$511,140	**$802,776**	**$291,636**	**36.3%**	**Total Licenses Insurance & Postage**	**$1,553,785**	**$2,199,387**	**$645,602**	**29.4%**
				Supplies & Other Expenses				
1,175	3,852	2,677	69.5%	Office and Other Supplies	5,839	30,770	24,931	81.0%
17,432	4,000	(13,432)	(335.8%)	Ergonomic Supplies	20,874	12,099	(8,775)	(72.5%)
1,453	5,153	3,700	71.8%	Commissary-Food & Beverage	3,287	19,022	15,735	82.7%
4,850	10,000	5,150	51.5%	Member Incentive Expense	4,850	10,300	5,450	52.9%
191	4,167	3,976	95.4%	Covid-19 Vaccination Incentive Expense	266	12,501	12,235	97.9%
0	100	100	100.0%	Covid-19 IT Expenses	0	300	300	100.0%
0	5,147	5,147	100.0%	Covid-19 Non IT Expenses	1,386	15,061	13,675	90.8%
$25,101	**$32,419**	**$7,318**	**22.6%**	**Total Supplies & Other Expense**	**$36,503**	**$100,053**	**$63,550**	**63.5%**
$5,712,880	**$7,194,645**	**$1,481,765**	**20.6%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$16,138,757**	**$20,646,811**	**$4,508,054**	**21.8%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED SEPTEMBER 30, 2022

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco UCS Blade	IT-FY23-01	$ -	$ -	**$ -**	$ 100,000	$ 100,000
	Veeam Backup Shelf	IT-FY23-02	$ -		**$ -**	$ 70,000	$ 70,000
	Cisco Nexus 9k	IT-FY23-03	$ -		**$ -**	$ 60,000	$ 60,000
	Pure Storage Shelf	IT-FY23-04	$ -		**$ -**	$ 70,000	$ 70,000
	Call Center Hardware	IT-FY23-05	$ -		**$ -**	$ 60,000	$ 60,000
	FAX DMG	IT-FY23-06	$ -		**$ -**	$ 80,000	$ 80,000
	Wireless)	IT-FY23-07	$ -		**$ -**	$ 60,000	$ 60,000
	Network / AV Cabling	IT-FY23-08	$ -		**$ -**	$ 60,000	$ 60,000
Hardware Subtotal			**$ -**	**$ -**	**$ -**	**$ 560,000**	**$ 560,000**
2. Software:							
	Zerto	AC-FY23-01	$ -		**$ -**	$ 80,000	$ 80,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 80,000**	**$ 80,000**
3. Building Improvement:							
	ADT (ACME) Security: Readers, HID Boxes, Doors - Planned/Unplanned requirements or repairs	FA-FY23-01	**$ -**	$ -	**$ -**	$ 50,000	$ 50,000
	HVAC (Clinton): Replace VAV boxes, equipment, duct work - Planned/Unplanned requirements or repairs	FA-FY23-02	$ -	$ -	**$ -**	$ 50,000	$ 50,000
	EV Charging Stations: Equipment, Electrical, Design, Engineering, Permits, Construction	FA-FY23-03	$ -	$ -	**$ -**	$ 100,000	$ 100,000
	Seismic Improvements (Carryover from FY22)	FA-FY23-07	$ 23,992	$ -	**$ 23,992**	$ 38,992	$ 15,000
	Contingencies	FA-FY23-16	**$ -**	$ -	**$ -**	$ 100,000	$ 100,000
Building Improvement Subtotal			**$ 23,992**	**$ -**	**$ 23,992**	**$ 338,992**	**$ 315,000**
4. Furniture & Equipment:							
			$ -		**$ -**	$ -	$ -
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
GRAND TOTAL			**$ 23,992**	**$ -**	**$ 23,992**	**$ 978,992**	**$ 955,000**
5. Reconciliation to Balance Sheet:							
	Fixed Assets @ Cost - 9/30/22				**$ 37,380,242**		
	Fixed Assets @ Cost - 6/30/22				**$ 37,356,250**		
	Fixed Assets Acquired YTD				**$ 23,992**		

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2023

TANGIBLE NET EQUITY (TNE)

	Jul-22	Aug-22	QTR. END Sep-22
Current Month Net Income / (Loss)	$5,704,828	$2,337,974	$3,995,061
YTD Net Income / (Loss)	$5,704,828	$8,042,802	$12,037,863
Actual TNE			
Net Assets	$236,329,129	$238,667,103	$242,662,164
Subordinated Debt & Interest	$0	$0	$0
Total Actual TNE	**$236,329,129**	**$238,667,103**	**$242,662,164**
Increase/(Decrease) in Actual TNE	$5,704,827	$2,337,974	$12,037,862
Required TNE[1]	**$37,812,719**	**$38,083,218**	**$37,973,977**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$56,719,078	$57,124,827	$56,960,965
TNE Excess / (Deficiency)	$198,516,410	$200,583,885	$204,688,187
Actual TNE as a Multiple of Required	**6.25**	**6.27**	**6.39**

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

LIQUID TANGIBLE NET EQUITY

	Jul-22	Aug-22	Sep-22
Net Assets	$236,329,129	$238,667,103	$242,662,164
Fixed Assets at Net Book Value	(5,604,558)	(5,560,412)	(5,492,549)
Net Lease Assets/Liabilities/Interest	106,376	204,722	206,107
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$230,480,947**	**$232,961,413**	**$236,819,615**
Liquid TNE as Multiple of Required	**6.10**	**6.12**	**6.24**

REPORT #8

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2023

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

	Actual Jul-22	Actual Aug-22	Actual Sep-22	Actual Oct-22	Actual Nov-22	Actual Dec-22	Actual Jan-23	Actual Feb-23	Actual Mar-23	Actual Apr-23	Actual May-23	Actual Jun-23	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	100,903	100,977	101,276										303,156
Adult	47,707	48,112	48,711										144,530
SPD	27,991	28,079	28,200										84,270
ACA OE	113,322	114,208	115,018										342,548
Duals	21,910	22,077	22,319										66,306
MCAL LTC	0	0	0										0
MCAL LTC Duals	0	0	0										0
Medi-Cal Program	311,833	313,453	315,524										940,810
Group Care Program	5,796	5,803	5,809										17,408
Total	**317,629**	**319,256**	**321,333**										**958,218**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	131	74	299										504
Adult	946	405	599										1,950
SPD	886	88	121										1,095
ACA OE	2,384	886	810										4,080
Duals	225	167	242										634
MCAL LTC	0	0	0										0
MCAL LTC Duals	0	0	0										0
Medi-Cal Program	4,572	1,620	2,071										8,263
Group Care Program	1	7	6										14
Total	**4,573**	**1,627**	**2,077**										**8,277**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	32.4%	32.2%	32.1%										32.2%
Adult % of Medi-Cal	15.3%	15.3%	15.4%										15.4%
SPD % of Medi-Cal	9.0%	9.0%	8.9%										9.0%
ACA OE % of Medi-Cal	36.3%	36.4%	36.5%										36.4%
Duals % of Medi-Cal	7.0%	7.0%	7.1%										7.0%
Medi-Cal Program % of Total	98.2%	98.2%	98.2%										98.2%
Group Care Program % of Total	1.8%	1.8%	1.8%										1.8%
Total	**100.0%**	**100.0%**	**100.0%**										**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2023

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

	Actual Jul-22	Actual Aug-22	Actual Sep-22	Actual Oct-22	Actual Nov-22	Actual Dec-22	Actual Jan-23	Actual Feb-23	Actual Mar-23	Actual Apr-23	Actual May-23	Actual Jun-23	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	54,340	52,198	52,418										158,956
Alameda Health System	62,784	63,910	64,424										191,118
	117,124	116,108	116,842										350,074
Delegated:													
CFMG	33,466	33,594	33,577										100,637
CHCN	119,514	121,703	122,696										363,913
Kaiser	47,525	47,851	48,218										143,594
Delegated Subtotal	200,505	203,148	204,491										608,144
Total	**317,629**	**319,256**	**321,333**										**958,218**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	2,973	(1,016)	734										2,691
Delegated:													
CFMG	58	128	(17)										169
CHCN	1,103	2,189	993										4,285
Kaiser	439	326	367										1,132
Delegated Subtotal	1,600	2,643	1,343										5,586
Total	**4,573**	**1,627**	**2,077**										**8,277**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	36.9%	36.4%	36.4%										36.5%
Delegated:													
CFMG	10.5%	10.5%	10.4%										10.5%
CHCN	37.6%	38.1%	38.2%										38.0%
Kaiser	15.0%	15.0%	15.0%										15.0%
Delegated Subtotal	63.1%	63.6%	63.6%										63.5%
Total	**100.0%**	**100.0%**	**100.0%**										**100.0%**

REPORT #9

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2023

	Budget Jul-22	Budget Aug-22	Budget Sep-22	Budget Oct-22	Budget Nov-22	Budget Dec-22	Budget Jan-23	Budget Feb-23	Budget Mar-23	Budget Apr-23	Budget May-23	Budget Jun-23	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program by Category of Aid:													
Child	101,120	101,423	101,727	101,930	102,134	102,338	101,787	101,043	100,298	99,552	98,806	98,059	1,210,217
Adult	46,703	47,030	47,359	47,501	47,644	47,787	46,980	45,856	44,731	43,605	42,478	41,349	549,023
SPD	28,283	28,368	28,453	28,510	28,567	28,624	29,006	28,941	28,876	28,811	28,746	28,681	343,866
ACA OE	113,561	114,129	114,700	115,044	115,389	115,735	114,009	111,510	109,009	106,505	103,999	101,490	1,335,080
Duals	21,650	21,715	21,780	21,824	21,868	21,912	21,781	21,488	21,194	20,900	20,606	20,312	257,030
MCAL LTC	0	0	0	0	0	0	300	300	300	300	300	300	1,800
MCAL LTC Duals	0	0	0	0	0	0	1,200	1,200	1,200	1,200	1,200	1,200	7,200
Medi-Cal Program	311,317	312,665	314,019	314,809	315,602	316,396	315,063	310,338	305,608	300,873	296,135	291,391	3,704,216
Group Care Program	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	5,828	69,936
Total	**317,145**	**318,493**	**319,847**	**320,637**	**321,430**	**322,224**	**320,891**	**316,166**	**311,436**	**306,701**	**301,963**	**297,219**	**3,774,152**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	6,309	303	304	203	204	204	(551)	(744)	(745)	(746)	(746)	(747)	3,248
Adult	5,627	327	329	142	143	143	(807)	(1,124)	(1,125)	(1,126)	(1,127)	(1,129)	273
SPD	1,538	85	85	57	57	57	382	(65)	(65)	(65)	(65)	(65)	1,936
ACA OE	10,125	568	571	344	345	346	(1,726)	(2,499)	(2,501)	(2,504)	(2,506)	(2,509)	(1,946)
Duals	1,874	65	65	44	44	44	(131)	(293)	(294)	(294)	(294)	(294)	536
MCAL LTC	0	0	0	0	0	0	300	0	0	0	0	0	300
MCAL LTC Duals	0	0	0	0	0	0	1,200	0	0	0	0	0	1,200
Medi-Cal Program	25,473	1,348	1,354	790	793	794	(1,333)	(4,725)	(4,730)	(4,735)	(4,738)	(4,744)	5,547
Group Care Program	(24)	0	0	0	0	0	0	0	0	0	0	0	(24)
Total	**25,449**	**1,348**	**1,354**	**790**	**793**	**794**	**(1,333)**	**(4,725)**	**(4,730)**	**(4,735)**	**(4,738)**	**(4,744)**	**5,523**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	32.5%	32.4%	32.4%	32.4%	32.4%	32.3%	32.3%	32.6%	32.8%	33.1%	33.4%	33.7%	32.7%
Adult % (Medi-Cal)	15.0%	15.0%	15.1%	15.1%	15.1%	15.1%	14.9%	14.8%	14.6%	14.5%	14.3%	14.2%	14.8%
SPD % (Medi-Cal)	9.1%	9.1%	9.1%	9.1%	9.1%	9.0%	9.2%	9.3%	9.4%	9.6%	9.7%	9.8%	9.3%
ACA OE % (Medi-Cal)	36.5%	36.5%	36.5%	36.5%	36.6%	36.6%	36.2%	35.9%	35.7%	35.4%	35.1%	34.8%	36.0%
Duals % (Medi-Cal)	7.0%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	7.0%	7.0%	6.9%
MCAL LTC % (Medi-Cal)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%
MCAL LTC Duals % (Medi-Cal)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.2%
Medi-Cal Program % of Total	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	98.1%	98.1%	98.1%	98.0%	98.1%
Group Care Program % of Total	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.9%	1.9%	1.9%	2.0%	1.9%
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 2023

	Budget Jul-22	Budget Aug-22	Budget Sep-22	Budget Oct-22	Budget Nov-22	Budget Dec-22	Budget Jan-23	Budget Feb-23	Budget Mar-23	Budget Apr-23	Budget May-23	Budget Jun-23	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted	116,747	117,272	117,799	118,102	118,406	118,710	118,871	116,928	114,985	113,037	111,088	109,138	1,391,083
Delegated:													
CFMG	33,731	33,837	33,943	34,013	34,083	34,153	33,970	33,696	33,422	33,148	32,874	32,599	403,469
CHCN	119,411	119,921	120,435	120,733	121,033	121,334	120,278	118,487	116,693	114,899	113,103	111,305	1,417,632
Kaiser	47,256	47,463	47,670	47,789	47,908	48,027	47,772	47,055	46,336	45,617	44,898	44,177	561,968
Delegated Subtotal	200,398	201,221	202,048	202,535	203,024	203,514	202,020	199,238	196,451	193,664	190,875	188,081	2,383,069
Total	**317,145**	**318,493**	**319,847**	**320,637**	**321,430**	**322,224**	**320,891**	**316,166**	**311,436**	**306,701**	**301,963**	**297,219**	**3,774,152**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	5,641	525	527	303	304	304	161	(1,943)	(1,943)	(1,948)	(1,949)	(1,950)	(1,968)
Delegated:													
CFMG	2,323	106	106	70	70	70	(183)	(274)	(274)	(274)	(274)	(275)	1,191
CHCN	13,180	510	514	298	300	301	(1,056)	(1,791)	(1,794)	(1,794)	(1,796)	(1,798)	5,074
Kaiser	4,305	207	207	119	119	119	(255)	(717)	(719)	(719)	(719)	(721)	1,226
Delegated Subtotal	19,808	823	827	487	489	490	(1,494)	(2,782)	(2,787)	(2,787)	(2,789)	(2,794)	7,491
Total	**25,449**	**1,348**	**1,354**	**790**	**793**	**794**	**(1,333)**	**(4,725)**	**(4,730)**	**(4,735)**	**(4,738)**	**(4,744)**	**5,523**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	36.8%	36.8%	36.8%	36.8%	36.8%	36.8%	37.0%	37.0%	36.9%	36.9%	36.8%	36.7%	36.9%
Delegated:													
CFMG	10.6%	10.6%	10.6%	10.6%	10.6%	10.6%	10.6%	10.7%	10.7%	10.8%	10.9%	11.0%	10.7%
CHCN	37.7%	37.7%	37.7%	37.7%	37.7%	37.7%	37.5%	37.5%	37.5%	37.5%	37.5%	37.4%	37.6%
Kaiser	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%
Delegated Subtotal	63.2%	63.2%	63.2%	63.2%	63.2%	63.2%	63.0%	63.0%	63.1%	63.1%	63.2%	63.3%	63.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

REPORT #9

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2023

	Variance Jul-22	Variance Aug-22	Variance Sep-22	Variance Oct-22	Variance Nov-22	Variance Dec-22	Variance Jan-23	Variance Feb-23	Variance Mar-23	Variance Apr-23	Variance May-23	Variance Jun-23	Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	(217)	(446)	(451)										(1,114)
Adult	1,004	1,082	1,352										3,438
SPD	(292)	(289)	(253)										(834)
ACA OE	(239)	79	318										158
Duals	260	362	539										1,161
MCAL LTC	0	0	0										0
MCAL LTC Duals	0	0	0										0
Medi-Cal Program	516	788	1,505										2,809
Group Care Program	(32)	(25)	(19)										(76)
Total	**484**	**763**	**1,486**										**2,733**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	377	(1,164)	(957)										(1,744)
Delegated:													
CFMG	(265)	(243)	(366)										(874)
CHCN	103	1,782	2,261										4,146
Kaiser	269	388	548										1,205
Delegated Subtotal	107	1,927	2,443										4,477
Total	**484**	**763**	**1,486**										**2,733**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED September 30, 2022

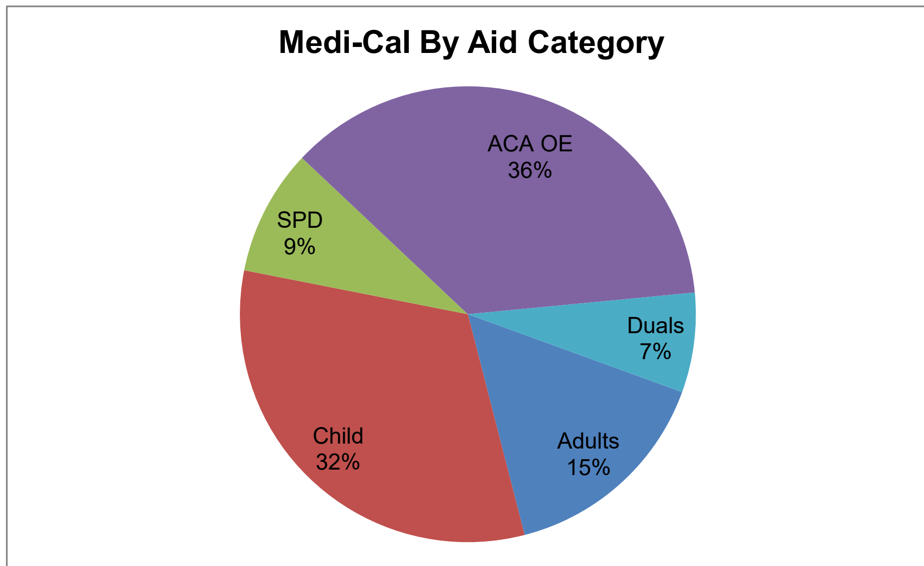
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	**Budget**	**$ Variance (Unfavorable)**	**% Variance (Unfavorable)**	**Account Description**	**Actual**	**Budget**	**$ Variance (Unfavorable)**	**% Variance (Unfavorable)**
				CAPITATED MEDICAL EXPENSES:				
$1,133,424	$1,986,456	$853,032	42.9%	PCP-Capitation	$3,406,175	$5,937,708	$2,531,533	42.6%
4,247,609	3,372,084	(875,525)	(26.0%)	PCP-Capitation - FQHC	12,612,826	10,074,102	(2,538,724)	(25.2%)
290,606	295,039	4,433	1.5%	Specialty-Capitation	873,449	882,348	8,899	1.0%
3,592,489	3,549,125	(43,364)	(1.2%)	Specialty-Capitation FQHC	10,629,119	10,600,193	(28,926)	(0.3%)
433,639	394,212	(39,427)	(10.0%)	Laboratory-Capitation	1,299,291	1,177,835	(121,456)	(10.3%)
962,682	959,541	(3,141)	(0.3%)	Transportation (Ambulance)-Cap	2,876,457	2,866,455	(10,002)	(0.3%)
232,318	232,486	168	0.1%	Vision Cap	695,083	694,591	(492)	(0.1%)
84,627	85,987	1,360	1.6%	CFMG Capitation	254,360	257,152	2,792	1.1%
179,691	177,694	(1,997)	(1.1%)	Anc IPA Admin Capitation FQHC	532,454	530,790	(1,664)	(0.3%)
11,115,977	11,066,863	(49,114)	(0.4%)	Kaiser Capitation	33,107,163	33,046,451	(60,712)	(0.2%)
1,004,731	794,227	(210,504)	(26.5%)	BHT Supplemental Expense	2,855,572	2,375,368	(480,204)	(20.2%)
44,866	546,711	501,845	91.8%	Maternity Supplemental Expense	1,230,283	1,629,242	398,959	24.5%
582,053	620,178	38,126	6.1%	DME - Cap	1,740,055	1,854,329	114,274	6.2%
$23,904,711	**$24,080,603**	**$175,892**	**0.7%**	**5-TOTAL CAPITATED EXPENSES**	**$72,112,286**	**$71,926,564**	**($185,722)**	**(0.3%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
(2,065,105)	0	2,065,105	0.0%	IBNP-Inpatient Services	3,373,574	0	(3,373,574)	0.0%
(61,954)	0	61,954	0.0%	IBNP-Settlement (IP)	101,207	0	(101,207)	0.0%
(165,207)	0	165,207	0.0%	IBNP-Claims Fluctuation (IP)	269,885	0	(269,885)	0.0%
28,897,282	30,926,081	2,028,799	6.6%	Inpatient Hospitalization-FFS	78,072,379	94,332,175	16,259,796	17.2%
1,501,141	0	(1,501,141)	0.0%	IP OB - Mom & NB	3,778,219	0	(3,778,219)	0.0%
81,503	0	(81,503)	0.0%	IP Behavioral Health	648,796	0	(648,796)	0.0%
751,611	1,336,770	585,159	43.8%	IP - Long Term Care	2,733,721	4,072,995	1,339,274	32.9%
827,564	0	(827,564)	0.0%	IP - Facility Rehab FFS	1,902,890	0	(1,902,890)	0.0%
$29,766,836	**$32,262,851**	**$2,496,015**	**7.7%**	**6-Inpatient Hospital & SNF FFS Expense**	**$90,880,670**	**$98,405,170**	**$7,524,500**	**7.6%**
12,032	0	(12,032)	0.0%	IBNP-PCP	16,938	0	(16,938)	0.0%
362	0	(362)	0.0%	IBNP-Settlement (PCP)	510	0	(510)	0.0%
962	0	(962)	0.0%	IBNP-Claims Fluctuation (PCP)	1,355	0	(1,355)	0.0%
1,437,927	1,270,088	(167,839)	(13.2%)	Primary Care Non-Contracted FF	3,983,604	3,873,987	(109,617)	(2.8%)
155,273	63,862	(91,411)	(143.1%)	PCP FQHC FFS	318,778	194,651	(124,127)	(63.8%)
1,986,504	2,846,796	860,292	30.2%	Prop 56 Direct Payment Expenses	5,940,264	8,500,724	2,560,460	30.1%
14,307	0	(14,307)	0.0%	Prop 56 Hyde Direct Payment Expenses	42,690	0	(42,690)	0.0%
77,687	0	(77,687)	0.0%	Prop 56-Trauma Expense	232,641	0	(232,641)	0.0%
99,112	0	(99,112)	0.0%	Prop 56-Dev. Screening Exp.	297,095	0	(297,095)	0.0%
692,618	0	(692,618)	0.0%	Prop 56-Fam. Planning Exp.	2,067,033	0	(2,067,033)	0.0%
(693)	0	693	0.0%	Prop 56-Value Based Purchasing	(2,171)	0	2,171	0.0%
$4,476,091	**$4,180,746**	**($295,345)**	**(7.1%)**	**7-Primary Care Physician FFS Expense**	**$12,898,737**	**$12,569,362**	**($329,375)**	**(2.6%)**
874,075	0	(874,075)	0.0%	IBNP-Specialist	635,066	0	(635,066)	0.0%
2,062,197	5,039,325	2,977,128	59.1%	Specialty Care-FFS	7,694,486	15,364,797	7,670,311	49.9%
142,508	0	(142,508)	0.0%	Anesthesiology - FFS	411,893	0	(411,893)	0.0%
704,682	0	(704,682)	0.0%	Spec Rad Therapy - FFS	2,519,068	0	(2,519,068)	0.0%
38,556	0	(38,556)	0.0%	Obstetrics-FFS	257,811	0	(257,811)	0.0%
301,595	0	(301,595)	0.0%	Spec IP Surgery - FFS	1,047,048	0	(1,047,048)	0.0%
602,702	0	(602,702)	0.0%	Spec OP Surgery - FFS	1,732,712	0	(1,732,712)	0.0%
337,856	0	(337,856)	0.0%	Spec IP Physician	1,085,833	0	(1,085,833)	0.0%
51,350	8,307	(43,043)	(518.2%)	SCP FQHC FFS	153,231	25,366	(127,865)	(504.1%)
26,223	0	(26,223)	0.0%	IBNP-Settlement (SCP)	19,050	0	(19,050)	0.0%
69,925	0	(69,925)	0.0%	IBNP-Claims Fluctuation (SCP)	50,803	0	(50,803)	0.0%
$5,211,670	**$5,047,632**	**($164,038)**	**(3.2%)**	**8-Specialty Care Physician Expense**	**$15,607,002**	**$15,390,163**	**($216,839)**	**(1.4%)**
364,607	0	(364,607)	0.0%	IBNP-Ancillary	432,076	0	(432,076)	0.0%
10,937	0	(10,937)	0.0%	IBNP Settlement (ANC)	12,961	0	(12,961)	0.0%
29,167	0	(29,167)	0.0%	IBNP Claims Fluctuation (ANC)	34,564	0	(34,564)	0.0%
267,427	0	(267,427)	0.0%	Acupuncture/Biofeedback	964,938	0	(964,938)	0.0%
114,410	0	(114,410)	0.0%	Hearing Devices	378,675	0	(378,675)	0.0%
35,514	0	(35,514)	0.0%	Imaging/MRI/CT Global	115,665	0	(115,665)	0.0%
51,015	0	(51,015)	0.0%	Vision FFS	136,538	0	(136,538)	0.0%
5,936	0	(5,936)	0.0%	Family Planning	47,101	0	(47,101)	0.0%
502,627	0	(502,627)	0.0%	Laboratory-FFS	2,251,468	0	(2,251,468)	0.0%
94,180	0	(94,180)	0.0%	ANC Therapist	326,166	0	(326,166)	0.0%
585,196	0	(585,196)	0.0%	Transportation (Ambulance)-FFS	1,634,771	0	(1,634,771)	0.0%
253,927	0	(253,927)	0.0%	Transportation (Other)-FFS	423,490	0	(423,490)	0.0%
416,481	0	(416,481)	0.0%	Hospice	1,192,991	0	(1,192,991)	0.0%
965,011	0	(965,011)	0.0%	Home Health Services	2,153,571	0	(2,153,571)	0.0%
1	4,171,925	4,171,924	100.0%	Other Medical-FFS	3	12,757,786	12,757,783	100.0%
44,728	0	(44,728)	0.0%	HMS Medical Refunds	74,025	0	(74,025)	0.0%
0	0	0	0.0%	Refunds-Medical Payments	(69)	0	69	0.0%
110,616	0	(110,616)	0.0%	DME & Medical Supplies	1,128,908	0	(1,128,908)	0.0%
0	658,464	658,464	100.0%	GEMT Direct Payment Expense	0	1,966,805	1,966,805	100.0%
47,392	0	(47,392)	0.0%	Community Based Adult Services (CBAS)	1,242,944	0	(1,242,944)	0.0%
898,158	705,592	(192,566)	(27.3%)	ECM Base FFS Ancillary	2,681,321	2,116,776	(564,545)	(26.7%)

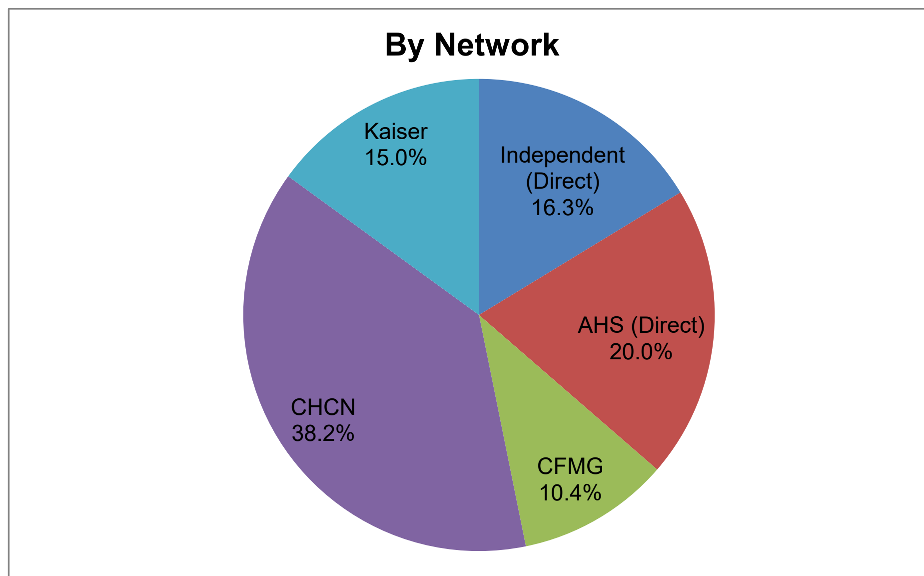
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED September 30, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,650	5,227	3,577	68.4%	ECM Outreach FFS Ancillary	4,540	15,681	11,141	71.0%
328,055	328,054	(1)	0.0%	CS - Housing Deposits FFS Ancillary	984,164	984,162	(2)	0.0%
580,032	580,031	(1)	0.0%	CS - Housing Tenancy FFS Ancillary	1,740,095	1,740,093	(2)	0.0%
220,282	220,281	(1)	0.0%	CS - Housing Navigation Services FFS Ancillary	660,846	660,843	(3)	0.0%
325,580	325,580	0	0.0%	CS - Medical Respite FFS Ancillary	976,740	976,740	0	0.0%
128,573	128,572	(1)	0.0%	CS - Medically Tailored Meals FFS Ancillary	385,719	385,716	(3)	0.0%
37,159	37,159	0	0.0%	CS - Asthma Remediation FFS Ancillary	111,478	111,477	(1)	0.0%
1,350	9,999	8,649	86.5%	MOT- Wrap Around (Non Medical MOT Cost)	8,674	29,997	21,323	71.1%
$6,420,008	**$7,170,884**	**$750,876**	**10.5%**	**9-Ancillary Medical Expense**	**$20,104,364**	**$21,746,076**	**$1,641,712**	**7.5%**
329,531	0	(329,531)	0.0%	IBNP-Outpatient	225,890	0	(225,890)	0.0%
9,886	0	(9,886)	0.0%	IBNP Settlement (OP)	6,777	0	(6,777)	0.0%
26,363	0	(26,363)	0.0%	IBNP Claims Fluctuation (OP)	18,072	0	(18,072)	0.0%
1,318,962	8,746,108	7,427,146	84.9%	Out-Patient FFS	3,920,971	26,790,201	22,869,230	85.4%
1,725,558	0	(1,725,558)	0.0%	OP Ambul Surgery - FFS	4,934,537	0	(4,934,537)	0.0%
1,046,500	0	(1,046,500)	0.0%	OP Fac Imaging Services-FFS	2,900,914	0	(2,900,914)	0.0%
721,240	0	(721,240)	0.0%	Behav Health - FFS	2,179,994	0	(2,179,994)	0.0%
1,049,072	0	(1,049,072)	0.0%	Behavioral Health Therapy - FFS	3,225,668	0	(3,225,668)	0.0%
457,717	0	(457,717)	0.0%	OP Facility - Lab FFS	1,523,131	0	(1,523,131)	0.0%
104,361	0	(104,361)	0.0%	OP Facility - Cardio FFS	312,059	0	(312,059)	0.0%
47,603	0	(47,603)	0.0%	OP Facility - PT/OT/ST FFS	136,666	0	(136,666)	0.0%
1,382,920	0	(1,382,920)	0.0%	OP Facility - Dialysis FFS	4,956,290	0	(4,956,290)	0.0%
$8,219,712	**$8,746,108**	**$526,396**	**6.0%**	**10-Outpatient Medical Expense Medical Expense**	**$24,340,969**	**$26,790,201**	**$2,449,232**	**9.1%**
514,372	0	(514,372)	0.0%	IBNP-Emergency	388,869	0	(388,869)	0.0%
15,431	0	(15,431)	0.0%	IBNP Settlement (ER)	11,663	0	(11,663)	0.0%
41,150	0	(41,150)	0.0%	IBNP Claims Fluctuation (ER)	31,110	0	(31,110)	0.0%
603,543	0	(603,543)	0.0%	Special ER Physician-FFS	1,924,506	0	(1,924,506)	0.0%
3,582,280	5,357,812	1,775,532	33.1%	ER-Facility	12,002,591	16,351,124	4,348,533	26.6%
$4,756,776	**$5,357,812**	**$601,036**	**11.2%**	**11-Emergency Expense**	**$14,358,739**	**$16,351,124**	**$1,992,385**	**12.2%**
570,097	0	(570,097)	0.0%	IBNP-Pharmacy	(55,477)	0	55,477	0.0%
17,103	0	(17,103)	0.0%	IBNP Settlement (RX)	(1,663)	0	1,663	0.0%
45,608	0	(45,608)	0.0%	IBNP Claims Fluctuation (RX)	(4,440)	0	4,440	0.0%
469,727	364,988	(104,739)	(28.7%)	Pharmacy-FFS	1,340,934	1,101,451	(239,483)	(21.7%)
1,002,699	5,969,207	4,966,508	83.2%	Pharmacy- Non-PBM FFS-Other Anc	13,453,361	18,194,274	4,740,913	26.1%
4,127,072	0	(4,127,072)	0.0%	Pharmacy- Non-PBM FFS-OP FAC	4,127,072	0	(4,127,072)	0.0%
117,546	0	(117,546)	0.0%	Pharmacy- Non-PBM FFS-PCP	117,546	0	(117,546)	0.0%
1,449,900	0	(1,449,900)	0.0%	Pharmacy- Non-PBM FFS-SCP	1,449,900	0	(1,449,900)	0.0%
4,146	0	(4,146)	0.0%	Pharmacy- Non-PBM FFS-FQHC	4,146	0	(4,146)	0.0%
14,766	0	(14,766)	0.0%	Pharmacy- Non-PBM FFS-HH	14,766	0	(14,766)	0.0%
(43,860)	0	43,860	0.0%	HMS RX Refunds	(59,360)	0	59,360	0.0%
0	11,429	11,429	100.0%	Pharmacy-Rebate	0	24,190	24,190	100.0%
$7,774,805	**$6,345,624**	**($1,429,181)**	**(22.5%)**	**12-Pharmacy Expense**	**$20,386,786**	**$19,319,915**	**($1,066,871)**	**(5.5%)**
$66,625,898	**$69,111,657**	**$2,485,760**	**3.6%**	**13-TOTAL FFS MEDICAL EXPENSES**	**$198,577,267**	**$210,572,011**	**$11,994,744**	**5.7%**
0	(402,261)	(402,261)	100.0%	Clinical Vacancy	0	(900,406)	(900,406)	100.0%
22,621	120,296	97,675	81.2%	Quality Analytics	214,364	361,826	147,462	40.8%
452,337	595,688	143,351	24.1%	Health Plan Services Department Total	1,344,381	1,613,009	268,628	16.7%
357,510	477,330	119,820	25.1%	Case & Disease Management Department Total	1,069,307	1,381,463	312,156	22.6%
252,434	289,381	36,947	12.8%	Medical Services Department Total	960,021	2,878,558	1,918,537	66.6%
383,410	823,331	439,921	53.4%	Quality Management Department Total	1,207,669	2,233,692	1,026,023	45.9%
147,606	182,844	35,238	19.3%	HCS Behavioral Health Department Total	301,088	500,623	199,535	39.9%
134,001	152,551	18,550	12.2%	Pharmacy Services Department Total	394,179	428,212	34,033	7.9%
20,395	125,756	105,361	83.8%	Regulatory Readiness Total	60,713	347,674	286,961	82.5%
$1,770,314	**$2,364,916**	**$594,602**	**25.1%**	**14-Other Benefits & Services**	**$5,551,720**	**$8,844,651**	**$3,292,931**	**37.2%**
				Reinsurance Expense				
(1,953,078)	(656,640)	1,296,438	(197.4%)	Reinsurance Recoveries	(3,302,611)	(1,962,444)	1,340,167	(68.3%)
811,346	875,521	64,175	7.3%	Stop-Loss Expense	2,421,084	2,616,592	195,508	7.5%
($1,141,731)	**$218,881**	**$1,360,612**	**621.6%**	**15-Reinsurance Expense**	**($881,527)**	**$654,148**	**$1,535,675**	**234.8%**
$91,159,192	**$95,776,057**	**$4,616,865**	**4.8%**	**17-TOTAL MEDICAL EXPENSES**	**$275,359,746**	**$291,997,374**	**$16,637,628**	**5.7%**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**Sep 2022**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	48,711	15%	9,318	9,715	835	19,929	8,914
Child	101,276	32%	7,483	9,279	30,528	35,326	18,660
SPD	28,200	9%	8,420	4,465	1,007	12,185	2,123
ACA OE	115,018	36%	16,543	37,625	1,205	44,573	15,072
Duals	22,319	7%	8,328	2,465	2	8,075	3,449
Medi-Cal	315,524		50,092	63,549	33,577	120,088	48,218
Group Care	5,809		2,326	875	-	2,608	-
Total	**321,333**	**100%**	**52,418**	**64,424**	**33,577**	**122,696**	**48,218**
Medi-Cal %	98.2%		95.6%	98.6%	100.0%	97.9%	100.0%
Group Care %	1.8%		4.4%	1.4%	0.0%	2.1%	0.0%
		Network Distribution	*16.3%*	*20.0%*	*10.4%*	*38.2%*	*15.0%*
			% Direct:	**36%**		**% Delegated:**	**64%**

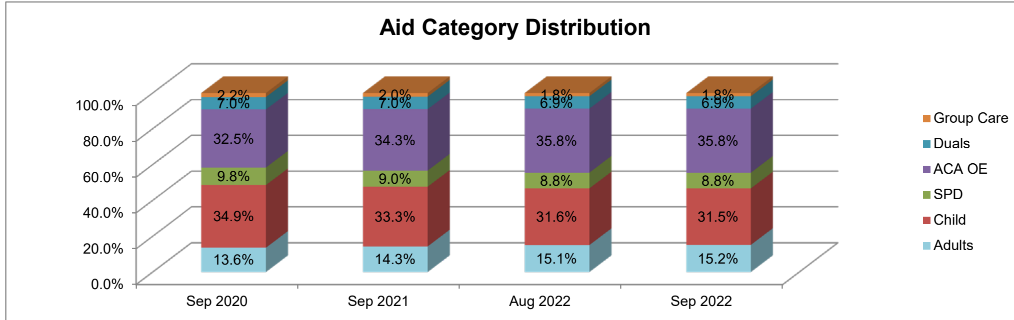




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

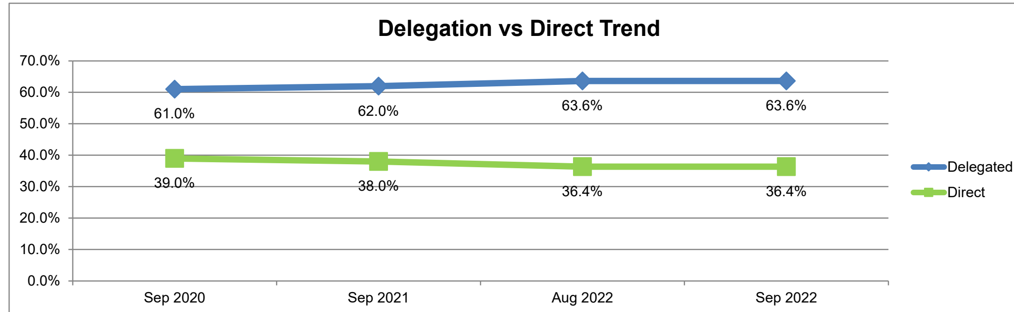
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	**Sep 2020**	**Sep 2021**	**Aug 2022**	**Sep 2022**	**Sep 2020**	**Sep 2021**	**Aug 2022**	**Sep 2022**	**Sep 2020 to Sep 2021**	**Sep 2021 to Sep 2022**	**Aug 2022 to Sep 2022**
Adults	36,301	41,924	48,112	48,711	13.6%	14.3%	15.1%	15.2%	15.5%	16.2%	1.2%
Child	93,378	97,460	100,977	101,276	34.9%	33.3%	31.6%	31.5%	4.4%	3.9%	0.3%
SPD	26,178	26,330	28,079	28,200	9.8%	9.0%	8.8%	8.8%	0.6%	7.1%	0.4%
ACA OE	86,713	100,469	114,208	115,018	32.5%	34.3%	35.8%	35.8%	15.9%	14.5%	0.7%
Duals	18,607	20,535	22,077	22,319	7.0%	7.0%	6.9%	6.9%	10.4%	8.7%	1.1%
Medi-Cal Total	261,177	286,718	313,453	315,524	97.8%	98.0%	98.2%	98.2%	9.8%	10.0%	0.7%
Group Care	6,011	5,914	5,803	5,809	2.2%	2.0%	1.8%	1.8%	-1.6%	-1.8%	0.1%
Total	**267,188**	**292,632**	**319,256**	**321,333**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.5%**	**9.8%**	**0.7%**



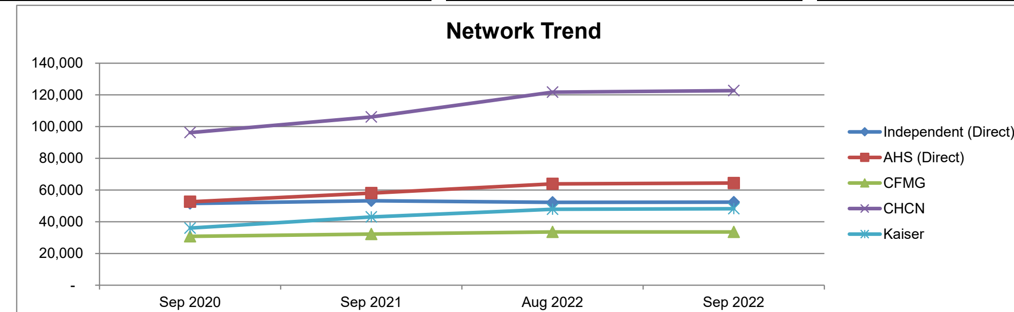
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	**Sep 2020**	**Sep 2021**	**Aug 2022**	**Sep 2022**	**Sep 2020**	**Sep 2021**	**Aug 2022**	**Sep 2022**	**Sep 2020 to Sep 2021**	**Sep 2021 to Sep 2022**	**Aug 2022 to Sep 2022**
Delegated	163,065	181,326	203,148	204,491	61.0%	62.0%	63.6%	63.6%	11.2%	12.8%	0.7%
Direct	104,123	111,306	116,108	116,842	39.0%	38.0%	36.4%	36.4%	6.9%	5.0%	0.6%
Total	**267,188**	**292,632**	**319,256**	**321,333**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.5%**	**9.8%**	**0.7%**



Network Trend

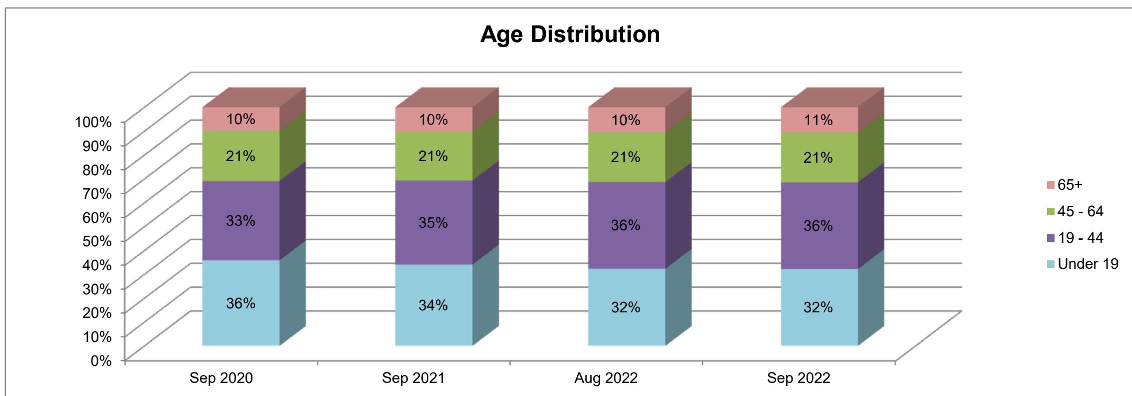
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	**Sep 2020**	**Sep 2021**	**Aug 2022**	**Sep 2022**	**Sep 2020**	**Sep 2021**	**Aug 2022**	**Sep 2022**	**Sep 2020 to Sep 2021**	**Sep 2021 to Sep 2022**	**Aug 2022 to Sep 2022**
Independent (Direct)	51,527	53,246	52,198	52,418	19.3%	18.2%	16.3%	16.3%	3.3%	-1.6%	0.4%
AHS (Direct)	52,596	58,060	63,910	64,424	19.7%	19.8%	20.0%	20.0%	10.4%	11.0%	0.8%
CFMG	30,803	32,217	33,594	33,577	11.5%	11.0%	10.5%	10.4%	4.6%	4.2%	-0.1%
CHCN	96,219	106,050	121,703	122,696	36.0%	36.2%	38.1%	38.2%	10.2%	15.7%	0.8%
Kaiser	36,043	43,059	47,851	48,218	13.5%	14.7%	15.0%	15.0%	19.5%	12.0%	0.8%
Total	**267,188**	**292,632**	**319,256**	**321,333**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.5%**	**9.8%**	**0.7%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

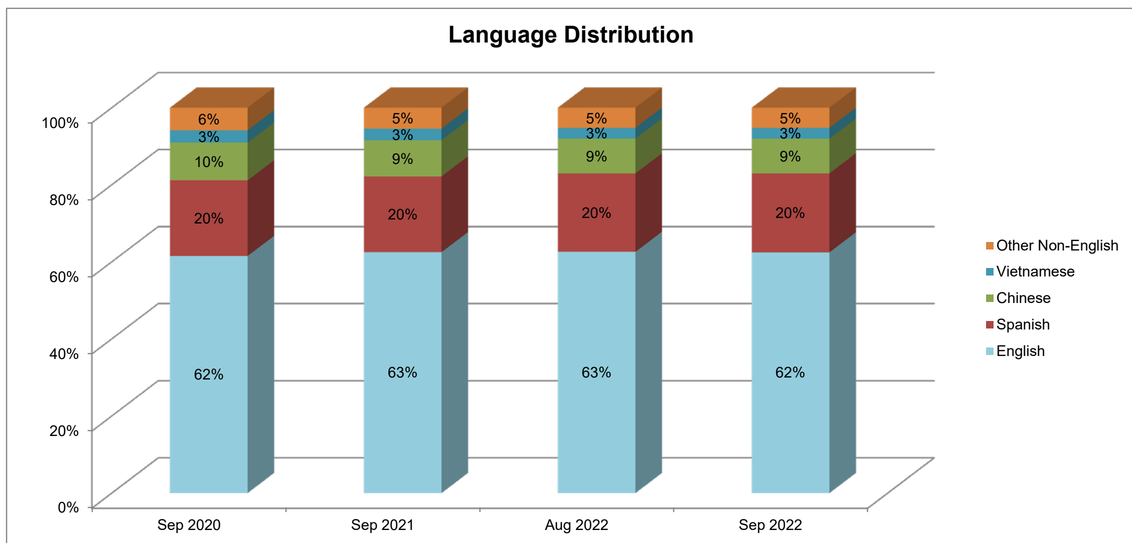
Age Category Trend

Age Category	Members Sep 2020	Members Sep 2021	Members Aug 2022	Members Sep 2022	% of Total (ie.Distribution) Sep 2020	Sep 2021	Aug 2022	Sep 2022	% Growth (Loss) Sep 2020 to Sep 2021	Sep 2021 to Sep 2022	Aug 2022 to Sep 2022
Under 19	95,849	99,751	103,223	103,516	36%	34%	32%	32%	4%	4%	0%
19 - 44	88,702	102,887	116,003	116,874	33%	35%	36%	36%	16%	14%	1%
45 - 64	56,396	60,370	66,526	66,989	21%	21%	21%	21%	7%	11%	1%
65+	26,241	29,624	33,504	33,954	10%	10%	10%	11%	13%	15%	1%
Total	**267,188**	**292,632**	**319,256**	**321,333**	**100%**	**100%**	**100%**	**100%**	**10%**	**10%**	**1%**



Language Trend

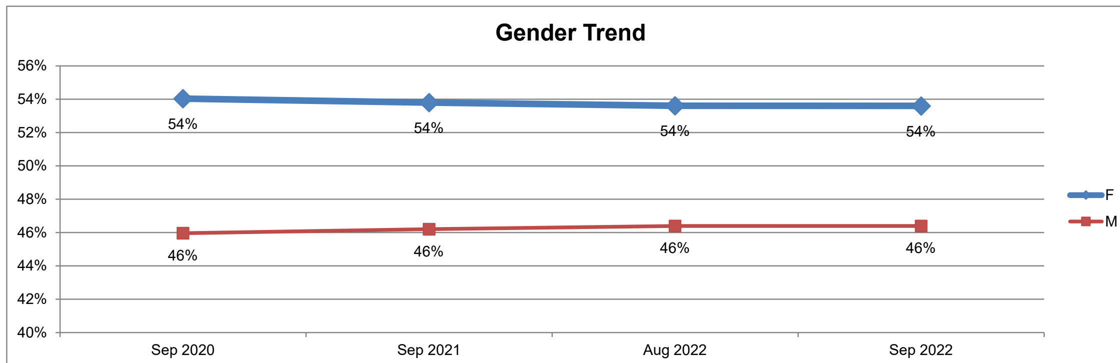
Language	Members Sep 2020	Members Sep 2021	Members Aug 2022	Members Sep 2022	% of Total (ie.Distribution) Sep 2020	Sep 2021	Aug 2022	Sep 2022	% Growth (Loss) Sep 2020 to Sep 2021	Sep 2021 to Sep 2022	Aug 2022 to Sep 2022
English	164,335	182,896	199,798	200,696	62%	63%	63%	62%	11%	10%	0%
Spanish	52,447	57,525	64,967	65,837	20%	20%	20%	20%	10%	14%	1%
Chinese	26,167	27,513	28,938	29,053	10%	9%	9%	9%	5%	6%	0%
Vietnamese	8,561	8,789	8,869	8,928	3%	3%	3%	3%	3%	2%	1%
Other Non-English	15,678	15,909	16,684	16,819	6%	5%	5%	5%	1%	6%	1%
Total	**267,188**	**292,632**	**319,256**	**321,333**	**100%**	**100%**	**100%**	**100%**	**10%**	**10%**	**1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

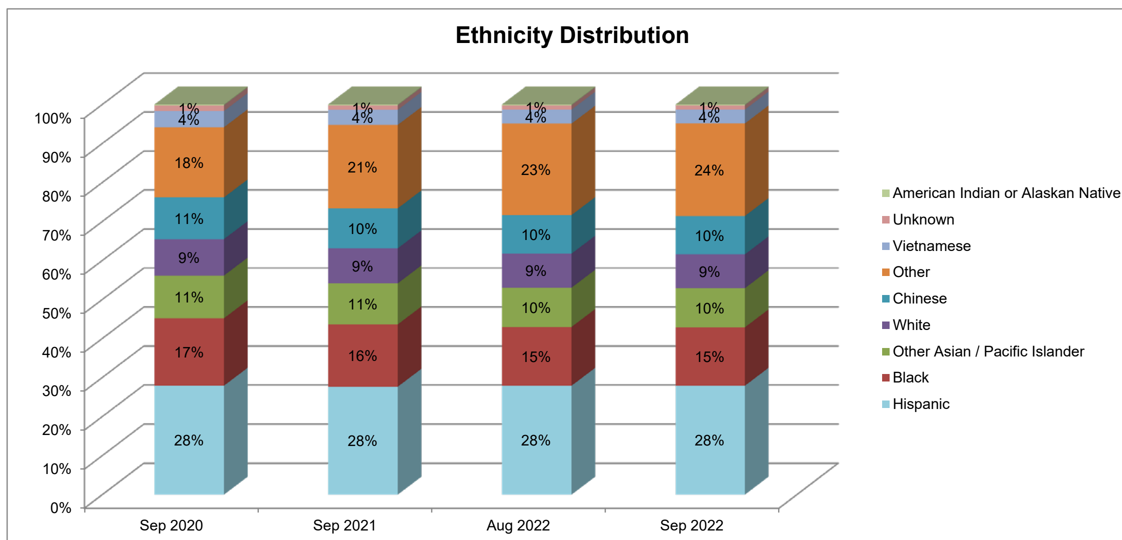
Gender Trend

Gender	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Sep 2020	Sep 2021	Aug 2022	Sep 2022	Sep 2020	Sep 2021	Aug 2022	Sep 2022	Sep 2020 to Sep 2021	Sep 2021 to Sep 2022	Aug 2022 to Sep 2022
F	144,383	157,426	171,141	172,247	54%	54%	54%	54%	9%	9%	1%
M	122,805	135,206	148,115	149,086	46%	46%	46%	46%	10%	10%	1%
Total	**267,188**	**292,632**	**319,256**	**321,333**	**100%**	**100%**	**100%**	**100%**	**10%**	**10%**	**1%**



Ethnicity Trend

Ethnicity	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Sep 2020	Sep 2021	Aug 2022	Sep 2022	Sep 2020	Sep 2021	Aug 2022	Sep 2022	Sep 2020 to Sep 2021	Sep 2021 to Sep 2022	Aug 2022 to Sep 2022
Hispanic	74,516	80,857	88,998	89,573	28%	28%	28%	28%	9%	11%	1%
Black	46,219	46,756	48,133	48,141	17%	16%	15%	15%	1%	3%	0%
Other Asian / Pacific Islander	29,208	30,769	32,123	32,208	11%	11%	10%	10%	5%	5%	0%
White	25,003	26,326	27,887	27,911	9%	9%	9%	9%	5%	6%	0%
Chinese	28,577	29,994	31,586	31,599	11%	10%	10%	10%	5%	5%	0%
Other	48,054	62,583	74,839	76,226	18%	21%	23%	24%	30%	22%	2%
Vietnamese	11,084	11,278	11,428	11,448	4%	4%	4%	4%	2%	2%	0%
Unknown	3,924	3,446	3,579	3,533	1%	1%	1%	1%	-12%	3%	-1%
American Indian or Alaskan Native	603	623	683	694	0%	0%	0%	0%	3%	11%	2%
Total	**267,188**	**292,632**	**319,256**	**321,333**	**100%**	**100%**	**100%**	**100%**	**10%**	**10%**	**1%**



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

Medi-Cal By City

City	Sep 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	123,812	39%	12,797	30,218	14,171	52,958	13,668
Hayward	49,508	16%	7,324	11,202	5,506	16,707	8,769
Fremont	28,689	9%	10,039	4,507	1,001	8,335	4,807
San Leandro	28,584	9%	4,643	4,303	3,479	10,864	5,295
Union City	13,086	4%	3,931	2,137	521	3,946	2,551
Alameda	12,003	4%	2,032	2,025	1,633	4,325	1,988
Berkeley	11,793	4%	1,515	1,775	1,328	5,347	1,828
Livermore	9,736	3%	1,036	718	1,908	4,304	1,770
Newark	7,335	2%	1,853	2,428	239	1,439	1,376
Castro Valley	7,856	2%	1,272	1,270	1,067	2,560	1,687
San Lorenzo	6,631	2%	866	1,168	713	2,492	1,392
Pleasanton	5,303	2%	982	412	513	2,457	939
Dublin	5,704	2%	996	441	690	2,483	1,094
Emeryville	2,150	1%	337	416	290	722	385
Albany	1,947	1%	246	228	375	693	405
Piedmont	387	0%	53	110	27	94	103
Sunol	66	0%	12	12	4	24	14
Antioch	39	0%	4	12	4	12	7
Other	895	0%	154	167	108	326	140
Total	**315,524**	**100%**	**50,092**	**63,549**	**33,577**	**120,088**	**48,218**

Group Care By City

City	Sep 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,893	33%	435	372	-	1,086	-
Hayward	652	11%	327	135	-	190	-
Fremont	617	11%	448	46	-	123	-
San Leandro	591	10%	225	87	-	279	-
Union City	309	5%	216	29	-	64	-
Alameda	278	5%	98	18	-	162	-
Berkeley	169	3%	48	11	-	110	-
Livermore	85	1%	26	1	-	58	-
Newark	145	2%	84	39	-	22	-
Castro Valley	178	3%	78	19	-	81	-
San Lorenzo	127	2%	51	17	-	59	-
Pleasanton	62	1%	26	3	-	33	-
Dublin	109	2%	38	10	-	61	-
Emeryville	33	1%	13	5	-	15	-
Albany	17	0%	5	1	-	11	-
Piedmont	14	0%	4	-	-	10	-
Sunol	-	0%	-	-	-	-	-
Antioch	27	0%	6	7	-	14	-
Other	503	9%	198	75	-	230	-
Total	**5,809**	**100%**	**2,326**	**875**	**-**	**2,608**	**-**

Total By City

City	Sep 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	125,705	39%	13,232	30,590	14,171	54,044	13,668
Hayward	50,160	16%	7,651	11,337	5,506	16,897	8,769
Fremont	29,306	9%	10,487	4,553	1,001	8,458	4,807
San Leandro	29,175	9%	4,868	4,390	3,479	11,143	5,295
Union City	13,395	4%	4,147	2,166	521	4,010	2,551
Alameda	12,281	4%	2,130	2,043	1,633	4,487	1,988
Berkeley	11,962	4%	1,563	1,786	1,328	5,457	1,828
Livermore	9,821	3%	1,062	719	1,908	4,362	1,770
Newark	7,480	2%	1,937	2,467	239	1,461	1,376
Castro Valley	8,034	3%	1,350	1,289	1,067	2,641	1,687
San Lorenzo	6,758	2%	917	1,185	713	2,551	1,392
Pleasanton	5,365	2%	1,008	415	513	2,490	939
Dublin	5,813	2%	1,034	451	690	2,544	1,094
Emeryville	2,183	1%	350	421	290	737	385
Albany	1,964	1%	251	229	375	704	405
Piedmont	401	0%	57	110	27	104	103
Sunol	66	0%	12	12	4	24	14
Antioch	66	0%	10	19	4	26	7
Other	1,398	0%	352	242	108	556	140
Total	**321,333**	**100%**	**52,418**	**64,424**	**33,577**	**122,696**	**48,218**

Alliance Community Outreach

Presented to the Alameda Alliance Board of Governors

Matthew Woodruff, Chief Operating Officer

November 11th, 2022

ALAMEDA Alliance FOR HEALTH

ALAMEDA Alliance FOR HEALTH

Agenda

- Outreach
- Social Media
- Online Advocacy

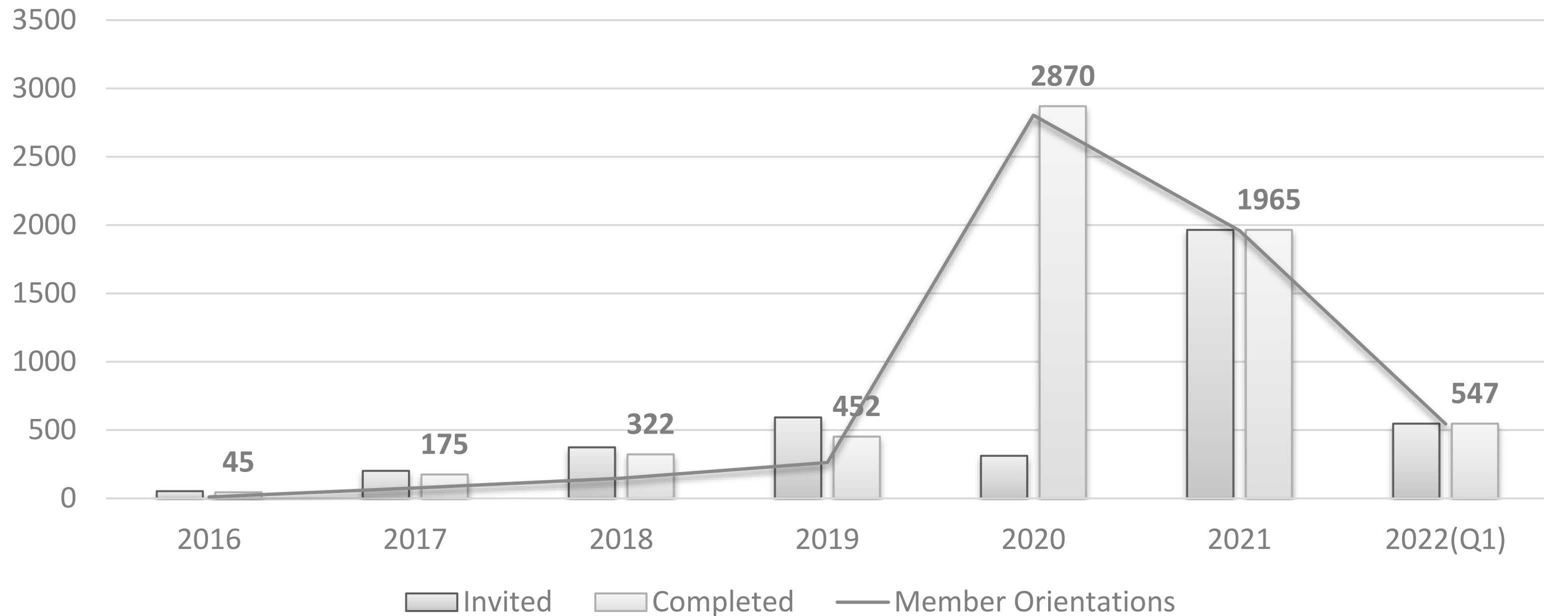
ALAMEDA **Alliance** FOR HEALTH

- **Started in 2016 to better engage our members, providers and community stakeholders:**
  - Service
    - → Advance the mission and vision of the Alliance
  - Presence
    - → Who we are and how we help improve health in our community
  - Branding
    - → Being a household name in Alameda County to better improve access to care and services
- **Who we hired and why:**
  - Communications Manager
  - Outreach Coordinators for each threshold language: English, Spanish, Cantonese / Mandarin (Chinese), Vietnamese, and Tagalog
  - Social Media Coordinator – *New in 2021*

Alameda Alliance for Health

Alliance Community Outreach

- **Events year over year:**
  - Our Accomplishments
    - Established Priorities
    - Community Outreach events completed peaked at **452** in 2019
    - Member Orientations completed peaked in 2020



ALAMEDA Alliance FOR HEALTH

Alliance Community Outreach

- **2018 started enhancing social media presence to tell the Alliance story:**
  - Effect of Glassdoor and Yelp
    - → Responding to crowdsourced reviews
  - Promoting outreach events and activities
  - Company milestones
  - Spotlights
- **2020 how we changed:**
  - Quickly pivoted to virtual outreach
  - Conducting member orientations by phone in all threshold languages
  - Virtual community events
  - Dedicated Social Media FTE

ALAMEDA Alliance FOR HEALTH

Alliance Community Outreach

- **2021 expanded social media presence**
  - Search Engine Optimization
  - Alliance Instagram page debuted in *June 2021*
  - COVID-19 Vaccine
  - Social Media Topics Publishing Calendar – National Recognitions and Health Observances
- **2022 results review**
  - Mental health feeds received the most reactions and feedback
  - Social Determinants of Health are second
  - Portal and Mobile App Campaigns and Member In-services
  - CalAIM requires AAH to expand and invest in relationships with community partners and stakeholders beyond healthcare and medical providers

ALAMEDA Alliance FOR HEALTH

Alliance Community Outreach

- **Social Media next stages**
  - Portal and Mobile App Campaigns and Member In-services
  - Increase Social Determinants of Health
- **Outreach next stages**
- CalAIM requires AAH to expand and invest in relationships with community partners and stakeholders beyond healthcare and medical providers
  - Housing and Community Services
  - Justice-involved
  - Increased populations of focus
- **Medicare**

Alameda Alliance for Health

Alliance Community Outreach

- **Advocacy**
  - To further advance our mission, the Alliance's Public Affairs Department has begun planning efforts to expand the organization's advocacy.
  - In 2023, work with Alliance CEO to determine policy priorities that the Public Affairs Department should focus on.
  - In 2023 and beyond, develop a legislative platform (policy agenda) to serve as a framework for the development and advocacy of positions on state legislative issues and budget proposals that impact the Alliance.
  - Work closely with the Alliance's Communications & Outreach department to reach wider audiences via our online footprint and increase awareness about the importance of programs and policies that impact the Medi-Cal population.

ALAMEDA Alliance FOR HEALTH

Alliance Community Outreach

- Questions

Staff Report

TO: Alameda Alliance for Health Board of Governors

FROM: Scott Coffin, Chief Executive Officer

DATE: November 11th, 2022

SUBJECT: Provisional Vote on Additional Board Seats to Take Effect Upon Ordinance Change

RECOMMENDED ACTION

To approve a motion to *provisionally* add four seats to the Alameda Alliance for Health (Alliance) Board of Governors, thereby increasing membership from 15 to 19 members effective upon change to the Alameda County Ordinance. The additional seats will include the following:

- Alameda County Health Care Services Agency (HCSA), Agency Director Seat
- Alameda County Social Services Agency (SSA), Agency Director Seat
- Community Health Center Network (CHCN), Executive Director Seat
- Long Term Support Services Seat (LTSS), At-Large Seat (designated for a subject-matter expert, not aligned to an entity)

Note: *If this vote is approved, the vote will be recorded, but it will not be effective unless and until the Alameda County Ordinances are changed to allow it.*

DISCUSSION

The Alliance Board of Governors desires to add the seats listed above in anticipation of the Alliance's transition to the single Medi-Cal Managed Care Plan of Alameda County, as set forth in an ordinance adopted by the Alameda County Board of Supervisors on September 28, 2021,[1] and to take effect on or before January 1, 2024 (contingent upon federal/state approvals).

[1] Ordinance No. 2021-38 "AN ORDINANCE AUTHORIZING THE TRANSITION TO A SINGLE MEDI-CAL MANAGED CARE HEALTH PLAN MODEL FOR THE COUNTY OF ALAMEDA'S MEDI-CAL BENEFICIARIES"

However, Board of Governors membership is currently limited to 15 voting members, both by its Bylaws,[2] and by Chapter 6.96 of the Alameda County Municipal Code.[3] Increasing the membership to 19 will therefore involve the following steps:

- Provisional Board Action Today:
  - Provisional Board vote to approve new seats:
    - HCSA as Designated Seat
    - SSA as Designated Seat
    - CHCH as Designated Seat
    - LTSS as At-Large Seat

    (*If vote passes it will be recorded but will only become effective upon County Ordinance changing to allow it)*.
- Next Steps:
  - Alliance to partner with Alameda County Board Clerk to get necessary changes to County Ordinances on the docket.
  - Board of Supervisors to approve amendment to section 6.96.040, specifically expanding the maximum number of board members from 15 to 19.
  - Alliance Board to sign Resolutions memorializing addition of seats.
  - Alliance Bylaws to be updated to reflect change.

FISCAL IMPACT

This action will not have a fiscal impact.

[2] Alliance Bylaws, approved by Board of Supervisors March 2, 2021

[3] Alameda County, Municipal Code Chapter 6.96, section § 6.96.040 https://library.municode.com/CA/alameda_county/codes/code_of_ordinances?nodeId=TIT6HESA_CH6.96ALALHE

Staff Report and Resolution

TO: Alameda Alliance for Health Board of Governors

FROM: Scott Coffin, Chief Executive Officer

DATE: November 11th, 2022

SUBJECT: Consumer Member Seat (Regular #13) Member Nomination

RECOMMENDED ACTION

1. Adopt Resolution 2022-04 titled: "A Resolution of Alameda Alliance for Health Approving Consumer Member Seat Nominee for Board of Governors Membership, and Recommending that the Alameda County Board of Supervisors Make an Appointment to the Board of Governors of Alameda Alliance for Health"

DISCUSSION

The Alameda Alliance for Health ("Alliance") Board of Governors has a vacancy of Regular Seat Number 13, Consumer Member. Section 3.D.5. of the Alliance *Bylaws* sets forth that the Consumer (Member) Advisory Committee ("MAC") will identify and nominate members of the health services consumer community to serve as Consumer Member representatives on the Board. The MAC has nominated Jody Moore, an Alameda mother and disability-rights activist, for this vacant seat. The Alliance Chief Executive Officer has reviewed this recommendation and now recommends that the Alliance Board of Governors approve Ms. Moore as the nominee.

Resolution 2022-04 provides for the approval of Ms. Moore as the Consumer Member Seat nominee. 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. Moore's appointment to the Board's vacant seat.

FISCAL IMPACT

This action will not have a fiscal impact.

ATTACHMENTS

1. Resolution 2022-04

RESOLUTION NO. 2022-04

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH APPROVING CONSUMER MEMBER SEAT NOMINEE FOR BOARD OF GOVERNORS MEMBERSHIP, AND RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS MAKE AN APPOINTMENT TO THE BOARD OF GOVERNORS OF ALAMEDA ALLIANCE FOR HEALTH

WHEREAS, The Alameda Alliance for Health ("Alliance") Board of Governors has a vacancy of Regular Seat Number 13, Consumer Member; and

WHEREAS, Pursuant to Section 3.D.5. of the Alliance *Bylaws*, the Consumer (Member) Advisory Committee ("MAC") has agreed on a recommendation to fill this vacant seat; and

WHEREAS, pursuant to Section 3.C. of the Alliance *Bylaws* the Alliance Chief Executive Officer has reviewed the recommendation and recommends that the Alliance Board of Governors nominate the MAC's recommendation to fill the vacant seat; and

WHEREAS, pursuant to Section 3.C. of the Alliance *Bylaws*, the Alliance Board of Governors has reviewed the nominee recommendation; and

WHEREAS, pursuant to Section 3.C. of the Alliance *Bylaws*, upon the approval of a nominee the Alliance Board of Governors is required to adopt a resolution which, in turn, will be provided to the Alameda County Board of Supervisors; and

WHEREAS, upon receipt of the resolution, the Alameda County Board of Supervisors may choose to adopt the resolution, by majority vote, appointing the member to the Alliance Board of Governors.

NOW, THEREFORE, THE BOARD OF GOVERNORS OF THE ALAMEDA ALLIANCE FOR HEALTH DOES HEREBY RESOLVE, DECLARE, DETERMINE, ORDER, AND RECOMMEND AS FOLLOWS:

SECTION 1. That the Alliance Board of Governors approves Jody Moore to fill Regular Seat Number 13, Consumer Member, on the Alliance Board of Governors, as created pursuant to Section 3.D.5. of the Alliance *Bylaws*.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors adopt a resolution by majority vote appointing Jody Moore to Regular Seat Number 13, Consumer Member, of the Alliance Board of Governors.

SECTION 3. The Alliance Secretary shall certify the adoption of this resolution and immediately forward it to the Clerk of the Board of the Alameda County Board of Supervisors.

PASSED AND ADOPTED by the Board at a meeting held on the 11th day of November 2022.

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CHAIR, BOARD OF GOVERNORS

ATTEST:

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Secretary

Operations

Matt Woodruff

To: Alameda Alliance for Health Board of Governors

From: Matthew Woodruff, Chief Operating Officer

Date: November 11th, 2022

Subject: Operations Report

Member Services

- 12-Month Trend Summary:
  - The Member Services Department received a seven percent (7%) increase in calls in October 2022, totaling 13,496 compared to 12,566 in October 2021. Call volume pre-pandemic in October 2019 was 14,208, which is five percent (5%) higher than the current call volume.
  - The abandonment rate for October 2022 was nineteen percent (19%), compared to thirteen percent (13%) in October 2021.
  - The Department's service level was forty-six percent (46%) in October 2022, compared to fifty-four percent (54%) in October 2021. Service levels continue to be directly impacted due to staffing challenges (unplanned/unscheduled absences related to COVID-19). Additional contributing factors that impacted the service levels for October were intermittent technical issues, mandatory training, and meetings. The Department continues to recruit to fill open positions and has made great progress in filling open positions. The Customer Service, support service vendor continues to provide overflow call center support.
  - The average talk time (ATT) was six minutes and fifty-three seconds (06:53) for October 2022 compared to six minutes and forty-three seconds (06:43) for October 2021.
  - Member utilization of self-service phone options totaled twelve-hundred forty-seven (1,247) in October 2022, which includes three hundred ninety-nine (399) for the member automated eligibility IVR system. The department continues to analyze IVR prompt utilization and employs member feedback to improve the member's experience and meet the ever-changing needs of our members.
  - The top five call reasons for October 2022 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3) Benefits, 4). Kaiser, 5). ID Card/Member Materials request. The top five call reasons for October 2021 were: 1). Eligibility/Enrollment, 2). Change of PCP, 3). Kaiser, 4). Benefits, 5). ID Card/Member Materials Request.

- The Department continues to service members via multiple non-contact communication channels (telephonic, email, online, web-based requests, and in-person) while honoring the organization's policies. The Department responded to six hundred forty-four (644) web-based requests in October 2022 compared to five hundred sixty-one (561) in October 2021. The top three web reason requests for October 2022 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information.

Claims

- 12-Month Trend Summary:

  - The Claims Department received 171,386 claims in October 2022 compared to 177,483 in October 2021.
  - Auto Adjudication was 81.8% in October 2022 compared to 80.1% in October 2021.
  - Claims compliance for the 30-day turn-around time was 99.5% in October 2022 compared to 97.4% in October 2021. The 45-day turn-around time was 99.9% in October 2022 compared to 99.9% in October 2021.

- Monthly Analysis:

  - In October, we received a total of 171,386 claims in the HEALTHsuite system. This represents a decrease of -2.60% from September and is lower, by 6,097 claims than the number of claims received in October 2021; the higher volume of received claims remains attributed to COBA claims and increased membership.
  - We received 85.53% of claims via EDI and 14.47% of claims via paper.
  - During October, 99.9% of our claims were processed within 45 working days.
  - The Auto Adjudication rate was 81.8% for October.

Provider Services

- 12-Month Trend Summary:

  - The Provider Services department's call volume in October 2022 was 5,944 calls compared to 5,594 calls in October 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 322 calls/visits during October 2022.
- The Provider Services department answered 3,281 calls for October 2022 and made 861 outbound calls.

Credentialing

- 12-Month Trend Summary:

    - At the Peer Review and Credentialing (PRCC) meeting held on October 18th, 2022, there were forty-six (46) initial network providers approved; zero (0) primary care providers, two (2) specialists, zero (0) ancillary providers, two (2) midlevel providers, and forty-two (42) behavioral health providers. Additionally, twenty-five (25) providers were re-credentialed at this meeting; six (6) primary care providers, twelve (12) specialists, two (2) ancillary providers, and five (5) midlevel providers.

    - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Provider Dispute Resolution

- 12-Month Trend Summary:

    - In October 2022, the Provider Dispute Resolution (PDR) team received 845 PDRs versus 729 in October 2021.
    - The PDR team resolved 920 cases in October 2022 compared to 603 cases in October 2021.
    - In October 2022, the PDR team upheld 67% of cases versus 67% in October 2021.
    - The PDR team resolved 99.8% of cases within the compliance standard of 95% within 45 working days in October 2022 compared to 100% in October 2021.

- Monthly Analysis:

    - AAH received 845 PDRs in October 2022.
    - In October, 920 PDRs were resolved. Out of the 920 PDRs, 612 were upheld, and 308 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 October 2022, the Alliance completed 905-member orientation outreach calls and 156 member orientations by phone.
  - The C&O Department reached 298 people (163 identified as Alliance members) during outreach activities, compared to 162 individuals (100% self-identified as Alliance members) in October 2021.
  - The Alliance spent a total of $5,000 in donations, fees, and/or sponsorships, compared to $0 in October 2021.
  - The C&O Department reached members in 16 cities/unincorporated areas throughout Alameda County, Bay Area, and the U.S., compared to 21 cities in October 2021.

- Monthly Analysis:
  - In October 2022, the C&O Department completed 905-member orientation outreach calls and 156 member orientations by phone, 43 Alliance website inquiries, 3 service requests, and 1 community event.
  - Among the 298 people reached, 55% identified as Alliance members.
  - In October 2022, the C&O Department reached members in 16 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	Oct 2022
Incoming Calls (R/V)	13,496
Abandoned Rate (R/V)	19%
Answered Calls (R/V)	10,951
Average Speed to Answer (ASA)	04:55
Calls Answered in 60 Seconds (R/V)	46%
Average Talk Time (ATT)	06:53
Outbound Calls	5,969

Top 5 Call Reasons (Medi-Cal and Group Care) Oct 2022
Change of PCP
Eligibility/Enrollment
Benefits
Kaiser
ID Card Requests

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

Claims Department September 2022 Final and October 2022 Final		
METRICS		
Claims Compliance	**Sep-22**	**Oct-22**
90% of clean claims processed within 30 calendar days	99.2%	99.5%
95% of all claims processed within 45 working days	99.9%	99.9%
Claims Volume (Received)	**Sep-22**	**Oct-22**
Paper claims	23,572	24,806
EDI claims	152,383	146,580
Claim Volume Total	**175,955**	**171,386**
Percentage of Claims Volume by Submission Method	**Sep-22**	**Oct-22**
% Paper	13.40%	14.47%
% EDI	86.60%	85.53%
Claims Processed	**Sep-22**	**Oct-22**
HEALTHsuite Paid (original claims)	104,137	106,521
HEALTHsuite Denied (original claims)	44,539	45,866
HEALTHsuite Original Claims Sub-Total	**148,676**	**152,387**
HEALTHsuite Adjustments	1,994	3,453
HEALTHsuite Total	**150,670**	**155,840**
Claims Expense	**Sep-22**	**Oct-22**
Medical Claims Paid	$58,297,687	$54,064,248
Interest Paid	$29,767	$22,350
Auto Adjudication	**Sep-22**	**Oct-22**
Claims Auto Adjudicated	121,587	124,725
% Auto Adjudicated	81.8%	81.8%
Average Days from Receipt to Payment	**Sep-22**	**Oct-22**
HEALTHsuite	18	18
Pended Claim Age	**Sep-22**	**Oct-22**
0-29 calendar days	10650	11169
HEALTHsuite		
30-59 calendar days	132	51
HEALTHsuite		
Over 60 calendar days	0	0
HEALTHsuite		
Overall Denial Rate	**Sep-22**	**Oct-22**
Claims denied in HEALTHsuite	44,539	45,866
% Denied	29.6%	29.4%

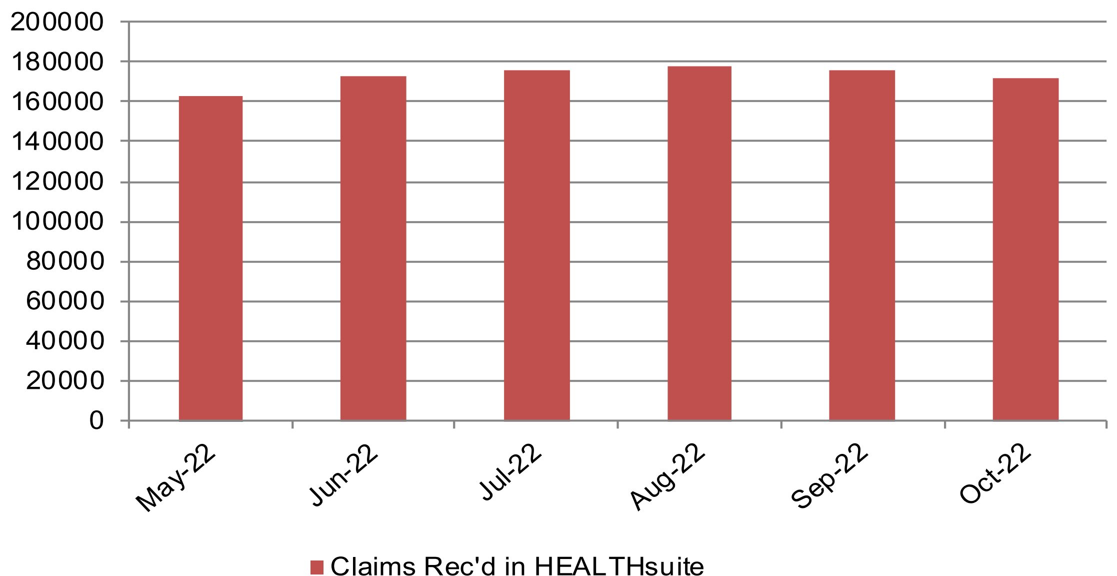
Claims Department
September 2022 Final and October 2022 Final

Oct-22

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	25%
No Benefits Found For Dates of Service	15%
Duplicate Claim	10%
Non-Covered Benefit for this Plan	10%
Member has Multiple Primary Payors	6%
% Total of all denials	**66%**

Claims Received By Month

Run Date	6/1/2022	7/1/2022	8/1/2022	9/1/2022	10/1/2022	11/1/2022
Claims Received Through	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**
Claims Rec'd in HEALTHsuite	163,272	173,269	176,217	177,945	175,955	171,386



Provider Relations Dashboard October 2022

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	4810	4334	6078	5767	5236	5215	4973	6243	5594	5944		
Abandoned Calls	626	586	2149	2219	1333	1512	1454	2083	2093	2663		
Answered Calls (PR)	4184	3748	3929	3548	3903	3703	3519	4160	3501	3281		
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	332	373	1067	1309	677	807	665	756	950	1495		
Abandoned Calls (R/V)												
Answered Calls (R/V)	332	373	1067	1309	677	807	665	756	950	1495		
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	624	680	664	640	677	573	685	722	748	861		
N/A												
Outbound Calls	624	680	664	640	677	573	685	722	748	861		
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	5766	5387	7809	7716	6590	6595	6323	7721	7292	8300		
Abandoned Calls	626	586	2149	2219	1333	1512	1454	2083	2093	2663		
Total Answered Incoming, R/V, Outbound Calls	5140	4801	5660	5497	5257	5083	4869	5638	5199	5637		

Provider Relations Dashboard October 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%	3.3%	3.4%	3.7%	3.5%	4.3%	3.4%		
Benefits	4.1%	3.4%	3.1%	3.8%	3.9%	3.1%	2.9%	2.9%	1.6%	2.1%		
Claims Inquiry	40.2%	41.5%	40.8%	48.8%	44.8%	47.8%	48.2%	49.5%	50.5%	50.2%		
Change of PCP	2.4%	4.0%	4.8%	4.1%	5.0%	4.2%	3.6%	4.2%	4.2%	4.4%		
Complaint/Grievance (includes PDR's)	4.9%	5.3%	4.8%	4.2%	3.8%	3.5%	3.9%	3.4%	2.3%	1.5%		
Contracts	0.5%	0.7%	0.8%	0.7%	1.1%	1.2%	1.0%	0.9%	1.0%	1.1%		
Correspondence Question/Followup	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%		
Demographic Change	0.1%	0.3%	0.0%	0.1%	0.0%	0.1%	0.1%	0.1%	0.0%	0.0%		
Eligibility - Call from Provider	25.3%	23.2%	22.6%	21.4%	23.2%	18.8%	19.0%	17.9%	19.8%	18.6%		
Exempt Grievance/ G&A	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.2%	0.0%		
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
Intrepreter Services Request	0.8%	0.4%	0.8%	0.7%	1.0%	0.8%	0.1%	0.8%	1.0%	1.1%		
Kaiser	0.0%	0.1%	0.1%	0.7%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%		
Member bill	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
Mystery Shopper Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
Provider Portal Assistance	4.5%	5.4%	4.9%	3.9%	4.2%	4.0%	4.9%	4.9%	3.9%	4.2%		
Pharmacy	1.2%	0.3%	0.3%	0.3%	0.2%	0.1%	0.2%	0.2%	0.2%	0.2%		
Provider Network Info	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.0%		
Transferred Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
All Other Calls	12.3%	10.8%	13.4%	8.2%	9.2%	12.8%	12.5%	11.4%	10.8%	13.3%		
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#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	7	15	7	10	47	74		
Contracting/Credentialing	8	10	28	20	12	14	11	9	31	44		
Drop-ins	0	0	0	0	0	0	0	0	104	174		
JOM's	1	2	3	1	4	2	3	4	0	1		
New Provider Orientation	22	15	34	22	22	5	15	10	6	20		
Quarterly Visits	211	274	159	175	201	149	182	240	3	2		
UM Issues	2	4	2	1	2	0	0	2	20	7		
Total Field Visits	253	323	243	231	248	185	218	275	211	322	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS						
Practitioners		BH/ABA 118	AHP 404	PCP 342	SPEC 628	PCP/SPEC 12
AAH/AHS/CHCN Breakdown			AAH 528	AHS 179	CHCN 406	COMBINATION OF GROUPS 391
Facilities	**307**					
VENDOR SUMMARY **Credentialing Verification Organization, Symply CVO**						
	Number		**Average Calendar Days in Process**	**Goal - Business Days**	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	790		56	25	Y	N
Recred Files in Process	52		28	25	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**						Y
Files currently in process	**842**					
CAQH Applications Processed in September 2022						
Standard Providers and Allied Health	**Invoice not received**					

October 2022 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	0
SPEC	2
ANCILLARY	0
MIDLEVEL/AHP	2
BH/ABA	42
	46
Recredentialing	
PCP	6
SPEC	12
ANCILLARY	2
MIDLEVEL/AHP	5
BH/ABA	0
	25
TOTAL	**71**

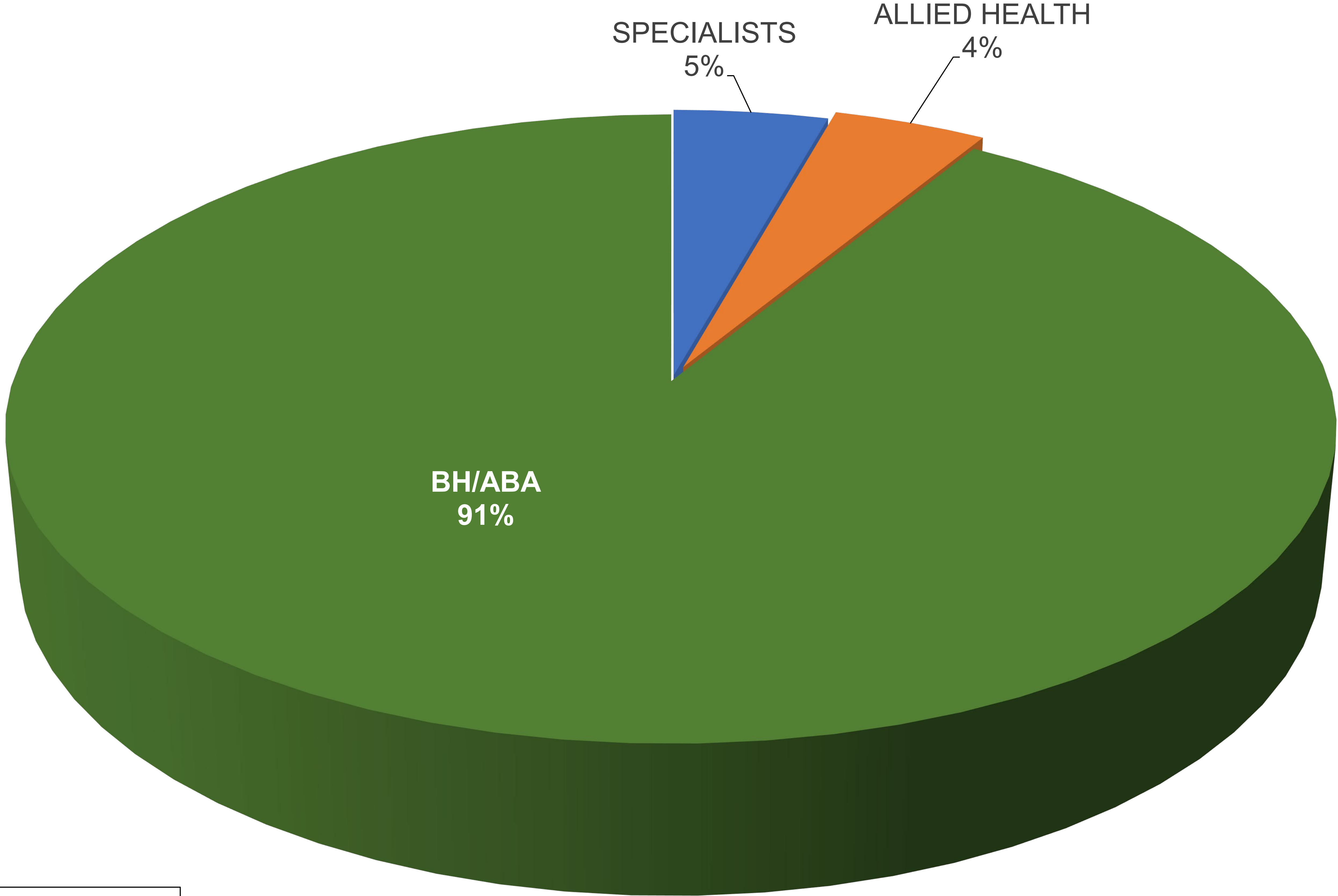
October 2022 Facility Approvals	
Initial Credentialing	7
Recredentialing	5
	12
Facility Files in Process	**35**

October 2022 Employee Metrics	5		
File Processing	Timely processing within 3 days of receipt		Y
Credentialing Accuracy	<3% error rate		Y
DHCS, DMHC, CMS, NCQA Compliant	98%		Y
MBC Monitoring	Timely processing within 3 days of receipt		Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Abdul-Rahman	Strauss	BH/ABA-Telehealth	INITIAL	10/18/2022
Ames	Harold	BH/ABA-Telehealth	INITIAL	10/18/2022
Barton	Cierra	BH/ABA-Telehealth	INITIAL	10/18/2022
Boehler	Jordan	BH/ABA	INITIAL	10/18/2022
Bumgarner	Abel	BH/ABA	INITIAL	10/18/2022
Celik	Tubanur	BH/ABA-Telehealth	INITIAL	10/18/2022
Chick	Christina	BH/ABA	INITIAL	10/18/2022
Colon	Aryana	BH/ABA-Telehealth	INITIAL	10/18/2022
Cromley	Whitney	BH/ABA-Telehealth	INITIAL	10/18/2022
Dillon	Alexander	Specialist	INITIAL	10/18/2022
Dolgoff	Robert	BH/ABA	INITIAL	10/18/2022
Doyle	Jackson	BH/ABA	INITIAL	10/18/2022
Elieff	Tangia	BH/ABA	INITIAL	10/18/2022
Farsi	Shireen	BH/ABA	INITIAL	10/18/2022
Fuentes	Alicia	BH/ABA	INITIAL	10/18/2022
Gibson	Joshua	BH/ABA-Telehealth	INITIAL	10/18/2022
Grewal	Rabeep	Specialist	INITIAL	10/18/2022
Harris	Jennifer	BH/ABA-Telehealth	INITIAL	10/18/2022
Hasan	Shadeed	BH/ABA-Telehealth	INITIAL	10/18/2022
Hernandez	Cheri	BH/ABA-Telehealth	INITIAL	10/18/2022
Jones	Shequita	BH/ABA	INITIAL	10/18/2022
Jones-Kazan	Denise	BH/ABA-Telehealth	INITIAL	10/18/2022
Le	Vuong	BH/ABA	INITIAL	10/18/2022
Li	Yan	Allied Health	INITIAL	10/18/2022
Lorenz	Phyllis	BH/ABA	INITIAL	10/18/2022
Macias	Margaret	BH/ABA	INITIAL	10/18/2022
Maisel	Richard	BH/ABA	INITIAL	10/18/2022
McCully	Caitlin	BH/ABA-Telehealth	INITIAL	10/18/2022
Mendoza	Daniel	BH/ABA-Telehealth	INITIAL	10/18/2022
Meyer	Karen	Allied Health	INITIAL	10/18/2022
Montgomery-Telfor	Brenda	BH/ABA	INITIAL	10/18/2022
Nguyen	Stephanie	BH/ABA	INITIAL	10/18/2022
Nwogu	Niekachi	BH/ABA	INITIAL	10/18/2022
Osorio	Rabita	BH/ABA-Telehealth	INITIAL	10/18/2022
Pabalate	Michelle	BH/ABA-Telehealth	INITIAL	10/18/2022
Paradowski	Pamela	BH/ABA	INITIAL	10/18/2022
Philips	Alice	BH/ABA	INITIAL	10/18/2022
Quick	Nichole	BH/ABA-Telehealth	INITIAL	10/18/2022
Rose	Karen	BH/ABA	INITIAL	10/18/2022
Shane	Elizabeth	BH/ABA	INITIAL	10/18/2022
Tran	Tu	BH/ABA-Telehealth	INITIAL	10/18/2022
Valenzuela	Barbara	BH/ABA	INITIAL	10/18/2022
Vincent	Pamela	BH/ABA-Telehealth	INITIAL	10/18/2022
Walker	Shakisha	BH/ABA-Telehealth	INITIAL	10/18/2022
Wallace	Shannon	BH/ABA	INITIAL	10/18/2022
Wood	Kathryn	BH/ABA	INITIAL	10/18/2022
Adame	Claudia	Allied Health	RE-CRED	10/18/2022
Brooks	Adam	Specialist	RE-CRED	10/18/2022
Bryson-Alderman	Jennifer	Allied Health	RE-CRED	10/18/2022
Chang	Heidi	Specialist	RE-CRED	10/18/2022
Chao	Kuang-Hwa	Specialist	RE-CRED	10/18/2022
Chu	Stefanie	Primary Care Physician	RE-CRED	10/19/2022

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Dexter	Danielle	Allied Health	RE-CRED	10/18/2022
Elliott	Tyronda	Specialist	RE-CRED	10/18/2022
Epstein	Ervin	Specialist	RE-CRED	10/18/2022
Freedman	Julie	Specialist	RE-CRED	10/18/2022
Ho	Stephanie	Specialist	RE-CRED	10/18/2022
Khaleel	Daniel	Specialist	RE-CRED	10/18/2022
Konda	Satyasree	Primary Care Physician	RE-CRED	10/19/2022
Kreps-Falk	Rachel	Primary Care Physician	RE-CRED	10/19/2022
Lavelle	Laura	Allied Health	RE-CRED	10/18/2022
Marcotrigiano	Leanne	Primary Care Physician	RE-CRED	10/19/2022
Marin	Andres	Primary Care Physician	RE-CRED	10/18/2022
Nam	Enoch	Specialist	RE-CRED	10/18/2022
Ninichuck	Joshua	Allied Health	RE-CRED	10/18/2022
Ocampo-Wong	Myla	Ancillary	RE-CRED	10/18/2022
Peniche	Alec	Specialist	RE-CRED	10/18/2022
Saleh	Mark	Specialist	RE-CRED	10/18/2022
Tian	David	Primary Care Physician	RE-CRED	10/18/2022
Winkle	Daniel	Specialist	RE-CRED	10/18/2022
Xu	Junhui	Ancillary	RE-CRED	10/18/2022

OCTOBER PEER REVIEW AND CREDENTIALING INITIAL APPROVALS BY SPECIALTY



Specialists	2
Allied Health	2
BH/ABA	42
Total	46

Provider Dispute Resolution
September 2022 and October 2022

METRICS

PDR Compliance	Sep-22	Oct-22
# of PDRs Resolved	866	920
# Resolved Within 45 Working Days	857	918
% of PDRs Resolved Within 45 Working Days	99.0%	99.8%

PDRs Received	Sep-22	Oct-22
# of PDRs Received	642	845
PDR Volume Total	**642**	**845**

PDRs Resolved	Sep-22	Oct-22
# of PDRs Upheld	610	612
% of PDRs Upheld	70%	67%
# of PDRs Overturned	256	308
% of PDRs Overturned	30%	33%
Total # of PDRs Resolved	**866**	**920**

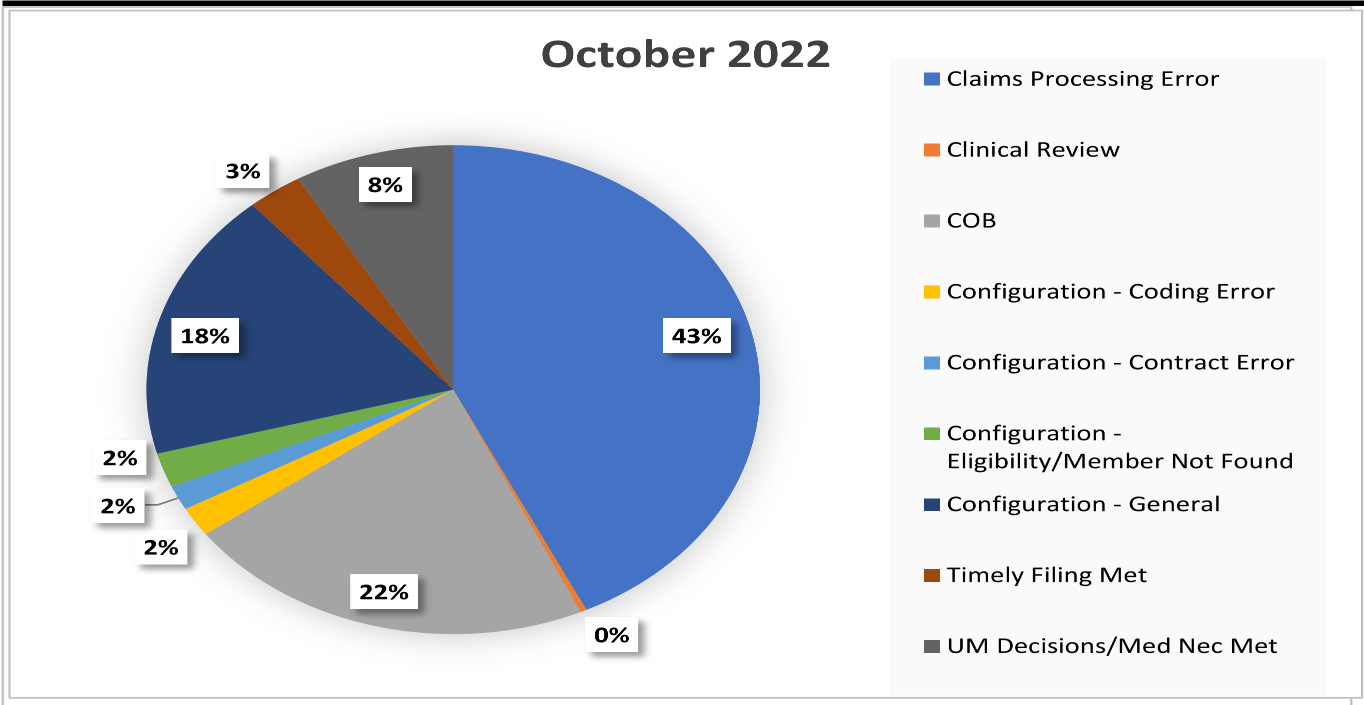
Average Turnaround Time	Sep-22	Oct-22
Average # of Days to Resolve PDRs	29	24
Oldest Unresolved PDR in Days	76	72

Unresolved PDR Age	Sep-22	Oct-22
0-45 Working Days	789	940
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**789**	**940**

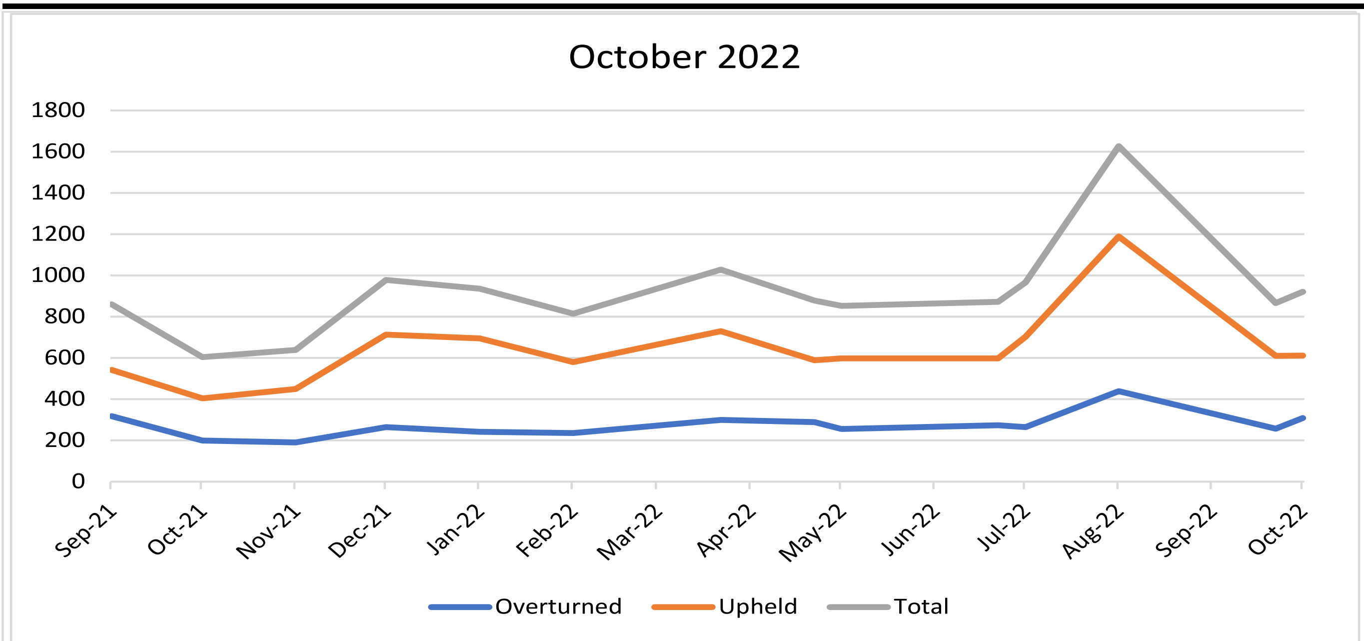
Provider Dispute Resolution
September 2022 and October 2022

Oct-22

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



ALLIANCE IN THE COMMUNITY

FY 2022-2023 | OCTOBER 2022 OUTREACH REPORT

During October 2022, the Alliance completed **905** member orientation outreach calls and conducted **156** member orientations (**17%** member participation rate). In addition, in October 2022, the Outreach team completed 43 Alliance website inquiries, 3 service requests, and 1 community event. The Alliance reached a total of 142 people and spent a total of $5,000 in donations, fees, and/or sponsorships at the Alameda County Emergency Preparedness Day community event. **

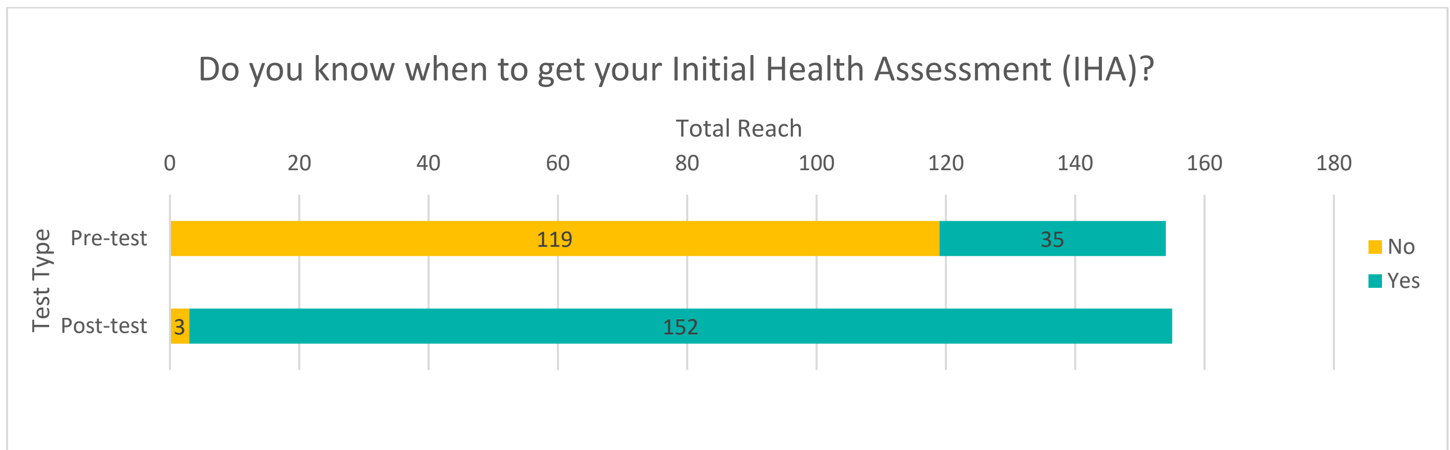
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **26,002** self-identified Alliance members have been reached during outreach activities.

On **Monday, March 16, 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 18, 2020,** the Alliance began conducting member orientations by phone. As of October 31st, 2022, the Outreach Team completed 22,574-member orientation outreach calls and conducted 6,170 member orientations (27.3% member participation rate).

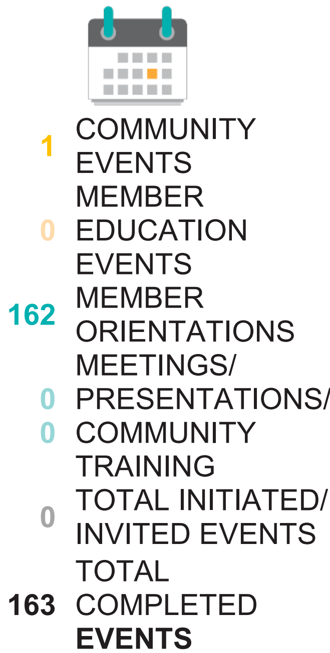
The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between October 1, through October 31, 2022 (21 working days) – **156** net new members completed a MO by phone.

After completing a MO **98.1%** of members who completed the post-test survey in October 2022 reported knowing when to get their IHA, compared to only **22.7%** of members knowing when to get their IHA in the pre-test survey.

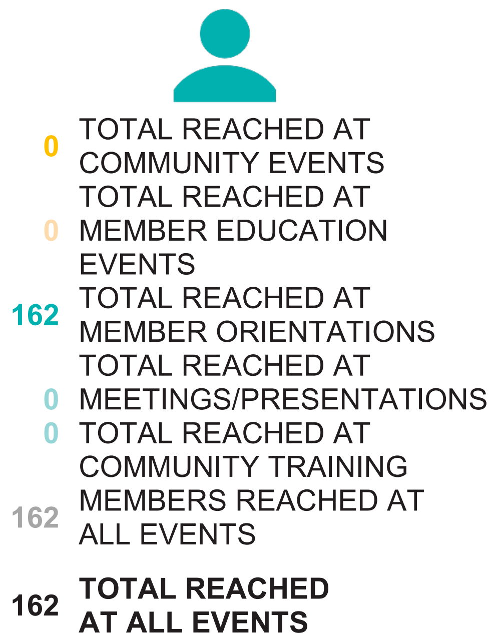


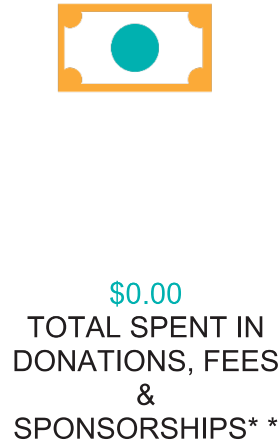
All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 22-23\Q2\1. October 2022**

FY 2021-2022 OCTOBER 2021 TOTALS

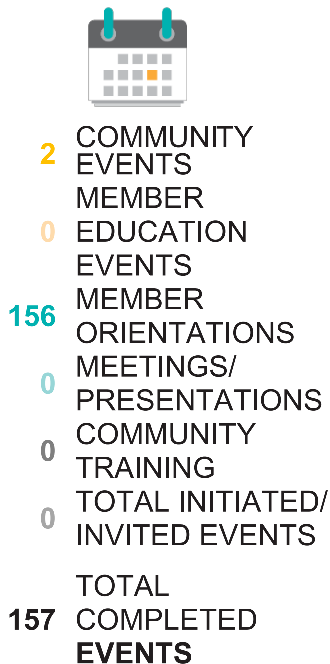


21 CITIES

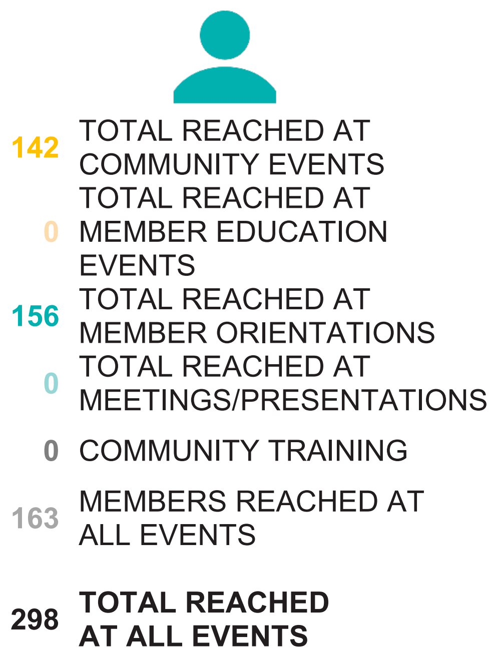


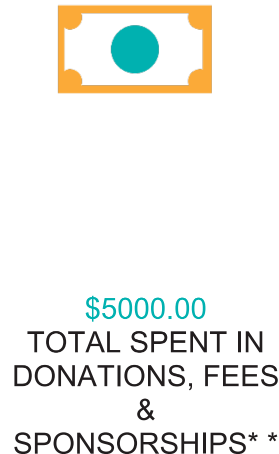


FY 2022-2023 OCTOBER 2022 TOTALS



16 CITIES*





**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: **November 11th, 2022**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2022 DHCS Routine Medical Survey:
  - The 2022 DHCS Routine Medical Survey was held on April 4th, 2022, and completed April 13th, 2022. The review period was April 1st, 2021, through March 31st, 2022. On September 13th, 2022, the Plan received the Final Audit Report, which detailed 15-findings, 8 of which were repeat findings from the previous audit year. The Plan had findings in Utilization Management; Case Management; Access & Availability; Emergency & Family Planning Claims; Member Rights; HIPAA & FWA. The Plan's CAP response and mitigation plans were provided back to the Department on October 14th, 2022.

- 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 reviewed the Plan's fiscal and administrative affairs and activities through the quarter-ending March 31st, 2022. On October 31st, 2022, the DMHC held an exit conference where it shared 7-findings, otherwise referred to as an Index of Exceptions. Findings were noted in Claims Reimbursement & Settlement Practices; PDR Acknowledgement and Determination; Fidelity Bonds Compliance; and Key Plan Personnel Reporting.

- 2022 DMHC Behavioral Health Investigation [MHPAEA]:
  - In 2021, the DMHC began investigating full-service commercial health plans to evaluate and assess barriers providers experience in providing behavioral health services. Pre-audit submissions concluded in July 2022 with more than 1,100 documents provided to DMHC auditors. The onsite review was held from September 7th, through September 8th, 2022. The Plan continued to manage Agency requests through the month of October and looks forward to either a preliminary or final report, when ready. Understanding this is the second year of this review for the agency, the Plan remains on standby for next steps.

- 2021 DMHC Routine Full Medical Survey:
  - The 2021 DMHC Routine Medical Survey, virtual audit took place from April 13th, 2021, through April 16th, 2021. On May 25th, 2022, the Plan received its 2021 Preliminary Audit Report and survey results. The preliminary report had a total of six (6) findings: three (3) in Grievances and Appeals; and three (3) in Prescription Drug Coverage. The Plan provided evidence for a corrected deficiency for G&A Deficiency #2, which the State accepted. The Plan returned its final CAP responses and supporting documentation to the Department on July 8th, 2022, with the remaining additional CAP items expected to be due to the Agency by December 30th, 2022. The DMHC will conduct a Follow-up Survey to assess the Plan's implementation efforts in approximately 9-months. The Follow-up Survey is expected in Summer 2023.

- 2021 DHCS Routine Full Medical Survey:
  - On January 13th, 2021, the DHCS sent notice of the 2021 DHCS Routine Medical Survey beginning April 12th, 2021. The audit was conducted jointly with the DMHC from April 13th, 2021, through April 23rd, 2021.The review period was June 1st, 2019, through March 31st, 2021. The Plan received the final audit report on August 24th, 2021, which had a total of thirty-three (33) findings and four (4) repeat findings. The Plan's final response to the findings was completed and provided to the State on September 23rd, 2022. No additional audit updates.

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 the coming months following CMS approval of State model transitions, with implementation to take place through December 31st, 2023. On September 15th, 2022, the State notified the Plan that the next deliverable submission date will be November 28th, 2022. The Plan was also notified that there will be a new workplan, which extended our deliverable submission requirements from two-hundred-forty-five (245) to a total of four-hundred-seventy-one (471) for the duration of the Operational Readiness contract. The State will provide more information on the remaining requirements in Spring 2023.

- 2022 Corporate Compliance Training – Board of Governors & Staff:
  - The Board of Governors Corporate Compliance Training concludes on November 15th, 2022.
  - The Annual Corporate Compliance Training for all Plan Staff was assigned on September 16th with a completion date of December 6th, 2022. At this time, 42% of staff have completed the assigned training.

Health Care Services

Steve O'Brien, MD

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

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

Date: **November 11th, 2022**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

- The carve in of Major Organ Transplant/Bone Marrow Transplant (MOT/BMT) went live on 1/1/2022. So far 230 members are in various stages of the Transplant process: 103 in Pre-Transplant, 18 on a Waitlist, 91 are post-Transplant. Most cases are going to UCSF, with a few to Stanford and other Centers of Excellence.

- Progress continues with UM/Claims configuration alignment, including Pharmacy claims. Providers are informed of the coding alignment changes so that they can bill and receive payment in a timely manner. Standardization improves accuracy and timeliness of claims payment through appropriate data integration between the authorization process and the claims processing. This project also supports accurate reporting of data to the state for a variety of initiatives.

- The process to refer members to Tertiary/Quaternary (T/Q) centers for specialized care has been revised to ensure that members appropriate for this higher-level care receive it in the most appropriate setting. Go live for implementation is set for 1/1/23, after communication with all stakeholders. Delegate CHCN already has implemented the T/Q policy which applies to adults newly seeking care

Outpatient Authorization Denial Rates			
Denial Rate Type	**July 2022**	**Aug 2022**	**Sept 2022**
Overall Denial Rate	**5.0%**	**3.8%**	**3.6%**
Denial Rate Excluding Partial Denials	**4.5%**	**3.5%**	**3.2%**
Partial Denial Rate	**0.5%**	**0.3%**	**0.4%**

Turn Around Time Compliance			
Line of Business	**July 2022**	**Aug 2022**	**Sept 2022**
Overall	**97%**	**98%**	**99%**
Medi-Cal	**97%**	**98%**	**99%**
IHSS	**97%**	**98%**	**98%**
Benchmark	***95%***	***95%***	***95%***

Utilization Management: Inpatient

- On January 1, 2023, FFS Medi-Cal members currently residing in Long Term Care SNFs will come back into AAH. Preparation for the influx of these 1500 to 1800 new members are underway, involving all departments in AAH, led by the Integrated Planning Department. The IP department continues with process improvements in the IP program to align with the carve in of Long-Term Care, including alignment with Delegate partners.

- IP Team implemented Preventing Unsafe Discharge and Administrative Day Review workflow to ensure that the safety net partners are appropriately compensated when there are barriers to members having a safe discharge. There are expected reductions in denial rates following this change.

- The inpatient department continues to track COVID admissions: Covid admissions increased slightly in July, and then declined to only 8 in October, with the average LOS hovering around 7-8 days. Overall, the rate continues to remain low, consistent with Alameda County data. The winter months may show an increase.

- Readmission reduction: CM continuing to collaborate with hospital partners and with their community-based TOC programs to focus on readmission reduction, aligning with their readmission reduction goals. There has been CM leadership changes at AHS, and AAH has re-established the partnership with Dr. Borneo and CAO Mark Brown, leadership of their Case Management and Ambulatory Transitions care team.

Inpatient Med-Surg Utilization Total All Aid Categories **Actuals (excludes Maternity)**			
Metric	**Jun 2022**	**July 2022**	**Aug 2022**
Authorized LOS	5.2	5.5	5.0
Admits/1,000	53.1	54.1	55.1
Days/1,000	273.9	298.2	276.8

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	25
Denied	38
Closed	116
Total	**179**

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

- Medications for menstrual bleeding, diabetes, migraines, nerve pain, Hepatitis B, psoriasis, COPD, infectious disease, and ear infection are top ten categories for denials.

Rank	Drug Name	Common Use	Common Denial Reason
1	TRANEXAMIC ACID 650 MG TABLET	Menstrual bleeding	Criteria for approval not met
2	RYBELSUS 3 MG TABLET	Diabetes	Criteria for approval not met
3	UBRELVY 50 MG TABLET	Migraines	Criteria for approval not met
4	BASAGLAR 100 UNIT/ML KWIKPEN	Diabetes	Criteria for approval not met
5	LIDOCAINE 5% PATCH	Nerve pain	Criteria for approval not met
6	VEMLIDY 25MG TABLET	Hepatitis B	Criteria for approval not met
7	CALCIPOTRIENE 0.005% OINTMENT	Psoriasis	Criteria for approval not met
8	BEVESPI AEROSPHERE INHALER	COPD	Criteria for approval not met
9	DOXYCYCLINE HYCLATE 20 MG TAB	Infectious disease	Criteria for approval not met
10	CIPRO HC OTIC SUSPENSION	Ear infection	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 October 28th, 2022, approximately 103.47 million point-of-sale pharmacy paid claims to participating pharmacies totaling approximately $12.89 billion in payments Processed 244,250 prior authorization requests
  - Answered 443,990 calls and 100 percent of virtual hold calls and voicemails have been returned
  - We have closed submitting Medi-Cal PAs and informing doctor offices to submit to Medi-Cal RX:

Month	Number of Total PA Closed
January 2022	169
February 2022	44
March 2022	31
April 2022	25
May 2022	7
June 2022	8
July 2022	27
August 2022	44
September 2022	66
October 2022	68

- The AAH Pharmacy Department is collaborating with QI/health education on providing input on diabetes assessment for future pharmacy referral.
    - The AAH Pharmacy Department is working with its Inpatient Department and Case Management Disease Management (CMDM) Department.
    - The AAH Pharmacy Department's TOC (Transition of Care) Program continues collaborating with the AAH Inpatient UM Department and Case Management Disease Management (CMDM) Department 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.
    - The inclusion criteria are members with heart failure, diabetes, sepsis, asthma/COPD, and use of anti-coagulants.
    - Referred cases from the CMDM daily feed are evaluated to determine if the AAH Pharmacy Dept is required for each case. The pharmacy department is focusing on lower volume, higher need cases where pharmacy may have the greatest impact on member outcomes:

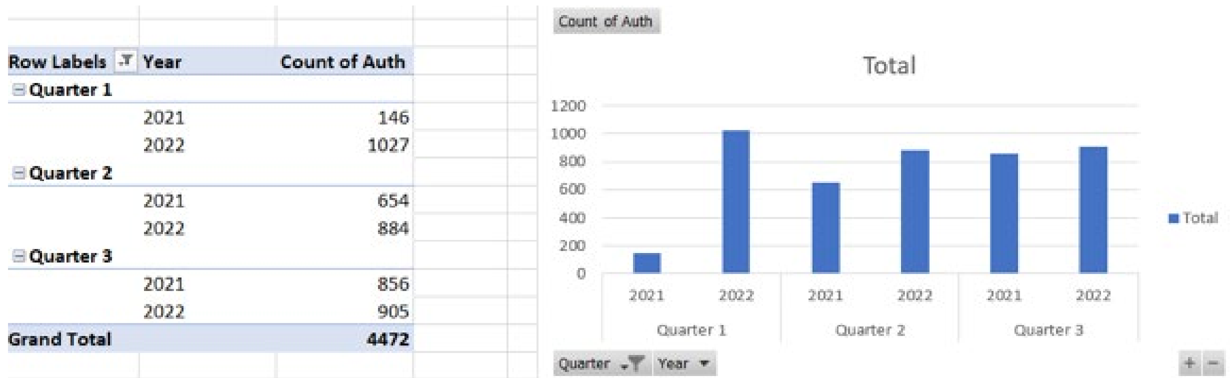
Month	Number of TOC Cases
January 2022	8
February 2022	38
March 2022	21
April 2022	22
May 2022	0
June 2022	1
July 2022	2
August 2022	12
September 2022	6
October 2022	7

- The AAH Pharmacy Department is collaborating with QI/health education on use of opioids and/or benzodiazepines
    - There was 55.6% increase among 90 MME users, 5.6% increase among 120 MME users, and 33% increase among 300 MME users.
    - There was 1% decrease among 50 MME users, 42.8% decrease among 200 MME users, and 25% decrease among 400 MME users.

Q3 2022			
MME	IHSS	MCAL	Total
July			254
50	5	202	207
90	1	9	10
120	1	18	19
200	0	7	7
300	0	3	3
400	0	8	8
August			279
50	5	211	216
90	0	15	15
120	1	28	29
200	0	9	9
300	0	1	1
400	0	9	9
September			257
50	4	200	204
90	0	13	13
120	1	19	20
200	0	10	10
300	0	4	4
400	0	6	6

- Pharmacy is leading initiatives on PAD (physician administered drugs) focused internal and external partnership and reviewed PAD related UM authorizations as follows. Note one auth is per drug:

Month	Number of Auth
January 2022	303
February 2022	303
March 2022	421
April 2022	330
May 2022	294
June 2022	260
July 2022	270
August 2022	289
September 2022	346



Row Labels	Year	Count of Auth
Quarter 1		
	2021	146
	2022	1027
Quarter 2		
	2021	654
	2022	884
Quarter 3		
	2021	856
	2022	905
Grand Total		4472

- Biosimilar utilization average was 73.2% during July 2022.
    - Savings achieved were $131k.

- Pharmacy has been working in collaboration with UM and other stakeholders to notify the AAH network that Enteral Nutrition Formula is a covered benefit by Medi-Cal Rx as a pharmacy billed item since 1/1/2022. On 11/1/2022, member and provider communications were sent out to inform AAH will no longer manage or cover Enteral Nutrition Formula for Medi-Cal members starting 12/1/2022. There will be no change to medical supplies related to Enteral Nutrition and AAH will continue to manage the benefit.

- Pharmacy is collaborating with CDPH, QI and HealthEd for additional asthma intervention strategies (e.g., data sharing, toolkit exchange and community worker training materials/programs).

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. Current bundles are Heme-Oncology, Dialysis, Asthma and Diabetes. CM's collaboration with the Quality Department on the implementation of the new Population Health Management (PHM) standards, include further expansion of Disease Management to include cardiovascular disease and Depression.

- CM is continuing to work with the Quality and Analytics Departments on updating the current Risk Stratification of AAH members as guided by the implementation of the new Population Health Management (PHM) standards. The new Risk Stratification will be used to evaluate and improve AAH's approach to connecting members to appropriate interventions and services.

- A portion of the Population Health Management standards include Transitional Care services for all members. CM is collaborating with Quality, Analytics and IP

UM to further enhance the current Transitions of Care programming to expand to meet the requirements for both 1/1/23 and 1/1/24.

- CM in collaboration with UM is working to prepare for Long-Term Care's Go-Live date of January 1st, 2023. This includes creating workflows and internal processes to address members transition(s) through the care continuum.

- Major Organ Transplant (MOT) CM Bundle was deployed, and the volume continues to increase, (230 cases YTD.) Processes to support members throughout the continuum of care, from Pre-Transplant, Transplantation, and Post-Transplant are being reviewed to further improve the collaboration between UM and CM to better service this population.

- Dialysis CM Bundle work continues 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 members can successfully manage their dialysis needs. CHCN has been invited into the regular high-risk rounds with DaVita SPCC to coordinate interventions and support to these highest risk members who require dialysis.

- CM is working closely with the Behavioral Health (BH) team to train BH on internal CM processes. CM will continue to integrate the BH team as Behavioral Health is carved-in to the Alliance.

Case Type	Cases Opened in September 2022	Total Open Cases as of September 2022	Cases Opened in October 2022	Total Open Cases as of October 2022
Care Coordination	335	631	307	617
Complex Case Management	34	90	36	101
Transitions of Care (TOC)	206	389	178	375

CalAIM

Enhanced Care Management

- ACBH launched as an ECM provider on September 1st, 2022

- Work with IPD, Analytics and Provider Service teams continues for next Populations of Focus (LTC to home; LTC diversion) to launch 01/01/23.

- In preparation for the new ECM Populations of Focus launching 1/1/23 (Adults Living in the Community Who are at Risk for LTC Institutionalization and Nursing

Facility Residents Transitioning to the Community) network expansion is expected. Potential ECM Providers are being evaluated.

- Collaboration is beginning with California Children's Services (CCS) to discuss the new ECM Population of Focus, Children and Youth, and CCS's role when this population launches in July of 2023.

- Continued communication with the Parole Board to discuss the new launch date of Individuals Transitioning from Incarceration of 2024 (month not specified).

- An ECM Dashboard has been developed which provides real time access to outcomes of ECM program, including member outcomes, utilization, and change in outcomes over time. ECM program shows 32% reductions in admissions and 25% reduction in ED usage before and after members were enrolled, and an approximately 25% reduction in ED/IP costs PMPM before and after members were enrolled.

Case Type	ECM Outreach in July 2022	Total Open Cases as of July 2022	ECM Outreach in August 2022	Total Open Cases as of August 2022	ECM Outreach in September 2022	Total Open Cases as of September 2022
ECM	226	799	243	850	195	890

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 authorizing care and are tracking program metrics.

- A CS dashboard has been completed to provide real time data review and reporting on the processes and outcomes of the CS program. Early evaluation shows a decrease in Admits/1000, Bed Days/1000, Average Length of Stay, ER Visits/1000.

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

- Recipe for Health (R4H) successfully launched as a Medically Supportive Food CS provider on 9/1/22.

- CS, ECM, Finance and Provider Relations are collaborating to consider a Self-Funded Pilot for 2 additional Community Supports Services. The Self-Funded Pilot would complement the incoming ECM Populations of Focus (January of 2023) and contribute to the success of the members' management:
  - Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities.
  - Community Transition Services/Nursing Facility Transition to a Home.

Community Supports	Services Authorized in Jul 2022	Services Authorized in Aug 2022	Services Authorized in Sept 2022	Services Authorized in Oct 2022
Housing Navigation	315	355	367	374
Housing Deposits	228	245	235	215
Housing Tenancy	936	970	1002	1009
Asthma Remediation	21	27	32	28
Meals	65	61	261	266
Medical Respite	37	33	37	30

Grievances & Appeals

- All cases were resolved within the goal of 95% within regulatory timeframes.

- Total grievances resolved in October were 7.24 complaints per 1,000 members.

- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of October 2022; we did meet our goal at 16.2% overturn rate.

October 2022 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	629	30 Calendar Days	95% compliance within standard	612	97.3%	1.94
Expedited Grievance	4	72 Hours	95% compliance within standard	4	100.0%	0.01
Exempt Grievance	1678	Next Business Day	95% compliance within standard	1678	100.0%	5.17
Standard Appeal	36	30 Calendar Days	95% compliance within standard	35	97.2%	0.11
Expedited Appeal	1	72 Hours	95% compliance within standard	1	100.0%	0.00
Total Cases:	2348		95% compliance within standard	2330	99.2%	7.24

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

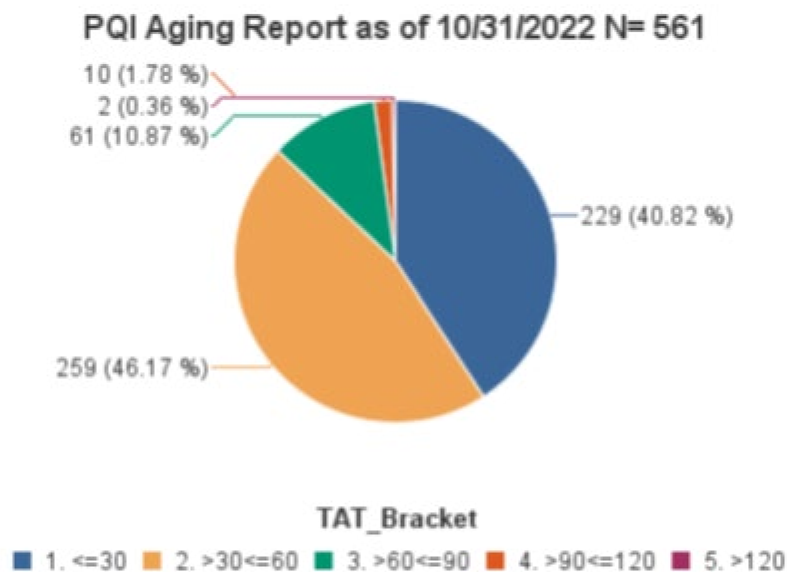
Quality

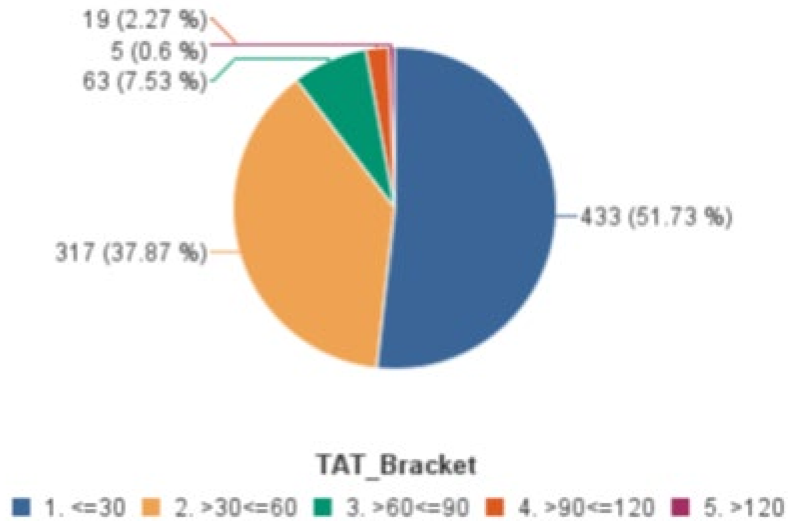
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records followed by final MD review when applicable.

- As part of an effort to streamline the PQI review process, Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics team.

- PQI cases open > 120 days made up 0.6% of total cases for September and 0.36% in October. Cases open for >120 days continues to be primarily related to delay in submission of medical records by specific providers. Measures to close these cases continues to be a priority.

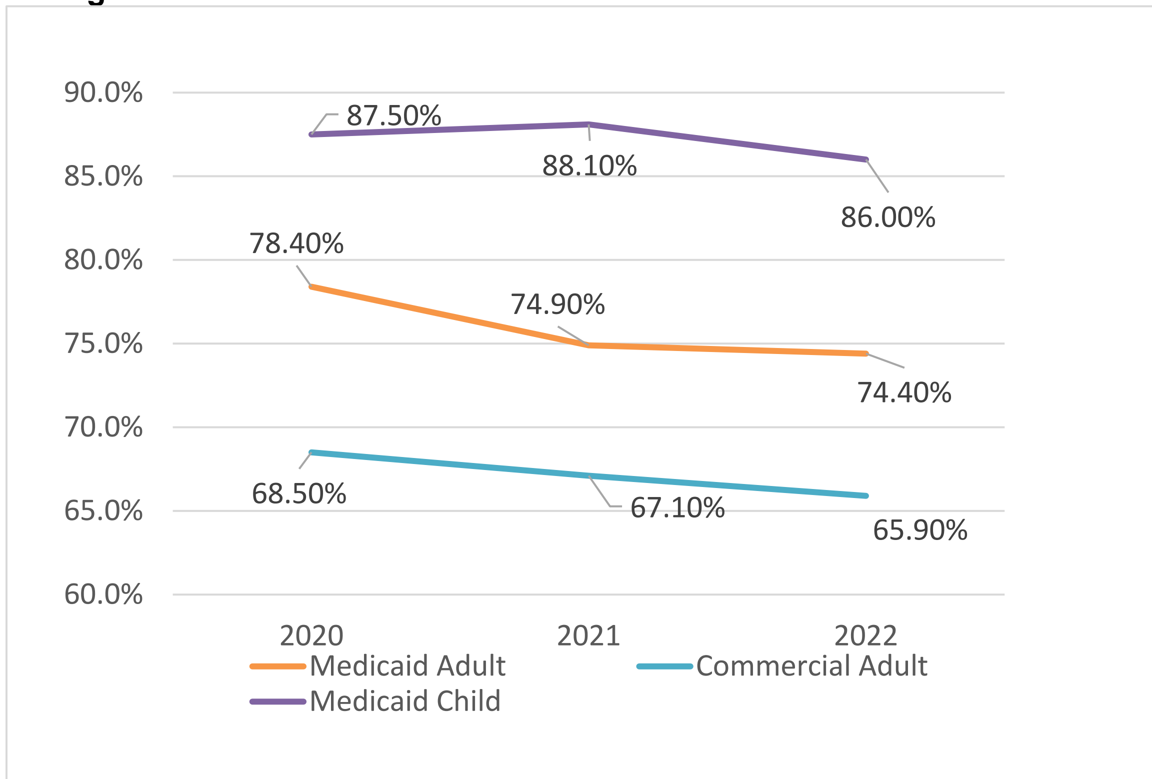
- It was also noted that for cases open >90 days, the percentage remains below 3%. Overall, the rate of case closure within 120 days is below the 5% benchmark as required by the PQI P&P QI-104.





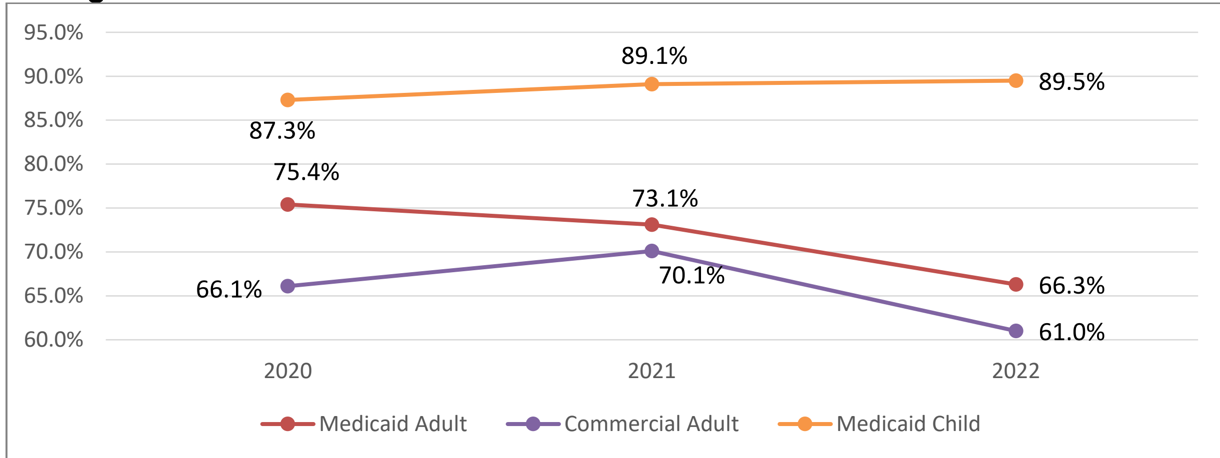
- CAHP 5.1 Survey Objective: The overall objective of the CAHPS study is to capture accurate and complete information about consumer reported experiences with health care. Specially, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of services have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of provided care.

Rating of Health Plan 8 to 10



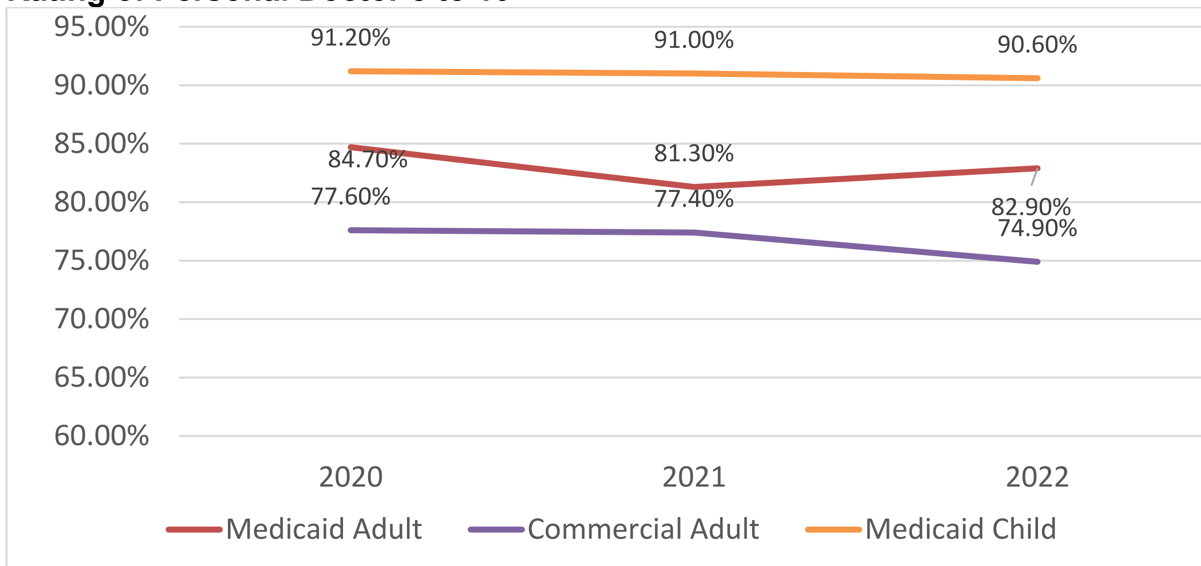
- Rates change from 2021 to 2022:
    - Medicaid Adult rate in 2022 decreased from 2021 by 0.5%.
    - Medicaid Child rate in 2022 decreased from 2021 by 2.1%.
    - Commercial Adult rate in 2022 decreased from 2021 by 1.2%.

Rating of Health Care 8 to 10



- Rates change from 2021 to 2022:
    - Medicaid Adult rate in 2022 decreased from 2021 by 6.8%.
    - Medicaid Child rate in 2022 increased from 2021 by 0.4%.
    - Commercial Adult rate in 2022 decreased from 2021 by 9.1%.

Rating of Personal Doctor 8 to 10



- Rates change from 2021 to 2022
    - Medicaid Adult rate in 2022 increased from 2021 by 1.6%.
    - Medicaid Child rate in 2022 decreased from 2021 by 0.4%.
    - Commercial Adult rate in 2022 decreased from 2021 by 2.5%.

- Next Step: In the next two quarters, Access and Availability will continue to collaborate interdepartmentally to identify best practices and opportunities for improvement and develop improvement action plan for implementation.

Information Technology

Sasikumar Karaiyan

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

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

Date: **November 11th, 2022**

Subject: **Information Technology Report**

Call Center System Availability

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

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.

- The Business Continuity Plan document has been drafted and completed. This document will serve as a playbook to help ensure the safety of our employees, to keep the organization and members informed through communication designed channels and restore business functions in the event of a disaster.

- The Discovery and Design phase of the project for all tier 1 applications has been completed. The Implementation phase of the project is now in progress and 85% of the tier 1 servers have been successfully seeded and are now replicating to our backup data center in Roseville. Part of this phase also includes the runbook creation for each application which will incorporate the recovery procedures.

- The initial Disaster Recovery tabletop test for all tier 1 application has been completed successfully on Friday, September 30th, 2022.

- The project team is working diligently to update the recovery procedures within the runbook to 95% by the end of October 2022 and schedule the final tabletop test before the end of December 2022.

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.

    - **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.

- Cyber Security is at 90% complete, M365 is at 95% complete, Azure 100% complete and overall, 90% complete for high-severity items.

- Protecting shared cloud applications with Multi-Factor Authentication and Single Sign-On has been included in the overall project. The design modeling phase of each cloud application has been completed. Testing phase is now in-progress and will be scheduled during non-business hours.

- The Extended 24/7 Security Support project is in progress and the portal onboarding and configuration has been completed. The Arctic Wolf sensor appliances have been delivered and the first appliance has been installed in our main data center in Alameda. The second appliance has been installed in the backup data center in Roseville on September 16th, 2022. Hardware configuration is now in progress and expected to complete the overall project by the end of November 2022.

Encounter Data

- In the month of October 2022, the Alliance submitted 171 encounter files to the Department of Health Care Services (DHCS) with a total of 330,592 encounters.

- Received encounters are higher than average in the month of October 2022 due primarily to higher-than-average CHCN submissions. CHCN encounter submissions were 77% higher than the previous 12-month average. Team is working with CHCN to identify the root cause for the encounter volume spike.

Enrollment

- The Medi-Cal Enrollment file for the month of October 2022 was received and processed on time.

HealthSuite

- A total of 152,387 claims were processed in the month of October 2022 out of which 124,725 claims auto adjudicated. This sets the auto-adjudication rate for this period to 81.8%.

TruCare

- A total of 13,969 authorizations were loaded and processed in the TruCare application.

- The TruCare application continues to operate with an uptime of 99.99%.

Consumer Portal

- In May 2022, the Alliance started the consumer portal enhancement. This consumer portal shall enable the Providers to submit prior authorizations, referrals, claims, and encounters to the Alliance and improve authorization and claim processing metrics.

- In October 2022, we made significant progress in building the portal foundation to support accepting the Behavioural Health provider forms, Long Term Care, and the Professional Services Claim Form.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 "Summary of Medi-Cal and Group Care member enrollment in the month of October 2022".
- See Table 1-2 "Summary of Primary Care Physician (PCP) Auto-assignment in the month of October 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 October 2022

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
October	317,397	4,208	2,402	5,804	128	120

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 October 2022

Auto-Assignments	Member Count
Auto-assignments MC	1,493
Auto-assignments Expansion	1,152
Auto-assignments GC	42
PCP Changes (PCP Change Tool) Total	2,657

TruCare Application

- See Table 2-1 "Summary of TruCare Authorizations for the month of October 2022".
- There were 13, 969 authorizations processed within the TruCare application.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of October 2022

Transaction Type	Inbound EDI Auths	Errored	Total Auths Loaded in TruCare
EDI	4,174	451	4,028
Paper to EDI	2,983	1,878	1,738
Provider Portal	2,913	671	2,835
Manual Entry	N/A	N/A	1527
Total			10,128

Key: EDI – Electronic Data Interchange

Web Portal Consumer Platform

- The following table 3-1 is a supporting document from the Web Portal summary section. (Portal reports always one month behind current month)

Table 3-1 Web Portal Usage for the Month September 2022

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	8,247	3,675	155,151	460
MCAL	87,519	2,128	5,226	798
IHSS	3,211	90	236	25
AAH Staff	175	49	875	2
Total	**99,152**	**5,942**	**161,488**	**1,285**

Table 3-2 Top Pages Viewed for the Month of September 2022

Top 25 Pages Viewed		
Category	**Page Name**	**September - 22**
Provider	Member Eligibility	684,325
Provider	Claim Status	145,294
Provider - Authorizations	Auth Submit	9,595
Provider - Authorizations	Auth Search	4,303
Member My Care	Member Eligibility	2,785
Provider	Member Roster	1,922
Member Help Resources	Find a Doctor or Hospital	1,473
Member Help Resources	ID Card	1,279
Member Help Resources	Select or Change Your PCP	895
Member My Care	MC ID Card	742
Provider - Provider Directory	Provider Directory	797
Member My Care	My Claims Services	764
Member Help Resources	Request Kaiser as my Provider	504
Provider - Home	Forms	289
Member My Care	Authorization	465
Member My Care	My Pharmacy Medication Benefits	231
Provider - Provider Directory	Manual	252
Provider - Provider Directory	Instruction Guide	200
Member Help Resources	FAQs	188
Member Help Resources	Authorizations Referrals	165
Member Help Resources	Forms Resources	226
Member My Care	Member Benefits Materials	178
Member Help Resources	Contact Us	137

Table 3-3 Member Portal Preferred Language for the Month of September 2022

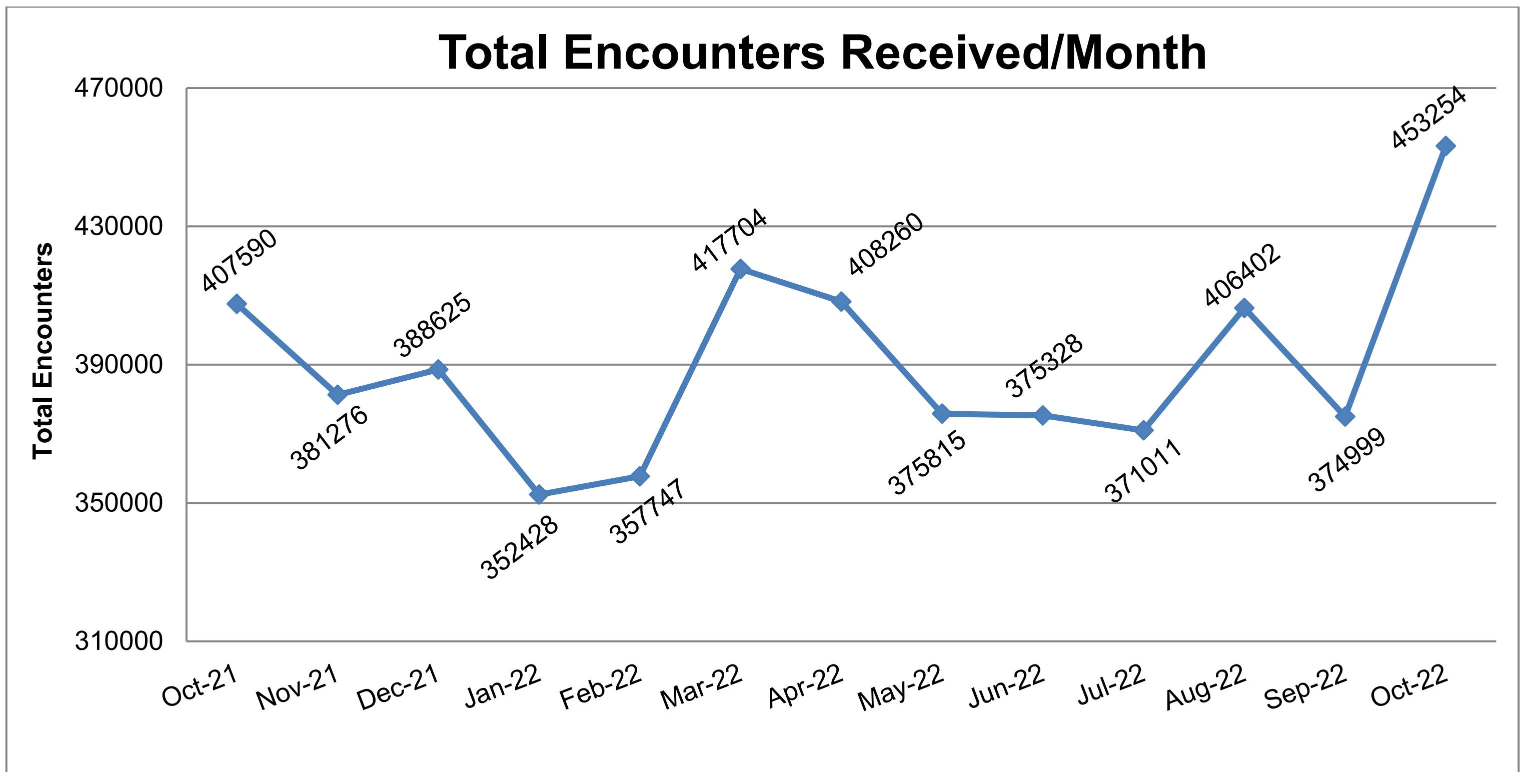
Member Portal Preferred Languages		
Member Group	**# of Individual User Accounts Accessed**	**Total Logins**
MCAL - English	2,127	5,225
MCAL - Spanish	1	1
MCAL - Vietnamese	-	-
MCAL - Tagalog	-	-
MCAL - Chinese	-	-
IHSS - English	90	236
IHSS - Spanish	-	-
IHSS - Vietnamese	-	-
IHSS - Tagalog	-	-
IHSS - Chinese	-	-
Total	**2,218**	**5,462**

Encounter Data from Trading Partners 2022

- **ACBH**: October monthly files (8 records) were received on time.
- **AHS**: October weekly files (5,589 records) were received on time.
- **BAC**: October monthly file (39 records) were received on time.
- **Beacon**: October weekly files (13,490 records) were received on time
- **CHCN**: October weekly files (136,445 records) were received on time.
- **CHME**: October monthly file (5,214 records) were received on time.
- **CFMG**: October weekly files (15,668 records) were received on time.
- **DocuStream**: October monthly files (1,294 records) were received on time.
- **HCSA**: October monthly files (2,098 records) were received on time.
- **Kaiser**: October bi-weekly files (63,341 records) were received on time.
- **LogistiCare**: October weekly files (19,041 records) were received on time.
- **March Vision**: October monthly file (3,693 records) were received on time.
- **Quest Diagnostics**: October weekly files (15,948 records) were received on time.
- **Teladoc**: October monthly files (0 records).
  - Teladoc has switched to submitting claims as of July 2022
- **Magellan**: October monthly files (321,029 records) were received on time.

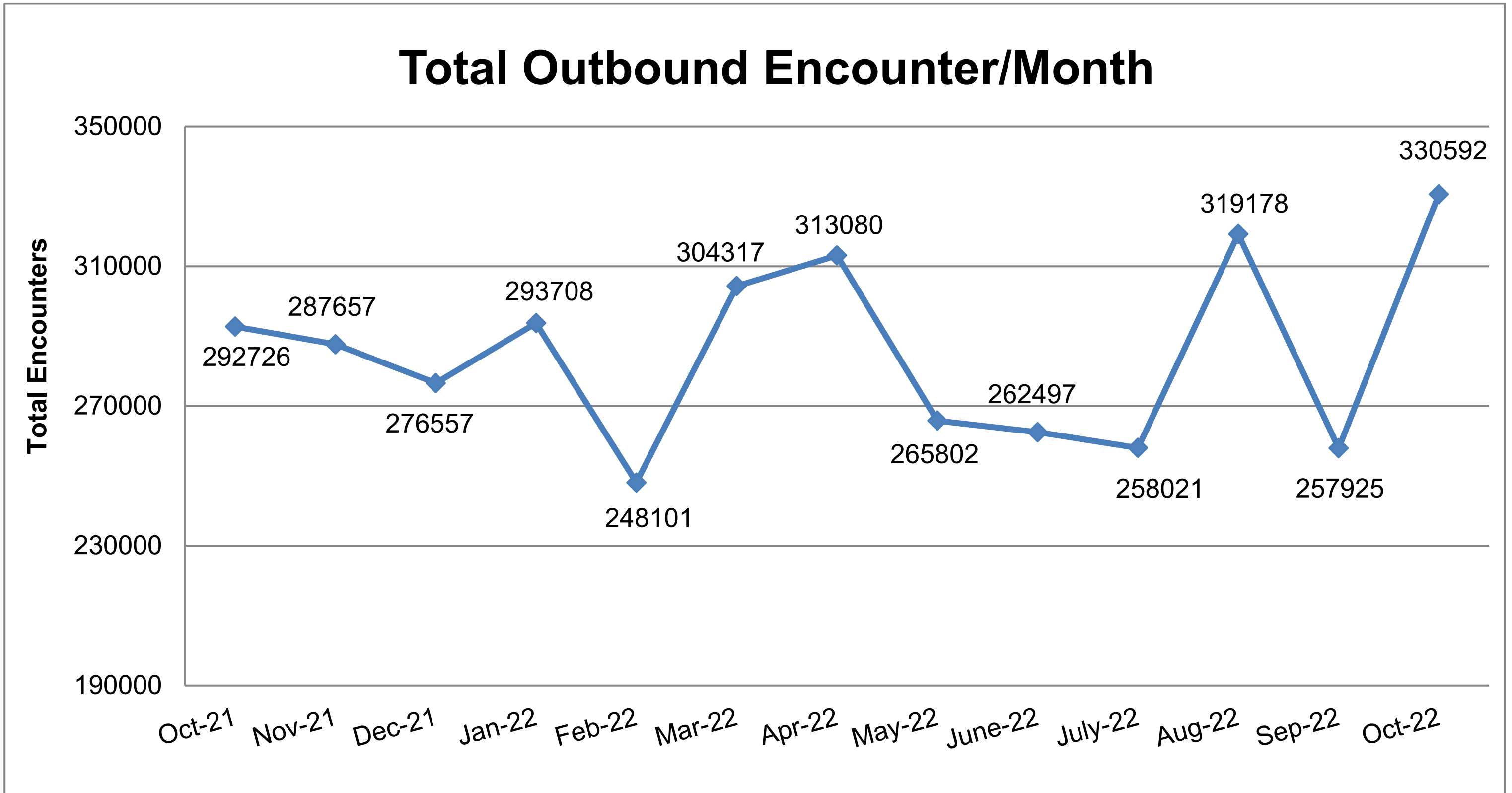
Trading Partner Medical Encounter Inbound Submission History

Trading Partners	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
HealthSuite	177483	167057	175441	162201	162433	185738	189172	163272	173269	176217	177945	175955	171386
ACBH													8
AHS	10625	8791	9314	6944	5630	6215	7717	6105	5486	5742	5482	5609	5589
BAC					34	12	45	63	53	66	53	37	39
Beacon	13693	12456	14899	9796	10966	16088	14303	13796	18340	15678	21310	16040	13490
CHCN	71581	99117	73269	75302	77276	79363	74683	80340	67339	69636	84302	75234	136445
CHME	4814	5003	4908	9254	4706	4778	4955	4551	4578	4853	4722	5191	5214
Claimsnet	15598	11032	12410	8643	13228	13522	10943	14075	10300	7744	10631	6940	15668
Docustream	1474	1185	1586	1703	1304	2130	2220	1140	1263	1236	1149	1715	1294
HCSA						3630	2029	1824	1880	3366	1869	4440	2098
Kaiser	75112	38085	63939	46458	52179	68530	69174	51214	62952	47584	62477	48613	63341
Logisticare	16977	22403	17125	16536	16393	19841	16232	20299	14590	20981	20200	19257	19041
March Vision	3377	3584	3220	2872	1445	3559	3425	3345	3188	3040	2708	3824	3693
Quest	16841	12542	12494	12696	12121	14268	13330	15757	12058	14868	13554	12144	15948
Teladoc	15	21	20	23	32	30	32	34	32	0	0	0	0
Total	407590	381276	388625	352428	357747	417704	408260	375815	375328	371011	406402	374999	453254



Outbound Medical Encounter Submission

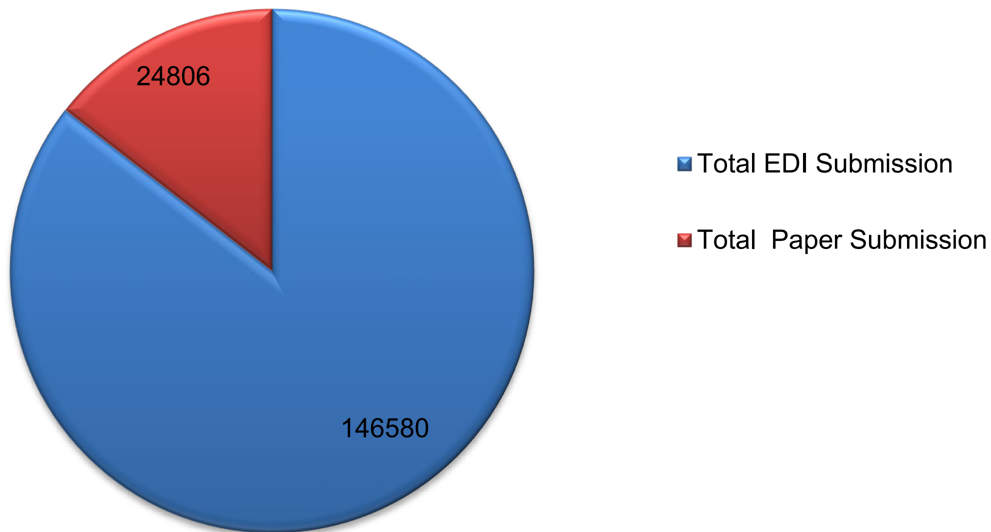
Trading Partners	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
HealthSuite	83690	100925	114507	95489	139452	97141	103843	133252	93919	90605	92682	121957	96495
ACBH													4
AHS	10176	8541	7728	7943	5524	6142	6251	7156	5363	5702	5168	4360	6626
BAC					34	12	45	61	52	63	50	37	37
Beacon	11423	9969	12659	7566	8140	12332	11273	9221	9534	14711	17246	12054	10967
CHCN	49171	67383	49080	52531	44745	58795	49365	49911	51060	49003	60678	50714	74449
CHME	4587	4849	4691	4496	4585	4702	4686	4448	4470	4714	4618	5069	5016
Claimsnet	10829	7406	8465	6114	9917	9677	8100	8410	7985	7209	7248	4614	10491
Docustream	1094	981	1185	1176	66	72	14	3406	854	1070	964	1436	1060
HCSA						3112	1810	1518	1719	1579	1770	2368	2013
Kaiser	73264	37473	63433	44248	51831	67559	67177	50894	62562	47331	61831	47861	62682
Logisticare	16231	19240	19787	16309	16242	19700	16123	19777	14677	20828	20022	19001	18457
March Vision	2608	2831	2490	2175	1072	2724	2575	2464	2392	2206	1969	2631	2601
Quest	12403	14457	11531	11676	8774	15620	12378	14602	11192	10923	15657	11285	14890
Teladoc	15	20	19	22	30	27	31	15	32	0	0	0	0
Total	292726	287657	276557	293708	248101	304317	313080	265802	262497	258021	319178	257925	330592



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
22-Oct	146580	24806	171386

Key: EDI – Electronic Data Interchange

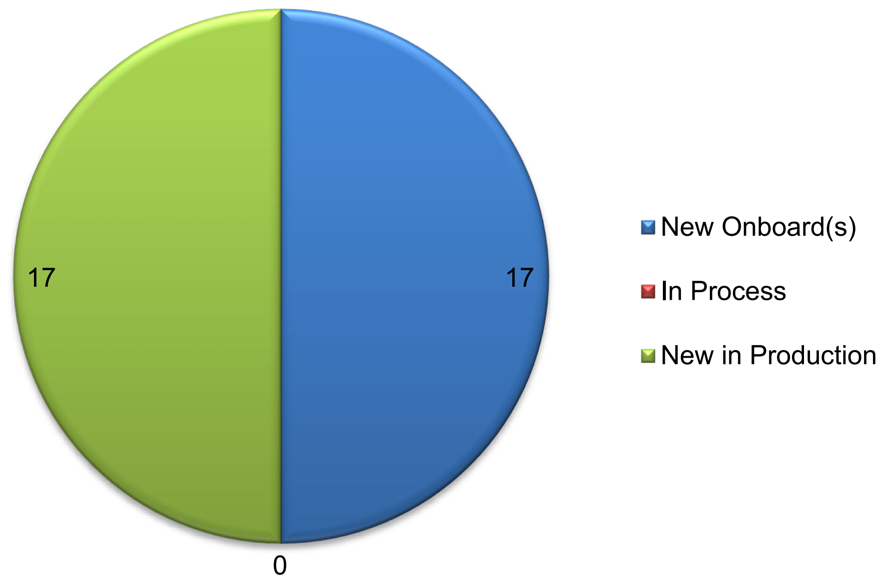


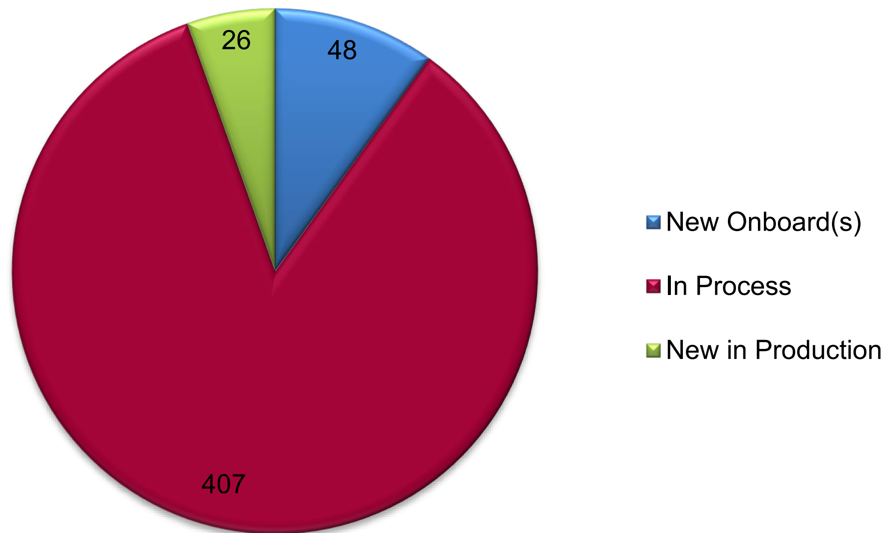
Onboarding EDI Providers - Updates

- October 2022 EDI Claims:
  - A total of 1427 new EDI submitters have been added since October 2015, with 17 added in October 2022.
  - The total number of EDI submitters is 2167 providers.

- October 2022 EDI Remittances (ERA):
  - A total of 541 new ERA receivers have been added since October 2015, with 26 added in October 2022.
  - The total number of ERA receivers is 568 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
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
May-22	17	3	14	2079	13	285	3	456
Jun-22	8	1	7	2086	29	301	13	469
Jul-22	38	1	27	2113	54	339	16	485
Aug-22	26	0	26	2139	46	354	31	516
Sep-22	11	0	11	2150	57	385	26	542
Oct-22	17	0	17	2167	48	407	26	568


837 EDI Submitters - October 2022
17
17
0
New Onboard(s)
In Process
New in Production


835 EDI Receivers - October 2022
26
48
407
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 October 2022.

File Type	Oct-22
837 I Files	30
837 P Files	141
Total Files	171

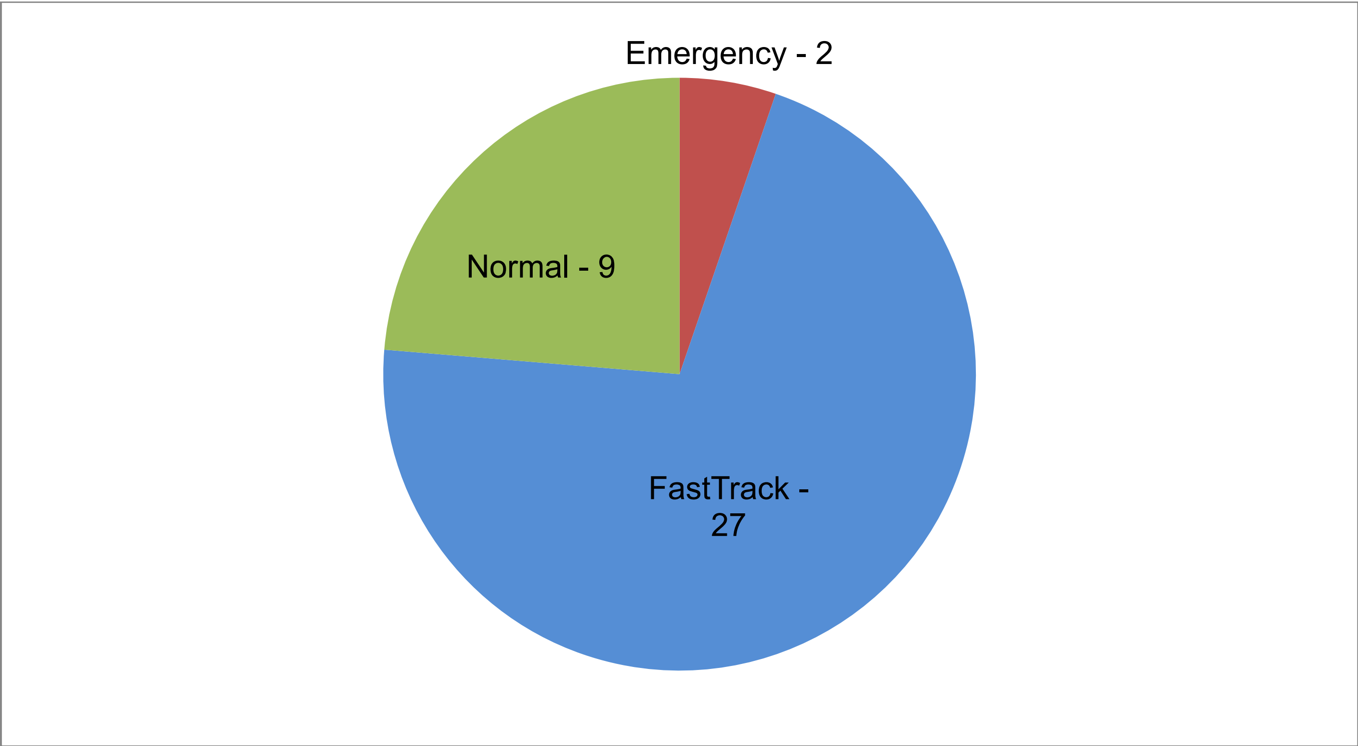
Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Oct-22	Target
Timeliness-% Within Lag Time – Institutional 0-90 days	91%	60%
Timeliness-% Within Lag Time – Institutional 0-180 days	95%	80%
Timeliness-% Within Lag Time – Professional 0-90 days	91%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	97%	80%

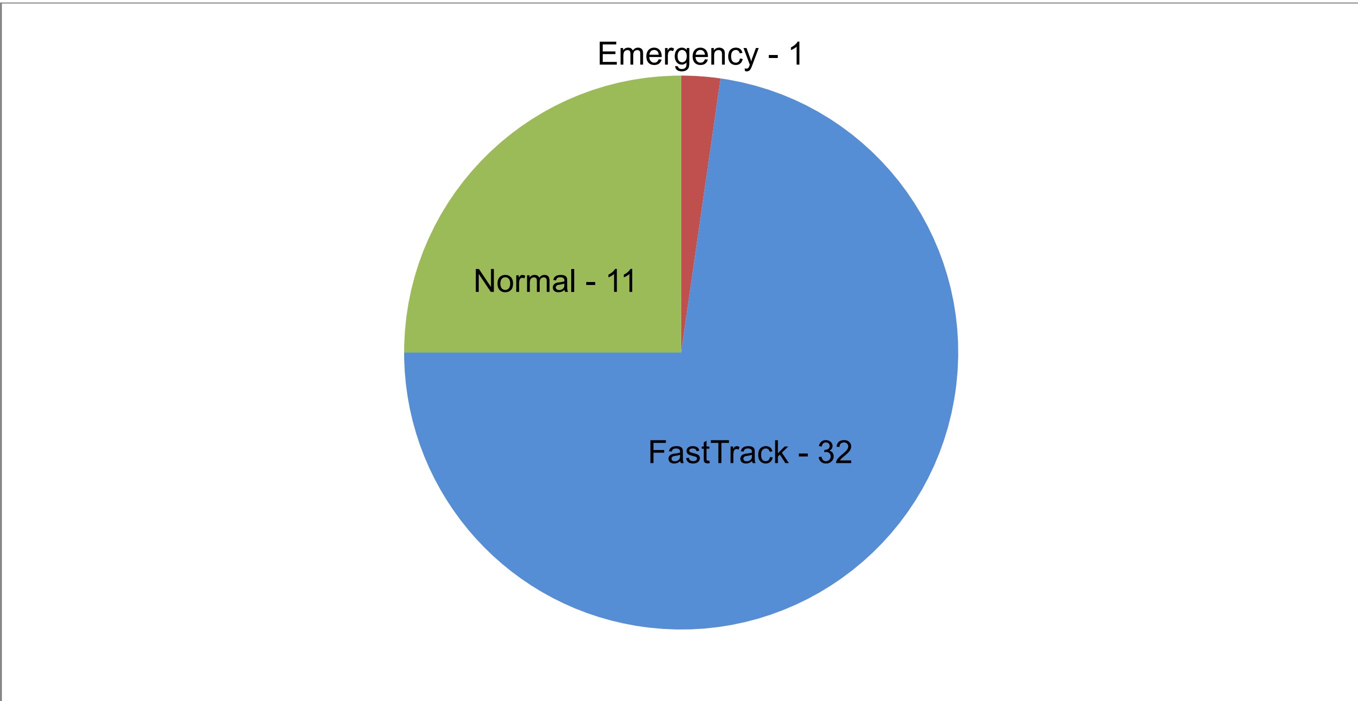
Change Management Key Performance Indicator (KPI)

- Change Request Overall Summary in the month of October 2022 KPI:
  - 38 Changes Submitted.
  - 44 Changes Completed and Closed.
  - 119 Active Change Requests in pipeline.
  - 5 Change Requests Cancelled or Rejected.

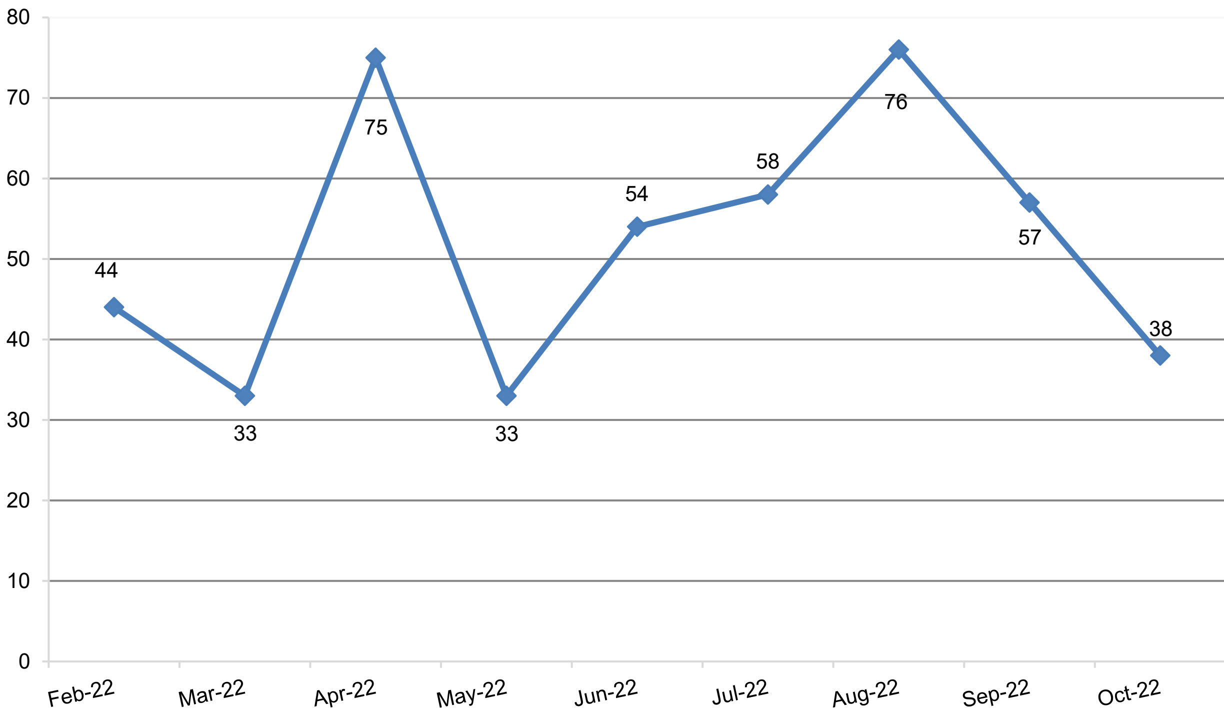
- 38 Change Requests Submitted/Logged in the month of October 2022



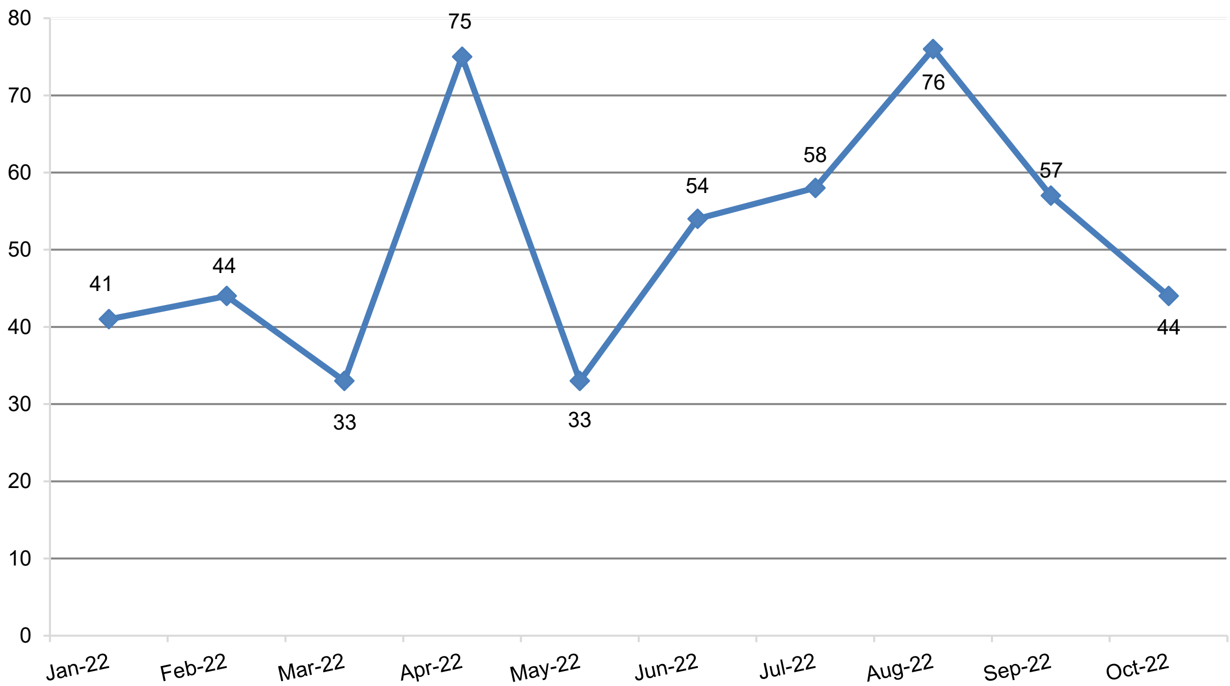
- 44 Change Requests Closed in the month of October 2022



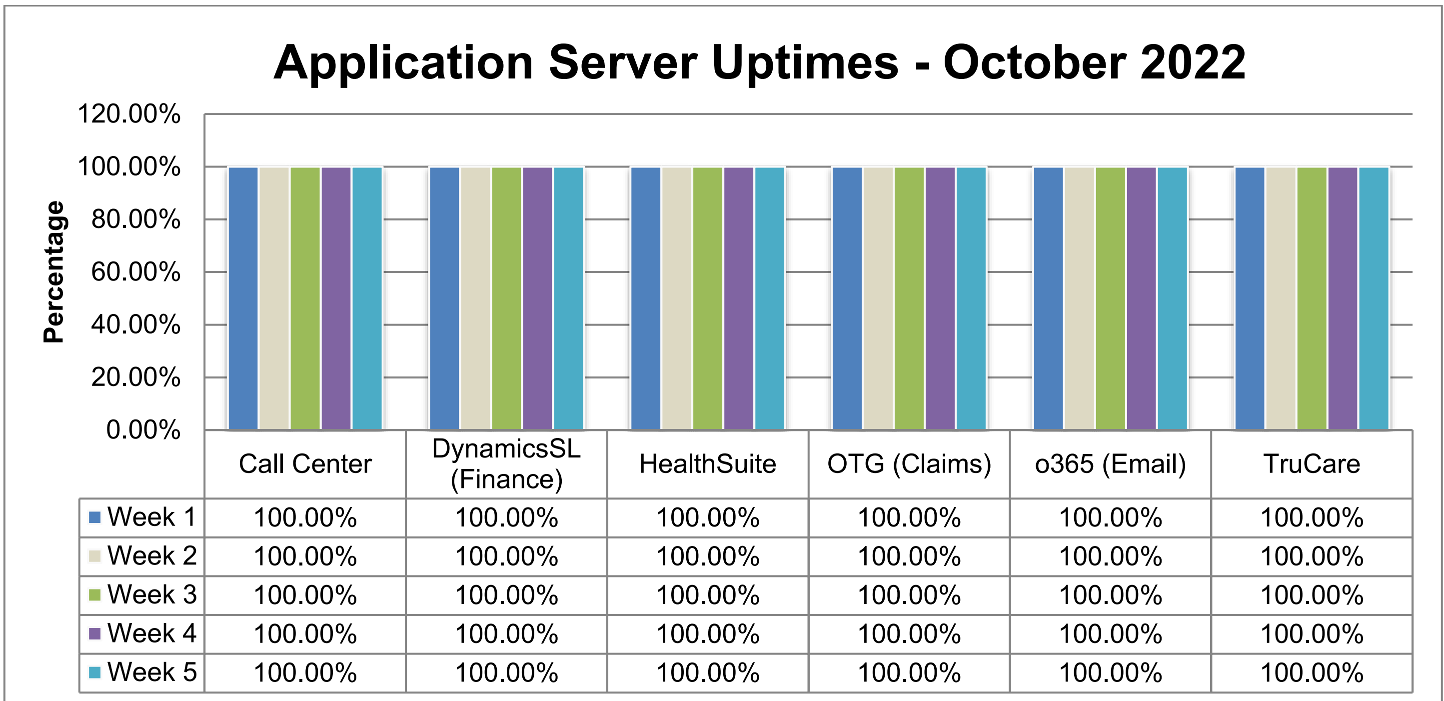
- Change Requests Submitted: Monthly Trend



- Change Requests Closed: Monthly Trend

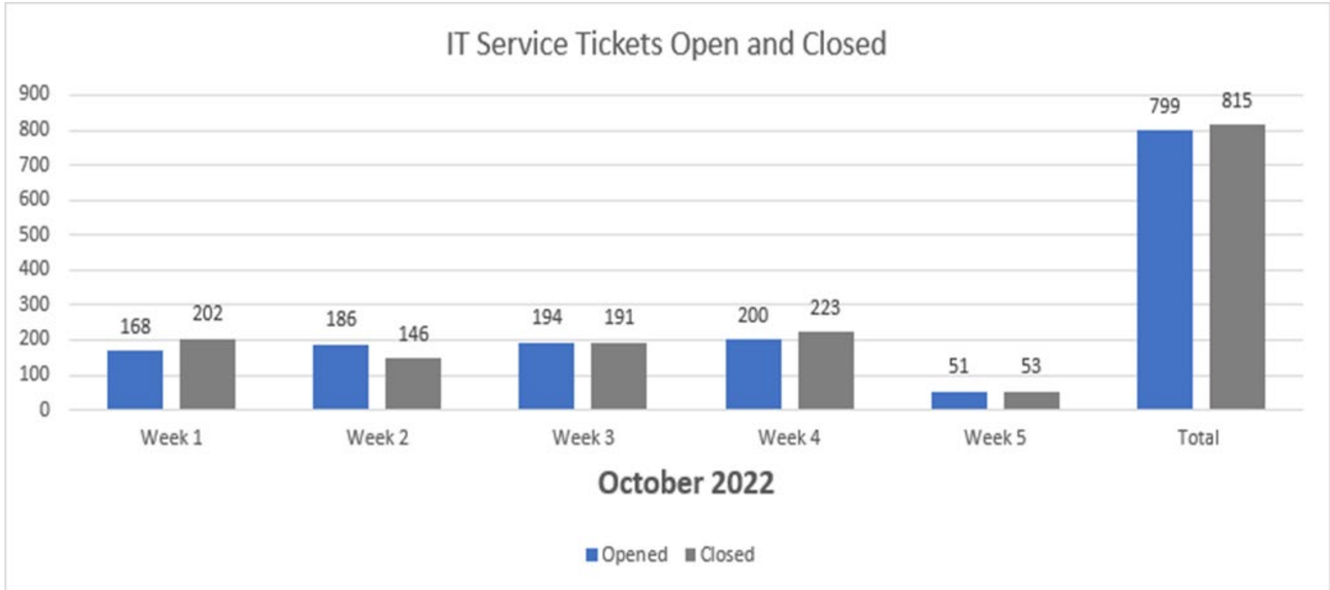


IT Stats: Infrastructure



	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 outages experienced in the month of October 2022.



	Week 1 (10/1 -10/9)	Week 2 (10/10- 10/16)	Week 3 (10/17- 10/23)	Week 4 (10/24 - 10/30)	Week 5 (10/31)	Total
Opened	168	186	194	200	51	799
Closed	202	146	191	223	53	815

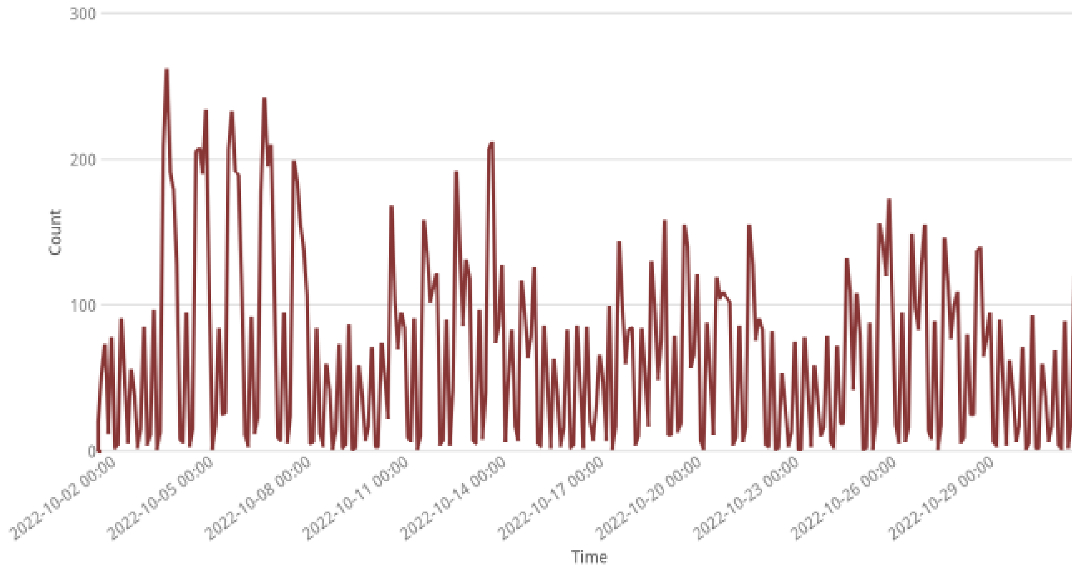
- 799 Service Desk tickets were opened in the month of October 2022, and 647 Service Desk tickets were closed.

- The open ticket count for the month of October is slightly higher than the previous 3-month average of 700.

October 2022

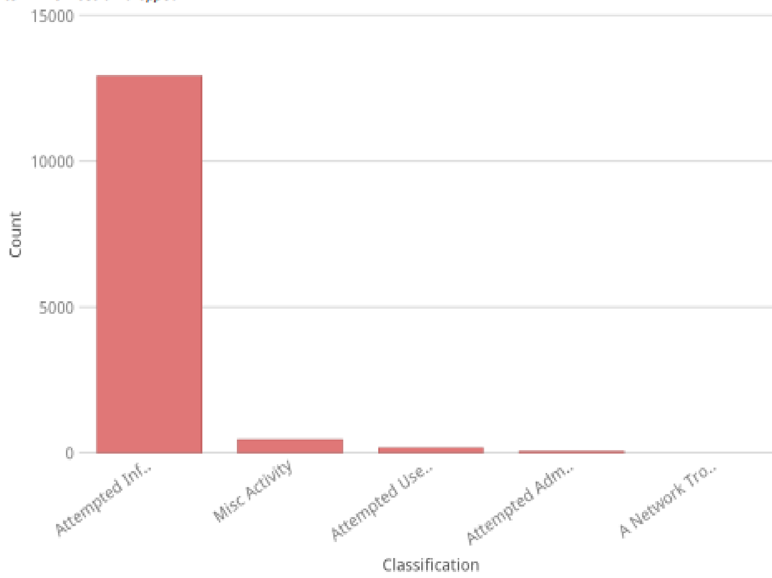
All Intrusion Events

Time Window: *2022-10-01 09:29:00 - 2022-10-31 09:29:00*



Dropped Intrusion Events

Time Window: *2022-10-01 09:30:00 - 2022-10-31 09:30:00*
Constraints: *Inline Result = dropped*



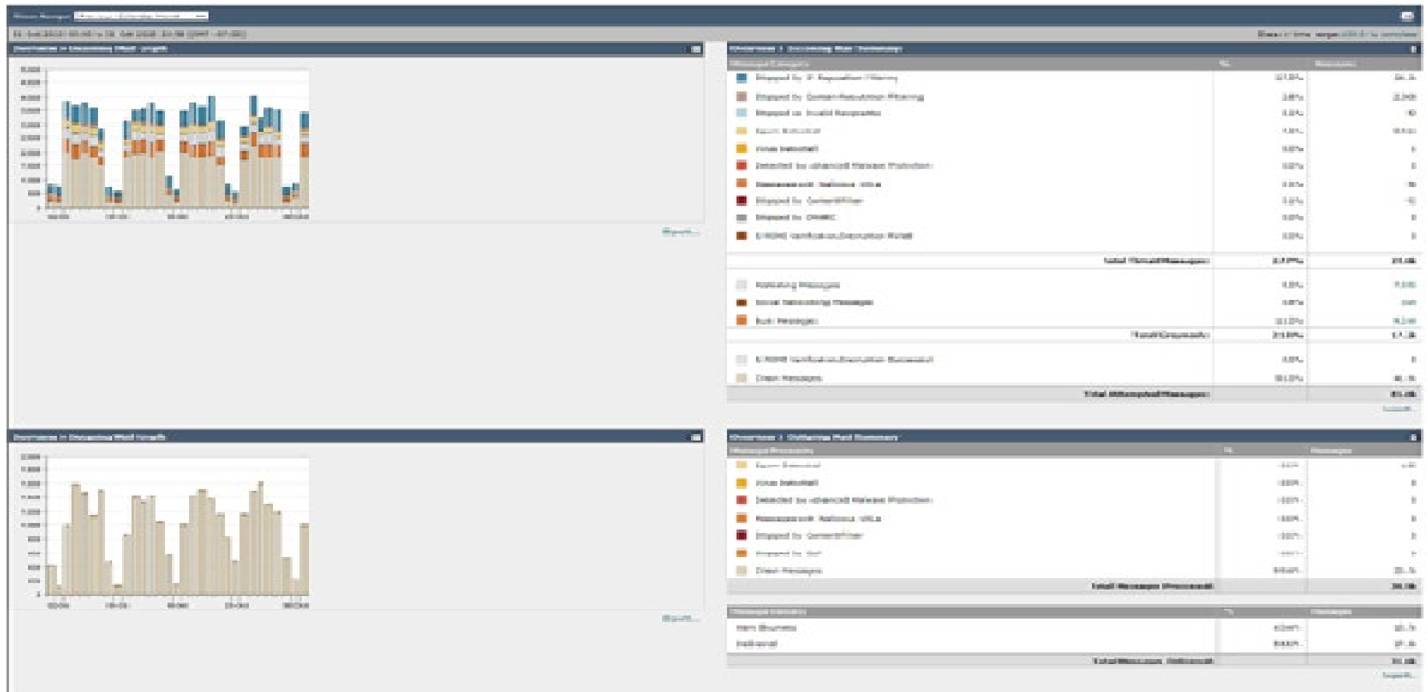
Classification	Count
Attempted Information Leak	12,942
Misc Activity	469
Attempted User Privilege Gain	180
Attempted Administrator Privilege Gain	68
A Network Trojan was Detected	2

IronPort Email Security Gateways

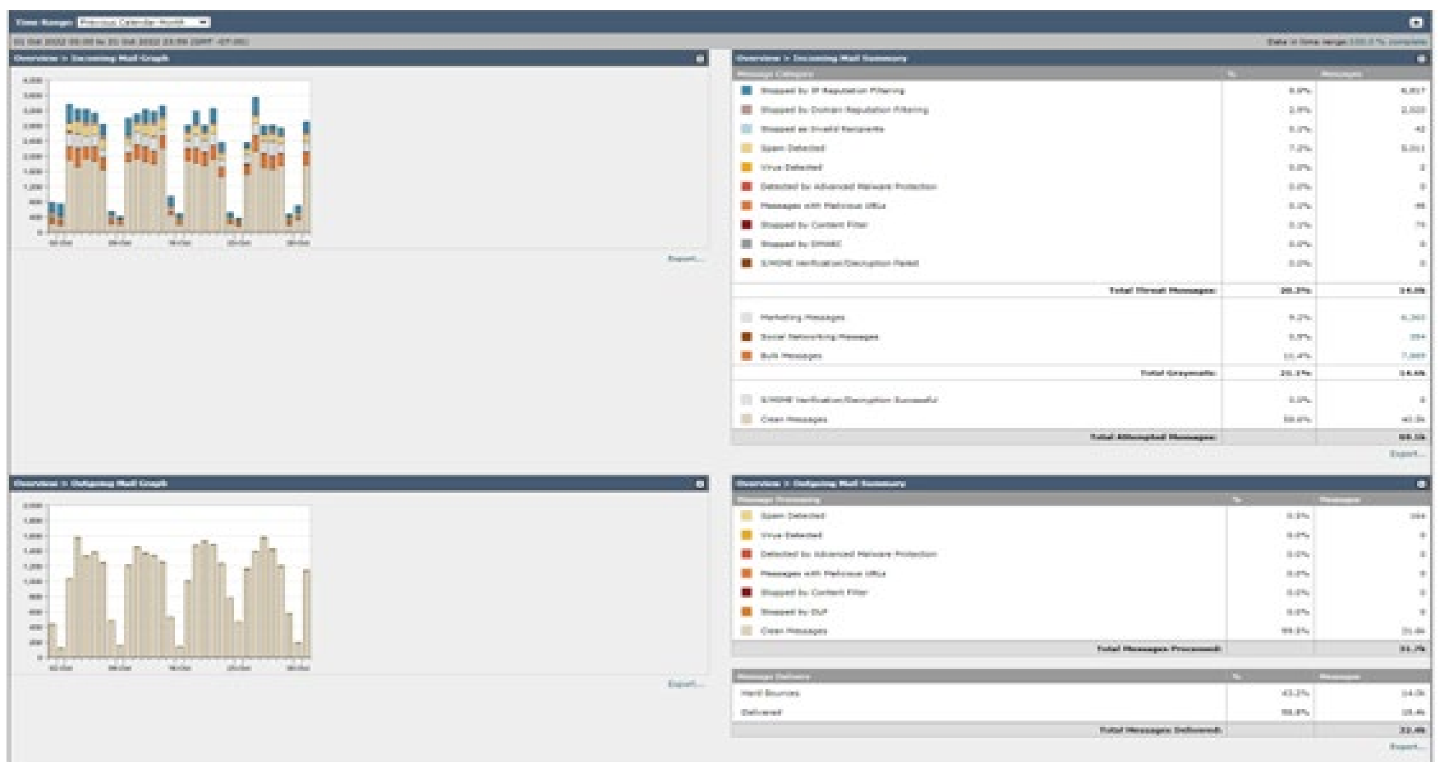
Email Filters

October 2022

MX4



MX9



Item / Date	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Stopped By Reputation	24.3k	39.3k	69.7k	42.4k	329.9k	52.8k	26k	36k	34.7k	28.2k	27.6k	43.6k	**20.9k**
Invalid Recipients	82	92	153	185	69	389	117	100	119	78	117	71	**94**
Spam Detected	5.6k	9,684	13.2k	10.3k	10.3k	15k	13.7k	13.9k	13.9k	11.6k	13.3k	14.6k	**10.9k**
Virus Detected	0	1	1	5	13	1	4	18	18	1	0	2	**3**
Advanced Malware	0	0	9	0	4	2	1	0	0	0	1	2	**0**
Malicious URLs	6	43	39	16	89	41	159	296	187	93	448	226	**102**
Content Filter	27	27	8	371	54	39	115	39	125	119	79	111	**171**
Marketing Messages	4,489	9,221	6,147	8,864	9,588	8,864	11.3k	10.7k	12.5k	12.6k	14.5k	13.7k	**13.9k**
Attempted Admin Privilege Gain	128	124	116	103	116	132	143	113	215	215	210	151	**68**
Attempted User Privilege Gain	6	13	49	117	663	789	401	549	157	153	722	395	**180**
Attempted Information Leak	7,782	9,376	13.7k	13.7k	5,813	5,192	5,207	5,924	7,839	18,414	12,210	10,748	**12,942**
Potential Corp Policy Violation	0	0	0	0	0	0	0	0	0	277	0	0	**0**
Network Scans Detected	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Web Application Attack	0	0	0	0	1	0	0	0	0	0	4	0	**0**
Attempted Denial of Service	0	0	0	0	0	0	50	0	86	218	215	436	**0**
Misc. Attack	8,550	76	161	275	626	308	78	874	88	407	733	3,295	**469**

- 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 decreased with a return to a reputation-based block for a total of 20.9 k.
- Attempted information leaks detected and blocked at the firewall is at 12,942 for the month of October 2022.
- Network scans returned a value of 0, which is in line with previous month’s data.
- Attempted User Privilege Gain is higher at 180 down from a previous six-month average of 396.

Integrated Planning

Ruth Watson

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

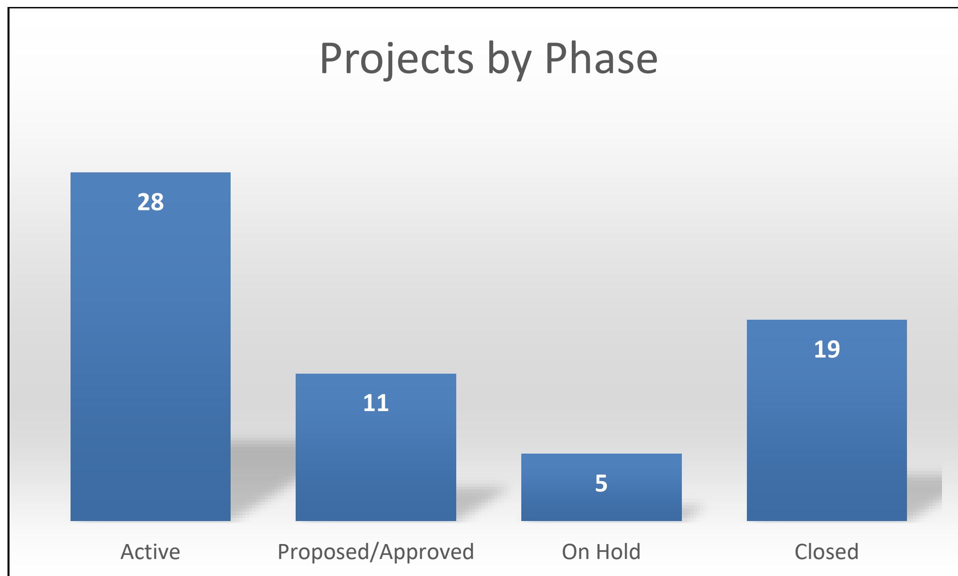
From: **Ruth Watson, Chief of Integrated Planning**

Date: **November 11th, 2022**

Subject: **Integrated Planning Report**

Project Management Office

- 44 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 28 Active projects (discovery, initiation, planning, execution, warranty)
    - 5 On Hold projects
    - 11 Proposed and Approved Projects
    - 19 Closed projects



Integrated Planning – CalAIM Initiatives

- Enhanced Care Management (ECM) and Community Supports (CS)
    - January 2023 ECM Populations of Focus (PoF)
        - Adults Living in the Community Who Are At-Risk for LTC Institutionalization
        - Nursing Facility Residents Transitioning to the Community
        - Model of Care (MOC) Addendums for the new PoF
            - Submitted additional ECM and CS MOC update to DHCS on October 28th.

        - Two existing ECM Providers will add the two new PoF being implemented January 2023.
        - Contracting efforts underway for two new ECM Providers to support the new PoF.
    - July 2023 ECM Populations of Focus
        - Children and Youth
        - MOC for this PoF will be due to DHCS February 1st, 2023.
    - January 2024 ECM Population of Focus
        - DHCS is adding an additional PoF of "High Risk Pregnant and Postpartum Individuals" with a scheduled implementation date of January 2024.
    - 2024 (specific date TBD)
        - Individuals Transitioning from Incarceration, originally scheduled for implementation in January 2023 and re-scheduled to July 2023 has been further delayed by DHCS.

- CalAIM Major Organ Transplants (MOT)
    - Submitted response to DHCS on January 7th regarding the Corrective Action Plan (CAP) received on December 10th, 2021 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.
        - DHCS has issued rate guidance so we can now execute a formal contract with UCSF for transplants.
            - Contract negotiations continue with UCSF.

- Long Term Care (LTC) Carve-In – AAH will be responsible for all members residing in LTC facilities as of January 1st, 2023
    - Does not include Pediatric and Adult Subacute Facilities, Intermediate Care Facilities (ICF), or Institutions for Mental Disease (IMD) which will be implemented no earlier than July 1st, 2023
    - LTC Readiness Deliverables
        - Network Readiness Template has been approved
            - DHCS Network Goal of 60% met, currently at 70%
    - MMCE Phase II – Network Certification Documentation approved by DHCS
    - Additional DHCS Deliverables due 11/28
        - P&Ps, Program Description and other artifacts updated with DHCS requirements
    - Contracting and Credentialing
        - Contracted with 73 facilities on SNF Readiness Template - Custodial Level of Care.
- 51 of the 73 facilities are credentialed
    - 77 PCP Providers identified; 23 contracts signed; awaiting packet from Spherical Group which will account for 20 additional providers)
        - Out of Area Facilities - 58 total; 14 contracts signed, 14 contracts in progress and 30 are pending.

- Communications:
  - Member notifications
    - Benefit Change letter will be sent to impacted members by DHCS 30 & 60 days before go live
    - LTC Member Welcome letters, Member FAQs and Member Portal update notices will be sent by AAH
  - Provider notifications
    - Provider FAQs, LTC Resource Guide, and Provider Manual
    - Provider Townhall training series scheduled for 11/3, 11/10 and 12/1
- Two (2) LTC Utilization Management Forms in development for the AAH Consumer Portal.
- Individual workstreams meetings continue weekly.

- Population Health Management (PHM) Program – effective January 1st, 2023
  - MCP 2023 PHM Readiness Submission guidance and template provided by DHCS on September 2nd.
  - Readiness template submitted to DHCS on October 21st.
  - Transitional Care requirements:
    - January 2023
      - MCPs must develop and execute a plan to ramp up transitional care services
      - MCPs must implement timely prior authorizations
      - MCPs must know when all members are admitted/ discharged/transferred
      - MCPs must ensure all transitional care services are complete for high-risk members
    - January 2024 – MCPs are required to ensure all transitional care services are complete for all members

- Community Health Worker Benefit – new benefit effective July 1st, 2022, to promote the MCP's contractual obligations to meet DHCS broader Population Health Management standards.
  - Initial impact assessment underway.
  - Intersects with PHM Readiness deliverable that was submitted in October.

- CalAIM Incentive Payment Program (IPP) – three-year DHCS program to provide funding for the support of ECM and CS in 1) Delivery System Infrastructure, 2) ECM Provider Capacity Building, and 3) Community Supports Provider Capacity Building and Community Supports Take-Up
  - As of end of October, the majority of the organizations have received their final IPP payment:
    - The remaining organizations' Status Reports are currently under review with payment expected in November.
  - AAH's IPP Payment 2 Report is still under review with DHCS.
  - DHCS recently announced the following updates to the IPP Reporting and Payment Structure:

        - Payment 2 for Program Year 1 (2022)
            - Payment 2 will now be released at the end of Q2 2023 instead of end of Q4 2022 as originally planned
            - An additional Gap-Filling Progress report will also be required
- Failure to submit or receive DHCS approval of this additional submission may result in recoupment of Payment 1
    - The total program period for IPP will be split between three distinct Program Years (PY):
            - For PY2 (2023) and PY3 (Jan-Jun 2024), MCPs will report on six-month measurement periods to earn the remaining payments.

Other Initiatives

- Mental Health (Mild to Moderate/Autism Spectrum Disorder) Insourcing – services currently performed by Beacon Health Options will be brought in-house as of March 31st, 2023.
- Material Modification is required for submission and approval by the Department of Managed Health Care (DMHC)
    - Submission #1 submitted September 2nd and included:
        - Narrative to DMHC (E-1 Exhibit)
        - Evidence of Coverage (EOC) – Group Care and Medi-Cal
        - Member and Provider Notices
        - Medi-Cal Notifications
        - Group Care Notifications
    - Submission #2 submitted September 30th and included:
        - Narrative to DMHC (E-1 Exhibit)
        - Policies & Procedures
        - Financial Assumptions
    - Submission #3 submitted October 12th and included:
        - Full Network Analysis by Provider Services
    - Boilerplate Contract and Cover Letter
        - DHCS – Submitted July 7th
            - Additional Information Request (AIR) received from DHCS; response was sent to DHCS on August 12th.
            - AIR2 from DHCS was received on September 12th; response is due to DHCS on October 7th and is on track.
        - DMHC – included with September 2nd submission
        - Contract distribution to providers continues and follow-up with providers who haven't returned contracts is on-going.
        - Contract and Credentialing – Peer Review & Credentialing Committee (PRCC) met on October 17th.
            - Credentialed:
                - Behavioral Health providers – 45
                - Applied Behavioral Analysis (ABA) providers – 60
                - Specialists – 9
                - Interns (pending) – 64
            - Received and Pending:
                - AHS Contract – total of 73 providers

- CHCN Contracts (8) – total of 129 providers
- Top 10 Rendering Providers – six (6) pending; total of 170 providers
- Mild to Moderate – 168; 154 pending
- ABA – 47; 32 pending (367 total providers)
  - Contracts may be signed but not considered executed until credentialing application is approved.

- Block Transfer Filing:
  - Request for pre-filing meeting sent by Compliance
    - Pending confirmation of meeting date to discuss requirements – forecasting week of November 14th
- Communications:
  - Member Notification:
    - 60/30 Day Member Notice and FAQs approved by DHCS on July 8th
    - Impacted Member Letter – Initially submitted to DHCS in July
      - AIR1 received and response submitted to DHCS on August 22nd
      - AIR2 received on September 8th and response submitted to DHCS on September 26th
    - Group Care Letters –submitted to DMHC on September 2nd (same letter submitted to DHCS was used for submission to DMHC for the Group Care Member Notification
    - Member Services call script created and approved by DHCS
  - Provider Notification – developing FAQs and call scripts:
    - Provider Notification submitted to DMHC on September 2nd.
    - Provider FAQs developed and submitted.
    - Provider Training and Townhall Meetings – planning deferred to December; meetings targeted for early February.
- Work in progress:
  - Development of Behavioral Health Initial Evaluation Web Form
    - Three (3) separate forms being developed.
  - Development of business requirements
    - HealthSuite claims requirements – in progress
    - TruCare authorization requirements – in progress
    - Portal Single Sign On for providers - Completed in Test environment and currently in QA
    - Individual workstream meetings continue
  - Data exchange – meetings in progress with CHCN and ACBH to clarify data exchange requirements.
- Deliverables, timelines, and risks will continue to be assessed frequently.

- Behavioral Health Integration (BHI) Incentive Program – DHCS pilot program commenced January 1st, 2021, and continues through December 31st, 2022.
- Program Year 2, Q1 milestone payment of $320,550 received from DHCS on October 6th.

- Student Behavioral Health Incentive Program (SBHIP) – DHCS program commenced January 1st, 2022 and continues through December 31st, 2024.
- Needs Assessment for all LEAs were submitted to AAH on October 17th.
- SBHIP Partners meeting held on October 21st; high-level overview of Needs Assessment results presented to the group.
- Survey sent to all LEAs requesting the identification of their top four (4) Targeted Interventions to assist in the selection of the interventions to be implemented in Alameda County; survey results due back on November 3rd.

- Housing and Homelessness Incentive Program (HHIP) – DHCS program commenced January 1st, 2022, and continues through December 31st, 2023:
  - Preparing award letter for HCSA for the agreed upon five (5) investment activities representing ~$13.5M in funding opportunities
  - Preparing MOU between AAH and HCSA to define deliverables and milestones that must be met by HCSA to receive the funding

- Justice-Involved/Coordinated Re-Entry:
  - January 2023 implementation has been delayed by DHCS; current go-live schedule for 2024 but no specific date announced.

- 2024 Managed Care Contract Operational Readiness:
  - 245 deliverables due to DHCS in three (3) phases with multiple packages included in each phase.
  - Submitted Phase 1 deliverables due to DHCS on 8/12/2022 and 9/12/2022.
  - AAH moved to Group 2 for remainder of the deliverables; next submission not due until November 28th.

- Portfolio Project Management (PPM) Tool – implementation will be a phased approached with initial go-live scheduled for January 2023:
  - Implementation kick-off held on October 13th.
  - Educational workshops started on October 31st and continue into November.

Recruiting and Staffing

- Project Management Open position(s):
  - Recruitment to commence or continues for the following positions:
  - Senior Business Analyst – new employee starting 11/7/2022
  - Director, Incentives and Reporting – offer accepted and candidate scheduled to start 11/28/2022
  - Senior Program Manager, Portfolio Programs
  - Manager, Project Management Office (PMO)
  - Project Manager
  - Technical Business Analyst

Projects and Programs

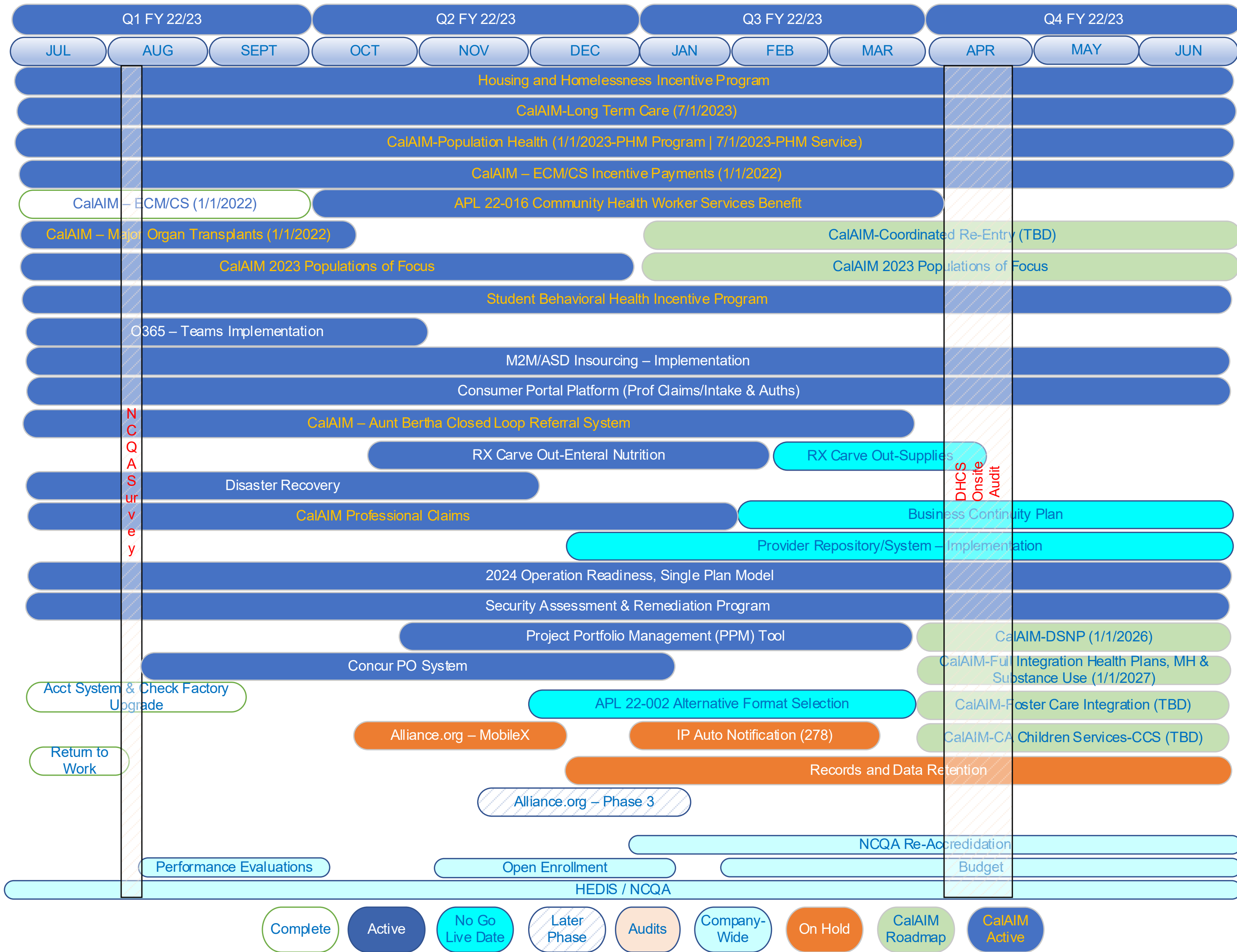
Supporting Documents

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.
    - Two (2) additional PoF will become effective on January 1st, 2023.
    - One (1) PoF will become effective on July 1st, 2023.
    - One (1) PoF will become effective on January 1st, 2024.
    - One (1) PoF will become effective in 2024 with no specific go live date announced.
  - 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.
    - Additional CS services may be required to be implemented to support the two LTC PoF that are effective January 2023.
  - 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 MCPs; will be carved into all MCPs effective January 1st, 2023.
    - ICF, IMD and Subacute facilities will be implemented July 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.
    - Originally scheduled for January 1st, 2023, then moved to July 1st, 2023, has now been further delayed to 2024 with no specific implementation date announced.

- 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.
- Community Health Worker Services Benefit – Community Health Worker (CHW) services became a billable Medi-Cal benefit effective July 1st, 2022. CHW services are covered as preventive services on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law for individuals who need such services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being.
- 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.
  - 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.
  - Needs Assessment and Project Plans for the selected Targeted Interventions are due to DHCS by December 31st, 2022.
- Housing and Homelessness Incentive Program (HHIP) – program launched in January 2022 and is part of the Home and Community-Based (HCBS) Spending Plan
  - Enables MCPs to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health
  - MCPs must collaborate with local homeless Continuums of Care (CoCs) and submit a Local Homelessness Plan (LHP) to be eligible for HHIP funding
    - LHP submitted to DHCS on June 30th, 2022.
    - 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.
    - Investment Plan submitted to DHCS on September 30th, 2022.
- 2024 Managed Care Plan Contract Operational Readiness – new MCP contract developed as part of Procurement RFP
  - All MCPs must adhere to new contract effective January 1st, 2024.
- Project Portfolio Management (PPM) Tool - Implementation of a PPM tool to support portfolio planning, resource capacity and demand planning and project scheduling.


Q1 FY 22/23
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Housing and Homelessness Incentive Program
CalAIM-Long Term Care (7/1/2023)
CalAIM-Population Health (1/1/2023-PHM Program | 7/1/2023-PHM Service)
CalAIM – ECM/CS Incentive Payments (1/1/2022)
CalAIM – ECM/CS (1/1/2022)
APL 22-016 Community Health Worker Services Benefit
CalAIM – Major Organ Transplants (1/1/2022)
CalAIM-Coordinated Re-Entry (TBD)
CalAIM 2023 Populations of Focus
CalAIM 2023 Populations of Focus
Student Behavioral Health Incentive Program
O365 – Teams Implementation
M2M/ASD Insourcing – Implementation
Consumer Portal Platform (Prof Claims/Intake & Auths)
NCQA Survey
CalAIM – Aunt Bertha Closed Loop Referral System
RX Carve Out-Enteral Nutrition
RX Carve Out-Supplies
DHCS Onsite Audit
Disaster Recovery
CalAIM Professional Claims
Business Continuity Plan
Provider Repository/System – Implementation
2024 Operation Readiness, Single Plan Model
Security Assessment & Remediation Program
Project Portfolio Management (PPM) Tool
CalAIM-DSNP (1/1/2026)
Concur PO System
CalAIM-Full Integration Health Plans, MH & Substance Use (1/1/2027)
Acct System & Check Factory Upgrade
APL 22-002 Alternative Format Selection
CalAIM-Foster Care Integration (TBD)
Alliance.org – MobileX
IP Auto Notification (278)
CalAIM-CA Children Services-CCS (TBD)
Return to Work
Records and Data Retention
Alliance.org – Phase 3
NCQA Re-Accredidation
Performance Evaluations
Open Enrollment
Budget
HEDIS / NCQA
Complete
Active
No Go Live Date
Later Phase
Audits
Company-Wide
On Hold
CalAIM Roadmap
CalAIM Active

Performance & Analytics

Tiffany Cheang

To: Alameda Alliance for Health Board of Governors

From: Tiffany Cheang, Chief Analytics Officer

Date: November 11th, 2022

Subject: Performance & Analytics Report

Member Cost Analysis

- The Member Cost Analysis below is based on the following 12 month rolling periods:
  Current reporting period: August 2021 – July 2022 dates of service
  Prior reporting period: August 2020 – July 2021 dates of service
  (Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 9.3% of members account for 84.6% of total costs.

- In comparison, the Prior reporting period was lower at 8.6% of members accounting for 83.6% of total costs.

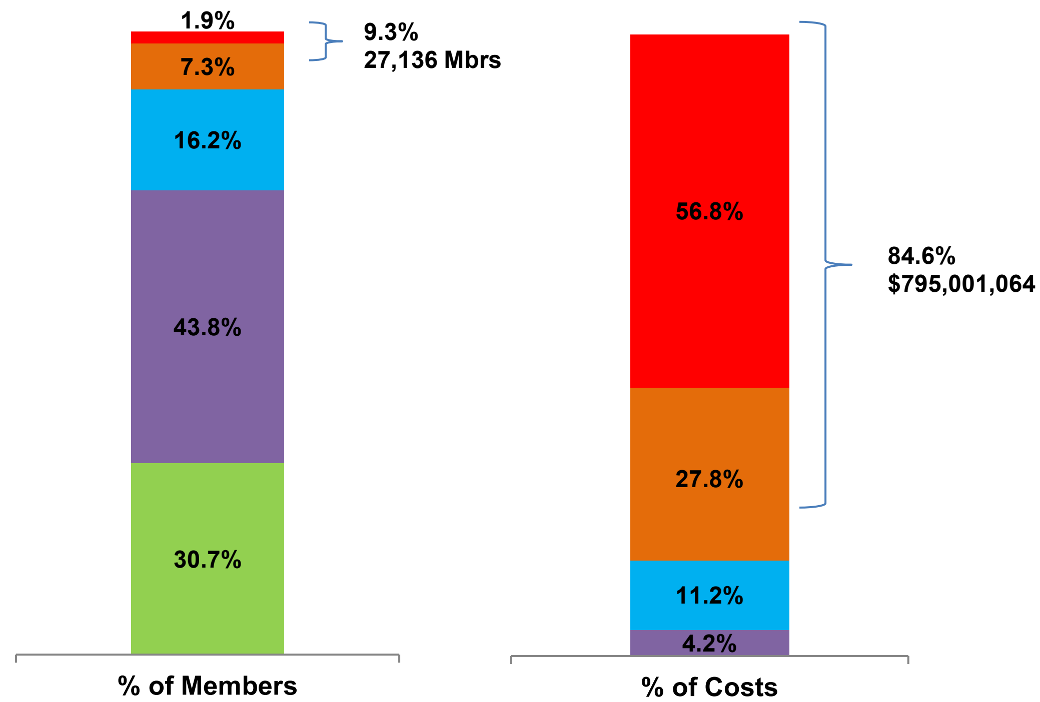
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:

  - The SPD (non-duals) and ACA OE categories of aid slightly increased to account for 60.7% of the members, with SPDs accounting for 26.6% and ACA OE's at 34.2%.
  - The percent of members with costs >= $30K slightly increased from 1.8% to 1.9%.
  - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.5%.
    - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 48.8%.
  - Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
  - However, the age distribution of the top 9.3% is more concentrated in the 45–66-year-old category (40.0%) compared to the overall population (20.8%).

Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Aug 2021 - Jul 2022
Note: Data incomplete due to claims lag
Run Date: 10/29/2022



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	5,687	1.9%	$ 533,629,791	56.8%
$5K - $30K	21,449	7.3%	$ 261,371,273	27.8%
$1K - $5K	47,264	16.2%	$ 104,954,734	11.2%
< $1K	127,942	43.8%	$ 39,792,507	4.2%
$0	89,740	30.7%	$ -	0.0%
Totals	**292,082**	**100.0%**	**$ 939,748,304**	**100.0%**

Enrollment Status	Members	Total Costs
Still Enrolled as of Jul 2022	269,752	$ 845,122,075
Dis-Enrolled During Year	22,330	$ 94,626,229
Totals	**292,082**	**$ 939,748,304**

Top 9.3% of Members = 84.6% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	1,349	0.5%	$ 305,201,144	32.5%
$75K to $100K	679	0.2%	$ 58,760,170	6.3%
$50K to $75K	1,292	0.4%	$ 78,796,992	8.4%
$40K to $50K	919	0.3%	$ 40,941,102	4.4%
$30K to $40K	1,448	0.5%	$ 49,930,384	5.3%
SubTotal	***5,687***	***1.9%***	***$ 533,629,791***	***56.8%***
$20K to $30K	3,082	1.1%	$ 75,160,211	8.0%
$10K to $20K	8,058	2.8%	$ 112,566,066	12.0%
$5K to $10K	10,309	3.5%	$ 73,644,996	7.8%
SubTotal	***21,449***	***7.3%***	***$ 261,371,273***	***27.8%***
Total	**27,136**	***9.3%***	**$ 795,001,064**	***84.6%***

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
9.3% of Members = 84.6% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Aug 2021 - Jul 2022
Note: Data incomplete due to claims lag
Run Date: 10/29/2022

9.3% of Members = 84.6% of Costs
26.6% of members are SPDs and account for 32.3% of costs.
34.2% of members are ACA OE and account for 34.0% of costs.
6.4% of members disenrolled as of Jul 2022 and account for 11.2% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	143	592	735	2.7%
MCAL	MCAL - ADULT	651	3,990	4,641	17.1%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	293	1,788	2,081	7.7%
	MCAL - ACA OE	1,878	7,389	9,267	34.2%
	MCAL - SPD	2,005	5,210	7,215	26.6%
	MCAL - DUALS	100	1,368	1,468	5.4%
Not Eligible	Not Eligible	617	1,112	1,729	6.4%
Total		**5,687**	**21,449**	**27,136**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 10,087,564	$ 6,502,666	$ 16,590,229	2.1%
MCAL	MCAL - ADULT	$ 53,200,913	$ 46,386,277	$ 99,587,190	12.5%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 17,780,649	$ 20,203,766	$ 37,984,415	4.8%
	MCAL - ACA OE	$ 180,697,029	$ 89,515,442	$ 270,212,470	34.0%
	MCAL - SPD	$ 188,809,416	$ 67,990,083	$ 256,799,499	32.3%
	MCAL - DUALS	$ 8,186,464	$ 16,743,133	$ 24,929,597	3.1%
Not Eligible	Not Eligible	$ 74,867,757	$ 14,029,906	$ 88,897,663	11.2%
Total		**$ 524,432,491**	**$ 256,862,051**	**$ 781,294,542**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
36.2% of members are SPDs and account for 35.1% of costs.
33.3% of members are ACA OE and account for 34.7% of costs.
15.4% of members disenrolled as of Jul 2022 and account for 16.9% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	25	1.9%
MCAL	MCAL - ADULT	127	9.4%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	29	2.1%
	MCAL - ACA OE	449	33.3%
	MCAL - SPD	489	36.2%
	MCAL - DUALS	22	1.6%
Not Eligible	Not Eligible	208	15.4%
Total		**1,349**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 4,217,829	1.4%
MCAL	MCAL - ADULT	$ 26,787,238	8.8%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 5,642,516	1.8%
	MCAL - ACA OE	$ 105,812,022	34.7%
	MCAL - SPD	$ 107,045,334	35.1%
	MCAL - DUALS	$ 4,252,827	1.4%
Not Eligible	Not Eligible	$ 51,443,378	16.9%
Total		**$ 305,201,144**	**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+	7%	0%	0%	6%	56%	1%	14%	6%	2%	7%
$75K to $100K	7%	0%	1%	9%	43%	3%	8%	5%	8%	12%
$50K to $75K	7%	0%	1%	8%	43%	4%	8%	7%	7%	13%
$40K to $50K	8%	1%	0%	8%	44%	6%	6%	5%	3%	14%
$30K to $40K	13%	1%	1%	7%	33%	14%	8%	6%	1%	16%
$20K to $30K	5%	2%	1%	9%	30%	8%	8%	7%	1%	16%
$10K to $20K	1%	0%	1%	10%	28%	6%	11%	9%	1%	14%
$5K to $10K	0%	0%	0%	10%	17%	8%	12%	14%	1%	18%
Total	**6%**	**0%**	**1%**	**8%**	**42%**	**5%**	**11%**	**7%**	**3%**	**12%**

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: **November 11th, 2022**

Subject: **Human Resources Report**

Staffing

- As of November 1st, 2022, the Alliance had 403 full time employees and 1-part time employee.

- On November 1st, 2022, the Alliance had 70 open positions in which 15 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 55 positions open to date. The Alliance is actively recruiting for the remaining 55 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by department:

Department	Open Positions November 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	17	6	11
Operations	29	4	25
Healthcare Analytics	3	0	3
Information Technology	2	0	2
Finance	6	1	5
Regulatory Compliance	3	1	2
Human Resources	5	2	3
Integrated Planning	5	1	4
Total	70	15	55

- Our current recruitment rate is 15%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in October 2022 included:
  - 5 years:
    - Jacqueline Speir-Villafan (Member Services)
    - Elsa Reyes (Provider Relation)
  - 6 years:
    - Elizabeth Olson (Vendor Management)
    - Jasdeep Joga (Apps Mgmt., IT Quality & Process Improvement)
    - Fernando Izaguirre (Claims)
    - Tina Vuu (Member Services)
  - 7 years:
    - Katrina Madriz (Provider Relation)
  - 8 years:
    - Cynthia Ngo (Claims)
  - 10 years:
    - Soniya Gupta (Apps Mgmt., IT Quality & Process Improvement)
  - 14 years:
    - Gia DeGrano (Member Services)
  - 16 years:
    - Esperanza Lopez (Member Services)