ALAMEDA Alliance FOR HEALTH

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

Board of Governors

Regular Meeting

Friday, April 8th, 2022
12:00 p.m. – 2:00 p.m.

Video Conference Call Only

1240 South Loop Road, Alameda, CA 94502

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, April 8th, 2022
12:00 p.m. – 2:00 p.m.

Video Conference Call

Alameda, CA 94502

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

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

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

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

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

1. **CALL TO ORDER**

   (A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on April 8th, 2022, at 12:00 p.m. in Alameda County, California, by Dr. Evan Seevak, Presiding Officer. This meeting is to take place by video conference call.)

2. **ROLL CALL**

3. **AGENDA APPROVAL OR MODIFICATIONS**

4. **INTRODUCTIONS**

5. **CONSENT CALENDAR**

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

   a) **MARCH 11th, 2022, BOARD OF GOVERNORS MEETING MINUTES**

   b) **APRIL 5th, 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 FEBRUARY 2022 MONTHLY FINANCIAL STATEMENTS**

   b) **REVIEW AND APPROVE RESOLUTION #2022-01 NOMINATING NATALIE WILLIAMS FOR REAPPOINTMENT TO DESIGNATED CONSUMER MEMBER SEAT**

   c) **COVID-19 VACCINATION AND INCENTIVES PROGRESS REPORT**

9. **STANDING COMMITTEE UPDATES**

   a) **PEER REVIEW AND CREDENTIALING COMMITTEE**

   b) **PHARMACY & THERAPEUTICS COMMITTEE**

   c) **HEALTH CARE QUALITY COMMITTEE**

   d) **MEMBERS ADVISORY COMMITTEE**

10. STAFF UPDATES

11. UNFINISHED BUSINESS

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

14. ADJOURNMENT

NOTICE TO THE PUBLIC

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

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

NOTICE TO THE PUBLIC

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

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

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

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

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

Business: Items in this category are general in nature and may require Board action. Public input will be received on each item of Board Business.

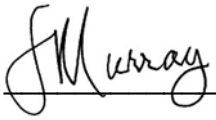
Public Input: If you are interested in addressing the Board, you may submit comments on any agenda item or on any item not on the agenda, in writing via mail to "Attn: Alliance Board," 1240 S. Loop Road, Alameda, CA 94502; or through e-comment at jmurray@alamedaalliance.org. You may also provide comments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

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

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

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

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org on March 7th, 2022, by 12:00 p.m.



_____Clerk of the Board – Jeanette Murray

ALAMEDA Alliance FOR HEALTH

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Consent Calendar

ALAMEDA Alliance FOR HEALTH

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Board of Governors Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING
March 11th, 2022
12:00 pm – 2:00 pm
(Video Conference Call)
Alameda, CA

SUMMARY OF PROCEEDINGS

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

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

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 March 11th, 2022, Consent Calendar. a) February 11th, 2022, Board of Governors Meeting Minutes b) March 8th, 2022, Finance Committee Meeting Minutes Motion to Approve March 11th, 2022, Board of Governors Consent Calendar. A roll call vote was taken, and the motion passed.	Motion to Approve March 11th, 2022, Board of Governors Consent Calendar. Motion: Dr. Kelley Meade Second: Marty Lynch 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 March 11th, 2022, at 10:30 am. Rebecca Gebhart gave the following Compliance Advisory Committee updates. 2020 Kindred Audit: • We are monitoring. Department of Health Care Services (DHCS) Medical Audit findings from 2021: • We have unpacked all the audit findings in our prior meetings. • We are continuing to receive follow-up requests from DHCS. The 2021 DHCS Audit was a joint Audit with DMHC, meaning they did it at the same time. The typical turn-around time for DMHC is much longer, so we have not received their response to our audit yet. We expect to receive it in the coming months. 2021 Delegate Audits: • We will hear right away if there are egregious issues – there have been none to date. For the routine findings, out of courtesy, the Board will not be informed as to issues until the issues are discussed with the delegates fully, and in fact, after the delegates have submitted their corrective action plans and had those corrective action plans accepted. • The delegates that have audits in process are CHCN, and the final audit report is scheduled to come to them in May. Beacon also – the final audit report is expected to be in May. March Vision was completed with no findings. CFMG the final report was delivered. Modivcare, the audit was March 9th. • Once the final report is issued to these delegates, the final report can be shared with the Compliance Advisory Committee, and we can bring those results to the Board.	Informational update to the Board of Governors. Vote not required.	None

	Question: Is there a certain threshold, do we already know what metrics will be reviewed at the Compliance Committee Meeting and then what will need to be triggered to bring them to the full Board? Answer: We haven't unpacked that fully with the Compliance Committee; we can discuss that together at the April meeting. There may be a threshold issue. 2022 DHCS Survey: • Currently in process. Compliance has submitted about 900 documents related to internal procedures and practices. • They are currently in process of doing mock audits; the timeline for the mock audits is March 23rd to March 24th. They're doing multiple interview sessions, providing audit questions and sequences of questions that have been asked, tips and best practices are provided. These mock audits encourage a learning environment. The ethical focus in this training is on truth and clarity – knowing how much of an answer to give while being completely truthful of the questions that are asked. • The next stage is the verification study for this audit. This is when DHCS selects cases that are within the audit period. The plan has provided 286 documents to address those cases. For example, if they picked a case related to a grievance, we would provide copies of the grievance, all correspondence related to the grievance, all of our internal notes and timelines related to the grievance, and any committee meetings that took up that issue in response • The onsite interview phase for this audit will be April 4th – April 15th, and this will be a virtual onsite series of meetings. Post audit phase will be corrective action plan development and submission, monitoring, and the final report stage. Upcoming Audits: • 2022 NCQA Reaccreditation – June 2022. • DMHC Financial Services Audit in August 2022. • 2022 DMHC Behavioral Health Investigation. Question: Is there any role for the Board in these audits or ways we can support you?		

	Answer: Operationally, no. It is the staff's responsibility to keep the Board informed. Our delegation program and subcontracted partners – their audits are routine for us. It is important for staff to develop thresholds which we must unpack internally and determine what would trigger a report to the Board. Informational update to the Board of Governors. Vote not required.		
6. b. BOARD MEMBER REPORT – FINANCE COMMITTEE			
Nicholas Peraino and Dr. R. Ferguson	The Finance Committee was held telephonically on Tuesday, March 8th, 2022. Dr. Ferguson handed over the Finance Committee report to Nicholas Peraino, Vice Chair, who presented the following updates: Highlights: • Our membership numbers are still very high and growing, which has put us on a solid financial footing. • January Financial Report was discussed, and Gil will be covering the finances in detail during his Board report. • Dr. Ferguson seconded Nicholas Peraino's comments and mentioned that MLR was almost 91% last month and 94.4% for the YTD. Additionally, the fiscal year second-quarter forecast was reviewed and approved. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None

7. CEO UPDATE			
Scott Coffin	Scott Coffin, Chief Executive Officer, presented the following updates: • Scott began by recognizing Board member Natalie Williams and wished her a happy birthday. Finances: • Review of the financial performance for the month of January and Fiscal Year 2022 forecast. • Alliance's leadership team has begun the Fiscal Year 2023 budget planning that started last month that continues through the month of May. We will be reporting the preliminary budget to the Board of Governors and Finance Committee in the month of June. Key Performance Indicators: • There are two of our regulatory metrics that are out of compliance and the teams are working to restore them back in compliance – the standard member grievances and the expedited grievances. Our teams are working to correct the workflows and other issues leading to the compliance delay. • Non-Regulatory – Member Services call center and our vacancy rates are also outside of our targeted range. We are taking steps to get both metrics in the normal range. CalAIM Incentive Programs: • We have five different incentive programs that were launched by the State of California. The DHCS has facilitated webinars during the last month. We are starting to see the specifics regarding allocations for each county, the spending guidelines, and reporting requirements. • We are in the process of developing a framework on how we will evaluate and disperse these funds. • A broader presentation will be shared with the Finance Committee and the Board of Governors in the month of May.	Informational update to the Board of Governors. Vote not required.	None

	Insourcing of Mild-Moderate Mental Health & Autism Spectrum Services: • The Alliance is moving forward to insource the mild to moderate mental health and autism spectrum services, and the target date to complete the transition of the administration of services is October 1st, 2022. • Beacon Health Options and Alameda Alliance are coordinating to develop a detailed transition work plan as we move closer to the readiness phase. We have also hired a Behavioral Health Clinical Director and have started the restructuring within the organization, including recruiting for key positions in FY2022, and will be presenting the hiring positions for FY2023 as part of the preliminary budget in June. Regulatory Audits & NCQA Accreditations: • On the issue of transparency, we've addressed transparency to the Board in several ways – first, through a public mechanism, the Compliance Committee, and establishing a public committee that talks through our deficiencies and enforcement actions. This provides a level of optics for the Board of Governors as well as the public on our regulatory matters. The other is as issues do surface regarding regulatory and enforcement actions, anything that relates to the functions – we make sure the report to the Board is timely and complete. Medi-Cal Managed Care Contract: • The DHCS has released the Request for Proposal (RFP) as of February 9th, 2022, for the Medi-Cal Managed Care program. Commercial health plans that apply are being evaluated in this process. The DHCS will complete that procurement process in the next 6 months and will be awarding selected entities. • Alameda County is exempt from this procurement process; this is related to the Single Plan Model, conditional approval that DHCS has granted. Both transitions – the procurement and Single Plan Model occur on January 1st, 2024.		

	• The DHCS is executing a new managed care contract with all managed care health plans serving Medi-Cal. The preliminary contract template was recently released by the DHCS, and analysis will be conducted to determine changes to the Alliance's operations. Single Plan Model: • The DHCS has confirmed the operational planning meetings with Alameda and Contra Costa counties for the single plan model, and that will be starting in the next 2 months. Medi-Cal strategy to support health & opportunity for children and families: • The Governor's initiative focuses on three goals and its outlined in the state budget: (1) The delivery of community-based integrated care where the care teams are talking more about patients and coordinating access; (2) promoting integrated care; (3) Whole-child model approach, which includes the Early and Periodic Diagnostic and Treatment (EPSDT) services, aligns with CalAIM, Behavioral Youth Initiative, and adverse childhood experiences screening (ACEs). Question: What is meant by incentivizing using CalAIM dollars? Answer: In the incentive program, they categorized it into 3 programs – infrastructure (systems, technology), Enhanced Care management (ECM) capacity building, and Community Support (CS) capacity building. One of the main focuses is looking at quality and quality outcome as the program goes on – it is a 3-year incentive program. The other piece they are looking at is health equity and disparities. Question: Are the quality items developed for ECM and community support already? Answer: Yes, they have defined the type of metrics for ECM and CS. They give us an option for which one we want to choose, for example, a list of 10, and we must choose 5 or 6 of the measures. Question: What changes are expected either with the Single Plan or the new Managed Care Model?		

Dr. S. O'Brien & Tiffany Cheang	Answer: It ties into every division in the organization, finance certainly; mandates around regulatory compliance and delegation oversight. Many parts of our operations will be impacted, and we must assess the impact. Question: How much will Kaiser impact our HEDIS score, and how aggressively are we starting to look toward the correction for 2023, 2024, and beyond? What do we do so we do not see a significant drop and we address it early enough? Answer: We are estimating our scores to drop 5-7% in CY2025. Historically Kaiser's quality scores are consolidated into the overall score for the Alliance. We are tracking the news of the contract between the State of California and Kaiser and looking into the impacts as well as the response that we will take. Quality is one of the elements we are looking at. We will come back to the Board with a response. S. Coffin introduced Dr. O'Brien and Tiffany Cheang to present on Early, Periodic Screening, Diagnosis & Treatment (EPSDT). Dr. S. O'Brien presented: • EPSDT – all the Medi-Cal services available for people up to the age of 21. The services are broken down to the following three areas, 1) Early Periodic Screening, 2) Diagnosis, and 3) Treatment. • Under the screening, it is identifying problems early starting at birth with a periodicity at regular intervals to screen and vaccinate at age-appropriate intervals. The State of California uses Bright Futures as their primary periodicity table and we follow that with our providers, who are doing an excellent job providing care and screening for members. The screening includes physical, mental, developmental, dental lab, substance abuse, hearing and vision screening, plus more. If during these screenings, anything is abnormal, diagnostic tests are covered. Treatment covers all necessary and non-experimental treatment to correct or ameliorate physical and mental illness and conditions. • The reason why there is a particular focus on kids is that many children are on Medi-Cal ~50% of all children, ~75% African American		

	and LatinX children in California. Additionally, poor children are more likely to have vision, hearing and speech issues, elevated lead levels, sickle cell, behavioral health issues, asthma, and many more conditions. Therefore, focusing intensely on this population is our attempt as a state to focus on health disparities and inequities. • There is a broad array of services, including California Children's Services (CCS), and serious mental illness and substance abuse are also carved out. • Alameda County Behavioral Health administers very robust programs for kids in their mental health department and under their Medi-Cal organized health system. Our primary responsibility is to have wrap-around services – case management care coordination to make sure that all services available under EPSDT are coordinated through the Alliance for members, including coordination with CCS. • We work very closely with our key partners to better serve our members and are making excellent progress. Tiffany Cheang continued the presentation. EPSDT Key Initiatives and AAH Members: • Medi-Cal's strategy to support health and opportunity for children and families includes addressing health disparities and advancing health equity and a whole-child, preventative approach informed by families. • For our Medi-Cal population, we have almost 93,000 members who are in the EPSDT, or under the age of 21 population. The average age is 10.7. Our members are primarily in Oakland and are of Hispanic ethnicity and speak English; a high percentage also speak Spanish. 3.6% of the EPSDT population utilize Mild-Moderate BH services. • 71% of this population is considered a utilizer, meaning they utilized some type of service. Comparing this to our overall Alliance membership, the utilizer percentage is 69%. Question: Is a non-utilizer someone who did not utilize services in a period or ever? Answer: This is a 12-month rolling period that we measure these by, so in a 12-month rolling period, they did not utilize any services.		

	Question: Are Kaiser members in this number? Answer: Kaiser is not included in this data right now. Informational update to the Board of Governors. Vote not required.		
8. a. BOARD BUSINESS – REVIEW AND APPROVE JANUARY 2022 MONTHLY FINANCIAL STATEMENTS			
Gil Riojas .	Gil Riojas gave the following January 2022 Finance updates: Enrollment: • For the month ending January 31st, 2022, the Alliance had an enrollment over 303,000 members, a net income of $4.1M (budgeted net income was $2.4M), and the tangible net equity was 543% of the required amount. • Our enrollment has increased by over 6,000 members since December 2021. Net Operating Results: • For the fiscal YTD ending January 31st, 2022, the actual net income was $1.1M, and the budgeted net loss was $6.8M. Revenue: • For the month ending January 31st, 2022, the actual revenue was $98.3M vs. the budgeted revenue of $96.8M. • For the fiscal year ending January 31st, 2021, the actual revenue was $688.1M vs. the budgeted revenue of $686.5M. Medical Expense: • For the month ending January 31st, 2022, the actual medical expense was $89.0M, and the budgeted medical expense was $86.5M.	Motion to Approve January 31st, 2022, Monthly Financial Statements as presented. Motion: Dr. K. Meade Second: N. Williams Vote: Yes No opposed or abstained.	None

	• For the fiscal year ending January 31st, 2022, the actual medical expense was $649.9M vs. the budgeted revenue of $650.9M. • On a PMPM basis, medical expense is 0.9% favorable to budget. Medical Loss Ratio (MLR): • For the month ending January 31st, 2022, the MLR was 90.5% and 94.4% for the fiscal year-to-date. Administrative Expense: • For the month ending January 31st, 2022, the actual administrative expense was $5.1M vs. the budgeted administrative expense of $7.9M. • For the fiscal YTD ending January 31st, 2022, the actual administrative expense was $37.1M vs. the budgeted administrative expense $42.4M. Other Income / (Expense): • As of January 31st, 2022, our YTD interest income from investments is $238,329, and YTD claims interest expense is $232,772. Tangible Net Equity (TNE): • Tangible net equity results continue to remain healthy, and at the end of January 31st, 2022, the TNE was reported at 543% of the required amount. Cash Position and Assets: • For the month ending January 31st, 2022, the Alliance reported $324.1M in cash; $197.3M in uncommitted cash. Our current ratio is above the minimum required at 1.68 compared to the regulatory minimum of 1.0. Capital Investment: • Fiscal year-to-date capital assets acquired: $112,000. • Annual capital budget: $1.4M. Question: Is it typical in January to get a big portion of cash from the state?		

	Answer: No, cash varies month-to-month. Sometimes it can be related to inter-governmental transfers. Inter-governmental transfers add a lot of cash to our balance sheet, but the bulk of that we pay on to our providers and hospital partners. January was a month where we saw those IGT's come in. Question: What the categories of new members were coming from? Answer: The majority of the members transitioning to Mandatory Managed Care were the kids and adults and the optional expansion. 51% of the members were kids; 24% were optional expansion; 18% were adults; and about 6% were SPD's. Question: What is a medical exemption? Answer: A medical exemption request is evaluated by clinical teams at the Department of Health Care Services. Motion to Approve January 31st, 2022, Monthly Financial Statements as presented. A roll call vote was taken, and the motion passed.		
8. b. BOARD BUSINESS – FISCAL YEAR 2022 SECOND QUARTER FORECAST			
Gil Riojas	Gil Riojas presented the following Fiscal Year 2022 Second Quarter Forecast Highlights: • Projected Net Income of $5.2M is $1.8M higher than the Final Budget presented to the Board of Governors on December 12, 2021. • Tangible Net Equity is 550% of required TNE at year-end. • Final Base rates were approximately 0.6% lower than the draft rates. • Administrative staffing is consistent with Budget, and we've added a few clinical positions. There's also been a decrease both in our Clinical Department Expense and Administrative Department Expense.	Informational update to the Board of Governors. Vote not required.	None

	Membership Projections: • There's been a significant member increase in January, and more members are expected to transition from HealthPAC in May. However, if the federal government ends the Public Health Emergency, there may be a decline in enrollment. We expect this to start in May or June and continue onto the next fiscal year. Revenue: • We anticipate increasing revenue by about $25M. The reduction in base Medi-Cal rates decreases revenue by about $4.5M. ECM revenue is included for $5.1M, Community Supports revenue of about $9.4M, revenue for Major Organ Transplants is about $6.3M. • We also had a County Wide Averaging net benefit of $2.5M. $1.2M is included for COVID Vaccine Incentives. Medical Expense: • Higher Medi-Cal enrollment adds about $22M in expenses. • Inpatient and ER services add $4.8M in expenses; net capitation contract changes; favorable reinsurance recoveries; ECM expense, expenses for Major Organ Transplants, and Community Supports expense is included for in our revenue. Additionally, we are anticipating spending $1.4M for COVID Vaccine Incentive expense. Comparison to Budget: • We are anticipating our enrollment at year-end to be about 306,000 members versus a budgeted amount of around 292,000. • We are anticipating our net income to be around $5.2M by the end of June. • We are anticipating our administrative expense rate to be 6.7% of our total revenue. • For Medical Loss Ratio, we are anticipating a 0.2% increase from what we had budgeted in December.		

	Staffing Comparison to Budget: • We anticipate our FTEs to be around 422 by the end of June, which is a slight increase. Comment: Regarding Vacancy Rate and Employee Hiring and Retention. We have increased our recruiting efforts to overcome the 14% vacancy. Informational update to the Board of Governors. Vote not required.		
8. c. BOARD BUSINESS – COVID-19 VACCINATION PROGRESS REPORT			
Matthew Woodruff	Matt Woodruff presented the COVID-19 Vaccination Progress Report: • As of February 28th, 2022, 74.4% of Medi-Cal members 12 years and older are vaccinated. • We are currently ranked 4th in the state for Managed Care Plans. We also averaged 11.4% increase among all key measured populations that the State had asked us to measure. • For our homebound Medi-Cal members and our Medi-Cal members aged 50-64 we are coming right on target, we will see how we do in our final report. • The 3 target ethnicities the State had asked us to do in Alameda County based on the low vaccination rate: Native American, we were able to raise 10%, and the Hispanic and Black populations we were able to raise by 15%. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None

9. a. STANDING COMMITTEE UPDATES – PEER REVIEW AND CREDENTIALING COMMITTEE			
Dr. Steve O'Brien	The Peer Review and Credentialing Committee (PRCC) was held telephonically on February 15th, 2022. Dr. Steve O'Brien gave the following Committee updates: • We credentialed fifteen (15) initial applicants, including three (3) PCPs. Additionally, thirty-eight (38) providers were re-credentialed at this meeting, including fourteen (14) PCP's. • There were eleven (11) providers terminated. • For 2021, there was two-hundred-eighteen (218) initial providers, and two-hundred-seventy-nine (279) providers who left. Last year was unusual, since we generally have more providers coming in as opposed to leaving. Informational update to the Board of Governors. Vote not required.	Informational update to the Board of Governors. Vote not required.	None
10. STAFF UPDATES			
Scott Coffin	None	None	None
11. UNFINISHED BUSINESS			
Scott Coffin	None	None	None
12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Scott Coffin	None	None	None
13. PUBLIC COMMENTS (NON-AGENDA ITEMS)			
Scott Coffin	None	None	None

14. CLOSED SESSION			
Dr. Evan Seevak	The Board, The Senior Leadership Team, and Scott Coffin attended the closed session.	None	None
15. ADJOURNMENT			
Dr. Evan Seevak	Dr. Evan Seevak adjourned the meeting at 1:39 pm to enter the closed session.	None	None

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

ALAMEDA Alliance FOR HEALTH

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Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

April 5th, 2022
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted by Teleconference

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

Board of Governor members on Conference Call: James Jackson

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

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
CALL TO ORDER, ROLL CALL, and INTRODUCTIONS			
Dr. Rollington Ferguson	Dr. Ferguson called the Finance Committee meeting to order at 8:00 am. The following public announcement was read. "The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County level, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with Assembly Bill 361 for the duration of the proclaimed state of emergency." "Audience, during each agenda item, you will be provided a reasonable amount of time to provide public comment." A telephonic Roll Call was then conducted.		

CONSENT CALENDAR			
Dr. Rollington Ferguson	Dr. Ferguson presented the Consent Calendar. March 8th, 2022, Finance Committee Minutes were approved at the Board of Governors meeting March 11th, 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: **Fiscal Year 2023 Budget:** Preliminary fiscal year 2023 Budget is tracking to complete in the month of May and will be presenting to the Finance Committee and Board of Governors in June. Highlights of what we are seeing include: 1) Enrollment in the Medi-Cal program has been increasing by 1,200 to 1,500 per month and setting record-highs each month; 2) California's Public Health Emergency (PHE) is coming to a close, and Governor Newsom is expected to terminate the PHE in April. The executive orders related to Medi-Cal re-determination will also be terminated, resulting in the resumption of Medi-Cal disenrollment processes through the Alameda County Social Services Agency; and 3) Administrative expenses are expected to increase due to increases in labor expenses, related to regulatory compliance. **Insourcing of Mild to Moderate and Autism Spectrum Services:** The initiaiveis on schedule to complete on October 1st, 2022. Next month a presentation will be delivered to the Finance Committee on the implementation timeline and updated costs. The Committee will recall that in April 2021, the Board of Governors approved the insourcing of services no later than December 2022. At that time, we projected implementation costs up to $1.7 million, and annual recurring costs ranging from $3.0 million to $4.5 million dollars. This original cost pro-forma includes the addition 36 new employees, distributed across the eight divisions in the Alliance organization. **Operational Readiness**: The project portfolio includes more than 25 projects. Preparation and implementation of the following CalAIM initiatives, mandated by the State of California, crosses over our current and next fiscal years (between April 2022 and December 2022): 1) Insourcing of mental health & autism spectrum – 10/1/22 2) New ECM Populations of Focus in 2023	Informational update to the Finance Committee Vote not required	

	3) Long-Term Care – 1/1/23 4) Justice Involved – 1/1/23 5) Behavioral health in schools – 1/1/23 6) Population health – 1/1/23 7) Single Plan Model – 1/1/24 The team will report back to the Finance Committee to discuss the financial implications of these projects as we proceed throughout the year.		
b.) Review and approve February 2022 Monthly Financial Statements			
Gil Riojas	**<u>February 2022 Financial Statement Summary</u>** **Enrollment:** Current enrollment is 303,173 and continues to trend upward. Total enrollment has increased by 6,445 members from January 2022, and 15,898 members since June 2021. As discussed in prior meeting, the significant increase in enrollment last month was due primarily to the mandatory enrollment in Managed Care that took place in January. Enrollment for February returned to more recent trends. The increases were primarily in the Child, Adult, and Optional Expansion categories of aid, and include slight increases in the Duals category of aid. SPD and Group Care remain relatively flat. Future enrollment trends will be impacted by the anticipated end of the Public Health Emergency (PHE) and addition of new members scheduled to transition from the County HealthPAC program in May. **Net Income:** For the month ending February 28th, 2022, the Alliance reported a Net Income of $3.4 million (versus budgeted Net Loss of $337,000). The favorable variance is attributed to lower than anticipated Administrative Expenses and Medical Expenses, which was slightly offset by lower than anticipated Revenue. For the year-to-date, the Alliance recorded a Net Income of $4.5 million versus a budgeted Net Loss of $7.1 million. **Revenue:** For the month ending February 28th, 2022, actual Revenue was slightly lower than anticipated at $92.1 million vs. our budgeted amount of $95.9 million. We are slightly under budget on Revenue. The unfavorable variance in Revenue is		

	largely due to unfavorable $6.0 million retroactive MCO Tax adjustment for FY14 through FY16. Our internal analysis projected a $6M liability which we have accrued. DHCS projected a $12M liability. We are working closely with the DHCS to understand the differences between what we calculated versus what they calculated and also to ascertain what tax rate they used to calculate the tax on a Per Member Per Month (PMPM) basis. We are hopeful that the State may revise the liability and reduce it to a level closer to where we believe it to be. **Question:** Dr. Ferguson asked why the liability hit the revenue versus showing as an expense somewhere. Gil Riojas answered that the liability is categorized as a contra-revenue. It directly impacted the Revenue we had previously received in a negative way, and we wanted to be clear in how we reported it. Shulin Lin added that for accounting purpose we need to be consistent for historical reporting. In this case, the State paid us $6.0 million, but they want to take back $12.0 million. Dr. Ferguson then explained that the period we are looking at was also the period that the Federal Government informed the State of California that it was not compliant with the guidelines for the MCO Tax and questioned the State's ability to perform this action. Gil Riojas confirmed that it was around 2014 that the Federal Government asserted that California's existing MCO Tax calculation did not align with CMS's understanding with how that Tax should work and added that the State was able to get a new calculation template approved very quickly to correct the error. It has taken the State these subsequent years to calculate the Plan's liability. Our plan and process is to work with the State to determine how they calculated their number versus ours. Given the number of years that have passed we want to ensure the State is using relevant tax rates to calculate the liability. Scott Coffin offered support for Gil's response and further explained we would first work with the State to determine the correct liability amount and then would look at their overall authority to collect. **Question:** Dr. Marchiano asked what would be the most favorable outcome we could hope for? Gil Riojas answered that the best-case scenario is that the State would determine that our original calculation of $6.0 million was correct and that there would not be any addition liability.		

	Medical Expense: Actual Medical Expenses for the month were $83.2 million, vs. our budgeted amount of $85.6 million. For the year-to-date, actual Medical Expenses were $733.1 million versus budgeted $736.5 million. Drivers leading to the favorable variance can be seen on the tables on page 11. Further explanation of the variances can be seen on pages 11 and 12, with specific call out of the Net Reinsurance favorable variance. **Medical Loss Ratio:** Our MLR ratio for this month was reported at 90.3%. Year-to-date MLR was at 94.0% vs our annual budgeted percentage 91.5%. **Administrative Expense:** Actual Administrative Expenses for the month ending February 28th, 2022 were $5.4 million vs. our budgeted amount of $10.7 million. Our Administrative Expense represents 5.8% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date. Reasons for the favorable month-end variances, as well as the favorable year-to-date variances can be attributed to 1) COVID-19 Vaccination Incentives, 2) Delayed timing of new project start dates for Consultants, Computer Support Services, and Purchased Services, and 3) Delayed hiring of new employees. **Other Income / (Expense):** As of February 28th, 2022, our YTD interest income from investments was $387,817. YTD claims interest expense is $262,135. **TangibleNet Equity (TNE):** We reported a TNE of 541%, with an excess of $172.5 million. This remains a healthy number in terms of our reserves. **Cash and Cash Equivalents:** We reported $283.7 million in cash; $185.4 million is uncommitted. Our current ratio is above the minimum required at 1.70 compared to regulatory minimum of 1.0.		

	Capital Investments: We have spent $112,000 in Capital Assets year-to-date. Our annual capital budget is $1.4 million. **Question:** Dr. Ferguson asked why COVID-19 initiatives were considered Administrative Expenses versus categorizing them as Medical Expenses, and what are the implications. Gil Riojas answered that the initiatives could be things like an outreach campaign, it could be billboards or radio spots, and these are things we cannot tie directly to patient care and therefore should not be considered Medical Expenses. Dr. Ferguson asked if it could be argued that everything we do for COVID-19 initiatives is ultimately for Primary Prevention Care? Gil Riojas explained that because the State has offered incentive funding to accommodate the expenses we incurred, adding the incentive expenses to our Medical Expense side would be "double-dipping" because not only are we paid now, but if it affected our future reimbursement rate, we would get paid later as well. Matt Woodruff added that we just submitted our first report to the State a two weeks ago for reimbursement from the State for Member Incentive Reimbursement, and the State allowed us to not only include the incentives the State was responsible for, but also our own. So, the State is reimbursing us for the $50 gift cards we issued to members. Scott Coffin offered that we would circle back with DHCS to confirm that we are booking the expenses appropriately.	Motion to accept **February 2022 Financial Statements** Motion: N. Peraino Seconded: Dr. Marchiano Motion Passed No opposed or abstained	
c.) Environmental Social Governance (ESG) Investing Update			
Gil Riojas	Gil Riojas shared a PowerPoint presentation to provide and ESG Investing update. ***Highlights of Presentation:*** Gil provided a recap of our Existing Portfolio • Average daily balance of invested funds is $280M. This is divided up as follows: ➢ 78% of investments maturing within 90 days ➢ 21% maturing within 180 days ➢ 1% maturing over 180 days. • Portfolio in compliance with California Government Code 53600 • Focus on liquidity and quality of investments.		

	Scott Coffin joined Gil in a meeting with the Alliance's investment banker at City National Rochdale and worked out a sample analysis: ESG Sample Analysis: • ESG scoring and investments are an emerging market. • Modeled using $50M allocated for long-term investments. • Assumed 1/3rd ($16.5M) allocated to ESG type investments. • Short-term investments remain in the current strategy. • Evaluated ESG investments that were the same quality and maturity as investments in the current strategy. • Shifted a portion of investments to taxable municipal "green" bonds that meet appropriate ESG characteristics. ESG Analysis Estimated Results: • Five municipal bonds and one US Treasury were used to model the potential returns. • Credit rating for ESG investments mirrors existing portfolio rating (A and above) • Based on existing performance, there would be a projected loss of three basis points in the portfolio by shifting $16.5M to these five investment vehicles. • Potential loss of $15-20K of annual investment return, moving the estimated long-term portfolio return from $685K to $670K. **Question:** Dr. Ferguson asked if given the anticipated increase in interest rates, wouldn't that cover any loss that might be projected? Gil Riojas answered that it might be provide more clarity to say that there is potential for losing a little bit of our investment return that we may have gotten otherwise, but that as short-term interest rates go up it reduces the likelihood of that scenario.	Motion to: **Allocate 1/3rd ($16.5 M) of our Long-**	

	Recommendation: • Allocate 1/3rd ($16.5M) of our long-term investment portfolio to ESG investments. • Measure actual performance against the remaining 2/3rd of the long-term portfolio • Reconvene in 12 months to determine actual results and determine if a shift in ESG investments is needed. • Overall investment returns may improve as the federal Reserve implements new rate hikes over the next 12-18 months.	**Term Investment Portfolio to ESG Investments** Motion: Dr. Ferguson Seconded: N. Peraino Motion Passed No opposed or abstained	
ADJOURNMENT			
Dr. Rollington Ferguson	Dr. Ferguson motioned to adjourn the meeting. The meeting adjourned at 8:55 am.	Motion to adjourn: Dr. Ferguson Seconded: N. Peraino No opposed or abstained.	

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

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CEO Update

Scott Coffin

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

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

Date: **April 8th, 2022**

Subject: **CEO Report**

- **Financials:**

  - Revenue $92.1 million in February, and $780.2 million Year-to-Date (YTD).

    - Medical expenses for February were $83.2 million, and $733 million year-to-date, representing the eight months of the fiscal year, and 5.4% in administrative expenses.

  - Tangible Net Equity (TNE): Financial reserves are 561% above the regulatory requirement, representing $172.5 million in excess TNE.

  - Total enrollment 304,452 in February 2022, increasing by more than 1,000 Medi-Cal members as compared to January. Preliminary enrollment in the month of April exceeds 309,000 members.

  - Medi-Cal enrollment increases range from 1,000 to 2,500 members per month. Approximately 8,000 new Medi-Cal beneficiaries are projected to enroll in the month of May 2022 related to the transition of undocumented adults (age 50 and over) into Medi-Cal managed care; population is currently enrolled in Alameda County's HealthPAC program.

  - Governor Newsom is expected to terminate the Public Health Emergency (PHE) in the month of April, and the Medi-Cal re-determination process will restart upon termination of the executive order.

  - Net Operating Performance by Line of Business:

	February	YTD
Medi-Cal.....	$3.6M	$5.2M
Group Care	($107.5K)	($736K)
Totals	$3.4M	$4.5M

- **Key Performance Indicators:**

  - Regulatory Metrics:

    - Standard member grievances (turnaround within 30 calendar days) met compliance at 95.5% based on 625 cases. A total of five (5) expedited grievances were received and two (2) were processed within the 72-hour timeframe, resulting in a rate of 40%. Expedited grievances were 55% below the compliance rate for the month of March. A remediation plan was implemented between Health Care Services and Operations Divisions, and addresses the staffing, technology, and volumes for the standard and exempt grievances.

  - Non-Regulatory Metrics:

    - The Member Services call center received 16,177 inbound calls in March, approximately 20% higher than previous month. The average wait time to speak with a Member Services Representative was 8 minutes and 49 seconds, resulting in 24% abandonment rate, which is 18% over the internal target. Subsequently, inbound calls answered in 30 seconds or less fell to 33%, which is 37% below the internal 70% service goal of. A remediation plan was implemented to increase staffing in the call center, including hiring additional Member Service Representatives, and in addition, adding an external call center vendor to support the call volumes.

    - The Alliance employs 371 full-time staff, and one (1) part-time employee. The vacancy rate for unfilled positions is 12%, which is 2% above the internal target. In the month of March, a total of fifty-two (52) job positions were being recruited and eleven (11) people were hired.

- **Regulatory Audits & NCQA:**

  - DHCS routine medical survey started on Monday, April 4th and continues through Friday, April 15th.
  - NCQA re-accreditation survey is scheduled for June 2022. Applies to both lines of business, Group Care and Medi-Cal.
  - DMHC routine financial survey is scheduled for mid-August.
  - DMHC focused mental health parity audit is pending confirmation and is expected to occur in calendar year 2022.

- **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 in 10/1/22

    - Medi-Cal Only:
        - CalAIM: New ECM Populations of Focus phases in 2023
        - CalAIM: Long-Term Care begins 1/1/23
        - CalAIM: Justice Involved begins 1/1/23
        - CalAIM: Behavioral health in schools begins 1/1/23
        - CalAIM: Population health begins 1/1/23

- **CalAIM Incentive Programs [2022-2024]:**

    - The State of California, authorized through Governor Newsom's revised budget, released five incentive programs related to the CalAIM program, including: 1) Behavioral Health Incentive Program, 2) Student Behavioral Health Incentive Program, 3) CalAIM Incentive Payment Program, 4) Housing & Homelessness Incentive Program, and 5) Vaccine Incentive Program. The Student Behavioral Health Incentive Program aligns Alameda Alliance with Alameda County's Office of Education and other agencies.
    - Incentive funding will be allocated to build capacity, invest in infrastructure, and to incentivize community-based organizations to participate in the delivery of CalAIM services.
    - Alameda Alliance is developing a process to address the incentive funding life cycles, and includes the application, evaluation, and the awarding of funds for the incentive programs.
    - Providing Access and Transforming Health (PATH) funding is available to county agencies to fund services excluded from the Whole-Person Care pilot. Alameda Alliance and Alameda County Health Care Services Agency (HCSA) are coordinating to maximize the funding opportunity. PATH funding addresses the justice-involved capacity building and supports the implementation of enhanced care management and community supports.

- **Single Plan Model:**

    - Alameda County remains in “conditional approval” status with the DHCS, and the DHCS and CMS are coordinating on terms & conditions to change the Medi-Cal delivery model from a two-plan to a single plan model.
    - Alameda County Health Care Services Agency (HCSA), Alameda Alliance for Health, and the Department of Health Care Services are scheduling a quarterly planning meeting. DHCS is combining Alameda and Contra Costa counties into a joint-planning workgroup.

- **Medi-Cal strategy to support health & opportunity for children and families:**

    - Provides family and community-based care.
    - Promotes integrated care.
    - Whole-child model approach, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT); aligns with CalAIM, Behavioral Health Youth Initiative (CYBHI), and Adverse childhood experiences (ACEs) screening.

- **COVID-19 Vaccinations:**

    - The COVID-19 vaccination campaign ended on February 28, 2021. This program applied to Medi-Cal members (12 years and older) and the goal was to reach 85% of our eligible members. The program started in October 2021 at 62.2% and ended in February 2022 at 75.1%, representing a gain of nearly 13%.
    - Alameda Alliance is ranked as the fourth-highest public health plan statewide in vaccination rates for Medi-Cal beneficiaries.
    - DHCS awarded Alameda Alliance up to $8.4 million for incentive funding to increase the vaccination rates, and established outcome measures were defined. A total of $2.2 million was paid to the Alliance by the DHCS, and $1.4 million in expenses have been incurred to date.
    - Alameda Alliance is identifying ways to further invest the remaining funds in community outreach and vaccination campaigns through community-based organizations.
    - Alameda Alliance is filing a mandatory vaccination report with the DHCS on or before April 20th, 2022.

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Executive Dashboard

OPERATIONS DASHBOARD

APRIL 2022

4/6/2022 10:44:30 AM

Financials

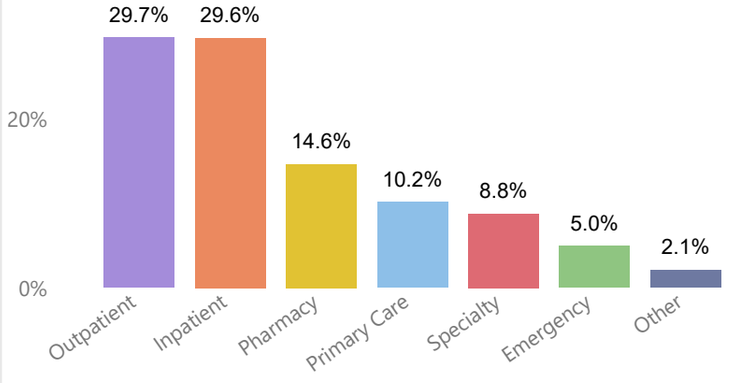
Income & Expenses

	FEBRUARY 2022	FISCAL YTD
REVENUE	$ 92.1 M	$ 780.2 M
MEDICAL EXPENSE	$ (83.2) M	$ (733.1) M
ADMIN EXPENSE	$ (5.4) M	$ (42.5) M
OTHER	$ (112) K	$ (223) K
NET INCOME	$ 3.4 M	$ 4.5 M

Gross Margin %

6.0%

Medical Expenses



Liquid Reserves

MLR Net %

94.0%

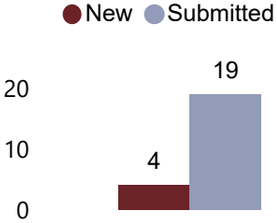
TNE %

561.2%

TNE $

$209.9M

Reinsurance Cases



Balance Sheet

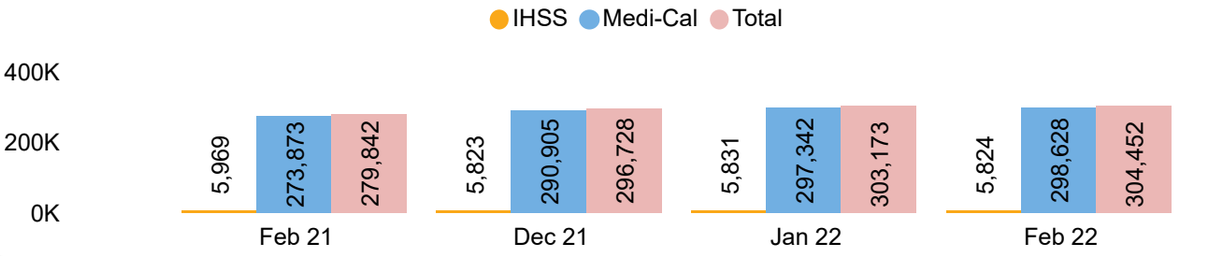
Cash Equivalents	$283.7M
Pass-Through Liabilities	$98.3M
Uncommitted Cash	$185.4M
Working Capital	$175.0M

Current Ratio %

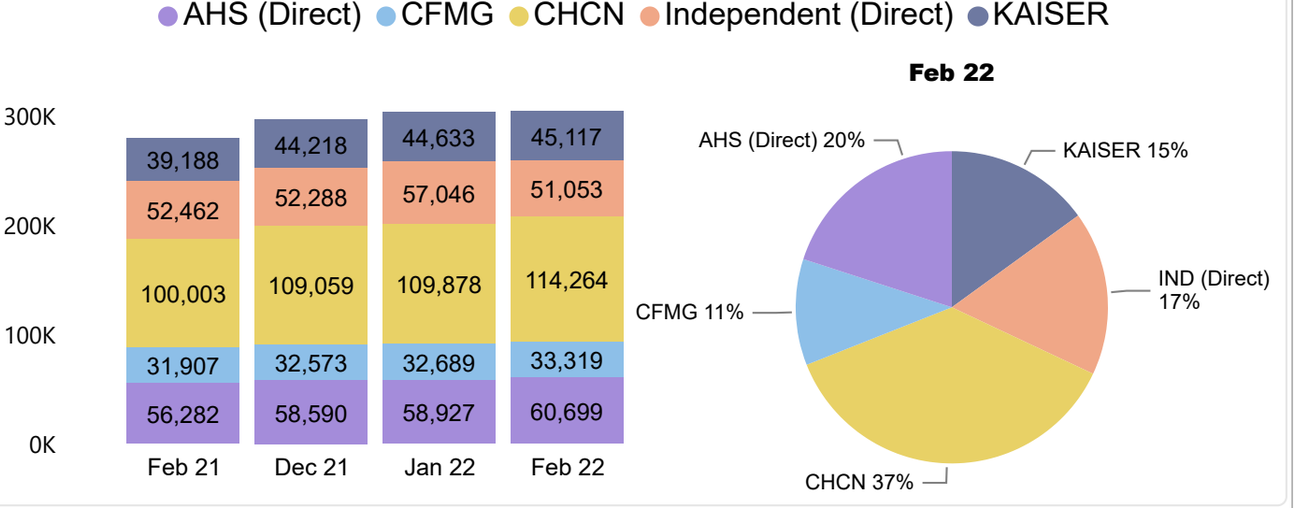
170.3%

Membership

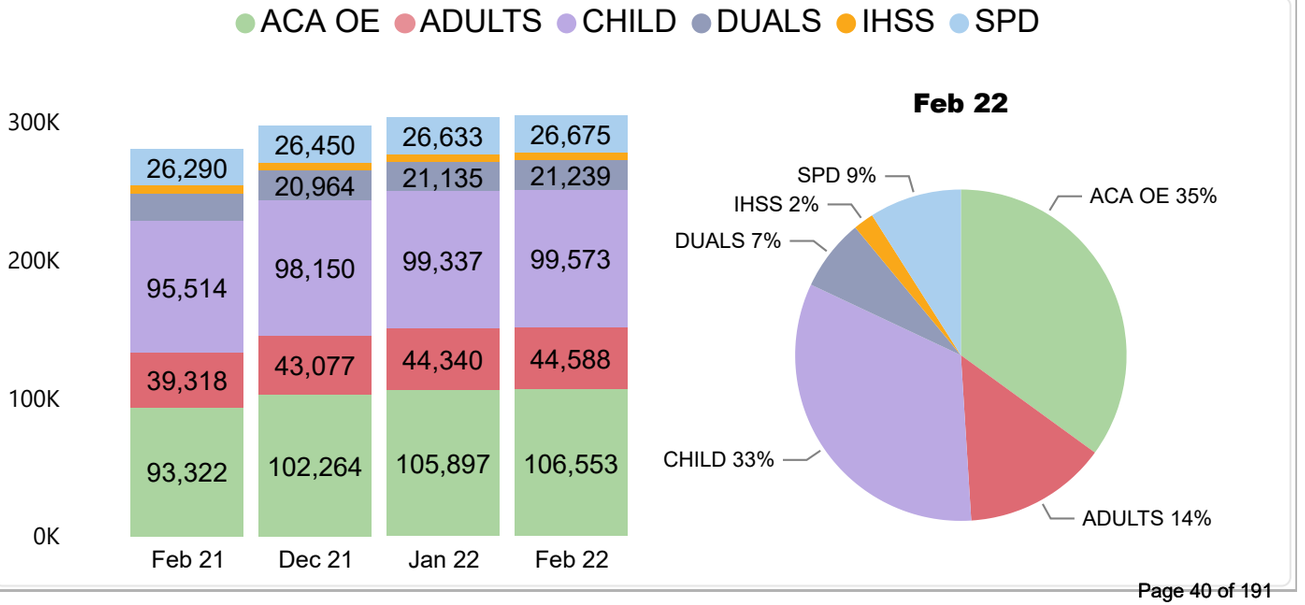
By Plan



By Network



By Category



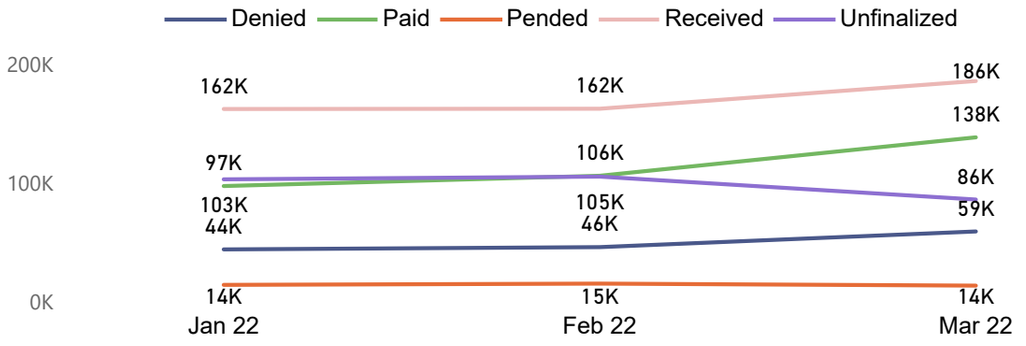
OPERATIONS DASHBOARD

APRIL 2022

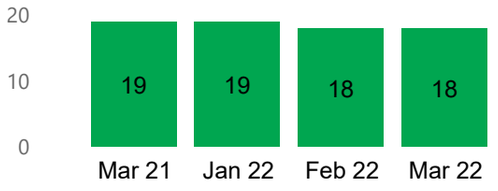
4/6/2022 10:44:30 AM

Claims

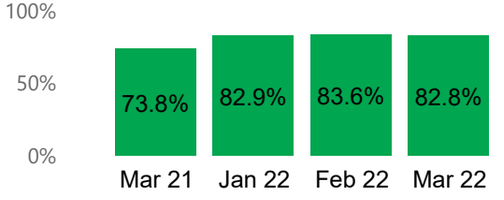
Claims Processing



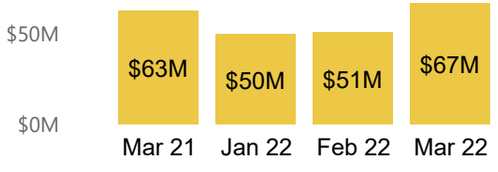
Average Payment TAT (Days)



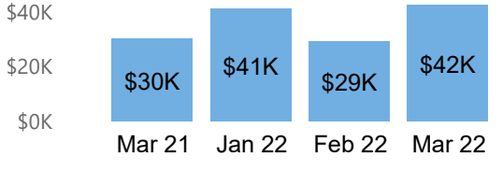
Auto Adjudication Rate (%)



Claims Paid ($)

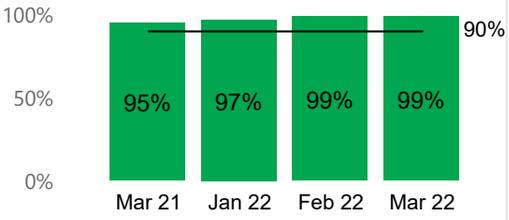


Interest Paid ($)

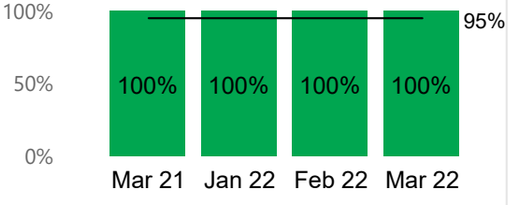


Claims Compliance

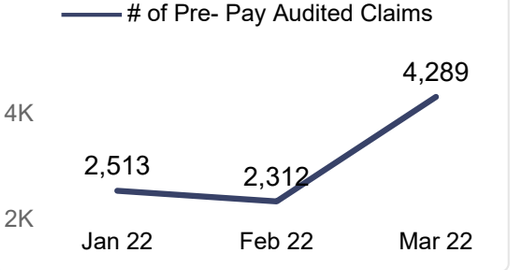
Processed 30 Cal Days (%)



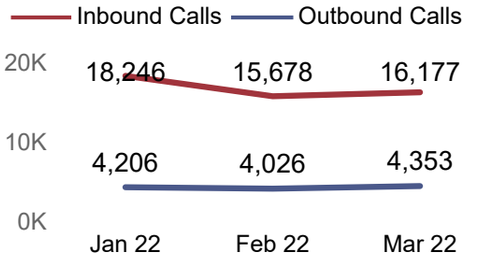
Processed 45 Work Days (%)



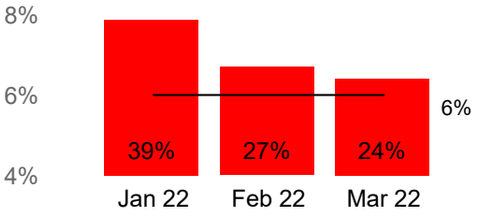
Claims Auditing



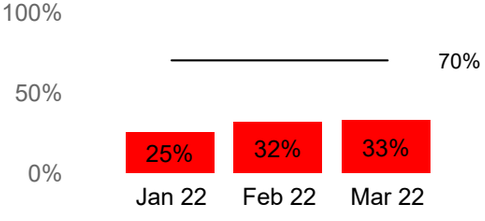
Member Services



Abandoned Call Rate (%)

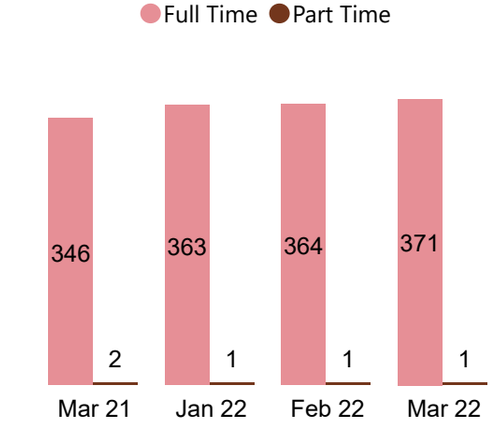


Calls Answered in 60 Seconds (%)



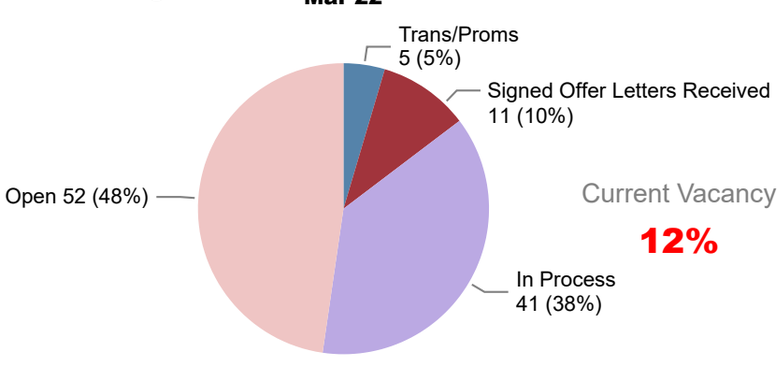
Average Call Times	Jan 22	Feb 22	Mar 22
Wait Time	11:52	08:30	08:49
Call Duration	06:29	05:43	05:56

Human Resources



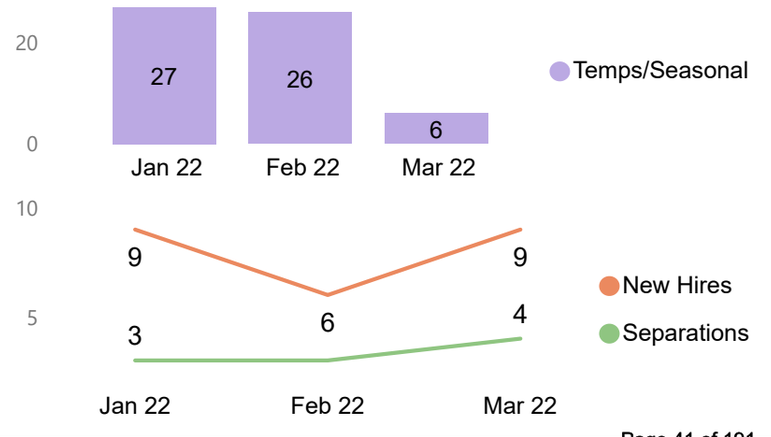
Recruiting Status

Mar 22



Current Vacancy

12%



OPERATIONS DASHBOARD

APRIL 2022

4/6/2022 10:44:30 AM

Provider Services

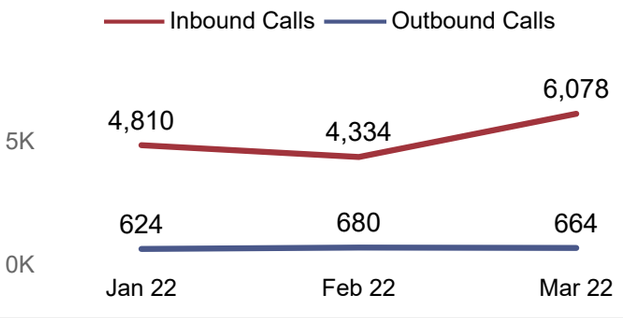
Provider Network

Hospital	17
Specialist	8,349
Primary Care Physician	719
Skilled Nursing Facility	65
Urgent Care	9
Health Centers (FQHCs and Non-FQHCs)	68
Transportation	380
TOTAL	**9,607**

Provider Credentialing

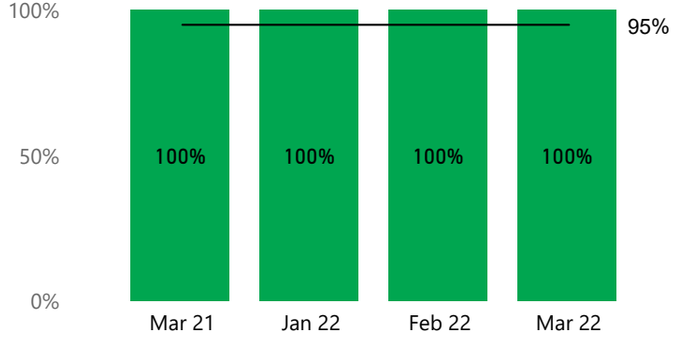
1,410

Provider Call Center



Provider Disputes & Resolutions

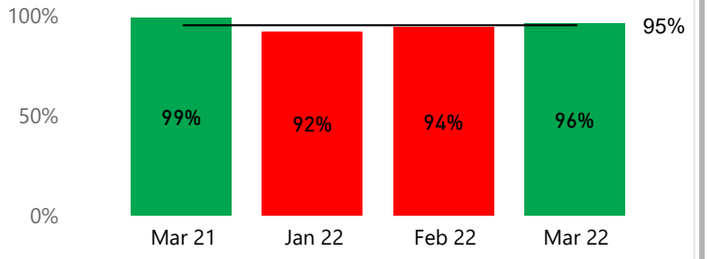
Turnaround Compliance (45 business days)



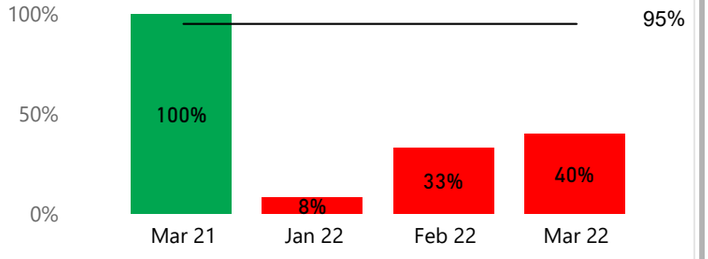
Compliance

Member Grievances

Standard (30 calendar days)

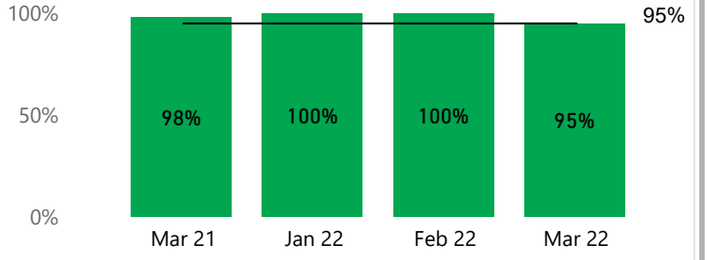


Expedited (3 calendar days)

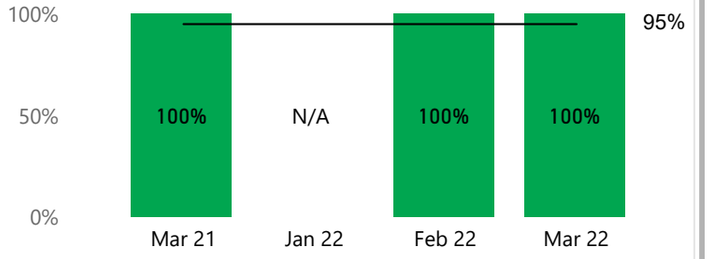


Member Appeals

Standard (30 calendar days)

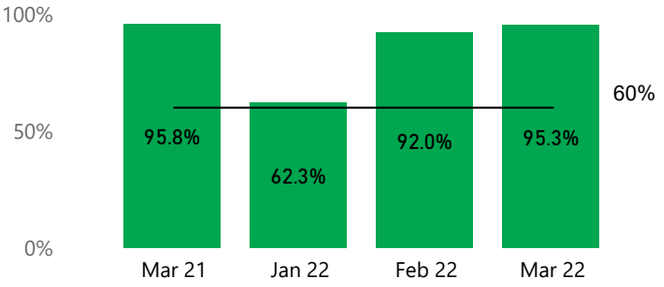


Expedited (3 calendar days)

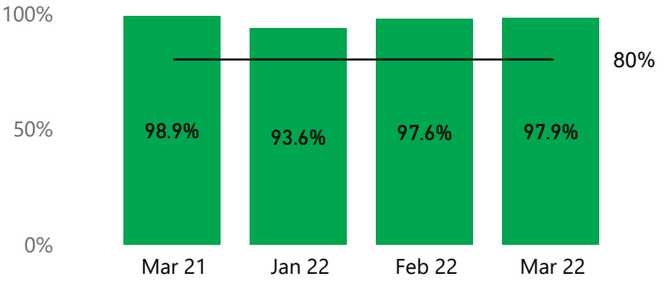


Encounter Data

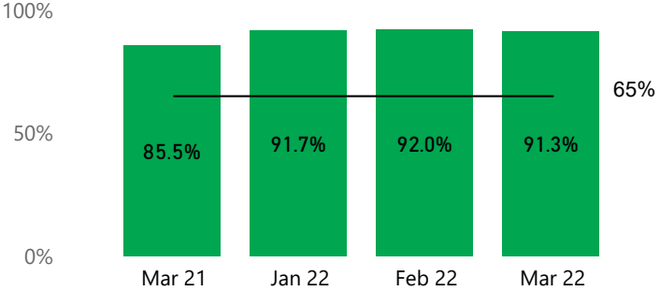
Institutional 0-90 days



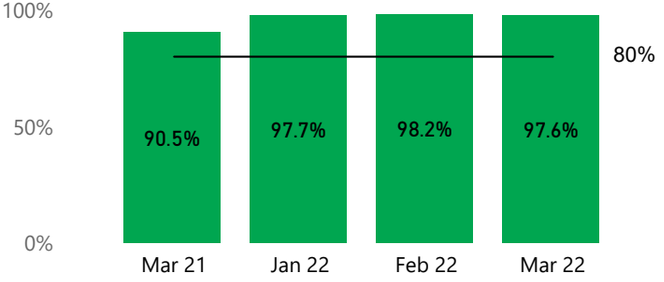
Institutional 0-180 days



Professional 0-90 days

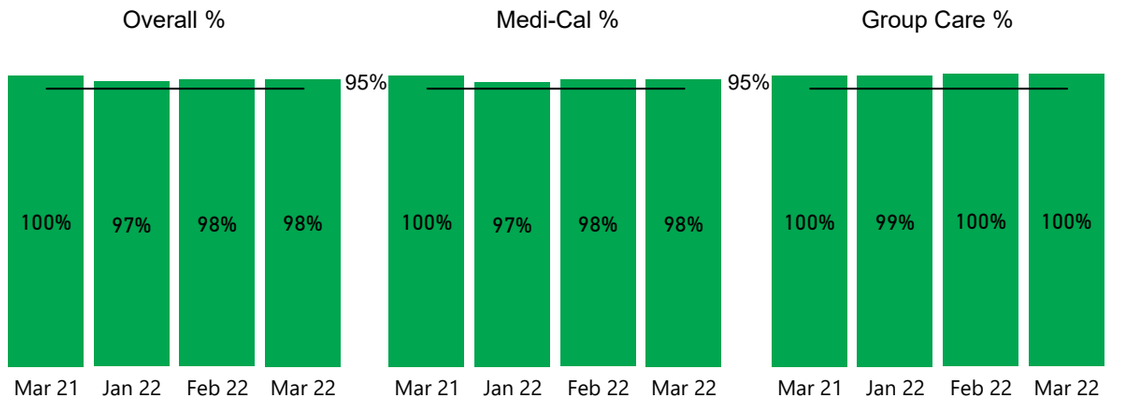


Professional 0-180 days

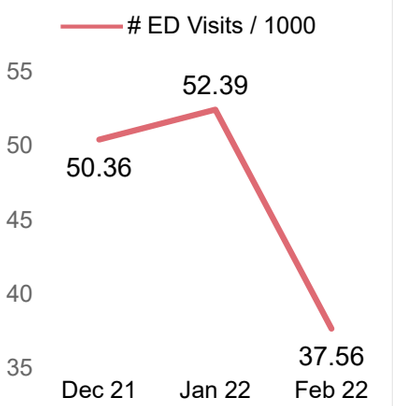


Health Care Services

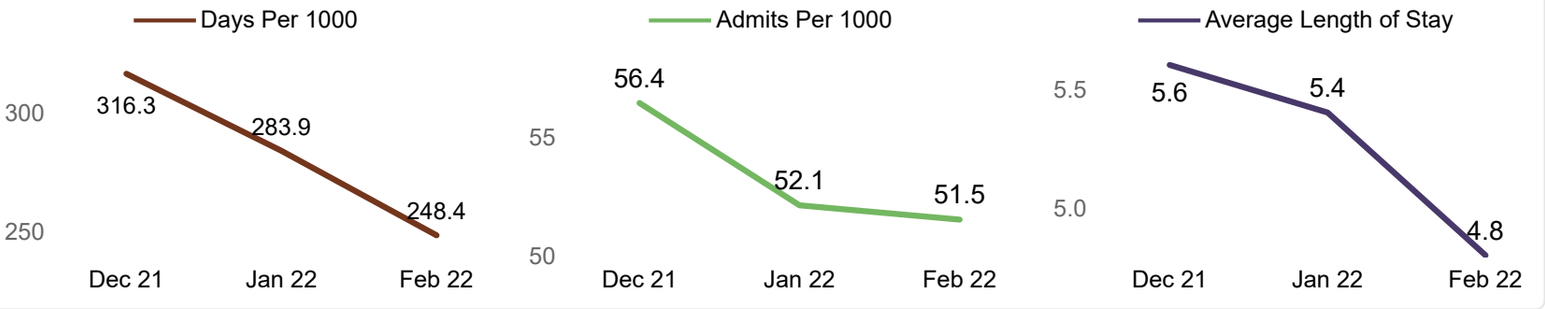
Authorization Turnaround



ED Utilization

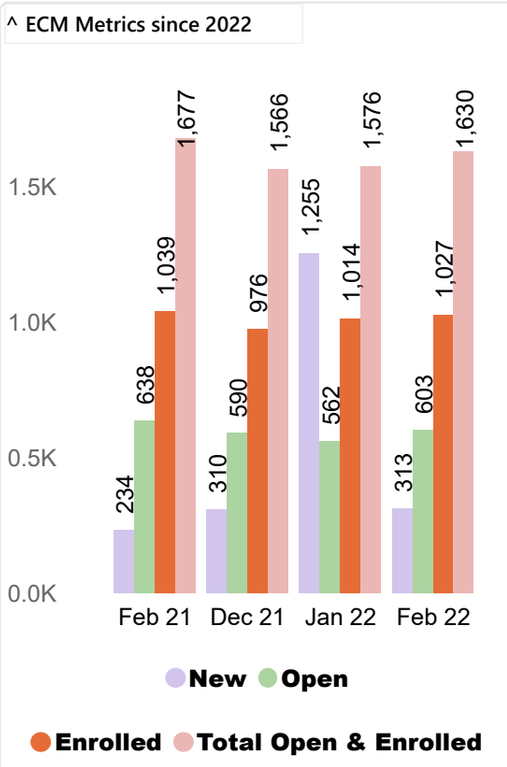


Inpatient Utilization

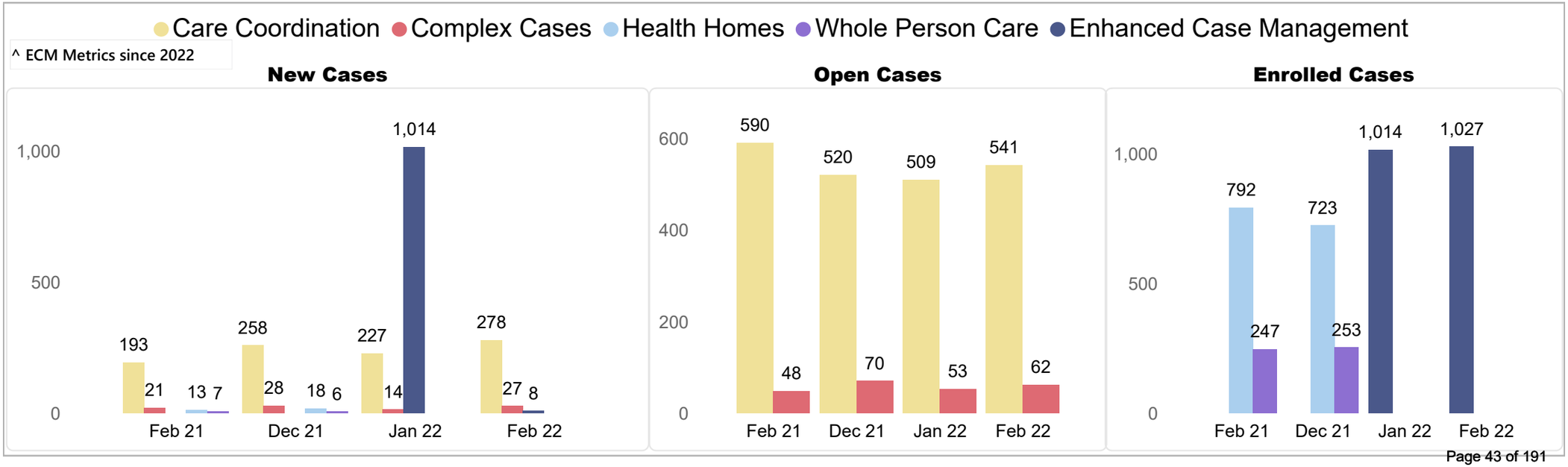


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Mar 21	Jan 22	Feb 22	Mar 22
HEALTHsuite System	100.0%	100.0%	98.9%	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	Mar 21	Jan 22	Feb 22	Mar 22
Denial Rate Excluding Partial Denials (%)	3.8%	3.6%	3.6%	2.9%
Overall Denial Rate (%)	3.8%	4.2%	4.1%	3.5%
Partial Denial Rate (%)	0.0%	0.7%	0.5%	0.6%

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

Pharmacy Authorizations

Authorizations	Mar 21	Jan 22	Feb 22	Mar 22
Approved Prior Authorizations	861	18	18	17
Closed Prior Authorizations	638	204	63	59
Denied Prior Authorizations	771	15	25	31
Total Prior Authorizations	2,270	237	106	107

ALAMEDA Alliance FOR HEALTH

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

COVID-19 Dashboard

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

Data as of: 2022-04-04

Network: All | LOB: All | City: All

ALAMEDA Alliance FOR HEALTH

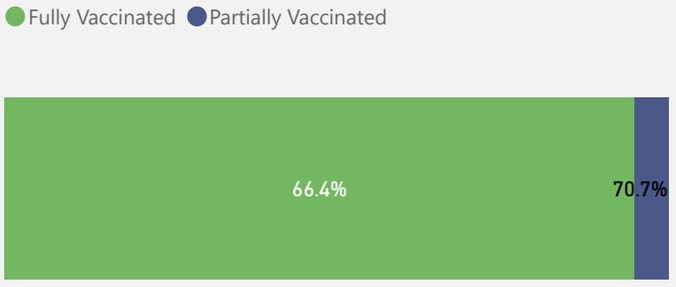
Members Fully Or Partially Vaccinated:

202,461

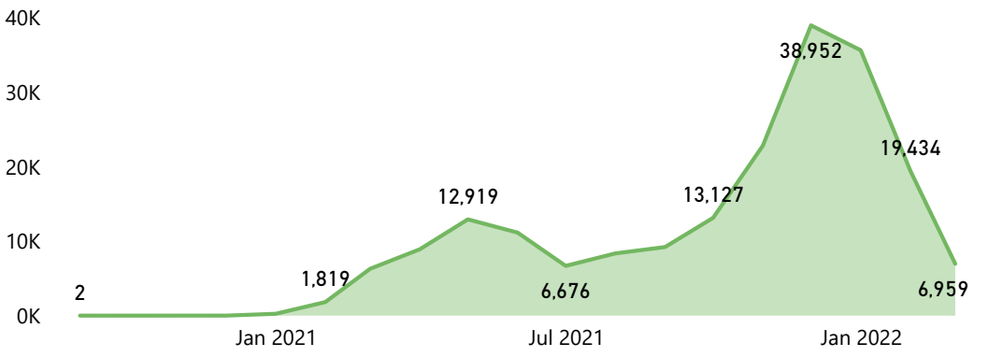
% Fully Or Partially Vaccinated:

70.7%

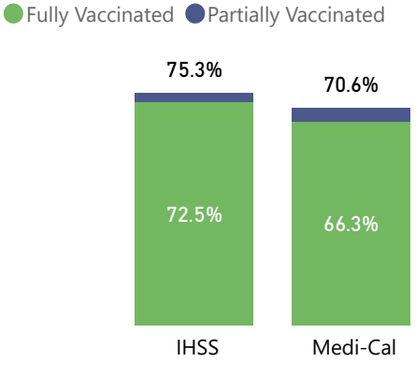
Breakout by Status



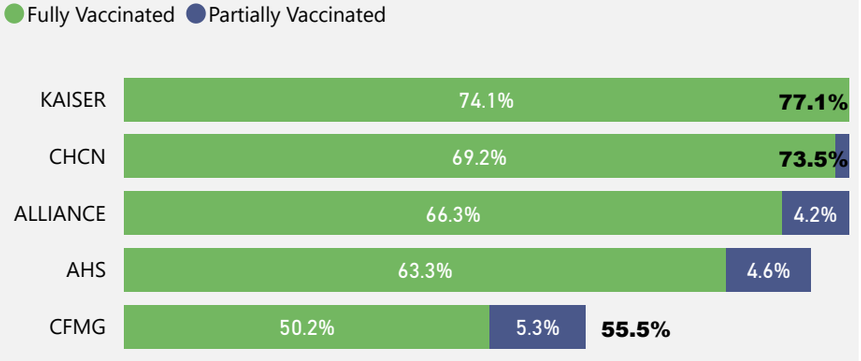
Monthly Trend



Medi-Cal vs IHSS

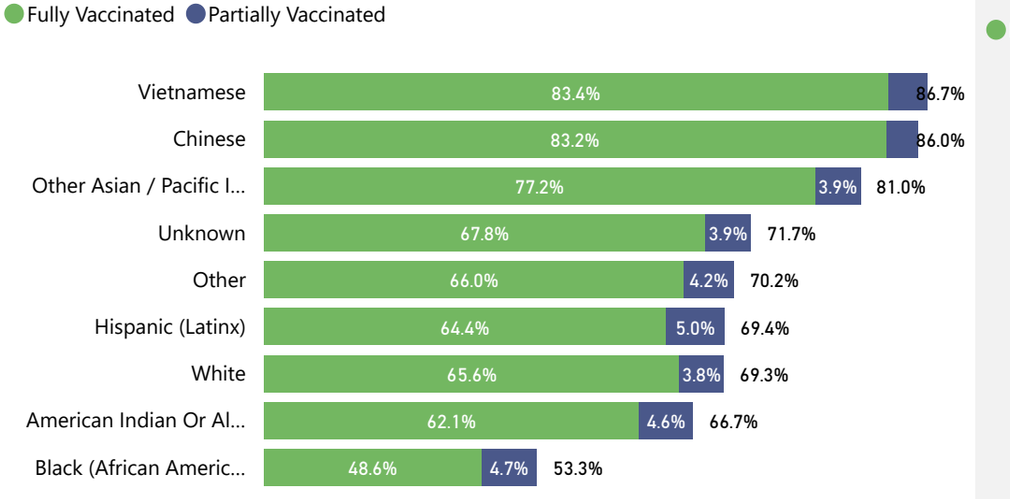


Network

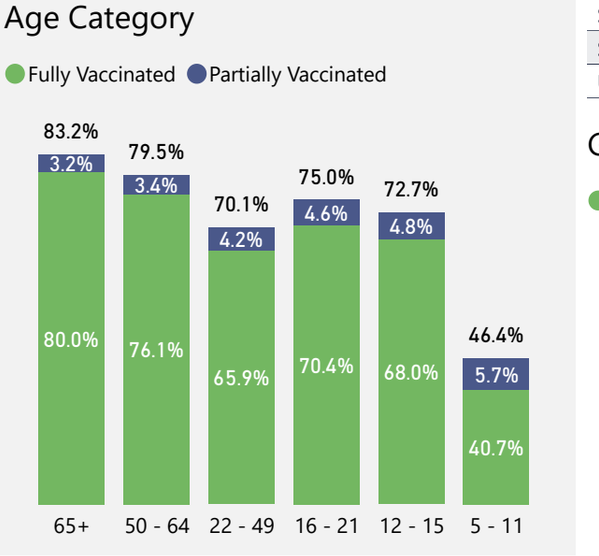


Top 15 Cities	Fully Vaccinated	Partially Vaccinated
ALAMEDA	72.9%	3.3%
ALBANY	76.7%	3.4%
BERKELEY	70.1%	4.1%
CASTRO VALLEY	69.8%	4.0%
DUBLIN	68.1%	4.6%
EMERYVILLE	63.9%	4.3%
FREMONT	69.2%	4.0%
HAYWARD	65.9%	4.0%
LIVERMORE	59.9%	4.2%
NEWARK	67.2%	3.9%
OAKLAND	63.4%	4.7%
PLEASANTON	68.5%	4.0%
SAN LEANDRO	69.4%	3.7%
SAN LORENZO	72.5%	4.0%
UNION CITY	71.7%	3.8%

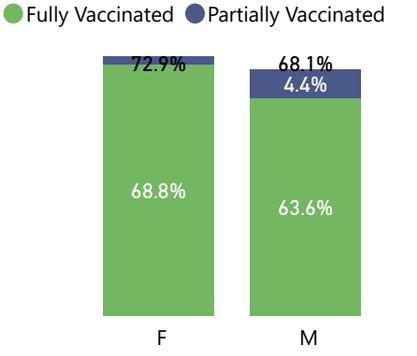
Ethnicity



Age Category



Gender



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

Data as of: 2022-04-04

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

ALAMEDA Alliance FOR HEALTH

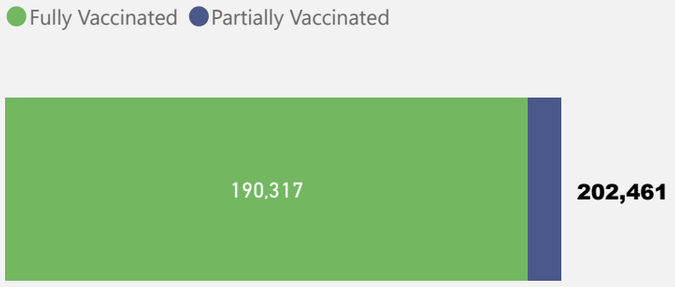
Members Fully Or Partially Vaccinated:

202,461

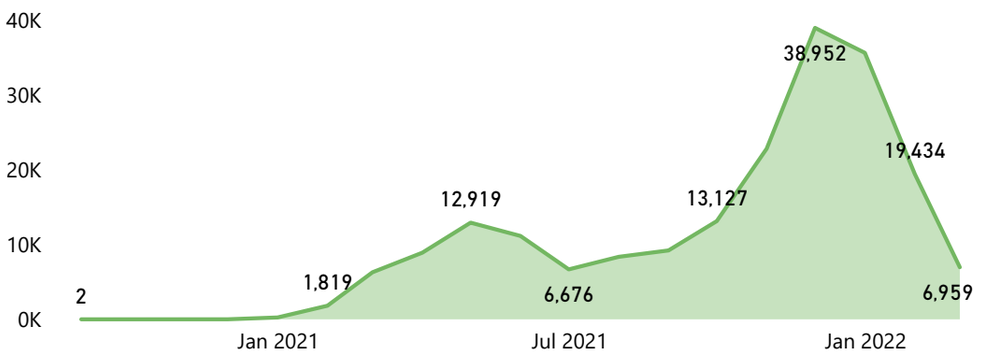
% Fully Or Partially Vaccinated:

70.7%

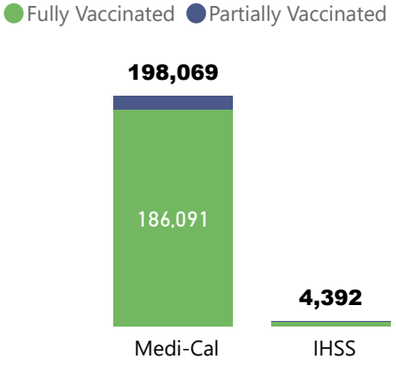
Breakout by Status



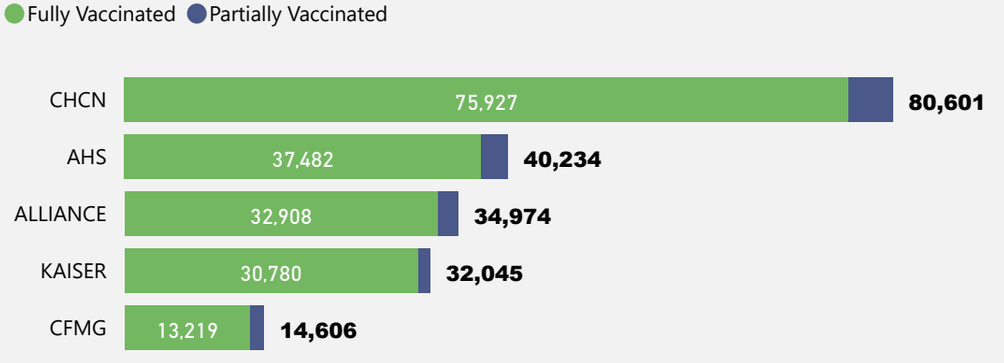
Monthly Trend



Medi-Cal vs IHSS

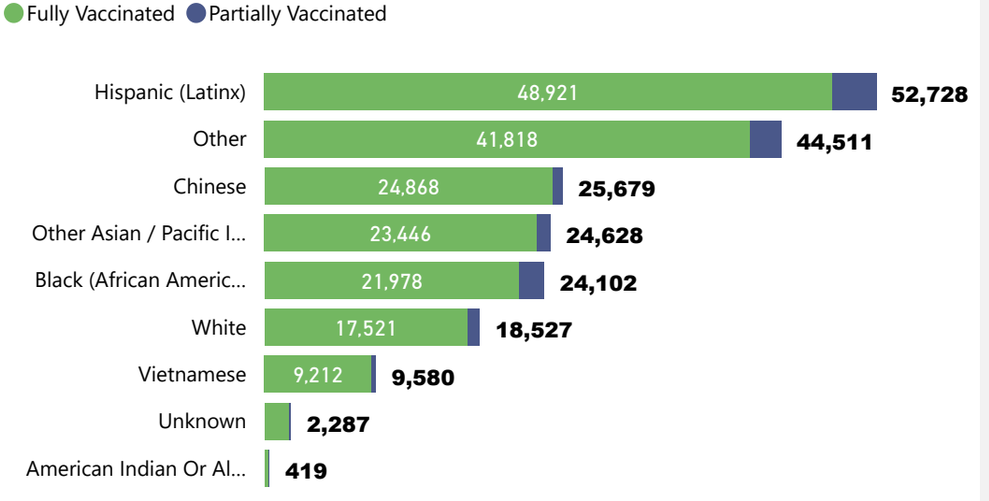


Network

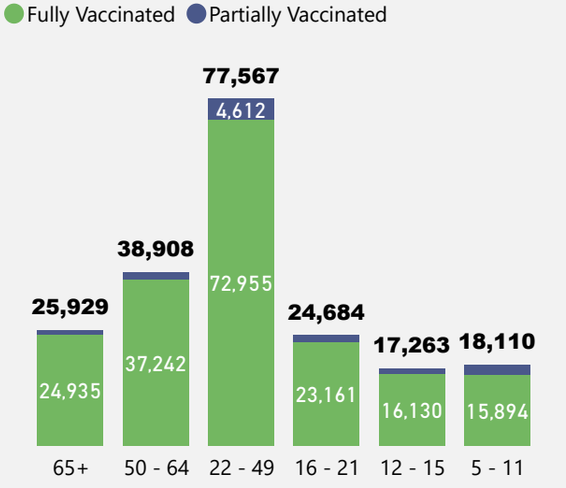


Top 15 Cities	Fully Vaccinated	Partially Vaccinated
ALAMEDA	8,203	372
ALBANY	1,365	61
BERKELEY	7,796	458
CASTRO VALLEY	5,088	288
DUBLIN	3,551	238
EMERYVILLE	1,241	84
FREMONT	18,263	1,062
HAYWARD	28,719	1,762
LIVERMORE	5,172	366
NEWARK	4,443	261
OAKLAND	71,292	5,273
PLEASANTON	3,308	194
SAN LEANDRO	17,836	955
SAN LORENZO	4,404	242
UNION CITY	8,775	470

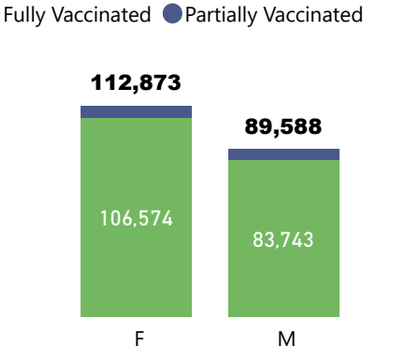
Ethnicity



Age Category



Gender



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.

Medi-Cal (Medicaid)

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

- **AB 1355 (Levine – D) Medi-Cal: Independent Medical Review System**
  - **Introduced:** 2/19/2021
  - **Status:** 1/27/22 Read third time. Passed. Ordered to Senate. In Senate. Read first time. To Com. on RLS. For assignment.
  - **Summary:** Would require the State Department of Health Care Services to establish the Independent Medical Review System (IMRS) for the Medi-Cal program, commencing on January 1st, 2023, which generally models specified requirements of the Knox-Keene Health Care Service Plan Act. The bill would provide that any Medi-Cal beneficiary appeal involving a disputed health care service is eligible for review under the IMRS if certain requirements are met, and would define "disputed health care service" as any service covered under the Medi-Cal program that has been denied, modified, or delayed by a decision of the department, or by one of its contractors, including, but not limited to, a Medi-Cal managed care plan, that makes a final decision, in whole or in part, due to a finding that the service is not medically necessary. The bill would require information on the IMRS to be displayed in or on specified material, including the "myMedi-Cal: How to Get the Health Care You Need" publication and the department's internet website.

- **AB 1859 (Levine – D) Mental Health Services**
  - **Introduced:** 2/8/2022
  - **Status:** 2/18/22 Referred to Com. on HEALTH.
  - **Summary:** Would require a health care service plan or a health insurance policy issued, amended, or renewed on or after January 1st, 2023, that includes coverage for mental health services to, among other things, approve the provision of mental health services for persons who are detained for 72-hour treatment and evaluation under the Lanterman-Petris-Short Act and to schedule an initial outpatient appointment for that person with a licensed mental health professional on a date that is within 48 hours of the person's release from detention. The bill would prohibit a noncontracting provider of covered mental health services from billing the previously described enrollee or insured more than the cost-sharing amount the enrollee or insured would pay to a contracting provider for those services.

- **AB1880 (Arambula – D) Prior Authorization and Step Therapy**
  - **Introduced:** 1/24/2022
  - **Status:** 3/29/22 Re-referred to Com. on HEALTH.
  - **Summary:** Current law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of

Managed Health Care and makes a willful violation of the act a crime. Current law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a health care service plan or health insurer to require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition, as specified. Current law requires a health care service plan or health insurer to expeditiously grant a step therapy exception request if the health care provider submits justification and supporting clinical documentation, as specified. 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 devices**
  - **Introduced:** 2/9/2022
  - **Status:** 3/24/22 Re-referred to Com. on HEALTH.
  - **Summary:** 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 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 1894 (Rivas) Designated public hospital financing advisory group**
  - **Introduced:** 2/9/2022
  - **Status:** 2/18/22 Referred to Com. on HEALTH.
  - **Summary:** Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, either through a fee-for-service or managed care delivery system. Current law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital reimbursement methodologies in order to maximize the use of federal funds consistent with federal Medicaid law and stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients, including designated public hospital systems, as defined. Under the Medi-Cal 2020 demonstration project, existing law establishes prescribed payment methodologies and requirements relating to the Medi-Cal Hospital/Uninsured Care Demonstration Project Act. This bill would require the department to create an advisory group to evaluate the increasing financial challenges faced by designated public hospital systems and would require the department to work with designated public hospitals on potential financing strategies to stabilize their financing.

- **AB 1900 (Arambula – D): Medi-Cal: income level for maintenance**
  - **Introduced:** 2/9/2022
  - **Status:** 3/23/22 Coauthors revised. From committee. Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 0.) (March 22nd). Re-referred to Com. on APPR.
  - **Summary:** Under current law, certain medically needy persons with higher incomes qualify for Medi-Cal with a share of cost, if they meet specified criteria. Under current law, the share of cost for those persons is generally the total after deducting an amount for maintenance from the person's monthly income. Current law requires the State Department of Health Care Services to establish income levels for maintenance at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal

financial participation will still be provided under applicable federal law. Under existing law, for a single individual, the amount of the income level for maintenance per month is based on a calculation of 80% of the highest amount that would ordinarily be paid to a family of 2 persons, without any income or resources, under specified cash assistance provisions, multiplied by the federal financial participation rate, adjusted as specified. This bill, to the extent that any necessary federal authorization is obtained, would increase the above-described income level for maintenance per month to be equal to the income limit for Medi-Cal without a share of cost for individuals who are 65 years of age or older or are disabled, generally totaling 138% of the federal poverty level.

- **AB 1929 (Gabriel - D) Medi-Cal: violence preventive services**
  - **Introduced:** 2/10/2022
  - **Status:** 3/29/22 In committee: Set, first hearing. Hearing cancelled at the request of author.
  - **Summary:** Would require the State Department of Health Care Services to establish a community violence prevention and recovery program, under which violence preventive services would be provided by qualified violence prevention professionals, as defined, as a covered benefit under the Medi-Cal program, in order to reduce the incidence of violent injury or reinjury, trauma, and related harms, and promote trauma recovery, stabilization, and improved health outcomes. Under the bill, the services would be available to a Medi-Cal beneficiary who (1) has been violently injured as a result of community violence, as defined, (2) for whom a licensed health care provider has determined that the beneficiary is at significant risk of experiencing violent injury as a result of community violence, or (3) has experienced chronic exposure to community violence. The bill would authorize the department to meet these requirements by ensuring that qualified violence prevention professionals are designated as community health workers.

- **AB 1930 (Arambula - D) Medi-Cal: comprehensive perinatal services**
  - **Introduced:** 2/10/2022
  - **Status:** 3/17/22 Re-referred to Com. on HEALTH.
  - **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy. This bill, during the one-year post pregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27th, 2021, during pregnancy and the initial 60-day post pregnancy period in effect on that date. The bill would require the department to collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered.

- **AB 1937 (Patterson - R) Medi-Cal: out-of-pocket pregnancy costs**
  - **Introduced:** 2/10/2022
  - **Status:** 3/17/22 Re-referred to Com. on HEALTH.
  - **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 1995 (Arambula - D) Medi-Cal: premiums or contribution**
  - **Introduced:** 1/24/2022
  - **Status:** 3/28/22 Re-referred to Com. on APPR.
  - **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 2024 (Friedman - D) Health care coverage: diagnostic imaging**
  - **Introduced:** 2/14/2022
  - **Status:** 3/31/22 From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH. Read second time and amended.
  - **Summary:** Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2023, to provide coverage for screening mammography, medically necessary diagnostic or supplemental breast examinations, or testing for screening or diagnostic purposes upon referral by specified professionals. The bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2023, from imposing cost sharing for screening mammography, medically necessary or supplemental breast examinations, or testing.

- **AB 2029 (Wicks - D) Health care coverage: treatment for infertility**
  - **Introduced:** 2/14/2022
  - **Status:** 2/24/22 Referred to Com. on HEALTH.
  - **Summary:** Would require a health care service plan contract or health 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. The bill would revise the definition of infertility and would remove the exclusion of in vitro fertilization from coverage. The bill would delete the exemption for religiously affiliated employers, health care service plans, and health insurance policies, from the requirements relating to coverage for the treatment of infertility, thereby imposing these requirements on these employers, plans, and policies. 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 prospective group contract holders.

- **AB 2077 (Calderon - D) Medi-Cal: monthly maintenance amount: personal and incidental needs**
  - **Introduced:** 2/14/2022
  - **Status:** 3/28/22 Re-referred to Com. on APPR.
  - **Summary:** 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. Existing law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $80.

- **AB 2352 (Nazarian - D) Prescription drug coverage**
  - **Introduced:** 2/16/2022
  - **Status:** 3/29/22 VOTE: Do pass as amended and be re-referred to the committee on [Appropriations] (Pass)
  - **Summary:** Would require a health care service plan or health insurer that provides prescription drug benefits and maintains one or more drug formularies to furnish specified information about a prescription drug upon request by an enrollee or insured, or their health care 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 health care provider from sharing the information furnished about the prescription drug or penalizing a provider for prescribing a lower cost 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 - D) Medi-Cal: continuous eligibility**
  - **Introduced:** 2/17/2022
  - **Status:** 3/30/22 Co-authors revised. From committee. Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 0.) (March 29th) Re-referred to Com. on APPR.
  - **Summary:** Current law requires the State Department of Health Care Services, to the extent federal financial participation is available, to exercise a federal option to extend continuous eligibility for the Medi-Cal program to children 19 years of age and younger until the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age. Under this bill, a child under 5 years of age would be continuously eligible for Medi-Cal, including without regard to income, until the child reaches 5 years of age. The bill would prohibit the redetermination of Medi-Cal eligibility before the child reaches 5 years of age, unless the department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and, except as specified, on the availability of federal financial participation.

- **AB 1944 (Lee – D) Local governments: open and public meetings**
  - **Introduced:** 1/24/2022
  - **Status:** 2/18/22 Referred to Com. on L. Gov.
  - **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. Current law, until January 1st, 2024, authorizes a local agency to use teleconferencing without complying with those specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect, or in other situations related to public health. This bill would specify that if a member of a legislative body elects to teleconference from a location that is not public, the address does not need to be identified in the notice and agenda or be accessible to the public when the legislative body has elected to allow members to participate via teleconferencing.

- **AB 2007 (Valladares – R) Health care language assistance services**
  - **Introduced:** 2/14/2022
  - **Status:** 2/24/22 Referred to Com. on HEALTH.
  - **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 2117 (Gipson – D) Mobile stroke units: health care coverage**
  - **Introduced:** 2/14/2022
  - **Status:** 2/24/22 Referred to Com. on HEALTH.
  - **Summary:** Current law provides for the licensure and regulation of health facilities by the State Department of Public Health and defines various types of health facilities for those purposes. This bill would define "mobile stroke unit" to mean a multijurisdictional mobile facility that serves as an emergency response critical care ambulance under the direction and approval of a local emergency medical services (EMS) agency, and as a diagnostic, evaluation, and treatment unit, providing radiographic imaging, laboratory testing, and medical treatment under the supervision of a physician in person or by telehealth, for patients with symptoms of a stroke, to the extent consistent with any federal definition of a mobile stroke unit, as specified.

- **AB 2123 (Villapudua – D) Bringing Health Care into Communities Act of 2023**
  - **Introduced:** 2/15/2022
  - **Status:** 3/28/22 Referred to Com. on H. & C.D and HEALTH pursuant to Assembly Rule 96.
  - **Summary:** Current law establishes various programs to facilitate the expansion of the health care workforce in rural and underserved communities, including, but not limited to, the Health Professions Career Opportunity Program and the California Registered Nurse Education Program. This bill, the Bringing Health Care into Communities Act of 2023, would establish the Bringing Health Care into Communities Program to be administered by the agency to provide housing grants to specified health professionals to be used for mortgage payments for a permanent residence in a health professional shortage area, as specified. Under the bill, a health professional would be eligible for a grant for up to 5 years. The bill would make its provisions operative upon appropriation by the Legislature.

- **AB 2304 (Bonta – D) Nutrition Assistance: "Food as Medicine"**
  - **Introduced:** 2/16/2022
  - **Status:** 2/17/22 From printer. May be heard in committee March 19th.
  - **Summary:** Current law provides for the California Health and Human Services Agency, which includes the State Department of Health Care Services, the State Department of Public Health, and the State Department of Social Services. Current law establishes various programs and services under those departments, including the Medi-Cal program, under which qualified low-income individuals receive health care services, such as enteral nutrition products, the California Special Supplemental Nutrition Program for Women, Infants, and Children, which is administered by the State Department of Public Health and counties and under which nutrition and other assistance are provided to eligible individuals who have been determined to be at nutritional risk, and the CalFresh program, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county. This bill would declare the intent of the Legislature to enact the Wilma Chan Food as Medicine Act of 2022.

- **AB 2449 (Rubio – D) Open meetings: local agencies: teleconferences**
  - **Introduced:** 1/24/2022
  - **Status:** 3/3/22 Referred to Com. on L. Gov.
  - **Summary:** Current law, until January 1st, 2024, authorizes a local agency to use teleconferencing without complying with specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect, or in other situations related to public health. This bill would authorize a local agency to use teleconferencing without complying with those specified teleconferencing requirements if at least a quorum of the members of the legislative body participates in person from a singular location clearly identified on the agenda that is open to the public and situated within the local agency's jurisdiction. The bill would impose prescribed requirements for this exception relating to notice, agendas, the means and manner of access, and procedures for disruptions. The bill would require the legislative body to implement a procedure for receiving and swiftly resolving requests for reasonable accommodation for individuals with disabilities, consistent with federal law.

- **AB 2458 (Weber – D) California Children's Services: reimbursement rates.**
  - **Introduced:** 2/17/2022
  - **Status:** 3/23/22: From committee. Do pass and re-refer to Com on APPR. (Ayes 13. Noes 0.) Re-referred to Com. on APPR.
  - **Summary:** Would make legislative findings relating to the need for an increase in the reimbursement rates for physician services provided under the California Children's Services (CCS) Program. Under the bill, subject to an appropriation, and commencing January 1st, 2023, those reimbursement rates would be increased by adding at least 25% to the above-described augmentation percentage relative to the applicable Medi-Cal rates. The bill would make the rate increase applicable only if the services are provided by a physician in a practice in which at least 30% of the practice's pediatric patients are Medi-Cal beneficiaries.

- **AB 2539 (Choi - R) Public health: COVID-19 vaccination: proof of status**
  - **Introduced:** 2/17/2022
  - **Status:** 2/18/22 From printer. May be heard in committee March 20th.

- **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:** 3/10/22 Referred to Com. on HEALTH.
  - **Summary:** Current law requires a health care service plan contract issued, amended, or renewed on or after January 1st, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. For provider contracts issued, amended, or renewed on and after January 1st, 2023, this bill would require a health care service plan that provides coverage for mental health and substance use disorders and credentials health care providers of those services for the health care service plan's networks, to assess and verify the qualifications of a health care provider within 45 days after receiving a completed provider credentialing application.

- **AB 2659 (Patterson - R) Medi-Cal managed care: midwifery services**
  - **Introduced:** 2/18/2022
  - **Status:** 3/22/22 Re-referred to Com. on HEALTH
  - **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:** 3/10/22 Referred to Com. on HEALTH.
  - **Summary:** Would require the department to create the Community Health Navigator Program to make direct grants to qualified community-based organizations, as defined, to conduct targeted outreach, enrollment, retention, and access activities for Medi-Cal-eligible individuals and families. The bill would specify the basis for issuing a grant, including specified factors in the applicant's service area. The bill would require the department to contract with a private foundation to administer the grant application and allocation process. The bill would require the department to contract with specified providers to furnish training and technical assistance to grant recipients. The bill would also require the department to coordinate and partner with Covered California and counties that elect to participate, on an approach for outreach, enrollment,

retention, and access activities for marketing to eligible individuals, including development of a joint application tracker system to allow specified persons and entities to track application and referrals between commercial and Medi-Cal enrollment progress and facilitation of quarterly meetings on enrollment and access barriers and solutions, among other requirements.

- **AB 2727 (Wood – D) Medi-Cal Eligibility**
  - **Introduced:** 1/24/2022
  - **Status:** 3/30/22 From committee: Do pass. (Ayes. Noes. 1) (March 29th)
  - **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. Existing law also conditions implementation of that provision on receipt of any necessary federal approvals and the availability of federal financial participation. Current law states the intent of the Legislature to provide, to the extent practicable, through the Medi-Cal program, for health care for those aged and other persons, including family persons who lack sufficient annual income to meet the costs of health care, and whose other assets are so limited that their application toward the costs of that care would jeopardize the person or family's future minimum self-maintenance and security. This bill would, commencing on January 1st, 2024, remove from that statement of legislative intent the above-described assets as an eligibility criterion.

- **AB 2813 (Santiago - D) Long-Term Services and Supports Benefit Program**
  - **Introduced:** 2/18/2022
  - **Status:** 3/17/22 Referred to Coms. On AGING & L.T.C. & HUM.S.
  - **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:** 3/28/22 Referred to Com. on HEALTH.
  - **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.

- **AB 2942 (Daly - D) Prescription drug cost sharing**
  - **Introduced:** 2/18/2022

- **Status:** 3/17/22 Referred to Com. on HEALTH.
- **Summary:** Current law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price. This bill would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would require a health care service plan or health insurer to, among other things, pass through to each enrollee or insured at the point of sale a good faith estimate of their decrease in cost sharing. The bill would require a health care service plan or health insurer to calculate an enrollee's or insured's defined cost sharing and provide that information to the dispensing pharmacy, as specified.

- **AB 2516 (Aguiar-Curry - D) Health care coverage: human papillomavirus**
  - **Introduced:** 2/17/2022
  - **Status:** 3/10/22 Referred to Com. on HEALTH.
  - **Summary:** Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after 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.

- **SB 853 (Wiener – D) Prescription drug coverage**
  - **Introduced:** 1/19/2022
  - **Status:** 3/29/22 Set for hearing April 20th.
  - **Summary:** Current law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law prohibits a health care service plan contract that covers prescription drug benefits or a specified health insurance policy from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which it was approved by the federal Food and Drug Administration if specified conditions are met. Current law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. This bill would expand the above-described prohibitions to prohibit limiting or excluding coverage of a dose of a drug or dosage form.

- **SB 858 (Wiener – D) Health care service plans: discipline: civil penalties.**
  - **Introduced:** 1/19/2022
  - **Status:** 3/29/22 Set for hearing April 20th.
  - **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 existing 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 maximum base amount of the civil penalty from $2,500 per violation to $25,000 per violation, which would be adjusted annually commencing January 1st, 2024, as specified.

- **SB 871 (Pan – D) Public Health: Immunization**
  - **Introduced:** 2/4/2022
  - **Status:** 2/24/22 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:** 3/29/22 Set for hearing April 20th.
  - 2/9/22 Referred to Com. on HEALTH.
  - **Summary:** Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1st, 2023, to provide coverage for biomarker testing, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition if the test is supported by medical and scientific evidence, as prescribed. This bill would apply these provisions relating to biomarker testing to the Medi-Cal program, including Medi-Cal managed care plans, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **SB 923 (Wiener – D) Gender- affirming care**
  - **Introduced:** 1/25/2022
  - **Status:** 3/30/22 Set for hearing April 6th.
  - **Summary:** Current law establishes the Transgender Wellness and Equity Fund, administered by the Office of Health Equity within the State Department of Public Health, for the purpose of grant funding focused on coordinating trans-inclusive health care for individuals who identify as transgender, gender nonconforming, or intersex (TGI). This bill would require a Medi-Cal managed care plan, a PACE organization, a health care service plan, or a health insurer, as specified, to require its staff and contracted providers to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for

individuals who identify as TGI. The bill would specify the required components of the training and would make use of any training curricula subject to approval by the respective departments.

- **SB 958 (Limon - D) Medication and Patient Safety Act**
  - **Introduced:** 2/09/2022
  - **Status:** 3/31/22 From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
  - **Summary:** Would prohibit a health care service plan or health insurer, or its designee, from arranging for or 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 prohibit a plan or insurer, or its designee, from requiring an infused or injected medication to be administered in an enrollee's or insured's home as a condition of coverage, unless the treating health care provider determines home administration is safe and appropriate. 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:** 3/24/22 From committee. Do pass and re-refer to Com. on APPR with recommendation: To consent calendar. (Ayes 11. Noes 0.) (March 23rd). Re-referred to Com on APPR.
  - **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. "Visit" is defined as a face-to-face encounter between an FQHC or RHC patient and any of specified health care professionals, including a physician, a licensed clinical social worker, or a marriage and family therapist. This bill would also include, within the definition of a visit, a face-to-face encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when supervised by a licensed behavioral health practitioner as required by the Board of Behavioral Sciences, as specified. The bill would make this provision operative 60 days after the termination of the national emergency declared on March 13th, 2020.

- **SB 974 (Portantino - D) Health care coverage: diagnostic imaging**
  - **Introduced:** 2/10/2022
  - **Status:** 3/29/22 Set for hearing April 20th.
  - **Summary:** Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2023, to provide coverage without imposing cost sharing for medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee or insured indicated to have a risk factor associated with breast cancer.

- **SB 987 (Portantino – D) Medi-Cal: time and distance standards**
  - **Introduced:** 2/14/2022
  - **Status:** 3/30/22 From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
  - **Summary:** Would require a Medi-Cal managed care plan to include in its contracted provider network at least one National Cancer Institute (NCI) Designated Cancer Center, as specified, and ensure that any beneficiary diagnosed with a complex cancer diagnosis, as defined, is referred to an NCI-Designated Cancer Center within 15 business days of the diagnosis, unless the beneficiary selects a different cancer treatment provider.

- **SB 1019 (Gonzalez – D) Medi-Ca managed care plans: mental health benefits**
  - **Introduced:** 2/14/2022
  - **Status:** 3/23/22 Set for hearing April 26th.
  - **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 fee-for-service and managed care. Current law requires a Medi-Cal managed care plan to provide mental health benefits covered in the state plan, excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver. This bill would require a Medi-Cal managed care plan to conduct annual outreach and education to its enrollees regarding the mental health benefits that are covered by the plan, and to also develop annual outreach and education to inform primary care physicians regarding those mental health benefits.

- **SB 1033 (Pan – D) Health care coverage**
  - **Introduced:** 2/15/2022
  - **Status:** 3/29/22 Set for hearing April 20th.
  - **Summary:** Current law requires the Department of Managed Health Care and Insurance Commissioner, in developing the regulations, to require health care service plans and health insurers to assess the linguistic needs of the enrollee and insured population, and to provide for translation and interpretation for medical services, as indicated. Current law requires the regulations to include, among other things, requirements for conducting assessments of the enrollees and insured groups, and requires health care service plans and health insurers to update the needs assessment, demographic profile, and language translation requirements every 3 years. This bill would require the Department of Managed Health Care and the commissioner to revise these regulations, no later than July 1st, 2023, and to require health care service plans and health insurers to assess the cultural, linguistic, and health-related social needs of the enrollees and insured groups for the purpose of identifying and addressing health disparities, improving health care quality and outcomes, and addressing population health.

- **SB 1089 Medi-Cal Eyeglasses: Prison Industry Authority**
  - **Introduced:** 1/24/2022
  - **Status:** 3/31/22 From committee: Do pass as amended and re-refer to Com. on PUB. S. (Ayes 10. Noes 0.) (March 30th).
  - **Summary:** Would, for purposes of Medi-Cal reimbursement for covered optometric services, authorize an optometrist to purchase eyeglasses from a private entity, as an alternative to a purchase of eyeglasses from the Prison Industry Authority. The bill would condition implementation of this provision on receipt of any necessary federal approvals and the availability of federal financial participation.

- **SB 1180 (Pan – D) Medi-Cal: CalAIM Access Report for Multiple Lines of Business**
  - **Introduced:** 2/17/2022
  - **Status:** 3/2/22 Referred to Com. on HEALTH.
  - **Summary:** Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, either through a fee-for-service or managed care delivery system. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would require that report also be sent to specified committees in the Senate and Assembly. This bill contains other existing laws.

- **SB 1184 (Cortese - D) Confidentiality of Medical Information Act: school-linked services coordinators**
    - **Introduced:** 2/17/2022
    - **Status:** 3/25/22 Set for hearing April 5th.
    - **Summary:** Would additionally require a provider of health care, a health care service plan, or a contractor to disclose medical information if the disclosure is compelled by a school-linked services coordinator. The bill would define the term "school-linked services coordinator" as any of certain individuals or entities, including a licensed educational psychologist, located on a school campus or under contract by a county behavioral health provider agency for the treatment and health care operations and referrals of students and their families. By expanding the crime of violating the act, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

- **SB 1207 (Portantino – D) Health care coverage: maternal and pandemic-related mental health conditions**
    - **Introduced:** 2/17/2022
    - **Status:** 3/23/22 Re-referred to Com. on HEALTH.
    - **Summary:** Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2023, to provide coverage for maternal mental health conditions and pandemic-related mental health conditions, as defined. The bill would require a subscriber, enrollee, insured, or policyholder to present written documentation from a treating health care provider diagnosing the maternal mental health condition or pandemic-related mental health condition. The bill would require treatment to continue until the treating provider determines and documents in writing that, in their clinical determination, the services are no longer required. The bill would specify that a health care service plan or health insurer is not prohibited from applying cost-sharing requirements as otherwise authorized by law.

- **SB 1298 (Ochoa Bogh - R) Behavioral Health Continuum Infrastructure Program**
    - **Introduced:** 2/18/2022
    - **Status:** 3/31/22 Set for hearing April 20th.
    - **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, among other things, intending to place their projects in any recently closed hospitals or skilled nursing facilities, as specified.

- **SB 1361 (Kamlager - D) Importation of prescription drugs**
    - **Introduced:** 2/18/2022
    - **Status:** 3/31/22 April 6th set for first hearing canceled at the request of author.
    - **Summary:** Current law establishes the California Health and Human Services Agency (CHHSA), which includes departments charged with the administration of health, social, and other human services. This bill would create the Affordable Prescription Drug Importation Program in CHHSA, under which the state would be a licensed wholesaler that imports prescription drugs, as specified, for the exclusive purpose of dispensing those drugs to program participants. The bill would require CHHSA to seek federal approval for the importation program on or before June 1st, 2023, and

would require CHHSA to contract with at least one contracted importer to provide services under the importation program within 6 months of receiving federal approval.

- **SB 1379 (Ochoa Bogh - R) Pharmacy: remote services**
  - **Introduced:** 2/18/2022
  - **Status:** 3/16/22 Set for hearing April 18th.
  - **Summary:** The Controlled Substances Act regulates, among other matters, the dispensing by prescription of controlled substances, which are classified into schedules, and the Pharmacy Law regulates, among other matters, the dispensing by prescription of dangerous drugs and dangerous devices, which also include controlled substances. Current law authorizes a prescriber, a prescriber's authorized agent, or a pharmacist to electronically enter a prescription or order from outside of a pharmacy or hospital, as specified, except for prescriptions for controlled substances classified in Schedules II, III, IV, or V. Under current law, a violation of these provisions is a crime. This bill would extend the authority to remotely enter a prescription or order to include prescriptions for controlled substances classified in Schedules II, III, IV, or V. The bill would also authorize a pharmacist to perform various services remotely, as specified, on behalf of a pharmacy located in California and under the written authorization of a pharmacist-in-charge.

Bills moved for action in second house:

- **SB 245 (Gonzalez – D) Health Care Coverage: Abortion Services: Cost of Sharing**
  - **Introduced:** 1/24/2022
  - **Status:** 3/22/22 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.

ALAMEDA Alliance FOR HEALTH

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

Board Business

Finance

Gil Riojas

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

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

Date: **April 8th, 2022**

Subject: **Finance Report – February 2022**

Executive Summary

- For the month ended February 28th, 2022, the Alliance had enrollment of 304,452 members, a Net Income of $3.4 million and 561% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$92,121	$780,233
Medical Expense	83,180	733,053
Admin. Expense	5,386	42,452
Other Inc. / (Exp.)	(112)	(223)
Net Income	**$3,443**	**$4,504**

Net Income by Program:

	Month	YTD
Medi-Cal	$3,551	$5,240
Group Care	(107)	(736)
	$3,443	**$4,504**

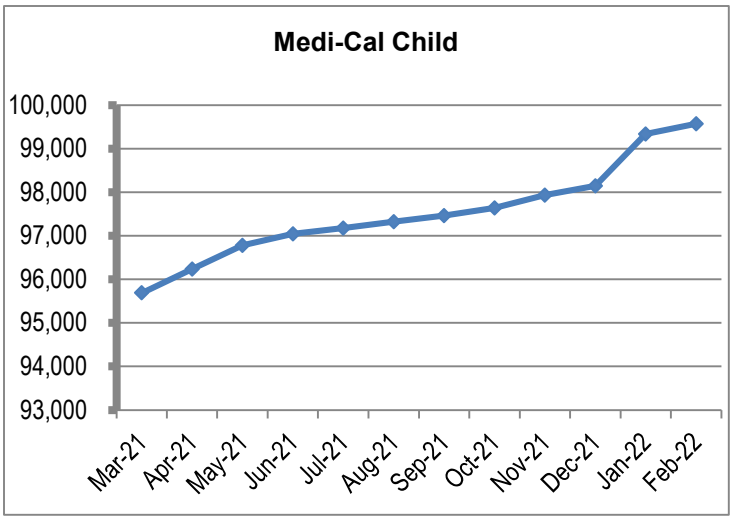
Enrollment

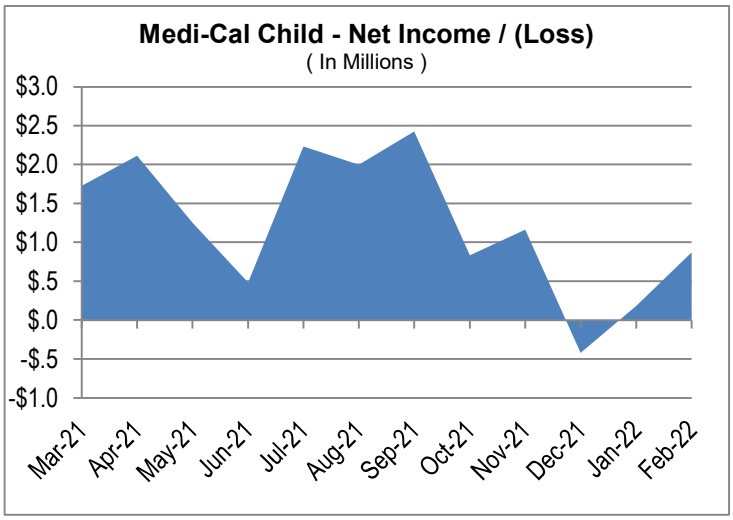
- Total enrollment increased by 1,279 members since January 2022.
- Total enrollment increased by 15,898 members since June 2021.

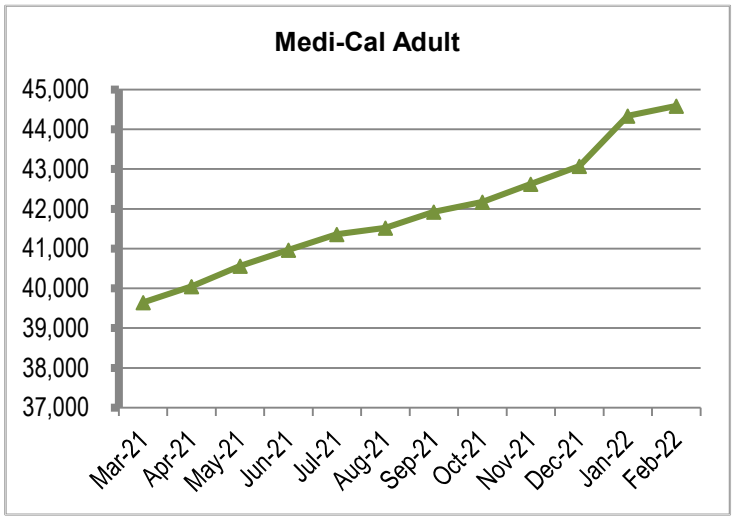
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

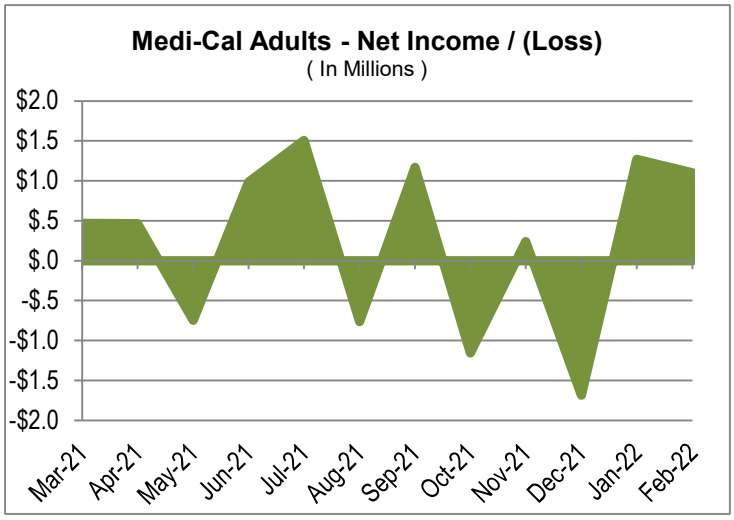
Enrollment					Member Months			
February-2022					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
44,588	42,733	1,855	4.3%	Adult	341,606	337,980	3,626	1.1%
99,573	98,621	952	1.0%	Child	784,594	783,611	983	0.1%
26,675	26,220	455	1.7%	SPD	211,517	210,859	658	0.3%
21,239	20,588	651	3.2%	Duals	165,979	165,048	931	0.6%
106,553	100,845	5,708	5.7%	ACA OE	816,423	805,646	10,777	1.3%
298,628	**289,007**	**9,621**	**3.3%**	**Medi-Cal Total**	**2,320,119**	**2,303,144**	**16,975**	**0.7%**
5,824	5,852	(28)	-0.5%	Group Care	46,910	47,025	(115)	-0.2%
304,452	**294,859**	**9,593**	**3.3%**	**Total**	**2,367,029**	**2,350,169**	**16,860**	**0.7%**

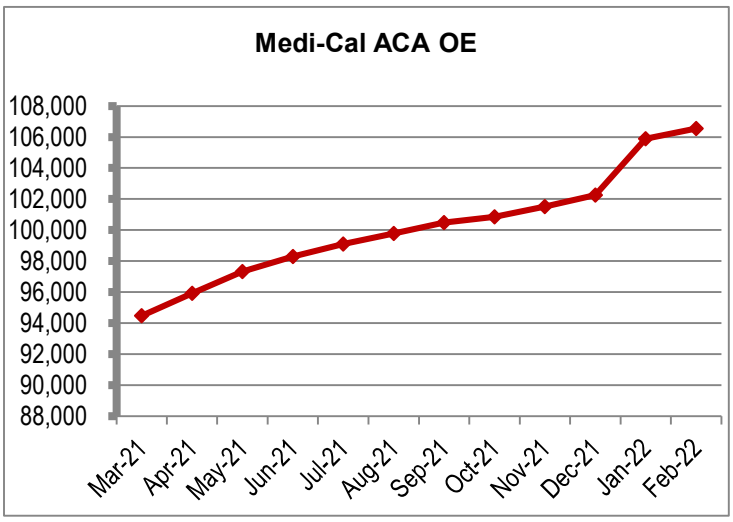
Enrollment and Profitability by Program and Category of Aid

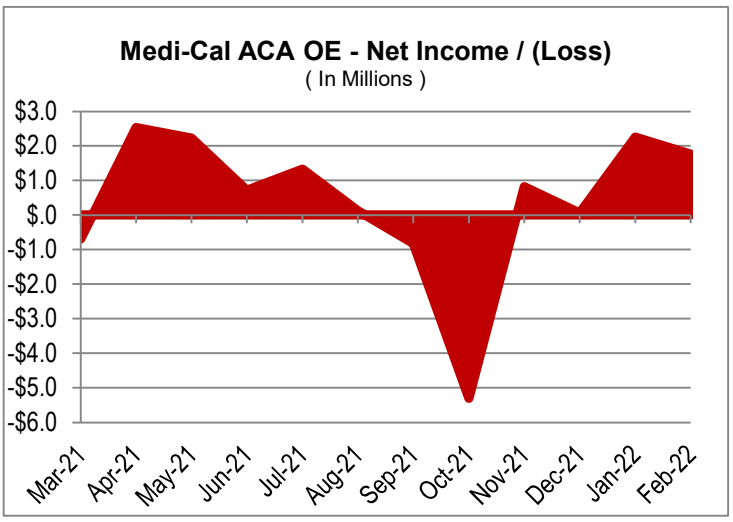




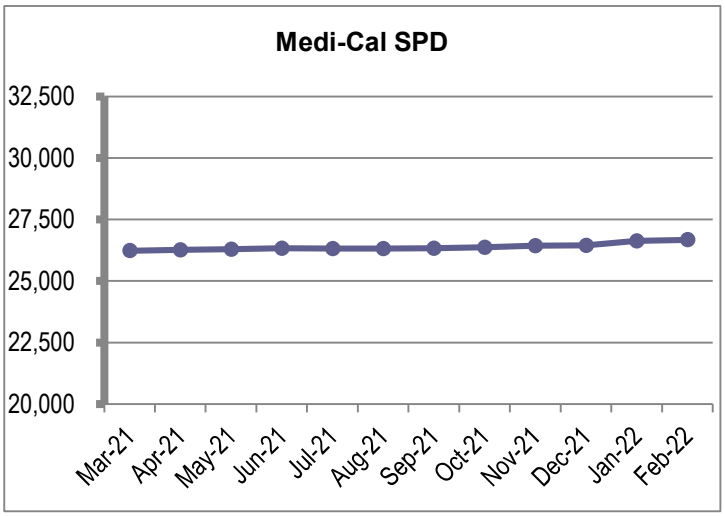


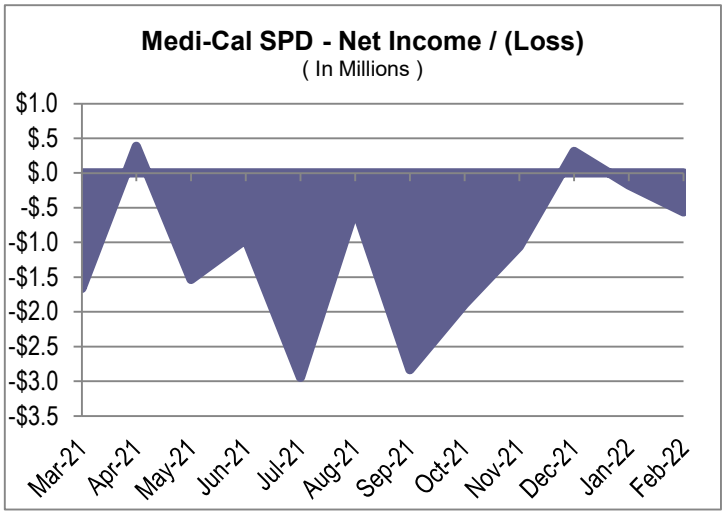


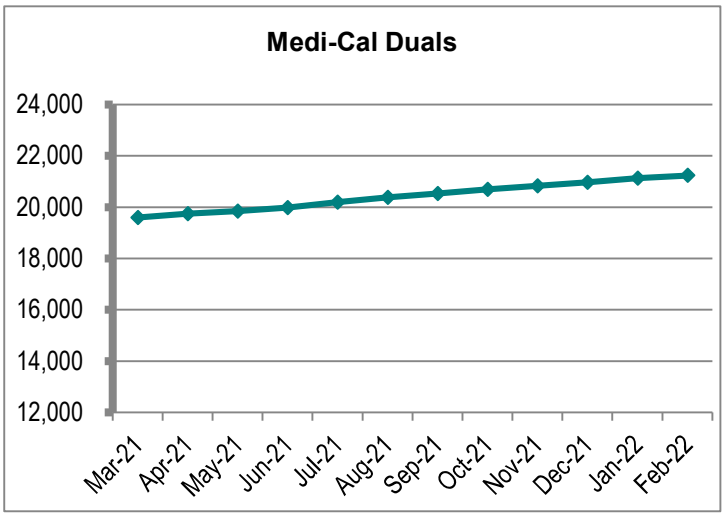


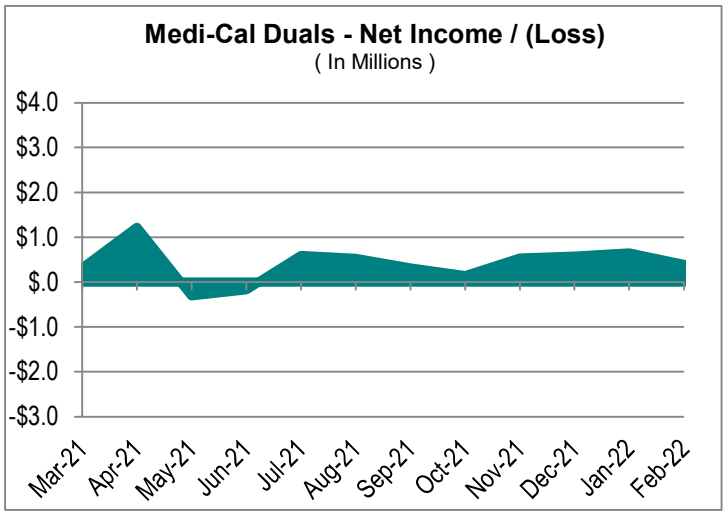


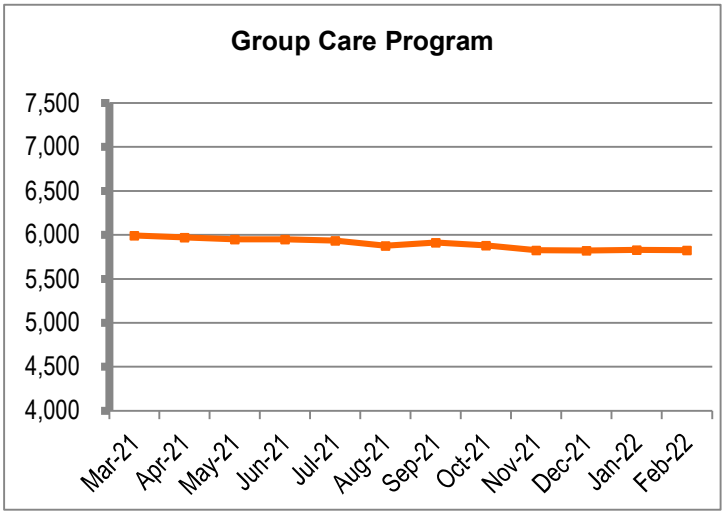
Enrollment and Profitability by Program and Category of Aid

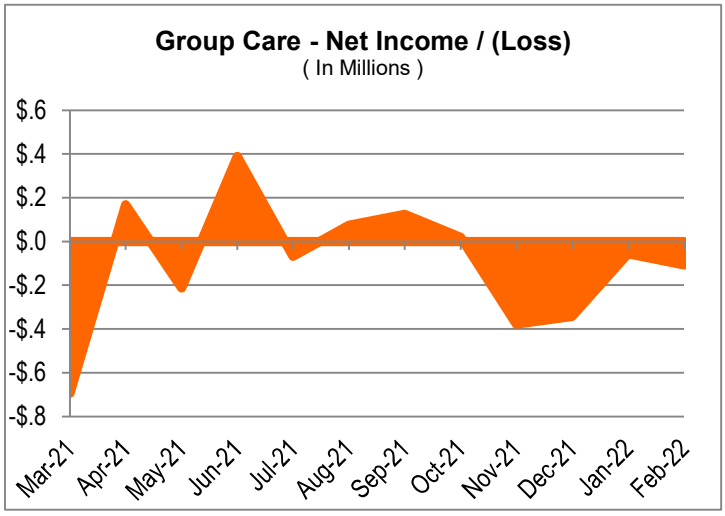




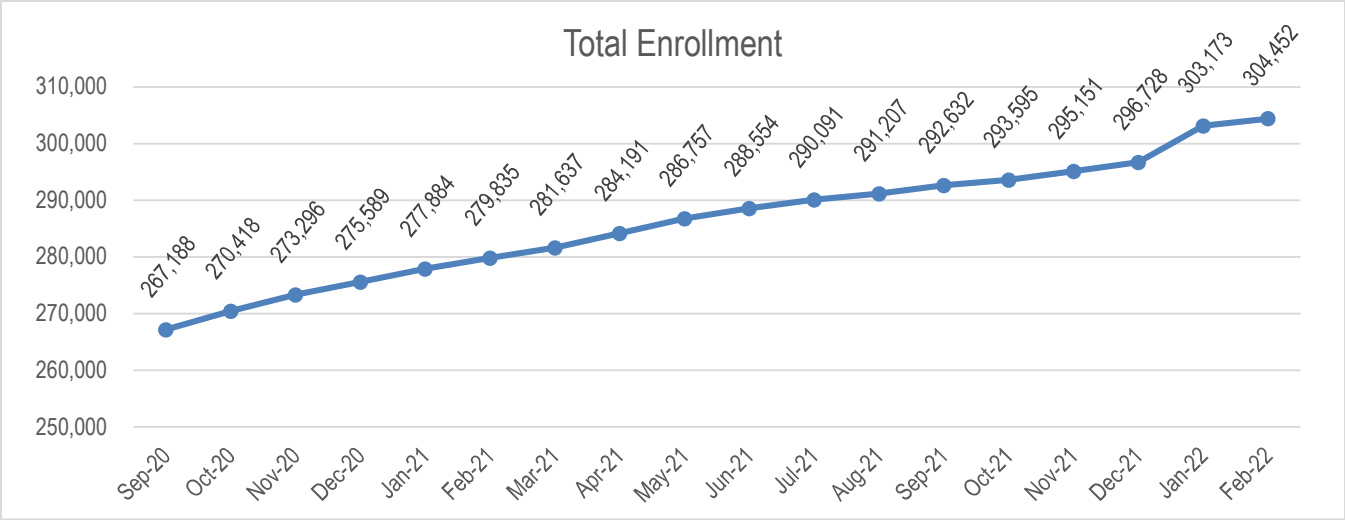


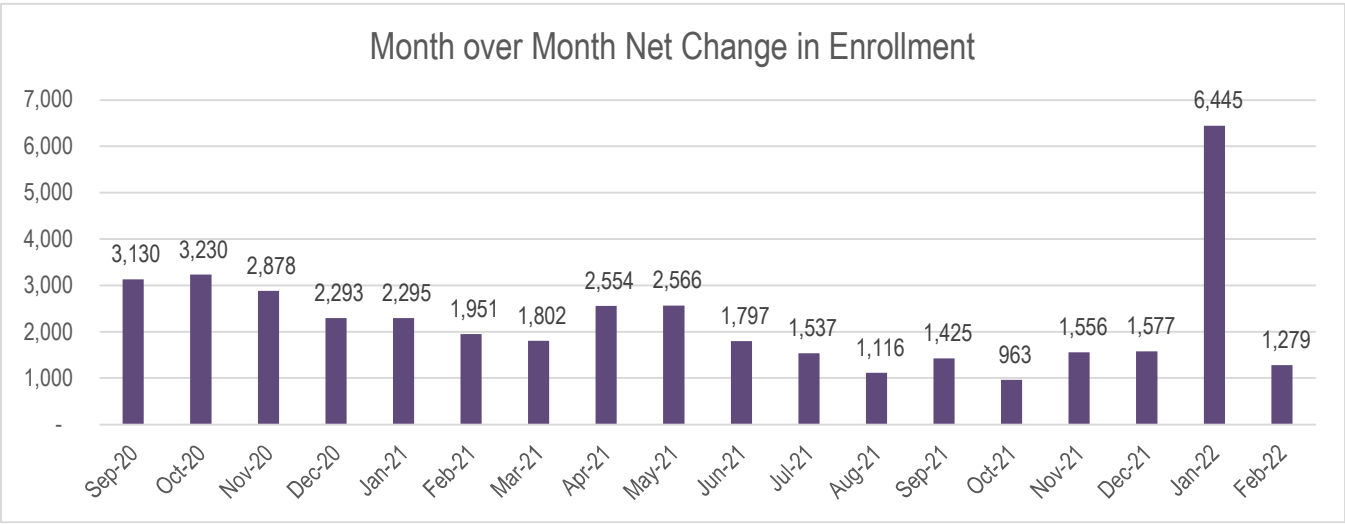






Net Change in Enrollment



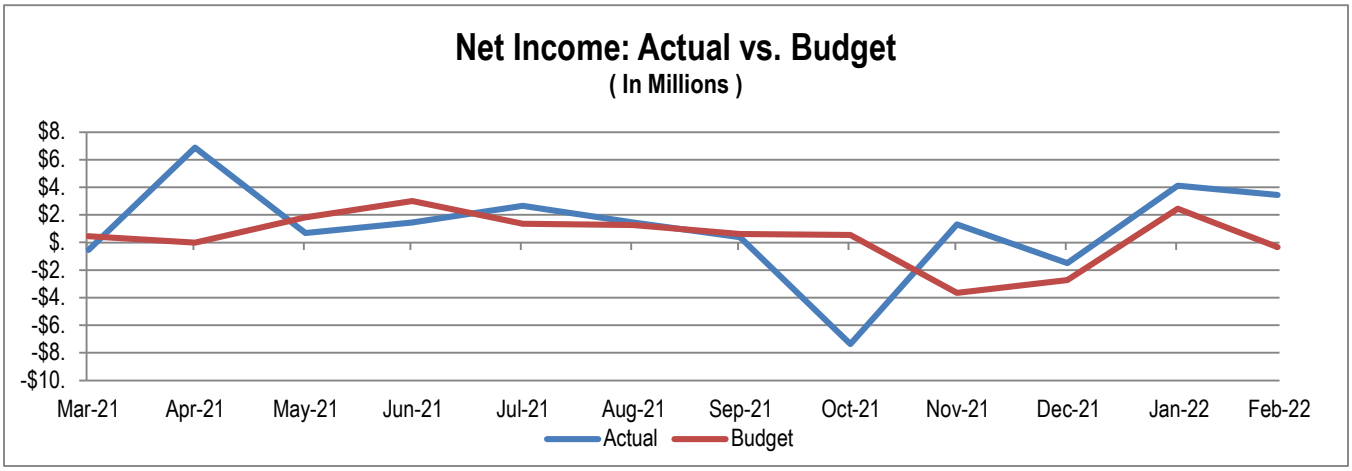


- Total monthly enrollment continues to increase. Future enrollment trends will be impacted by the anticipated end of the Public Health Emergency (PHE) and addition of new members scheduled to transition from the County HealthPAC program in May.

Net Income

- For the month ended February 28th, 2022:
  - Actual Net Income: $3.4 million.
  - Budgeted Net Loss: $337,000.

- For the fiscal YTD ended February 28th, 2022:
  - Actual Net Income: $4.5 million.
  - Budgeted Net Loss: $7.1 million.

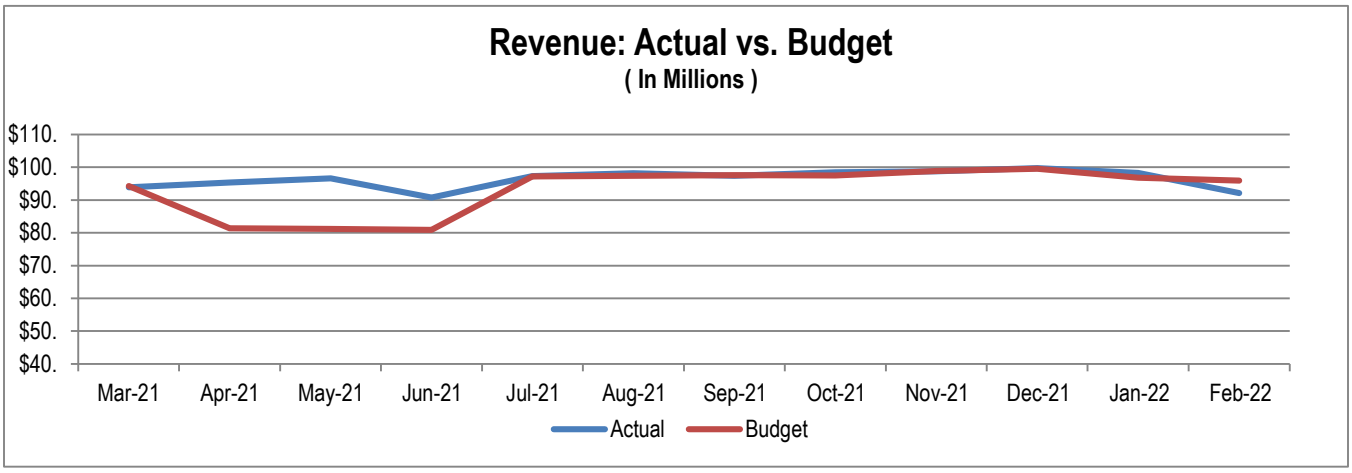


- The favorable variance of $3.8 million in the current month is primarily due to:
  - Favorable $5.3 million lower than anticipated Administrative Expense.
  - Favorable $2.4 million lower than anticipated Medical Expense.
  - Unfavorable $3.8 million lower than anticipated Revenue.

Revenue

- For the month ended February 28th, 2022:
  - Actual Revenue: $92.1 million.
  - Budgeted Revenue: $95.9 million.

- For the fiscal YTD ended February 28th, 2022:
  - Actual Revenue: $780.2 million.
  - Budgeted Revenue: $782.4 million.

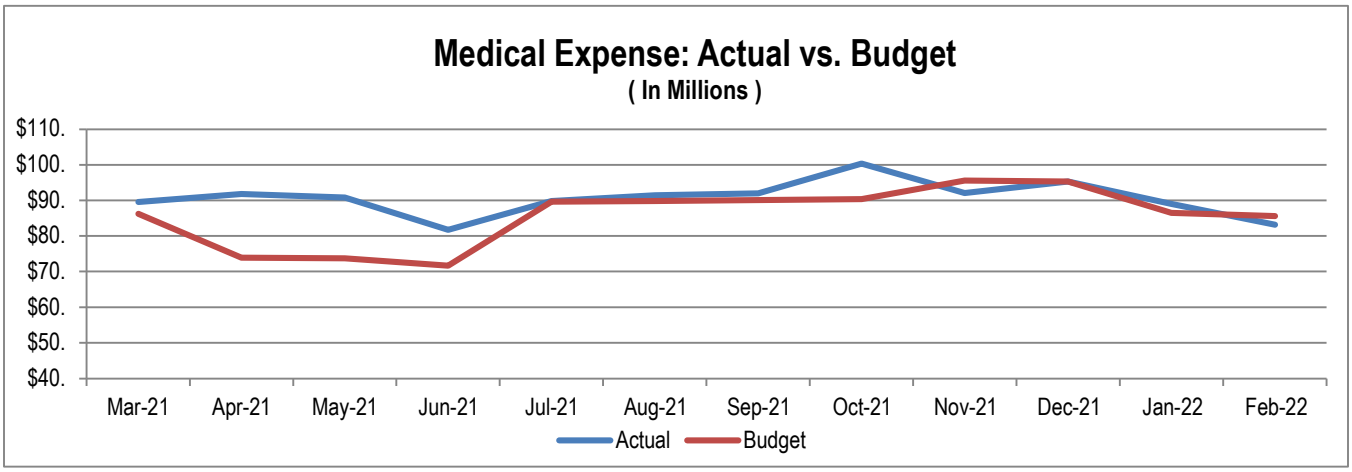


- For the month ending February 28th, 2022, the unfavorable revenue variance of$3.8 million is largely due to unfavorable $6.0 million retroactive MCO Tax adjustment for FY14-FY16, partially offset by favorable $1.5 million CalAIM Incentive Revenue and favorable $1.4 million Medi-Cal Base Capitation revenue.

Medical Expense

- For the month ended February 28th, 2022:
  - Actual Medical Expense: $83.2 million.
  - Budgeted Medical Expense: $85.6 million.

- For the fiscal YTD ended February 28th, 2022:
  - Actual Medical Expense: $733.1 million.
  - Budgeted Medical Expense: $736.5 million.



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

- For February, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $1.2 million. The estimate for prior years increased by $3.1 million vs. Budget (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	$175,981,542	$0	$175,981,542	$178,879,592	$2,898,050	1.6%
Primary Care FFS	35,257,818	$28,500	$35,286,318	35,928,488	$670,670	1.9%
Specialty Care FFS	36,985,459	$191,498	$37,176,957	37,399,547	$414,087	1.1%
Outpatient FFS	65,258,819	$295,217	$65,554,036	67,276,333	$2,017,514	3.0%
Ancillary FFS	42,330,945	$257,457	$42,588,402	38,653,868	($3,677,076)	-9.5%
Pharmacy FFS	106,029,253	$1,261,720	$107,290,973	104,367,902	($1,661,351)	-1.6%
ER Services FFS	36,209,835	$220,820	$36,430,656	35,952,003	($257,832)	-0.7%
Inpatient Hospital & SNF FFS	216,447,417	$867,555	$217,314,972	220,471,019	$4,023,602	1.8%
Other Benefits & Services	15,968,689	$0	$15,968,689	17,082,788	$1,114,100	6.5%
Net Reinsurance	(539,049)	$0	($539,049)	501,774	$1,040,822	207.4%
	$729,930,729	**$3,122,767**	**$733,053,496**	**$736,513,314**	**$6,582,584**	**0.9%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

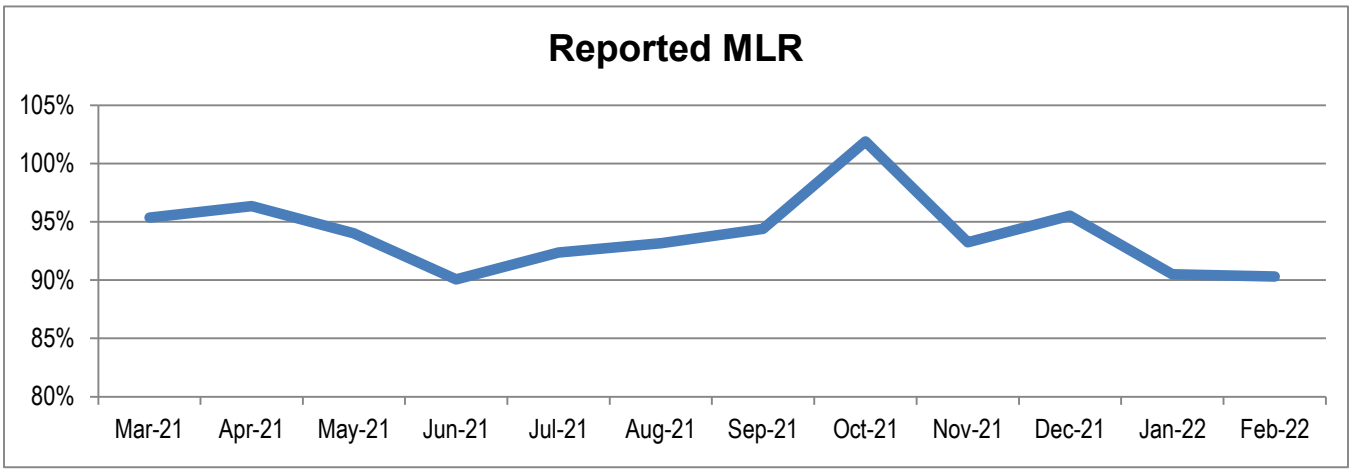
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$74.35	$0.00	$74.35	$76.11	$1.77	2.3%
Primary Care FFS	$14.90	$0.01	$14.91	$15.29	$0.39	2.6%
Specialty Care FFS	$15.63	$0.08	$15.71	$15.91	$0.29	1.8%
Outpatient FFS	$27.57	$0.12	$27.69	$28.63	$1.06	3.7%
Ancillary FFS	$17.88	$0.11	$17.99	$16.45	($1.44)	-8.7%
Pharmacy FFS	$44.79	$0.53	$45.33	$44.41	($0.39)	-0.9%
ER Services FFS	$15.30	$0.09	$15.39	$15.30	$0.00	0.0%
Inpatient Hospital & SNF FFS	$91.44	$0.37	$91.81	$93.81	$2.37	2.5%
Other Benefits & Services	$6.75	$0.00	$6.75	$7.27	$0.52	7.2%
Net Reinsurance	($0.23)	$0.00	($0.23)	$0.21	$0.44	206.7%
	$308.37	**$1.32**	**$309.69**	**$313.39**	**$5.01**	**1.6%**

- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $6.6 million favorable to final budget. On a PMPM basis, medical expense is 1.6% favorable to budget.
    - Capitated Expense is slightly under budget primarily due to delayed submissions for payment for BHT and Maternity Supplemental Expenses from our global subcontractor.
    - Primary Care Expense is below budget driven by favorable utilization in the ACA OE and Adult populations and favorable unit cost in the SPD population.

- Specialty Care is favorable compared to budget generally driven by favorable utilization in the ACA OE, Adult, and Child populations.
- Outpatient Expense is under budget, driven by favorable utilization offset by unfavorable unit cost.
- Ancillary Expense is above budget due to unfavorable Home Heath, DME, Outpatient Therapy, Laboratory and Radiology, Non-Emergency Transportation, Other Medical Professional offset by favorability in ECM and Community Support, CBAS, Ambulance and Hospice service categories. Overall utilization is unfavorable partially offset by favorable unit cost.
- Pharmacy Expense is above budget due to unfavorable Non-PBM expense driven by unfavorable unit cost in the ACA OE, Adult and Group Care populations.
- Emergency Room Expense is favorable, due to favorable unit cost, offset by unfavorable utilization across ACA OE, Adult and Dual populations.
- Inpatient Expense is under budget driven by favorable unit cost offset by unfavorable utilization.
- Inpatient Expense is under budget driven by favorable unit cost partially offset by unfavorable utilization.
- Other Benefits & Services are favorable to budget, primarily due to open positions in the Clinical Organization and lower than expected costs in licensing, insurance, fees, supplies and purchased services.
- Net Reinsurance year-to-date is favorable to budget because the Plan received recoveries at higher levels than expected.

Medical Loss Ratio (MLR)

- The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 90.3% for the month and 94.0% for the fiscal year-to-date.



Administrative Expense

- For the month ended February 28th, 2022:
  - Actual Administrative Expense: $5.4 million.
  - Budgeted Administrative Expense: $10.7 million.
- For the fiscal YTD ended February 28th, 2022:
  - Actual Administrative Expense: $42.5 million.
  - Budgeted Administrative Expense: $53.0 million.

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

Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$2,902,868	$3,698,258	$795,390	21.5%	Employee Expense	$23,803,723	$26,079,579	$2,275,856	8.7%
292,974	314,828	21,854	6.9%	Medical Benefits Admin Expense	4,657,421	4,672,010	14,589	0.3%
841,016	1,719,156	878,140	51.1%	Purchased & Professional Services	5,592,306	9,255,628	3,663,322	39.6%
1,348,926	4,920,590	3,571,664	72.6%	Other Admin Expense	8,398,834	13,039,903	4,641,069	35.6%
$5,385,784	$10,652,832	$5,267,048	49.4%	Total Administrative Expense	$42,452,284	$53,047,120	$10,594,836	20.0%

The year-to-date variances include:

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

Administrative loss ratio (ALR) represented 5.8% of net revenue for the month and 5.4% of net revenue year-to-date.

Other Income / (Expense)

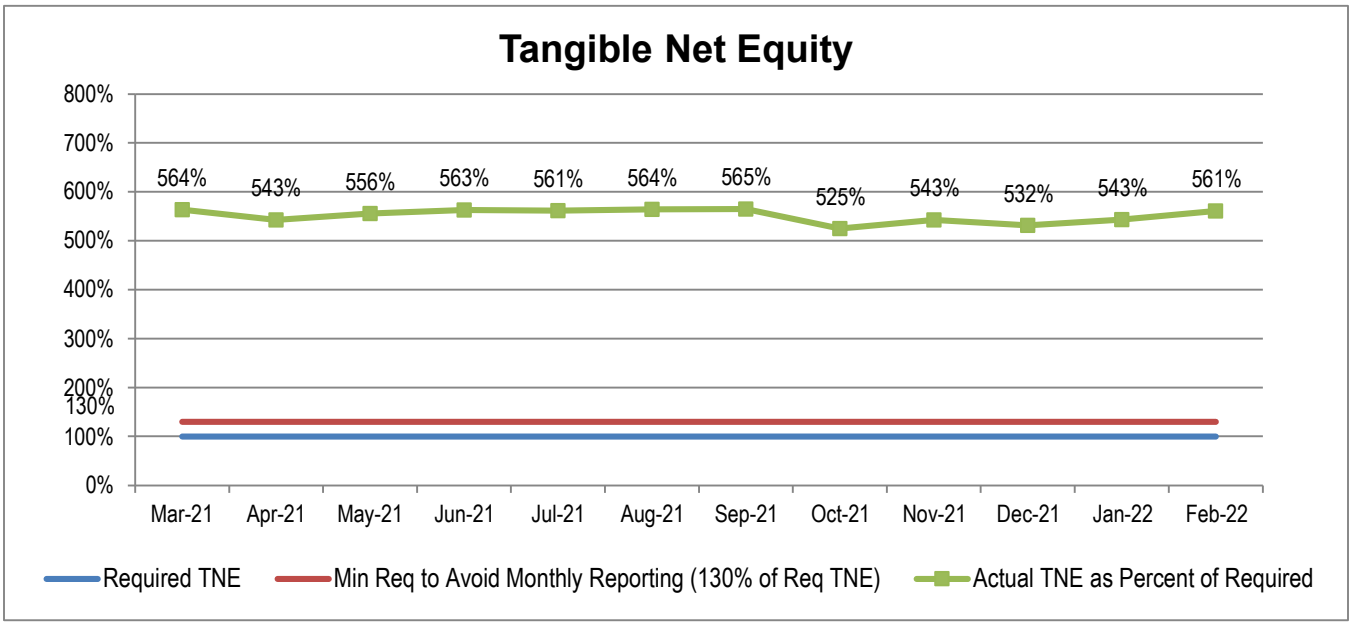
Other Income & Expense is comprised of investment income and claims interest.

- Fiscal year-to-date interest income from investments is $387,817.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $262,135.

Tangible Net Equity (TNE)

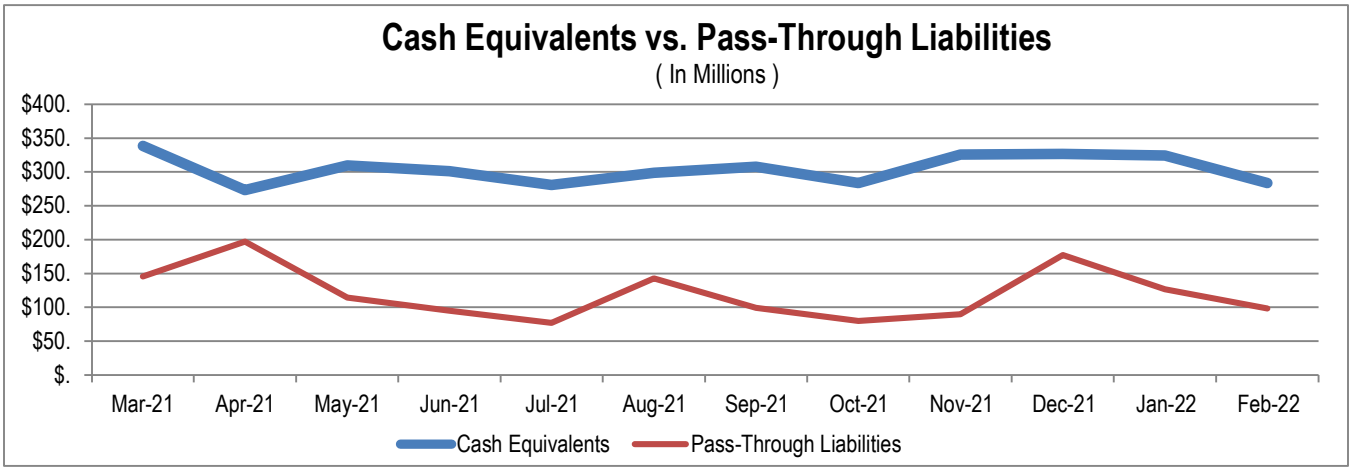
- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to consumers. TNE is a calculation of a company's total tangible assets minus the company's total liabilities. The Alliance exceeds DMHC's required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

- Required TNE $37.4 million
- Actual TNE $209.9 million
- Excess TNE $172.5 million
- TNE as % of Required TNE 561%



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

- Key Metrics
  - Cash & Cash Equivalents $283.7 million
  - Pass-Through Liabilities $98.3 million
  - Uncommitted Cash $185.4 million
  - Working Capital $175.0 million
  - Current Ratio 1.70 (regulatory minimum is 1.0)



Capital Investment

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

Caveats to Financial Statements

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

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET (WITH MEDICAL EXPENSE BY PAYMENT TYPE)
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED February 28, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
298,628	289,007	9,621	3.3%	1 - Medi-Cal	2,320,119	2,303,144	16,975	0.7%
5,824	5,852	(28)	(0.5%)	2 - Group Care	46,910	47,025	(115)	(0.2%)
304,452	**294,859**	**9,593**	**3.3%**	**3 - Total Member Months**	**2,367,029**	**2,350,169**	**16,860**	**0.7%**
				REVENUE				
$92,121,285	**$95,884,461**	**($3,763,176)**	**(3.9%)**	**4 - TOTAL REVENUE**	**$780,233,143**	**$782,385,876**	**($2,152,733)**	**(0.3%)**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
20,766,471	22,244,909	1,478,438	6.6%	5 - Capitated Medical Expense	175,981,542	178,879,605	2,898,063	1.6%
				Fee for Service Medical Expenses:				
26,305,656	27,663,235	1,357,579	4.9%	6 - Inpatient Hospital & SNF FFS Expense	217,314,972	220,471,021	3,156,049	1.4%
4,278,302	4,570,562	292,260	6.4%	7 - Primary Care Physician FFS Expense	35,286,318	35,928,485	642,167	1.8%
4,296,400	4,648,544	352,144	7.6%	8 - Specialty Care Physician Expense	37,176,957	37,399,548	222,591	0.6%
7,260,025	6,377,788	(882,237)	(13.8%)	9 - Ancillary Medical Expense	42,588,402	38,653,868	(3,934,534)	(10.2%)
7,182,735	8,236,584	1,053,849	12.8%	10 - Outpatient Medical Expense	65,554,036	67,276,331	1,722,295	2.6%
3,888,830	4,334,452	445,622	10.3%	11 - Emergency Expense	36,430,656	35,952,004	(478,652)	(1.3%)
5,781,343	5,114,107	(667,236)	(13.0%)	12 - Pharmacy Expense	107,290,973	104,367,907	(2,923,066)	(2.8%)
58,993,291	60,945,272	1,951,981	3.2%	13 - Total Fee for Service Expense	541,642,313	540,049,164	(1,593,150)	(0.3%)
3,252,057	2,251,747	(1,000,310)	(44.4%)	14 - Other Benefits & Services	15,968,689	17,082,772	1,114,084	6.5%
167,804	135,429	(32,375)	(23.9%)	15 - Reinsurance Expense	(539,049)	501,775	1,040,824	207.4%
83,179,624	**85,577,357**	**2,397,733**	**2.8%**	**17 - TOTAL MEDICAL EXPENSES**	**733,053,496**	**736,513,316**	**3,459,820**	**0.5%**
8,941,661	**10,307,104**	**(1,365,443)**	**(13.2%)**	**18 - GROSS MARGIN**	**47,179,648**	**45,872,560**	**1,307,088**	**2.8%**
				ADMINISTRATIVE EXPENSES				
2,902,867	3,698,258	795,391	21.5%	19 - Personnel Expense	23,803,723	26,079,579	2,275,856	8.7%
292,973	314,828	21,855	6.9%	20 - Benefits Administration Expense	4,657,421	4,672,010	14,589	0.3%
841,014	1,719,156	878,142	51.1%	21 - Purchased & Professional Services	5,592,307	9,255,628	3,663,321	39.6%
1,348,928	4,920,590	3,571,662	72.6%	22 - Other Administrative Expense	8,398,832	13,039,903	4,641,071	35.6%
5,385,782	**10,652,832**	**5,267,050**	**49.4%**	**23 -Total Administrative Expense**	**42,452,282**	**53,047,120**	**10,594,838**	**20.0%**
3,555,880	**(345,728)**	**3,901,607**	**1,128.5%**	**24 - NET OPERATING INCOME / (LOSS)**	**4,727,365**	**(7,174,560)**	**11,901,925**	**165.9%**
				OTHER INCOME / EXPENSE				
(112,442)	**8,751**	**(121,193)**	**(1,384.9%)**	**25 - Total Other Income / (Expense)**	**(223,124)**	**32,689**	**(255,813)**	**(782.6%)**
$3,443,438	**($336,977)**	**$3,780,415**	**1,121.9%**	**26 - NET INCOME / (LOSS)**	**$4,504,241**	**($7,141,871)**	**$11,646,112**	**163.1%**
5.8%	11.1%	5.3%	47.4%	27 - Admin Exp % of Revenue	5.4%	6.8%	1.3%	19.8%

ALAMEDA ALLIANCE FOR HEALTH
SUMMARY BALANCE SHEET 2022
CURRENT MONTH VS. PRIOR MONTH
February 28, 2022

	February	January	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$53,264,413	$22,722,582	$30,541,832	134.41%
Short-Term Investments	230,404,150	301,369,725	(70,965,575)	-23.55%
Interest Receivable	273,353	102,795	170,558	165.92%
Other Receivables - Net	131,641,850	126,383,532	5,258,318	4.16%
Prepaid Expenses	5,428,857	5,952,175	(523,318)	-8.79%
Prepaid Inventoried Items	4,951	12,259	(7,308)	-59.61%
CalPERS Net Pension Asset	(1,665,176)	(1,665,176)	0	0.00%
Deferred CalPERS Outflow	4,501,849	4,501,849	0	0.00%
TOTAL CURRENT ASSETS	**423,854,247**	**459,379,740**	**(35,525,492)**	**-7.73%**
OTHER ASSETS:				
Long-Term Investments	28,740,697	14,458,804	14,281,893	98.78%
Restricted Assets	350,000	350,000	0	0.00%
TOTAL OTHER ASSETS	**29,090,697**	**14,808,804**	**14,281,893**	**96.44%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	9,626,797	9,611,531	15,265	0.16%
Furniture And Equipment	11,540,223	11,540,223	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Construction in Process	275,666	169,640	106,025	62.50%
Internally-Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	37,169,134	37,047,843	121,291	0.33%
Less: Accumulated Depreciation	(31,347,529)	(31,273,657)	(73,872)	0.24%
NET PROPERTY AND EQUIPMENT	**5,821,605**	**5,774,186**	**47,419**	**0.82%**
TOTAL ASSETS	**$458,766,549**	**$479,962,729**	**($21,196,180)**	**-4.42%**
CURRENT LIABILITIES:				
Accounts Payable	$2,974,142	$2,177,752	$796,390	36.57%
Pass-Through Liabilities	98,253,753	126,775,285	(28,521,532)	-22.50%
Claims Payable	16,166,369	14,150,981	2,015,387	14.24%
IBNP Reserves	116,953,749	115,770,906	1,182,843	1.02%
Payroll Liabilities	5,250,172	5,152,276	97,896	1.90%
CalPERS Deferred Inflow	859,093	859,093	0	0.00%
Risk Sharing	8,124,932	8,124,932	0	0.00%
Provider Grants/ New Health Program	270,058	280,660	(10,602)	-3.78%
Deferred Revenue	0	200,000	(200,000)	-100.00%
TOTAL CURRENT LIABILITIES	**248,852,266**	**273,491,885**	**(24,639,618)**	**-9.01%**
TOTAL LIABILITIES	**248,852,266**	**273,491,885**	**(24,639,618)**	**-9.01%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	204,569,809	204,569,809	0	0.00%
Year-to Date Net Income / (Loss)	4,504,241	1,060,803	3,443,438	324.61%
TOTAL NET WORTH	**209,914,283**	**206,470,845**	**3,443,438**	**1.67%**
TOTAL LIABILITIES AND NET WORTH	**$458,766,549**	**$479,962,729**	**($21,196,180)**	**-4.42%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 2/28/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$84,976,842	$254,986,654	$625,501,392	$758,744,050
Commercial Premium Revenue	2,176,328	6,531,612	13,164,480	17,575,208
Other Income	34,571	711,175	1,668,172	2,063,646
Investment Income	(223,324)	(306,839)	(215,269)	(176,789)
Cash Paid To:				
Medical Expenses	(80,547,082)	(266,630,930)	(550,880,089)	(727,889,144)
Vendor & Employee Expenses	(3,916,362)	(16,753,981)	(30,770,916)	(42,131,010)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	2,500,973	(21,462,309)	58,467,770	8,185,961
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	(121,290)	(121,290)	(233,657)	(233,657)
Net Cash Provided By (Used In) Financing Activities	(121,290)	(121,290)	(233,657)	(233,657)
Cash Flows from Investing Activities:				
Changes in Investments	(14,281,893)	(28,740,696)	(28,740,697)	(28,740,697)
Restricted Cash	(28,521,534)	8,465,700	(44,632,587)	3,421,217
Net Cash Provided By (Used In) Investing Activities	(42,803,427)	(20,274,996)	(73,373,284)	(25,319,480)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**(40,423,744)**	**(41,858,595)**	**(15,139,171)**	**(17,367,176)**
Cash @ Beginning of Period	324,092,306	325,527,154	298,807,720	301,035,736
Subtotal	$283,668,562	$283,668,559	$283,668,549	$283,668,560
Rounding	1	4	14	3
Cash @ End of Period	**$283,668,563**	**$283,668,563**	**$283,668,563**	**$283,668,563**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$3,443,440	$6,069,408	$403,587	$4,504,240
Depreciation	73,873	231,061	485,829	684,188
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	(5,428,876)	(28,882,688)	56,810,318	4,489,023
Prepaid Expenses	530,626	211,040	631,403	740,318
Trade Payables	796,389	(670,998)	37,084	(1,324,997)
Claims payable & IBNP	3,198,231	1,575,413	(426,517)	(1,209,627)
Deferred Revenue	(200,000)	0	0	0
Accrued Interest	0	0	0	0
Other Liabilities	87,292	4,459	526,080	302,818
Subtotal	2,500,975	(21,462,305)	58,467,784	8,185,963
Rounding	(2)	(4)	(14)	(2)
Cash Flows from Operating Activities	**$2,500,973**	**($21,462,309)**	**$58,467,770**	**$8,185,961**
Rounding Difference	(2)	(4)	(14)	(2)

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 2/28/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,176,328	$6,531,612	$13,164,480	$17,575,208
Total	2,176,328	6,531,612	13,164,480	17,575,208
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	89,880,072	282,922,503	569,964,460	760,546,308
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	(200,000)	0	0	0
Premium Receivable	(4,703,230)	(27,935,849)	55,536,932	(1,802,258)
Total	84,976,842	254,986,654	625,501,392	758,744,050
Investment & Other Income Cash Flows				
Other Revenue (Grants)	34,571	711,175	1,668,172	2,063,646
Interest Income	(52,766)	(52,895)	27,785	86,993
Interest Receivable	(170,558)	(253,944)	(243,054)	(263,782)
Total	(188,753)	404,336	1,452,903	1,886,857
Medical & Hospital Cash Flows				
Total Medical Expenses	(83,179,623)	(267,453,890)	(551,821,252)	(733,053,495)
Other Receivable	(555,088)	(692,895)	1,516,440	6,555,063
Claims Payable	2,015,388	(3,507,878)	(12,529,548)	(17,297,901)
IBNP Payable	1,182,843	5,083,291	14,327,948	18,313,191
Risk Share Payable	0	0	(2,224,917)	(2,224,917)
Health Program	(10,602)	(59,558)	(148,760)	(181,085)
Other Liabilities	0	0	0	0
Total	(80,547,082)	(266,630,930)	(550,880,089)	(727,889,144)
Administrative Cash Flows				
Total Administrative Expenses	(5,415,144)	(16,589,101)	(32,600,072)	(42,714,422)
Prepaid Expenses	530,626	211,040	631,403	740,318
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	796,389	(670,998)	37,084	(1,324,997)
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	97,894	64,017	674,840	483,903
Depreciation Expense	73,873	231,061	485,829	684,188
Total	(3,916,362)	(16,753,981)	(30,770,916)	(42,131,010)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**2,500,973**	**(21,462,309)**	**58,467,770**	**8,185,961**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 2/28/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(14,281,893)	(28,740,696)	(28,740,697)	(28,740,697)
	(14,281,893)	(28,740,696)	(28,740,697)	(28,740,697)
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	(28,521,534)	8,465,700	(44,632,587)	3,421,217
Restricted Cash	0	0	0	0
	(28,521,534)	8,465,700	(44,632,587)	3,421,217
Fixed Asset Cash Flows				
Depreciation expense	73,873	231,061	485,829	684,188
Fixed Asset Acquisitions	(121,290)	(121,290)	(233,657)	(233,657)
Change in A/D	(73,873)	(231,061)	(485,829)	(684,188)
	(121,290)	(121,290)	(233,657)	(233,657)
Total Cash Flows from Investing Activities	**(42,924,717)**	**(20,396,286)**	**(73,606,941)**	**(25,553,137)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**(40,423,744)**	**(41,858,595)**	**(15,139,171)**	**(17,367,176)**
Rounding	1	4	14	3
Cash @ Beginning of Period	324,092,306	325,527,154	298,807,720	301,035,736
Cash @ End of Period	**$283,668,563**	**$283,668,563**	**$283,668,563**	**$283,668,563**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 2/28/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$3,443,440	$6,069,408	$403,587	$4,504,240
Add back: Depreciation	73,873	231,061	485,829	684,188
Receivables				
Premiums Receivable	(4,703,230)	(27,935,849)	55,536,932	(1,802,258)
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	(170,558)	(253,944)	(243,054)	(263,782)
Other Receivable	(555,088)	(692,895)	1,516,440	6,555,063
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	(5,428,876)	(28,882,688)	56,810,318	4,489,023
Prepaid Expenses	530,626	211,040	631,403	740,318
Trade Payables	796,389	(670,998)	37,084	(1,324,997)
Claims Payable, IBNR & Risk Share				
IBNP	1,182,843	5,083,291	14,327,948	18,313,191
Claims Payable	2,015,388	(3,507,878)	(12,529,548)	(17,297,901)
Risk Share Payable	0	0	(2,224,917)	(2,224,917)
Other Liabilities	0	0	0	0
Total	3,198,231	1,575,413	(426,517)	(1,209,627)
Unearned Revenue				
Total	(200,000)	0	0	0
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	97,894	64,017	674,840	483,903
Health Program	(10,602)	(59,558)	(148,760)	(181,085)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	87,292	4,459	526,080	302,818
Cash Flows from Operating Activities	**$2,500,975**	**($21,462,305)**	**$58,467,784**	**$8,185,963**
Difference (rounding)	2	4	14	2

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF FEBRUARY 2022

	Child	Adult	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	99,573	44,588	26,675	106,553	21,239	298,628	5,824	304,452
Net Revenue	$11,764,861	$13,420,298	$23,947,885	$36,744,986	$4,066,927	$89,944,956	$2,176,329	$92,121,285
Medical Expense	$10,449,924	$11,574,274	$22,580,651	$32,978,052	$3,502,518	$81,085,420	$2,094,204	$83,179,624
Gross Margin	$1,314,936	$1,846,024	$1,367,234	$3,766,934	$564,409	$8,859,537	$82,125	$8,941,661
Administrative Expense	$435,425	$729,495	$1,891,428	$1,973,623	$171,665	$5,201,636	$184,145	$5,385,782
Operating Income / (Expense)	$879,512	$1,116,529	($524,195)	$1,793,311	$392,743	$3,657,900	($102,021)	$3,555,880
Other Income / (Expense)	($10,528)	($18,315)	($36,466)	($37,411)	($4,286)	($107,007)	($5,435)	($112,442)
Net Income / (Loss)	$868,984	$1,098,214	($560,661)	$1,755,899	$388,457	$3,550,894	($107,456)	$3,443,438
Revenue PMPM	$118.15	$300.98	$897.77	$344.85	$191.48	$301.19	$373.68	$302.58
Medical Expense PMPM	$104.95	$259.58	$846.51	$309.50	$164.91	$271.53	$359.58	$273.21
Gross Margin PMPM	$13.21	$41.40	$51.26	$35.35	$26.57	$29.67	$14.10	$29.37
Administrative Expense PMPM	$4.37	$16.36	$70.91	$18.52	$8.08	$17.42	$31.62	$17.69
Operating Income / (Expense) PMPM	$8.83	$25.04	($19.65)	$16.83	$18.49	$12.25	($17.52)	$11.68
Other Income / (Expense) PMPM	($0.11)	($0.41)	($1.37)	($0.35)	($0.20)	($0.36)	($0.93)	($0.37)
Net Income / (Loss) PMPM	$8.73	$24.63	($21.02)	$16.48	$18.29	$11.89	($18.45)	$11.31
Medical Loss Ratio	88.8%	86.2%	94.3%	89.7%	86.1%	90.2%	96.2%	90.3%
Gross Margin Ratio	11.2%	13.8%	5.7%	10.3%	13.9%	9.8%	3.8%	9.7%
Administrative Expense Ratio	3.7%	5.4%	7.9%	5.4%	4.2%	5.8%	8.5%	5.8%
Net Income Ratio	7.4%	8.2%	-2.3%	4.8%	9.6%	3.9%	-4.9%	3.7%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE - FEBRUARY 2022

	Child	Adult	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Member Months	784,594	341,606	211,517	816,423	165,979	2,320,119	46,910	2,367,029
Net Revenue	$97,796,985	$111,953,557	$218,217,317	$305,110,422	$29,578,432	$762,656,714	$17,576,429	$780,233,143
Medical Expense	$85,016,964	$104,459,543	$212,965,109	$289,258,293	$24,484,028	$716,183,937	$16,869,558	$733,053,496
Gross Margin	$12,780,022	$7,494,014	$5,252,208	$15,852,129	$5,094,404	$46,472,777	$706,871	$47,179,648
Administrative Expense	$3,481,941	$5,754,412	$14,845,171	$15,569,769	$1,362,775	$41,014,068	$1,438,215	$42,452,282
Operating Income / (Expense)	$9,298,081	$1,739,602	($9,592,963)	$282,360	$3,731,629	$5,458,709	($731,344)	$4,727,365
Other Income / (Expense)	($13,742)	($58,468)	($59,718)	($79,383)	($7,259)	($218,571)	($4,553)	($223,124)
Net Income / (Loss)	$9,284,339	$1,681,134	($9,652,681)	$202,977	$3,724,369	$5,240,138	($735,897)	$4,504,241
Revenue PMPM	$124.65	$327.73	$1,031.68	$373.72	$178.21	$328.71	$374.68	$329.63
Medical Expense PMPM	$108.36	$305.79	$1,006.85	$354.30	$147.51	$308.68	$359.62	$309.69
Gross Margin PMPM	$16.29	$21.94	$24.83	$19.42	$30.69	$20.03	$15.07	$19.93
Administrative Expense PMPM	$4.44	$16.85	$70.18	$19.07	$8.21	$17.68	$30.66	$17.93
Operating Income / (Expense) PMPM	$11.85	$5.09	($45.35)	$0.35	$22.48	$2.35	($15.59)	$2.00
Other Income / (Expense) PMPM	($0.02)	($0.17)	($0.28)	($0.10)	($0.04)	($0.09)	($0.10)	($0.09)
Net Income / (Loss) PMPM	$11.83	$4.92	($45.64)	$0.25	$22.44	$2.26	($15.69)	$1.90
Medical Loss Ratio	86.9%	93.3%	97.6%	94.8%	82.8%	93.9%	96.0%	94.0%
Gross Margin Ratio	13.1%	6.7%	2.4%	5.2%	17.2%	6.1%	4.0%	6.0%
Administrative Expense Ratio	3.6%	5.1%	6.8%	5.1%	4.6%	5.4%	8.2%	5.4%
Net Income Ratio	9.5%	1.5%	-4.4%	0.1%	12.6%	0.7%	-4.2%	0.6%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED February 28, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$2,902,867	$3,698,258	$795,391	21.5%	Personnel Expenses	$23,803,723	$26,079,579	$2,275,856	8.7%
292,973	314,828	21,855	6.9%	Benefits Administration Expense	4,657,421	4,672,010	14,589	0.3%
841,014	1,719,156	878,142	51.1%	Purchased & Professional Services	5,592,307	9,255,628	3,663,321	39.6%
251,119	277,767	26,648	9.6%	Occupancy	2,054,900	2,190,757	135,857	6.2%
299,222	230,199	(69,023)	(30.0%)	Printing Postage & Promotion	1,641,799	1,610,356	(31,443)	(2.0%)
499,894	681,593	181,699	26.7%	Licenses Insurance & Fees	3,863,181	4,451,173	587,992	13.2%
298,692	3,731,031	3,432,339	92.0%	Supplies & Other Expenses	838,952	4,787,617	3,948,665	82.5%
2,482,915	6,954,574	4,471,659	64.3%	Total Other Administrative Expense	18,648,559	26,967,541	8,318,982	30.8%
$5,385,782	**$10,652,832**	**$5,267,050**	**49.4%**	**Total Administrative Expenses**	**$42,452,282**	**$53,047,120**	**$10,594,838**	**20.0%**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED February 28, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
$1,924,858	$2,191,551	$266,693	12.2%	Salaries & Wages	$15,690,417	$16,209,884	$519,467	3.2%
207,371	240,515	33,144	13.8%	Paid Time Off	1,621,904	1,755,773	133,869	7.6%
1,050	2,569	1,519	59.1%	Incentives	14,552	19,702	5,150	26.1%
0	25,000	25,000	100.0%	Severance Pay	0	100,000	100,000	100.0%
39,376	59,804	20,428	34.2%	Payroll Taxes	352,212	447,301	95,089	21.3%
27,092	15,088	(12,004)	(79.6%)	Overtime	229,346	216,487	(12,859)	(5.9%)
163,392	185,833	22,441	12.1%	CalPERS ER Match	1,214,704	1,316,060	101,356	7.7%
0	0	0	0.0%	Mandated Covid -19 Supplemental Sick Leave	10,398	10,400	2	0.0%
478,858	695,158	216,300	31.1%	Employee Benefits	3,835,954	4,351,023	515,069	11.8%
660	0	(660)	0.0%	Personal Floating Holiday	103,349	112,983	9,634	8.5%
525	18,174	17,649	97.1%	Employee Relations	43,677	104,176	60,499	58.1%
7,320	9,452	2,132	22.6%	Work from Home Stipend	55,980	63,546	7,566	11.9%
383	1,116	733	65.7%	Transportation Reimbursement	604	5,059	4,455	88.1%
0	4,084	4,084	100.0%	Travel & Lodging	1,471	30,302	28,831	95.1%
32,249	80,213	47,964	59.8%	Temporary Help Services	468,187	704,683	236,496	33.6%
12,219	64,478	52,259	81.0%	Staff Development/Training	54,183	296,822	242,639	81.7%
7,515	105,223	97,708	92.9%	Staff Recruitment/Advertising	106,785	335,378	228,593	68.2%
2,902,867	**3,698,258**	**795,391**	**21.5%**	**Total Employee Expenses**	**23,803,723**	**26,079,579**	**2,275,856**	**8.7%**
				Benefit Administration Expense				
3,846	52,790	48,944	92.7%	RX Administration Expense	2,511,359	2,554,969	43,610	1.7%
270,973	245,287	(25,686)	(10.5%)	Behavioral Hlth Administration Fees	2,004,850	1,979,499	(25,351)	(1.3%)
18,155	16,751	(1,404)	(8.4%)	Telemedicine Admin Fees	141,213	137,542	(3,671)	(2.7%)
292,973	**314,828**	**21,855**	**6.9%**	**Total Employee Expenses**	**4,657,421**	**4,672,010**	**14,589**	**0.3%**
				Purchased & Professional Services				
360,390	499,824	139,434	27.9%	Consulting Services	2,235,733	3,307,962	1,072,229	32.4%
289,878	651,230	361,352	55.5%	Computer Support Services	2,195,590	3,459,917	1,264,327	36.5%
38,596	25,583	(13,013)	(50.9%)	Professional Fees-Accounting	108,637	96,656	(11,981)	(12.4%)
0	10	10	100.0%	Professional Fees-Medical	95	40	(55)	(138.1%)
30,973	282,281	251,308	89.0%	Other Purchased Services	257,997	931,453	673,456	72.3%
4,145	5,000	855	17.1%	Maint.& Repair-Office Equipment	38,243	41,809	3,566	8.5%
57,553	128,171	70,618	55.1%	HMS Recovery Fees	318,490	611,079	292,589	47.9%
0	0	0	0.0%	MIS Software (Non-Capital)	0	125,001	125,001	100.0%
35,787	33,000	(2,787)	(8.4%)	Hardware (Non-Capital)	160,394	272,117	111,723	41.1%
12,579	21,492	8,913	41.5%	Provider Relations-Credentialing	100,662	130,714	30,052	23.0%
11,113	72,565	61,452	84.7%	Legal Fees	176,465	278,880	102,415	36.7%
841,014	**1,719,156**	**878,142**	**51.1%**	**Total Purchased & Professional Services**	**5,592,307**	**9,255,628**	**3,663,321**	**39.6%**
				Occupancy				
73,872	95,979	22,107	23.0%	Depreciation	684,190	737,914	53,724	7.3%
70,286	70,286	0	0.0%	Building Lease	564,661	564,661	0	0.0%
379	2,006	1,627	81.1%	Leased and Rented Office Equipment	16,232	16,146	(86)	(0.5%)
11,318	14,879	3,561	23.9%	Utilities	101,081	113,799	12,718	11.2%
82,950	71,401	(11,549)	(16.2%)	Telephone	578,050	575,005	(3,045)	(0.5%)
12,314	23,216	10,902	47.0%	Building Maintenance	110,688	183,232	72,544	39.6%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED February 28, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$251,119	**$277,767**	**$26,648**	**9.6%**	**Total Occupancy**	**$2,054,900**	**$2,190,757**	**$135,857**	**6.2%**
				Printing Postage & Promotion				
84,874	39,821	(45,053)	(113.1%)	Postage	274,869	358,557	83,688	23.3%
1,445	7,000	5,555	79.4%	Design & Layout	19,490	44,888	25,398	56.6%
172,612	49,331	(123,281)	(249.9%)	Printing Services	506,674	461,299	(45,375)	(9.8%)
16,915	2,500	(14,415)	(576.6%)	Mailing Services	32,627	20,894	(11,733)	(56.2%)
5,266	3,225	(2,041)	(63.3%)	Courier/Delivery Service	32,037	29,128	(2,909)	(10.0%)
0	1,233	1,233	100.0%	Pre-Printed Materials and Publications	601	4,269	3,668	85.9%
0	0	0	0.0%	Promotional Products	0	2,500	2,500	100.0%
7,000	118,589	111,589	94.1%	Community Relations	623,155	553,187	(69,968)	(12.6%)
(67)	0	67	0.0%	Health Education-Member	(67)	0	67	0.0%
11,177	8,500	(2,677)	(31.5%)	Translation - Non-Clinical	152,414	135,634	(16,780)	(12.4%)
299,222	**230,199**	**(69,023)**	**(30.0%)**	**Total Printing Postage & Promotion**	**1,641,799**	**1,610,356**	**(31,443)**	**(2.0%)**
				Licenses Insurance & Fees				
20,711	20,800	89	0.4%	Bank Fees	162,819	164,865	2,046	1.2%
61,920	61,377	(543)	(0.9%)	Insurance	492,643	491,014	(1,629)	(0.3%)
369,739	517,851	148,112	28.6%	Licenses, Permits and Fees	2,693,281	3,201,805	508,524	15.9%
47,524	81,565	34,041	41.7%	Subscriptions & Dues	514,438	593,489	79,051	13.3%
499,894	**681,593**	**181,699**	**26.7%**	**Total Licenses Insurance & Postage**	**3,863,181**	**4,451,173**	**587,992**	**13.2%**
				Supplies & Other Expenses				
1,951	6,067	4,116	67.8%	Office and Other Supplies	39,424	110,673	71,249	64.4%
7,163	12,000	4,837	40.3%	Ergonomic Supplies	17,512	46,880	29,368	62.6%
263	5,948	5,685	95.6%	Commissary-Food & Beverage	5,070	18,845	13,775	73.1%
0	4,150	4,150	100.0%	Member Incentive Expense	4,850	23,500	18,650	79.4%
289,315	3,701,400	3,412,085	92.2%	Covid-19 Vaccination Incentive Expense	771,300	4,581,255	3,809,955	83.2%
0	100	100	100.0%	Covid-19 IT Expenses	0	400	400	100.0%
0	1,366	1,366	100.0%	Covid-19 Non IT Expenses	797	6,064	5,267	86.9%
298,692	**3,731,031**	**3,432,339**	**92.0%**	**Total Supplies & Other Expense**	**838,952**	**4,787,617**	**3,948,665**	**82.5%**
$5,385,782	**$10,652,832**	**$5,267,050**	**49.4%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$42,452,282**	**$53,047,120**	**$10,594,838**	**20.0%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED FEBRUARY 28, 2022

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Network Hardware	IT-FY22-07	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Cisco UCS Blade	IT-FY22-08	$ -		**$ -**	$ 100,000	$ 100,000
	Veeam Backup	IT-FY22-10	$ -		**$ -**	$ 60,000	$ 60,000
	Call Center Hardware	IT-FY22-11	$ -		**$ -**	$ 100,000	$ 100,000
	Network / AV Cabling	IT-FY22-13	$ -		**$ -**	$ 150,000	$ 150,000
Hardware Subtotal			**$ -**	**$ -**	**$ -**	**$ 560,000**	**$ 560,000**
2. Software:							
	Patch Management	AC-FY22-01	$ -		**$ -**	$ 20,000	$ 20,000
	Zerto Licenses (DR - Replication Orchestration)	AC-FY22-02	$ -		**$ -**	$ 50,000	$ 50,000
	Monitoring Software	AC-FY22-03	$ -		**$ -**	$ 40,000	$ 40,000
	Identity and Access Management (Security)	AC-FY22-04	$ -		**$ -**	$ 40,000	$ 40,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 150,000**	**$ 150,000**
3. Building Improvement:							
	1240 Emergency Generator (carryover from FY21)	FA-FY22-06	**$ 106,025**	$ 121,291	**$ 227,316**	$ 360,800	$ 133,484
	1240 Electrical Requirements for EV Charging Stations (est.)	FA-FY22-07	$ -		**$ -**	$ 20,000	$ 20,000
	1240 EV Charging stations installation, fees (est. only)	FA-FY22-08	$ -		**$ -**	$ 50,000	$ 50,000
	1240 Seismic Improvements (carryover from FY21)	FA-FY22-09	$ -		**$ -**	$ 50,000	$ 50,000
	Contingency	FA-FY22-16	**$ 6,341**		**$ 6,341**	$ 100,000	$ 93,659
Building Improvement Subtotal			**$ 112,366**	**$ 121,291**	**$ 233,657**	**$ 580,800**	**$ 347,143**
4. Furniture & Equipment:							
	Replace, reconfigure, re-design workstations/add barriers or plexiglass	FA-FY22-20	$ -		**$ -**	$ 125,000	$ 125,000
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ 125,000**	**$ 125,000**
GRAND TOTAL			**$ 112,366**	**$ 121,291**	**$ 233,657**	**$ 1,415,800**	**$ 1,182,143**

5. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 2/28/22	**$ 37,169,134**
Fixed Assets @ Cost - 6/30/21	**$ 36,935,477**
Fixed Assets Acquired YTD	**$ 233,657**

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

TANGIBLE NET EQUITY (TNE)

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

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

LIQUID TANGIBLE NET EQUITY

Net Assets	$208,055,654	$209,510,696	$209,880,873	$202,529,977	$203,844,876	$202,348,828	$206,470,845	$209,914,283
Fixed Assets at Net Book Value	(6,161,088)	(6,073,778)	(6,093,339)	(6,013,994)	(5,931,375)	(5,851,942)	(5,774,186)	(5,821,605)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(5,320,118)	(14,808,804)	(29,090,697)
Liquid TNE (Liquid Reserves)	**$201,544,566**	**$203,086,918**	**$203,437,534**	**$196,165,983**	**$197,563,501**	**$191,176,768**	**$185,887,855**	**$175,001,981**
Liquid TNE as Multiple of Required	**5.44**	**5.47**	**5.48**	**5.09**	**5.26**	**5.02**	**4.89**	**4.68**

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

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

	Actual Jul-21	Actual Aug-21	Actual Sep-21	Actual Oct-21	Actual Nov-21	Actual Dec-21	Actual Jan-22	Actual Feb-22	Actual Mar-22	Actual Apr-22	Actual May-22	Actual Jun-22	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	97,179	97,324	97,460	97,636	97,935	98,150	99,337	99,573					784,594
Adult	41,358	41,519	41,924	42,177	42,623	43,077	44,340	44,588					341,606
SPD	26,320	26,316	26,330	26,366	26,427	26,450	26,633	26,675					211,517
ACA OE	99,105	99,783	100,469	100,844	101,508	102,264	105,897	106,553					816,423
Duals	20,194	20,388	20,535	20,692	20,832	20,964	21,135	21,239					165,979
Medi-Cal Program	284,156	285,330	286,718	287,715	289,325	290,905	297,342	298,628					2,320,119
Group Care Program	5,935	5,877	5,914	5,880	5,826	5,823	5,831	5,824					46,910
Total	**290,091**	**291,207**	**292,632**	**293,595**	**295,151**	**296,728**	**303,173**	**304,452**					**2,367,029**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	131	145	136	176	299	215	1,187	236					2,525
Adult	392	161	405	253	446	454	1,263	248					3,622
SPD	(3)	(4)	14	36	61	23	183	42					352
ACA OE	824	678	686	375	664	756	3,633	656					8,272
Duals	206	194	147	157	140	132	171	104					1,251
Medi-Cal Program	1,550	1,174	1,388	997	1,610	1,580	6,437	1,286					16,022
Group Care Program	(13)	(58)	37	(34)	(54)	(3)	8	(7)					(124)
Total	**1,537**	**1,116**	**1,425**	**963**	**1,556**	**1,577**	**6,445**	**1,279**					**15,898**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	34.2%	34.1%	34.0%	33.9%	33.8%	33.7%	33.4%	33.3%					33.8%
Adult % of Medi-Cal	14.6%	14.6%	14.6%	14.7%	14.7%	14.8%	14.9%	14.9%					14.7%
SPD % of Medi-Cal	9.3%	9.2%	9.2%	9.2%	9.1%	9.1%	9.0%	8.9%					9.1%
ACA OE % of Medi-Cal	34.9%	35.0%	35.0%	35.0%	35.1%	35.2%	35.6%	35.7%					35.2%
Duals % of Medi-Cal	7.1%	7.1%	7.2%	7.2%	7.2%	7.2%	7.1%	7.1%					7.2%
Medi-Cal Program % of Total	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.1%	98.1%					98.0%
Group Care Program % of Total	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	1.9%	1.9%					2.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**					**100.0%**

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

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

	Actual Jul-21	Actual Aug-21	Actual Sep-21	Actual Oct-21	Actual Nov-21	Actual Dec-21	Actual Jan-22	Actual Feb-22	Actual Mar-22	Actual Apr-22	Actual May-22	Actual Jun-22	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	53,189	53,441	53,246	53,081	53,438	52,288	57,046	51,053					426,782
Alameda Health System	58,045	57,812	58,060	58,049	58,073	58,590	58,927	60,699					468,255
	111,234	111,253	111,306	111,130	111,511	110,878	115,973	111,752					895,037
Delegated:													
CFMG	32,217	32,167	32,217	32,232	32,266	32,573	32,689	33,319					259,680
CHCN	104,433	105,113	106,050	106,808	107,583	109,059	109,878	114,264					863,188
Kaiser	42,207	42,674	43,059	43,425	43,791	44,218	44,633	45,117					349,124
Delegated Subtotal	178,857	179,954	181,326	182,465	183,640	185,850	187,200	192,700					1,471,992
Total	**290,091**	**291,207**	**292,632**	**293,595**	**295,151**	**296,728**	**303,173**	**304,452**					**2,367,029**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(24)	19	53	(176)	381	(633)	5,095	(4,221)					494
Delegated:													
CFMG	20	(50)	50	15	34	307	116	630					1,122
CHCN	1,094	680	937	758	775	1,476	819	4,386					10,925
Kaiser	447	467	385	366	366	427	415	484					3,357
Delegated Subtotal	1,561	1,097	1,372	1,139	1,175	2,210	1,350	5,500					15,404
Total	**1,537**	**1,116**	**1,425**	**963**	**1,556**	**1,577**	**6,445**	**1,279**					**15,898**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	38.3%	38.2%	38.0%	37.9%	37.8%	37.4%	38.3%	36.7%					37.8%
Delegated:													
CFMG	11.1%	11.0%	11.0%	11.0%	10.9%	11.0%	10.8%	10.9%					11.0%
CHCN	36.0%	36.1%	36.2%	36.4%	36.5%	36.8%	36.2%	37.5%					36.5%
Kaiser	14.5%	14.7%	14.7%	14.8%	14.8%	14.9%	14.7%	14.8%					14.7%
Delegated Subtotal	61.7%	61.8%	62.0%	62.1%	62.2%	62.6%	61.7%	63.3%					62.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**					**100.0%**

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

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

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

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

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

	Variance Jul-21	Variance Aug-21	Variance Sep-21	Variance Oct-21	Variance Nov-21	Variance Dec-21	Variance Jan-22	Variance Feb-22	Variance Mar-22	Variance Apr-22	Variance May-22	Variance Jun-22	Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	123	162	(254)	952					983
Adult	0	0	0	0	193	394	1,184	1,855					3,626
SPD	0	0	0	0	25	12	166	455					658
ACA OE	0	0	0	0	289	670	4,110	5,708					10,777
Duals	0	0	0	0	(17)	(42)	339	651					931
Medi-Cal Program	0	0	0	0	613	1,196	5,545	9,621					16,975
Group Care Program	0	0	0	0	(37)	(29)	(21)	(28)					(115)
Total	**0**	**0**	**0**	**0**	**576**	**1,167**	**5,524**	**9,593**					**16,860**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	0	0	0	0	(28)	(1,073)	3,524	341					2,764
Delegated:													
CFMG	0	0	0	0	(28)	217	(159)	790					820
CHCN	0	0	0	0	418	1,534	1,628	7,024					10,604
Kaiser	0	0	0	0	214	489	531	1,438					2,672
Delegated Subtotal	0	0	0	0	604	2,240	2,000	9,252					14,096
Total	**0**	**0**	**0**	**0**	**576**	**1,167**	**5,524**	**9,593**					**16,860**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED February 28, 2022

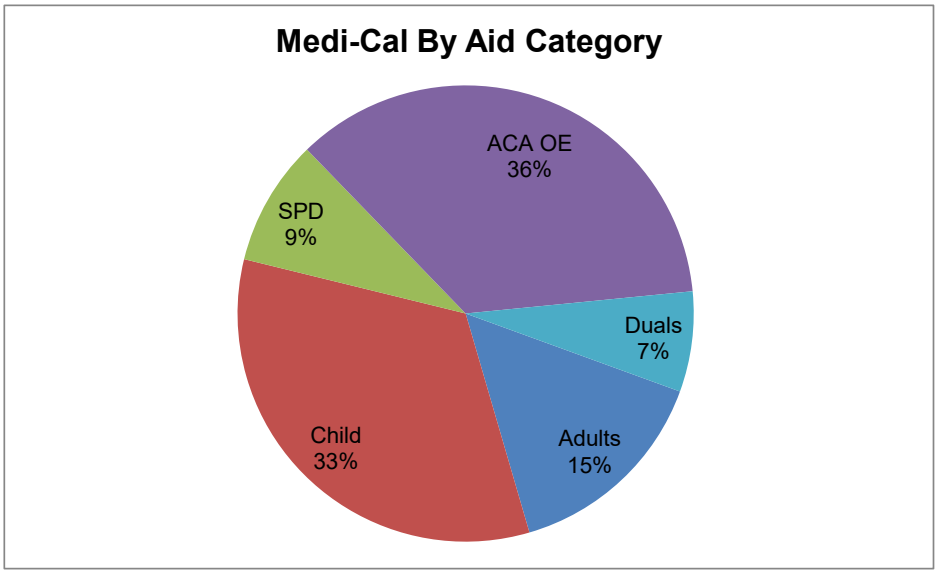
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,926,507	$1,834,366	($92,141)	(5.0%)	PCP-Capitation	$14,985,052	$14,834,114	($150,938)	(1.0%)
3,184,802	3,181,946	(2,856)	(0.1%)	PCP-Capitation - FQHC	24,183,616	24,261,602	77,986	0.3%
289,256	274,567	(14,689)	(5.3%)	Specialty-Capitation	2,254,836	2,230,680	(24,156)	(1.1%)
3,315,247	3,324,130	8,883	0.3%	Specialty-Capitation FQHC	25,128,336	25,276,731	148,395	0.6%
376,329	365,662	(10,667)	(2.9%)	Laboratory-Capitation	2,937,744	2,915,417	(22,327)	(0.8%)
913,359	884,577	(28,782)	(3.3%)	Transportation (Ambulance)-Cap	7,451,543	7,144,315	(307,228)	(4.3%)
222,242	215,904	(6,338)	(2.9%)	Vision Cap	1,732,892	1,721,891	(11,001)	(0.6%)
84,267	79,992	(4,275)	(5.3%)	CFMG Capitation	657,028	649,952	(7,076)	(1.1%)
166,888	167,042	154	0.1%	Anc IPA Admin Capitation FQHC	1,266,069	1,271,869	5,800	0.5%
9,370,302	10,088,448	718,146	7.1%	Kaiser Capitation	84,751,405	84,936,856	185,451	0.2%
129,361	764,846	635,485	83.1%	BHT Supplemental Expense	3,549,022	5,863,410	2,314,388	39.5%
0	0	0	0.0%	Hep-C Supplemental Expense	102,679	100,877	(1,802)	(1.8%)
235,989	488,192	252,203	51.7%	Maternity Supplemental Expense	2,623,401	3,192,618	569,217	17.8%
551,921	575,237	23,316	4.1%	DME - Cap	4,357,920	4,479,273	121,353	2.7%
20,766,471	**22,244,909**	**1,478,438**	**6.6%**	**5-TOTAL CAPITATED EXPENSES**	**175,981,542**	**178,879,605**	**2,898,063**	**1.6%**
				FEE FOR SERVICE MEDICAL EXPENSES:				
769,104	0	(769,104)	0.0%	IBNP-Inpatient Services	9,727,644	0	(9,727,644)	0.0%
23,072	0	(23,072)	0.0%	IBNP-Settlement (IP)	291,826	0	(291,826)	0.0%
61,527	0	(61,527)	0.0%	IBNP-Claims Fluctuation (IP)	778,208	0	(778,208)	0.0%
23,038,544	26,357,435	3,318,891	12.6%	Inpatient Hospitalization-FFS	180,636,305	215,238,607	34,602,302	16.1%
1,157,041	0	(1,157,041)	0.0%	IP OB - Mom & NB	9,395,155	0	(9,395,155)	0.0%
66,795	0	(66,795)	0.0%	IP Behavioral Health	1,559,837	0	(1,559,837)	0.0%
900,006	1,305,800	405,794	31.1%	IP - Long Term Care	8,997,714	5,232,414	(3,765,300)	(72.0%)
289,566	0	(289,566)	0.0%	IP - Facility Rehab FFS	5,928,283	0	(5,928,283)	0.0%
26,305,656	**27,663,235**	**1,357,579**	**4.9%**	**6-Inpatient Hospital & SNF FFS Expense**	**217,314,972**	**220,471,021**	**3,156,049**	**1.4%**
(135,530)	0	135,530	0.0%	IBNP-PCP	11,267	0	(11,267)	0.0%
(4,066)	0	4,066	0.0%	IBNP-Settlement (PCP)	341	0	(341)	0.0%
(10,843)	0	10,843	0.0%	IBNP-Claims Fluctuation (PCP)	903	0	(903)	0.0%
476	0	(476)	0.0%	Telemedicine FFS	7,518	0	(7,518)	0.0%
1,094,046	1,315,509	221,463	16.8%	Primary Care Non-Contracted FF	9,282,259	22,968,540	13,686,281	59.6%
45,383	81,317	35,934	44.2%	PCP FQHC FFS	389,262	325,563	(63,699)	(19.6%)
1,887,510	3,173,736	1,286,226	40.5%	Prop 56 Direct Payment Expenses	14,638,309	12,634,382	(2,003,927)	(15.9%)
12,870	0	(12,870)	0.0%	Prop 56 Hyde Direct Payment Expenses	26,524	0	(26,524)	0.0%
75,271	0	(75,271)	0.0%	Prop 56-Trauma Expense	602,825	0	(602,825)	0.0%
97,364	0	(97,364)	0.0%	Prop 56-Dev. Screening Exp.	794,698	0	(794,698)	0.0%
645,457	0	(645,457)	0.0%	Prop 56-Fam. Planning Exp.	5,115,247	0	(5,115,247)	0.0%
570,364	0	(570,364)	0.0%	Prop 56-Value Based Purchasing	4,417,165	0	(4,417,165)	0.0%
4,278,302	**4,570,562**	**292,260**	**6.4%**	**7-Primary Care Physician FFS Expense**	**35,286,318**	**35,928,485**	**642,167**	**1.8%**
(143,535)	0	143,535	0.0%	IBNP-Specialist	930,985	0	(930,985)	0.0%
2,414,263	4,643,601	2,229,338	48.0%	Specialty Care-FFS	18,820,020	37,379,711	18,559,691	49.7%
69,610	0	(69,610)	0.0%	Anesthesiology - FFS	903,402	0	(903,402)	0.0%
607,133	0	(607,133)	0.0%	Spec Rad Therapy - FFS	5,826,383	0	(5,826,383)	0.0%
99,569	0	(99,569)	0.0%	Obstetrics-FFS	883,700	0	(883,700)	0.0%
331,472	0	(331,472)	0.0%	Spec IP Surgery - FFS	2,230,263	0	(2,230,263)	0.0%
555,183	0	(555,183)	0.0%	Spec OP Surgery - FFS	4,111,327	0	(4,111,327)	0.0%
341,492	0	(341,492)	0.0%	Spec IP Physician	3,029,383	0	(3,029,383)	0.0%
37,003	4,943	(32,060)	(648.6%)	SCP FQHC FFS	339,089	19,837	(319,252)	(1,609.4%)
(4,306)	0	4,306	0.0%	IBNP-Settlement (SCP)	27,928	0	(27,928)	0.0%
(11,483)	0	11,483	0.0%	IBNP-Claims Fluctuation (SCP)	74,477	0	(74,477)	0.0%
4,296,400	**4,648,544**	**352,144**	**7.6%**	**8-Specialty Care Physician Expense**	**37,176,957**	**37,399,548**	**222,591**	**0.6%**
78,411	0	(78,411)	0.0%	IBNP-Ancillary	1,411,019	0	(1,411,019)	0.0%
2,352	0	(2,352)	0.0%	IBNP Settlement (ANC)	42,331	0	(42,331)	0.0%
6,273	0	(6,273)	0.0%	IBNP Claims Fluctuation (ANC)	112,881	0	(112,881)	0.0%
508,618	0	(508,618)	0.0%	Acupuncture/Biofeedback	3,414,683	0	(3,414,683)	0.0%
157,220	0	(157,220)	0.0%	Hearing Devices	693,543	0	(693,543)	0.0%
11,741	0	(11,741)	0.0%	Imaging/MRI/CT Global	251,940	0	(251,940)	0.0%
55,297	0	(55,297)	0.0%	Vision FFS	379,502	0	(379,502)	0.0%
23,651	0	(23,651)	0.0%	Family Planning	177,371	0	(177,371)	0.0%
1,051,673	0	(1,051,673)	0.0%	Laboratory-FFS	5,650,250	0	(5,650,250)	0.0%
81,331	0	(81,331)	0.0%	ANC Therapist	719,307	0	(719,307)	0.0%
0	0	0	0.0%	ANC Diagnostic Procedures	(166)	0	166	0.0%
301,771	0	(301,771)	0.0%	Transportation (Ambulance)-FFS	2,357,496	0	(2,357,496)	0.0%
140,545	0	(140,545)	0.0%	Transportation (Other)-FFS	1,099,199	0	(1,099,199)	0.0%
514,794	0	(514,794)	0.0%	Hospice	4,186,894	0	(4,186,894)	0.0%
504,421	0	(504,421)	0.0%	Home Health Services	5,319,910	0	(5,319,910)	0.0%
0	3,451,719	3,451,719	100.0%	Other Medical-FFS	0	31,622,217	31,622,217	100.0%

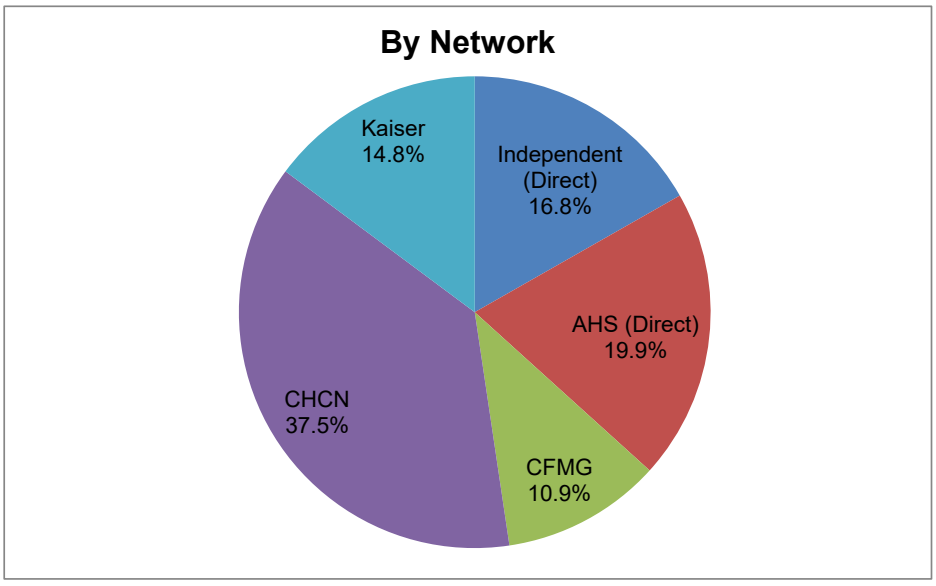
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED February 28, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
($151,295)	$0	$151,295	0.0%	HMS Medical Refunds	($130,976)	$0	$130,976	0.0%
1,100	0	(1,100)	0.0%	Refunds-Medical Payments	1,036	0	(1,036)	0.0%
415,790	0	(415,790)	0.0%	DME & Medical Supplies	3,685,875	0	(3,685,875)	0.0%
0	0	0	0.0%	Denials	167	0	(167)	0.0%
621,543	586,834	(34,709)	(5.9%)	GEMT Direct Payment Expense	4,739,258	2,346,869	(2,392,389)	(101.9%)
481,231	0	(481,231)	0.0%	Community Based Adult Services (CBAS)	3,576,021	0	(3,576,021)	0.0%
841,688	717,366	(124,322)	(17.3%)	ECM Base FFS Ancillary	1,677,122	1,441,045	(236,077)	(16.4%)
0	10,001	10,001	100.0%	ECM Outreach FFS Ancillary	0	20,001	20,001	100.0%
398,608	398,608	0	0.0%	CS - Housing Deposits FFS Ancillary	797,216	797,216	0	0.0%
407,667	407,667	0	0.0%	CS - Housing Tenancy FFS Ancillary	815,334	815,334	0	0.0%
298,956	298,956	0	0.0%	CS - Housing Navigation Services FFS Ancillary	597,912	597,912	0	0.0%
241,313	241,312	(1)	0.0%	CS - Medical Respite FFS Ancillary	482,625	482,624	(1)	0.0%
230,081	230,081	0	0.0%	CS - Medically Tailored Meals FFS Ancillary	460,163	460,162	(1)	0.0%
35,244	35,244	0	0.0%	CS - Asthma Remediation FFS Ancillary	70,489	70,488	(1)	0.0%
7,260,025	**6,377,788**	**(882,237)**	**(13.8%)**	**9-Ancillary Medical Expense**	**42,588,402**	**38,653,868**	**(3,934,534)**	**(10.2%)**
292,981	0	(292,981)	0.0%	IBNP-Outpatient	2,047,299	0	(2,047,299)	0.0%
8,789	0	(8,789)	0.0%	IBNP Settlement (OP)	61,420	0	(61,420)	0.0%
23,439	0	(23,439)	0.0%	IBNP Claims Fluctuation (OP)	163,785	0	(163,785)	0.0%
1,068,827	8,236,584	7,167,757	87.0%	Out-Patient FFS	9,991,967	67,276,331	57,284,364	85.1%
1,314,825	0	(1,314,825)	0.0%	OP Ambul Surgery - FFS	10,223,225	0	(10,223,225)	0.0%
1,190,441	0	(1,190,441)	0.0%	OP Fac Imaging Services-FFS	8,847,111	0	(8,847,111)	0.0%
611,078	0	(611,078)	0.0%	Behav Health - FFS	14,143,126	0	(14,143,126)	0.0%
869,451	0	(869,451)	0.0%	Behavioral Health Therapy - FFS	1,759,125	0	(1,759,125)	0.0%
415,725	0	(415,725)	0.0%	OP Facility - Lab FFS	3,696,990	0	(3,696,990)	0.0%
63,275	0	(63,275)	0.0%	OP Facility - Cardio FFS	785,893	0	(785,893)	0.0%
40,583	0	(40,583)	0.0%	OP Facility - PT/OT/ST FFS	380,933	0	(380,933)	0.0%
1,283,321	0	(1,283,321)	0.0%	OP Facility - Dialysis FFS	13,453,162	0	(13,453,162)	0.0%
7,182,735	**8,236,584**	**1,053,849**	**12.8%**	**10-Outpatient Medical Expense Medical Expense**	**65,554,036**	**67,276,331**	**1,722,295**	**2.6%**
(388,689)	0	388,689	0.0%	IBNP-Emergency	1,432,429	0	(1,432,429)	0.0%
(11,661)	0	11,661	0.0%	IBNP Settlement (ER)	42,971	0	(42,971)	0.0%
(31,095)	0	31,095	0.0%	IBNP Claims Fluctuation (ER)	114,594	0	(114,594)	0.0%
559,784	0	(559,784)	0.0%	Special ER Physician-FFS	4,913,468	0	(4,913,468)	0.0%
3,760,491	4,334,452	573,961	13.2%	ER-Facility	29,927,193	35,952,004	6,024,811	16.8%
3,888,830	**4,334,452**	**445,622**	**10.3%**	**11-Emergency Expense**	**36,430,656**	**35,952,004**	**(478,652)**	**(1.3%)**
592,884	0	(592,884)	0.0%	IBNP-Pharmacy	937,729	0	(937,729)	0.0%
17,787	0	(17,787)	0.0%	IBNP Settlement (RX)	28,134	0	(28,134)	0.0%
47,432	0	(47,432)	0.0%	IBNP Claims Fluctuation (RX)	75,020	0	(75,020)	0.0%
380,480	344,619	(35,861)	(10.4%)	Pharmacy-FFS	70,701,217	70,054,496	(646,721)	(0.9%)
4,797,215	4,787,620	(9,595)	(0.2%)	Pharmacy- Non-PBM FFS-Other Anc	39,647,233	37,777,831	(1,869,402)	(4.9%)
(54,455)	0	54,455	0.0%	HMS RX Refunds	(673,232)	0	673,232	0.0%
0	(18,132)	(18,132)	100.0%	Pharmacy-Rebate	(3,425,129)	(3,464,420)	(39,291)	1.1%
5,781,343	**5,114,107**	**(667,236)**	**(13.0%)**	**12-Pharmacy Expense**	**107,290,973**	**104,367,907**	**(2,923,066)**	**(2.8%)**
58,993,291	**60,945,272**	**1,951,981**	**3.2%**	**13-TOTAL FFS MEDICAL EXPENSES**	**541,642,313**	**540,049,164**	**(1,593,150)**	**(0.3%)**
0	(37,675)	(37,675)	100.0%	Clinical Vacancy	0	(244,563)	(244,563)	100.0%
98,525	118,020	19,495	16.5%	Quality Analytics	592,599	623,975	31,376	5.0%
384,892	521,660	136,768	26.2%	Health Plan Services Department Total	3,226,830	3,806,182	579,352	15.2%
389,117	427,483	38,366	9.0%	Case & Disease Management Department Total	4,411,695	4,604,024	192,329	4.2%
1,557,025	235,193	(1,321,832)	(562.0%)	Medical Services Department Total	2,624,901	1,355,607	(1,269,293)	(93.6%)
586,937	752,977	166,040	22.1%	Quality Management Department Total	3,730,437	5,238,485	1,508,048	28.8%
66,804	52,109	(14,695)	(28.2%)	HCS Behavioral Health Department Total	223,129	346,384	123,255	35.6%
110,185	127,821	17,636	13.8%	Pharmacy Services Department Total	905,127	1,024,050	118,923	11.6%
58,574	54,159	(4,415)	(8.2%)	Regulatory Readiness Total	253,971	328,628	74,657	22.7%
3,252,057	**2,251,747**	**(1,000,310)**	**(44.4%)**	**14-Other Benefits & Services**	**15,968,689**	**17,082,772**	**1,114,084**	**6.5%**
				Reinsurance Expense				
(388,893)	(406,286)	(17,393)	4.3%	Reinsurance Recoveries	(4,897,185)	(3,833,057)	1,064,128	(27.8%)
556,698	541,715	(14,983)	(2.8%)	Stop-Loss Expense	4,358,136	4,334,832	(23,304)	(0.5%)
167,804	**135,429**	**(32,375)**	**(23.9%)**	**15-Reinsurance Expense**	**(539,049)**	**501,775**	**1,040,824**	**207.4%**
83,179,624	**85,577,357**	**2,397,733**	**2.8%**	**17-TOTAL MEDICAL EXPENSES**	**733,053,496**	**736,513,316**	**3,459,820**	**0.5%**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**Feb 2022**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	44,588	15%	8,850	9,180	681	17,816	8,061
Child	99,573	33%	7,626	8,987	30,449	34,438	18,073
SPD	26,675	9%	8,085	4,202	1,054	11,287	2,047
ACA OE	106,553	36%	15,956	35,157	1,135	40,478	13,827
Duals	21,239	7%	8,141	2,303	-	7,686	3,109
Medi-Cal	298,628		48,658	59,829	33,319	111,705	45,117
Group Care	5,824		2,395	870	-	2,559	-
Total	**304,452**	**100%**	**51,053**	**60,699**	**33,319**	**114,264**	**45,117**
Medi-Cal %	98.1%		95.3%	98.6%	100.0%	97.8%	100.0%
Group Care %	1.9%		4.7%	1.4%	0.0%	2.2%	0.0%
	Network Distribution		*16.8%*	*19.9%*	*10.9%*	*37.5%*	*14.8%*
			% Direct:	**37%**		**% Delegated:**	**63%**

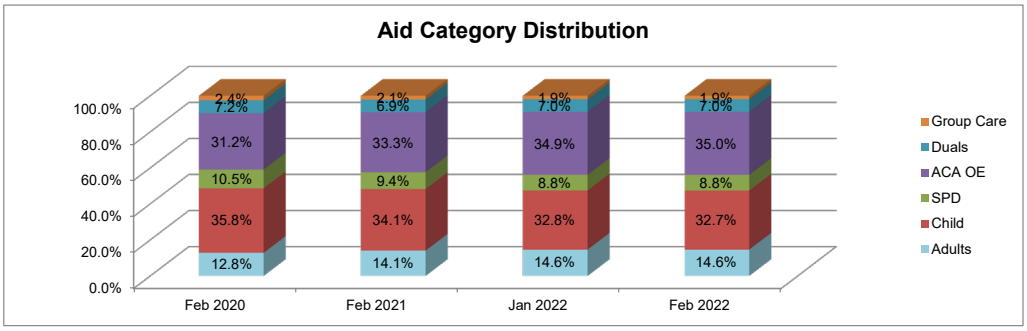




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

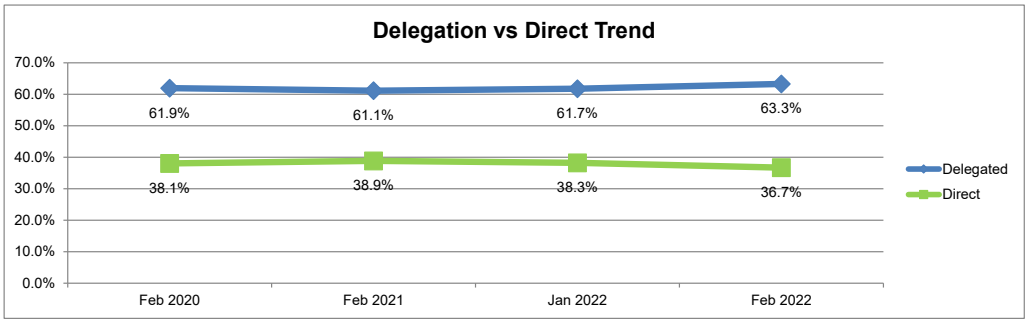
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020 to Feb 2021	Feb 2021 to Feb 2022	Jan 2022 to Feb 2022
Adults	31,635	39,318	44,340	44,588	12.8%	14.1%	14.6%	14.6%	24.3%	13.4%	0.6%
Child	88,086	95,514	99,337	99,573	35.8%	34.1%	32.8%	32.7%	8.4%	4.2%	0.2%
SPD	25,853	26,290	26,633	26,675	10.5%	9.4%	8.8%	8.8%	1.7%	1.5%	0.2%
ACA OE	76,921	93,322	105,897	106,553	31.2%	33.3%	34.9%	35.0%	21.3%	14.2%	0.6%
Duals	17,844	19,429	21,135	21,239	7.2%	6.9%	7.0%	7.0%	8.9%	9.3%	0.5%
Medi-Cal Total	240,339	273,873	297,342	298,628	97.6%	97.9%	98.1%	98.1%	14.0%	9.0%	0.4%
Group Care	6,005	5,969	5,831	5,824	2.4%	2.1%	1.9%	1.9%	-0.6%	-2.4%	-0.1%
Total	**246,344**	**279,842**	**303,173**	**304,452**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**13.6%**	**8.8%**	**0.4%**



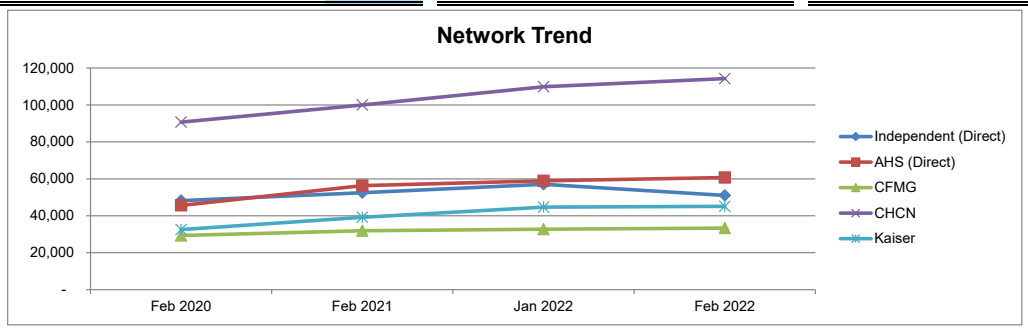
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020 to Feb 2021	Feb 2021 to Feb 2022	Jan 2022 to Feb 2022
Delegated	152,563	171,098	187,200	192,700	61.9%	61.1%	61.7%	63.3%	12.1%	12.6%	2.9%
Direct	93,781	108,744	115,973	111,752	38.1%	38.9%	38.3%	36.7%	16.0%	2.8%	-3.6%
Total	**246,344**	**279,842**	**303,173**	**304,452**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**13.6%**	**8.8%**	**0.4%**



Network Trend

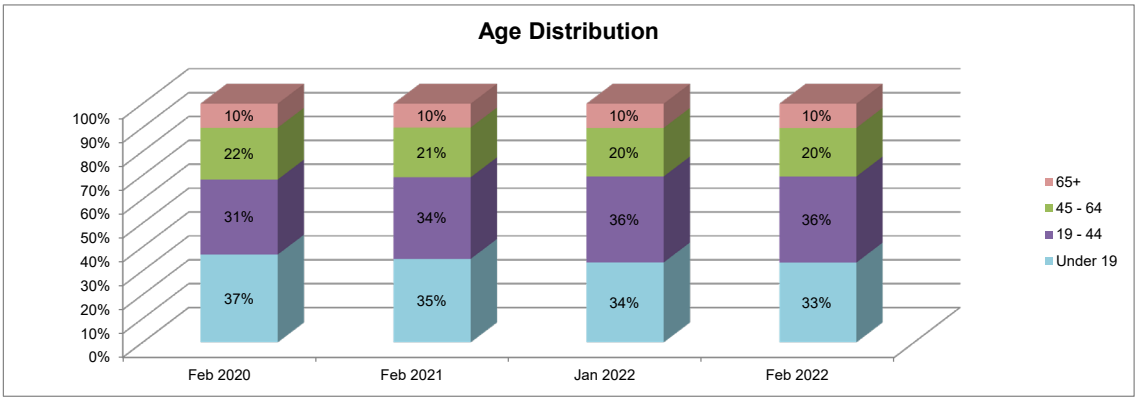
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020 to Feb 2021	Feb 2021 to Feb 2022	Jan 2022 to Feb 2022
Independent (Direct)	48,187	52,462	57,046	51,053	19.6%	18.7%	18.8%	16.8%	8.9%	-2.7%	-10.5%
AHS (Direct)	45,594	56,282	58,927	60,699	18.5%	20.1%	19.4%	19.9%	23.4%	7.8%	3.0%
CFMG	29,338	31,907	32,689	33,319	11.9%	11.4%	10.8%	10.9%	8.8%	4.4%	1.9%
CHCN	90,696	100,003	109,878	114,264	36.8%	35.7%	36.2%	37.5%	10.3%	14.3%	4.0%
Kaiser	32,529	39,188	44,633	45,117	13.2%	14.0%	14.7%	14.8%	20.5%	15.1%	1.1%
Total	**246,344**	**279,842**	**303,173**	**304,452**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**13.6%**	**8.8%**	**0.4%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

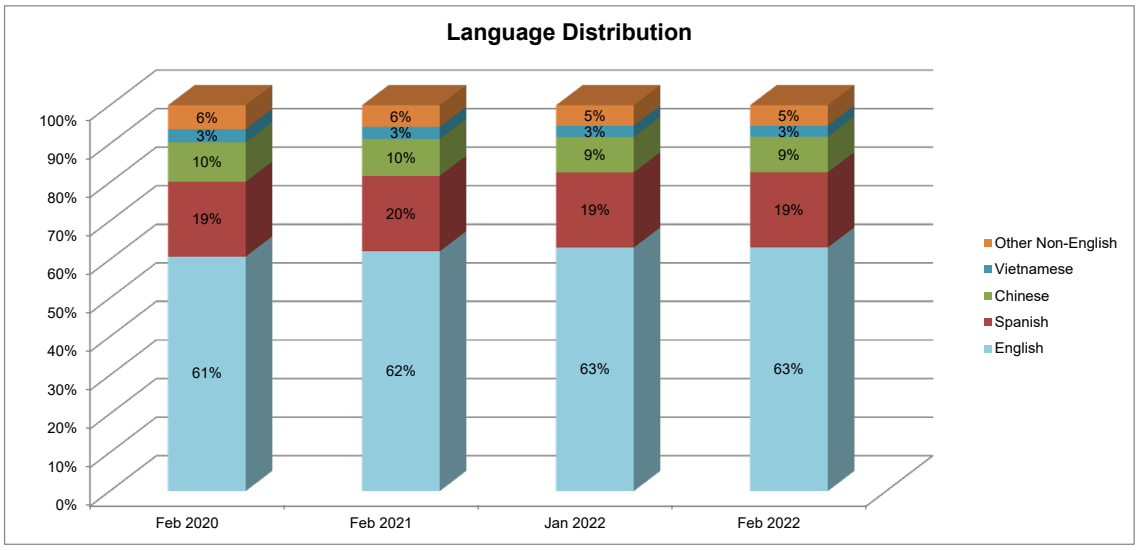
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020 to Feb 2021	Feb 2021 to Feb 2022	Jan 2022 to Feb 2022
Under 19	90,651	97,915	101,615	101,831	37%	35%	34%	33%	8%	4%	0%
19 - 44	77,479	95,719	109,198	109,790	31%	34%	36%	36%	24%	15%	1%
45 - 64	53,449	58,334	61,651	61,957	22%	21%	20%	20%	9%	6%	0%
65+	24,765	27,874	30,709	30,874	10%	10%	10%	10%	13%	11%	1%
Total	**246,344**	**279,842**	**303,173**	**304,452**	**100%**	**100%**	**100%**	**100%**	**14%**	**9%**	**0%**



Language Trend

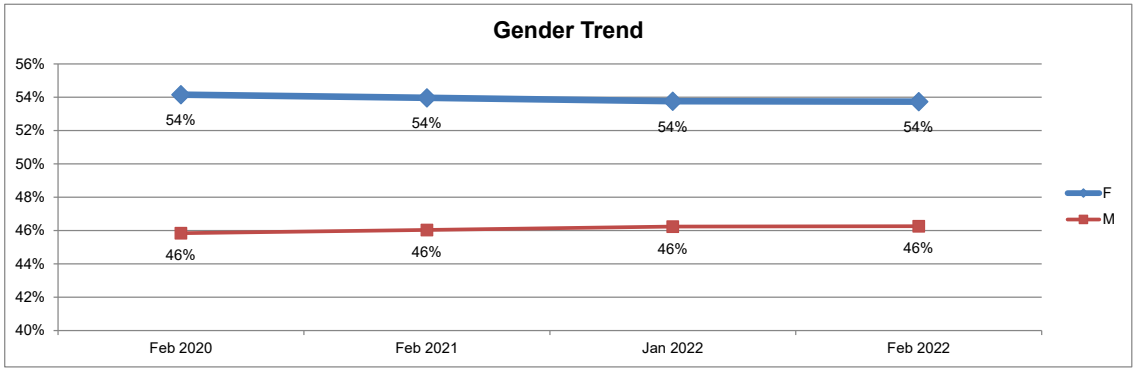
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020 to Feb 2021	Feb 2021 to Feb 2022	Jan 2022 to Feb 2022
English	149,691	173,798	191,279	192,183	61%	62%	63%	63%	16%	11%	0%
Spanish	47,773	54,775	59,086	59,339	19%	20%	19%	19%	15%	8%	0%
Chinese	25,291	26,772	27,931	28,043	10%	10%	9%	9%	6%	5%	0%
Vietnamese	8,322	8,730	8,831	8,819	3%	3%	3%	3%	5%	1%	0%
Other Non-English	15,267	15,767	16,046	16,068	6%	6%	5%	5%	3%	2%	0%
Total	**246,344**	**279,842**	**303,173**	**304,452**	**100%**	**100%**	**100%**	**100%**	**14%**	**9%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

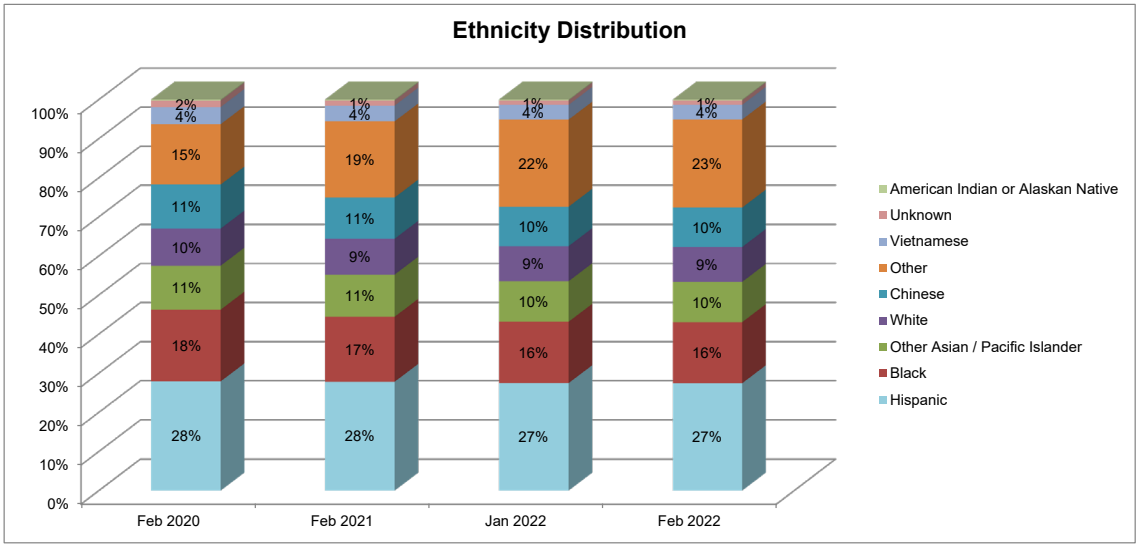
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020 to Feb 2021	Feb 2021 to Feb 2022	Jan 2022 to Feb 2022
F	133,410	151,018	162,997	163,606	54%	54%	54%	54%	13%	8%	0%
M	112,934	128,824	140,176	140,846	46%	46%	46%	46%	14%	9%	0%
Total	**246,344**	**279,842**	**303,173**	**304,452**	**100%**	**100%**	**100%**	**100%**	**14%**	**9%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020	Feb 2021	Jan 2022	Feb 2022	Feb 2020 to Feb 2021	Feb 2021 to Feb 2022	Jan 2022 to Feb 2022
Hispanic	68,723	77,793	83,229	83,453	28%	28%	27%	27%	13%	7%	0%
Black	45,209	46,546	47,604	47,596	18%	17%	16%	16%	3%	2%	0%
Other Asian / Pacific Islander	27,682	30,152	31,403	31,340	11%	11%	10%	10%	9%	4%	0%
White	23,442	25,716	27,265	27,221	10%	9%	9%	9%	10%	6%	0%
Chinese	27,725	29,512	30,557	30,703	11%	11%	10%	10%	6%	4%	0%
Other	38,042	54,528	67,560	68,575	15%	19%	22%	23%	43%	26%	2%
Vietnamese	10,813	11,249	11,406	11,400	4%	4%	4%	4%	4%	1%	0%
Unknown	4,124	3,738	3,506	3,520	2%	1%	1%	1%	-9%	-6%	0%
American Indian or Alaskan Native	584	608	643	644	0%	0%	0%	0%	4%	6%	0%
Total	**246,344**	**279,842**	**303,173**	**304,452**	**100%**	**100%**	**100%**	**100%**	**14%**	**9%**	**0%**



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

Medi-Cal By City

City	Feb 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	117,725	39%	12,586	28,590	14,094	49,637	12,818
Hayward	46,516	16%	6,978	10,218	5,400	15,675	8,245
Fremont	26,950	9%	9,698	4,212	930	7,583	4,527
San Leandro	26,950	9%	4,292	4,168	3,445	10,154	4,891
Union City	12,581	4%	3,886	2,010	522	3,756	2,407
Alameda	11,478	4%	2,096	1,850	1,631	4,054	1,847
Berkeley	11,068	4%	1,505	1,648	1,311	4,902	1,702
Livermore	9,145	3%	981	769	1,917	3,814	1,664
Newark	6,887	2%	1,798	2,234	225	1,330	1,300
Castro Valley	7,457	2%	1,288	1,213	1,101	2,315	1,540
San Lorenzo	6,375	2%	852	1,117	741	2,314	1,351
Pleasanton	4,944	2%	908	436	507	2,231	862
Dublin	5,335	2%	949	454	681	2,250	1,001
Emeryville	2,016	1%	336	386	303	643	348
Albany	1,851	1%	256	218	357	635	385
Piedmont	365	0%	58	100	22	92	93
Sunol	57	0%	13	10	5	17	12
Antioch	26	0%	4	6	7	3	6
Other	902	0%	174	190	120	300	118
Total	**298,628**	**100%**	**48,658**	**59,829**	**33,319**	**111,705**	**45,117**

Group Care By City

City	Feb 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,928	33%	471	361	-	1,096	-
Hayward	644	11%	319	137	-	188	-
Fremont	620	11%	460	49	-	111	-
San Leandro	573	10%	223	88	-	262	-
Union City	325	6%	228	30	-	67	-
Alameda	288	5%	115	20	-	153	-
Berkeley	166	3%	49	9	-	108	-
Livermore	80	1%	27	1	-	52	-
Newark	145	2%	88	37	-	20	-
Castro Valley	181	3%	80	19	-	82	-
San Lorenzo	125	2%	54	14	-	57	-
Pleasanton	59	1%	24	2	-	33	-
Dublin	107	2%	36	10	-	61	-
Emeryville	34	1%	11	6	-	17	-
Albany	13	0%	5	1	-	7	-
Piedmont	14	0%	4	-	-	10	-
Sunol	-	0%	-	-	-	-	-
Antioch	27	0%	5	8	-	14	-
Other	495	8%	196	78	-	221	-
Total	**5,824**	**100%**	**2,395**	**870**	**-**	**2,559**	**-**

Total By City

City	Feb 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	119,653	39%	13,057	28,951	14,094	50,733	12,818
Hayward	47,160	15%	7,297	10,355	5,400	15,863	8,245
Fremont	27,570	9%	10,158	4,261	930	7,694	4,527
San Leandro	27,523	9%	4,515	4,256	3,445	10,416	4,891
Union City	12,906	4%	4,114	2,040	522	3,823	2,407
Alameda	11,766	4%	2,211	1,870	1,631	4,207	1,847
Berkeley	11,234	4%	1,554	1,657	1,311	5,010	1,702
Livermore	9,225	3%	1,008	770	1,917	3,866	1,664
Newark	7,032	2%	1,886	2,271	225	1,350	1,300
Castro Valley	7,638	3%	1,368	1,232	1,101	2,397	1,540
San Lorenzo	6,500	2%	906	1,131	741	2,371	1,351
Pleasanton	5,003	2%	932	438	507	2,264	862
Dublin	5,442	2%	985	464	681	2,311	1,001
Emeryville	2,050	1%	347	392	303	660	348
Albany	1,864	1%	261	219	357	642	385
Piedmont	379	0%	62	100	22	102	93
Sunol	57	0%	13	10	5	17	12
Antioch	53	0%	9	14	7	17	6
Other	1,397	0%	370	268	120	521	118
Total	**304,452**	**100%**	**51,053**	**60,699**	**33,319**	**114,264**	**45,117**

ALAMEDA Alliance FOR HEALTH

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

Staff Report and Resolution

TO: Alameda Alliance for Health Board of Governors

FROM: Scott Coffin

DATE: April 8th, 2022

SUBJECT: Regular Seat #7, Consumer Member, Nomination for Reappointment

RECOMMENDED ACTION

1. Adopt Resolution 2022-01 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 Reappoint a Member to the Board of Governors of Alameda Alliance for Health."

DISCUSSION

Ms. Natalie Williams' current term in the Alameda Alliance for Health ("Alliance") Board of Governors Regular Seat #7, Consumer Member, will expire on June 29th, 2022. Ms. Williams has chosen to serve an additional two-year term pursuant to Section 3.F. of the Alliance Bylaws and has been recommended for reappointment by the Chief Executive Officer. Section 3.J.1. of the Bylaws provides that the Board shall review the recommendation and that the Board's approval shall be by resolution.

Resolution 2022-01 provides for the approval of Ms. Williams to Regular Seat #7, Consumer Member for reappointment. If the resolution is passed and adopted by the Board of Governors, it will be sent to the Alameda County Board of Supervisors, who will vote on Ms. Williams' reappointment to Regular Seat #7, Consumer Member.

FISCAL IMPACT

This action will not have a fiscal impact.

ATTACHMENTS

Resolution 2022-01.

RESOLUTION NO. 2022-01

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 REAPPOINT A MEMBER TO THE BOARD OF GOVERNORS OF ALAMEDA ALLIANCE FOR HEALTH

WHEREAS, Natalie Williams' current term as an Alameda Alliance for Health (Alliance) Board of Governors member, in Regular Seat #7, Consumer Member, will expire on JUNE, 29th, 2022; and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors nominate Ms. Williams for reappointment to Regular Seat #7, Consumer Member, pursuant to Section 3.C of the Bylaws of the Alliance; and

WHEREAS, pursuant to Sections 3.C and 3.J of the Bylaws of the Alliance, the Alliance Board of Governors has reviewed the recommendation; and

WHEREAS, the Alliance Board of Governors desires to nominate Ms. Williams for reappointment to Regular Seat #7, Consumer Member; and

WHEREAS, pursuant to Sections 3.C and 3.J of the Alliance Bylaws, 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 Alliance Board of Governors' resolution, the Alameda County Board of Supervisors may choose to reappoint by majority vote this member to the Alliance Board of Governors.

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

SECTION 1. That the Alliance Board of Governors approves the Chief Executive Officer's recommendation to nominate Ms. Williams for reappointment to the Regular Seat #7, Consumer Member, on the Alliance Board of Governors, as created pursuant to Section 3.D.5. of the Bylaws of the Alliance.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors reappoint by majority vote Ms. Williams to Regular Seat #7, Consumer Member, on 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 8th day of April 2022.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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COVID-19 Vaccination Progress Report

COVID-19 Vaccinations & Incentives

Progress Report

Presented to the Alameda Alliance Board of Governors

Matthew Woodruff, Chief Operating Officer

April 8th, 2022

Vaccination Progress Report

- **Where we are:** The Alliance as of March 28th, 2022:
  - 75.1% of Medi-Cal members 12 years and older are vaccinated (fully/partially) based on internal claims and encounter data (please note: there may be a lag in CAIR2 data)
    - → Medi-Cal: 179,729 out of 239,469 people
  - Ranked 4th highest Managed Care Plan in CA for eligible members who have completed at least 1-dose
  - Averaged 12%+ increase among all key measured populations and approximately 1000+ vaccines per week
  - Key measures 1 and 2 – final reporting date March 6th (Due April 30th)

Rates as of 3/06/2022 – Final Reporting Date	Numerator	Denominator	Achievement Rate	Target Rate*
Measure 1: Percent of homebound Medi-Cal beneficiaries who received at least one dose of a COVID-19 vaccine (5% weight).	2,622	3,115	84.2%	100.0%
Measure 2: Percent of Medi-Cal beneficiaries ages 50-64 years of age with one or more chronic diseases (as defined by the federal Centers for Disease Control and Prevention (CDC) who received at least one dose of a COVID-19 vaccine (5% weight).	17,273	20,008	86.3%	100.0%
Sum of Achievement Values as of 03/06/2022 ***Target rate = 30% over the baseline rate or 85% for a measure at any evaluation point in time.**				

Vaccination Progress Report

Where we ended

Measure (and weight)	**Baseline Rate (Aug. 29, 2021)**	Achievement Rate (Oct. 31, 2021)	Achievement Rate (Jan. 2, 2022)	**Achievement Rate (Mar. 6, 2022)**	Reported by
Measure 1: Percent of homebound Medi-Cal beneficiaries who received at least one dose of a COVID-19 vaccine (5% weight).	**68.9%**	70.6%	75.8%	**84.2%**	Alliance
Measure 2: Percent of Medi-Cal beneficiaries ages 50-64 years of age with one or more chronic diseases who received at least one dose of a COVID-19 vaccine (5% weight).	**79%**	82.4%	84.6%	**86.3%**	Alliance
Percent of Medi-Cal beneficiaries ages **12 years** and older who received at least one dose of a COVID-19 vaccine (35% weight).	**62.5%**	70.5%	72.2%	**75.1%**	DHCS
Percent of Medi-Cal beneficiaries ages **12-25 years** who received at least one dose of a COVID-19 vaccine (10% weight).	**57.1%**	66.8%	69.2%	**73.3%**	DHCS
Percent of Medi-Cal beneficiaries ages **26-49 years** who received at least one dose of a COVID-19 vaccine (5% weight).	**58.4%**	65.7%	68.2%	**70.9%**	DHCS
Percent of Medi-Cal beneficiaries ages **50-64 years** who received at least one dose of a COVID-19 vaccine (5% weight).	**70.2%**	76.9%	78.3%	**80.2%**	DHCS
Percent of Medi-Cal beneficiaries ages **65+ years** who received at least one dose of a COVID-19 vaccine (5% weight).	**75.9%**	81.8%	82.4%	**83.7%**	DHCS
Percent of Medi-Cal beneficiaries ages 12 years and older from the race/ethnicity group with the lowest baseline vaccination rate who received at least one dose of a COVID-19 vaccine (15% weight).	**42.4% (Black/African American)**	52.3%	54.7%	**57.9% (Black/African American)**	DHCS
Percent of Medi-Cal beneficiaries ages 12 years and older from the race/ethnicity group with the second-lowest baseline vaccination rate who received at least one dose of a COVID-19 vaccine (15% weight).	**59.3% (American Indian/Alaskan Native)**	64.4%	67.9%	**71.1% (American Indian/Alaskan Native)**	DHCS

Vaccination Progress Report

- **Funding:**

  - The Alliance was awarded $1,207,333 million for our initial vaccination response plan last September.
  - To date, the Alliance has spent $1,421,989 million on local vaccination programs.
  - Total funding received to date is $2,180,639.
  - The Alliance recently received an additional $973,305 in funding on March 18th for improving vaccination rates for Measures 4-10 (September 21st, 2021, through December 31st, 2021).
  - The Alliance received no additional funding in this first round for measures 1 and 2.
  - The Alliance filed our member incentive on March 31st for reimbursement and our final member reimbursement report is due to the State in August.
  - The Alliance anticipates receiving additional award funding for improving vaccination rates in the key measures during the final 8 weeks around the end of June 2022.

- Alliance Member Gift Card Incentive:

State-Sponsored $50 Gift Cards (September 2021 to February 2022)	Foodmaxx	Safeway	Total
Medi-Cal Members 12+	46	74	120
Medi-Cal Members 5 to 11 years old	40	65	105
Medi-Cal Friends & Family Referral	4	3	7
Total as of March 28th, 2022	90	142	**232**

Alliance-Sponsored $10 Gift Cards (January 2021 - August 2021)	Foodmaxx	Safeway	Total
Group Care (IHSS) and Medi-Cal Members	478	1,153	**1,631**

- **What we will do next:**
  - Continue working to help the remaining 59K+ unvaccinated members get vaccinated.
  - Restart Alliance-sponsored gift card for unvaccinated members who complete their vaccination between April 1st, 2022, and June 30th, 2022.
    - → Please note: The Alliance budget for incentives next fiscal year is dependent upon Board approval of the budget.
  - Continue partnering with ongoing Alameda County programs to promote the vaccine and booster among all Alliance members.

Operations

Matt Woodruff

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

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

Date: **April 8th, 2022**

Subject: **Operations Report**

Member Services

- 12-Month Trend Summary:

    - The Member Services Department received a nineteen percent (19%) increase in calls in March 2022, totaling 16,177 compared to 13,159 in March 2021. Call volume pre-pandemic in March 2019 was 15,277, which is six percent (6%) lower than the current call volume.
    - March utilization for the member automated eligibility IVR system totaled two hundred-ten (210).
    - The abandonment rate for March 2022 was twenty-four percent (24%), compared to four percent (4%) in March 2021.
    - The Department's service level was thirty-three percent (33%) in March 2022, compared to eighty-three percent (83%) in March 2021. The Department continues to recruit to fill open positions. Service levels continue to be directly impacted due to the increased volume of calls, increase in membership, and staffing challenges (unplanned callouts related to personal or family illnesses with COVID-19). Training of customer call support vendor is ongoing to augment queue support.
    - The average talk time (ATT) was five minutes fifty-six seconds (05:56) for March 2022 compared to six minutes and thirteen seconds (06:13) for March 2021.
    - The top five call reasons for March 2022 were: 1). Kaiser, 2). Change of PCP 3). Eligibility/Enrollment, 4). Benefits, 5). ID Card/Member Materials requests. The top five call reasons for March 2021 were: 1). Eligibility/Enrollment, 2). Kaiser, 3). Change of PCP, 4). Benefits, 5). ID Card Requests.
    - The Department continues to service members via multiple non-contact communication channels (telephonic, email, web-based requests) while honoring the organization's policies. The Department responded to nine hundred seventy-four (974) web-based requests (32% increase) in March 2022 compared to six hundred sixty-five (665) in March 2021. The top three web reason requests for March 2022 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information.

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

Claims

- 12-Month Trend Summary:
    - The Claims Department received 185,738 claims in March 2022 compared to 143,171 in March 2021.
    - The Auto Adjudication was 82.8% in March 2022 compared to 73.8% in March 2021.
    - Claims compliance for the 30-day turn-around time was 98.8% in March 2022 compared to 94.9% in March 2021. The 45-day turn-around time was 99.9% in March 2022 compared to 99.9% in March 2021.

- Training:
    - Routine and new hire training is being conducted remotely by the Claims Trainer.

- Monthly Analysis:
    - In March, we received a total of 185,738 claims in the HEALTHsuite system. This represents an increase of 14.35% from February and is higher, than the number of claims received in February 2021; the higher volume of received claims remains attributed to COVID-19, COBA implementation, and increased membership.
    - We received 84% of claims via EDI and 16% of claims via paper.
    - During March, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 82.8% for March.

Provider Services

- 12-Month Trend Summary:
    - The Provider Services department's call volume in March 2022 was 6,078 calls compared to 5,816 calls in March 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 243 call/visits during March 2022.
    - The Provider Services department answered over 3,929 calls for March 2022 and made over 664 outbound calls.

Credentialing

- 12-Month Trend Summary:
    - At the Peer Review and Credentialing (PRCC) meeting held on March 15th, 2022, there were thirty-eight (38) initial providers approved; nine (9) primary care providers, fourteen (14) specialists, three (3) ancillary providers, and twelve (12) midlevel providers. Additionally, twenty-five (25) providers were re-credentialed at this meeting; seven (7) primary care providers, twelve (12) specialists, one (1) ancillary provider, and five (5) midlevel providers.
    - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Provider Dispute Resolution

- 12-Month Trend Summary:
    - In March 2022, the Provider Dispute Resolution (PDR) team received 788 PDRs versus 599 in March 2021.
    - The PDR team resolved 1,028 cases in March 2022 compared to 790 cases in March 2021.
    - In March 2022, the PDR team upheld 71% of cases versus 70% in March 2021.
    - The PDR team resolved 99.7% of cases within the compliance standard of 95% within 45 working days in March 2022 compared to 99.6% in March 2021.

- Monthly Analysis:

    - AAH received 788 PDRs in March 2022.
    - In March, 1,028 PDRs were resolved. Out of the 1028 PDRs, 729 were upheld and 299 were overturned.
    - The overturn rate for PDRs was 29% which did not meet our goal of 25% or less.

Community Relations and Outreach

- 12-Month Trend Summary:

    - In Q3 2022, the Alliance completed 1,013-member orientation outreach calls and 309 member orientations by phone.
    - The C&O Department reached 309 people (100% identified as Alliance members) during outreach activities, compared to 604 individuals (100% identified as Alliance members) in Q3 2021.
    - The C&O Department spent $0 in donations, fees, and/or sponsorships, compared to $0 in Q3 2021.
    - The C&O Department reached members in 19 cities/unincorporated areas throughout Alameda County, Bay Area, and the U.S., compared to 24 cities in Q3 2021.

- Quarterly Analysis:

    - In Q3 2022, the C&O Department completed 1,013-member orientation outreach calls and 309 member orientations by phone.
    - Among the 309 people reached, 100% identified as Alliance members.
    - In Q3 2022, the C&O Department reached members in 19 locations throughout Alameda County, Bay Area, and the U.S.

- Monthly Analysis:

    - In March 2022, the C&O Department completed 403-member orientation outreach calls and 102 member orientations by phone, and 86 Alliance website inquiries.
    - Among the 102 people reached, 100% identified as Alliance members.
    - In March 2022, the C&O Department reached members in 15 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	March 2022
Incoming Calls (R/V)	16,177
Abandoned Rate (R/V)	24%
Answered Calls (R/V)	11,591
Average Speed to Answer (ASA)	08:49
Calls Answered in 60 Seconds (R/V)	33%
Average Talk Time (ATT)	05:56
Outbound Calls	4,353

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

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

Claims Department
February 2022 Final and March 2022 Final

METRICS

Claims Compliance	Feb-22	Mar-22
90% of clean claims processed within 30 calendar days	98.8%	98.2%
95% of all claims processed within 45 working days	99.9%	99.9%

Claims Volume (Received)	Feb-22	Mar-22
Paper claims	22,386	28,901
EDI claims	140,047	156,837
Claim Volume Total	**162,433**	**185,738**

Percentage of Claims Volume by Submission Method	Feb-22	Mar-22
% Paper	13.78%	15.56%
% EDI	86.22%	84.44%

Claims Processed	Feb-22	Mar-22
HEALTHsuite Paid (original claims)	106,093	138,388
HEALTHsuite Denied (original claims)	46,104	59,276
HEALTHsuite Original Claims Sub-Total	**152,197**	**197,664**
HEALTHsuite Adjustments	952	3,694
HEALTHsuite Total	**153,149**	**201,358**

Claims Expense	Feb-22	Mar-22
Medical Claims Paid	$50,549,917	$66,699,289
Interest Paid	$29,329	$42,308

Auto Adjudication	Feb-22	Mar-22
Claims Auto Adjudicated	127,197	163,706
% Auto Adjudicated	83.6%	82.8%

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

Pended Claim Age	Feb-22	Mar-22
0-29 calendar days		
HEALTHsuite	15,305	13,594
30-59 calendar days		
HEALTHsuite	134	152
Over 60 calendar days		
HEALTHsuite	1	0

Overall Denial Rate	Feb-22	Mar-22
Claims denied in HEALTHsuite	46,104	59,276
% Denied	30.1%	29.4%

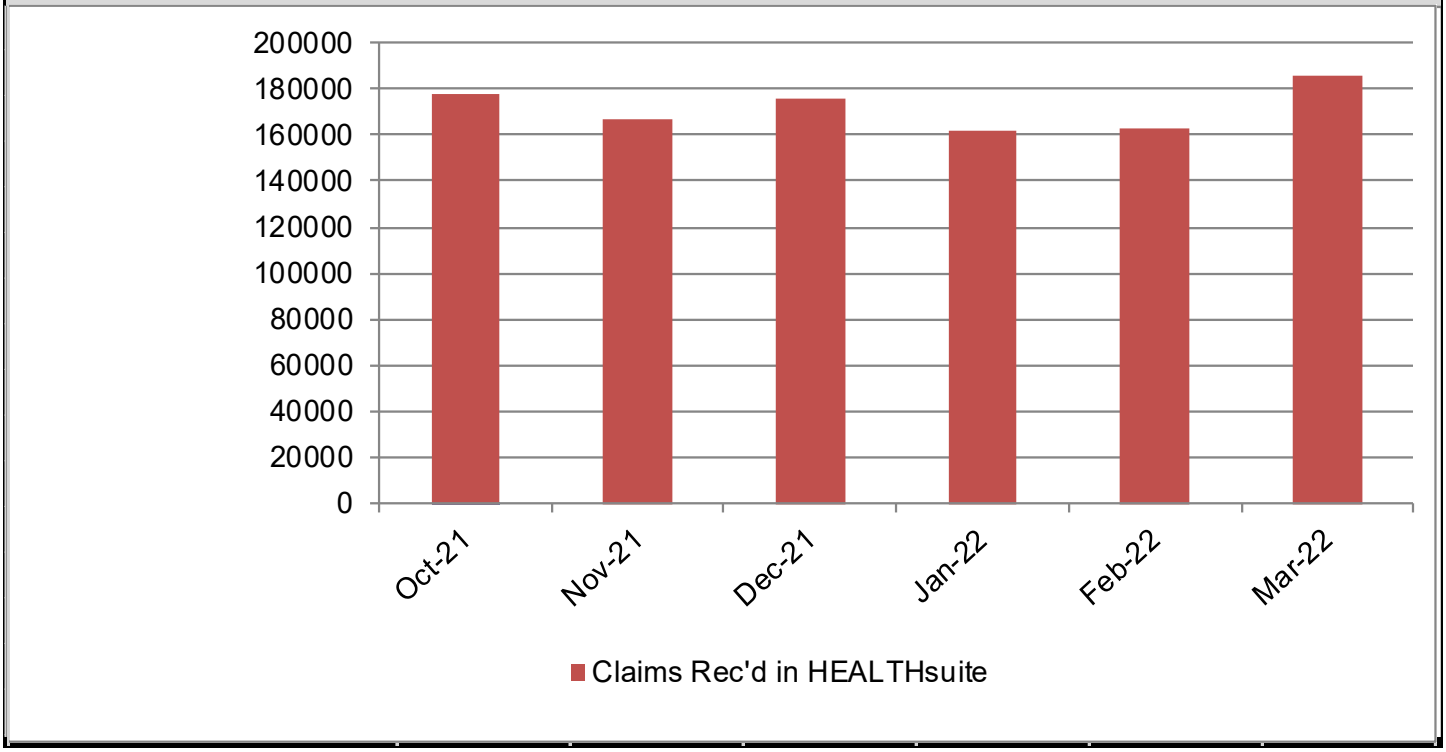
Claims Department
February 2022 Final and March 2022 Final

Mar-22

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	26%
No Benefits Found For Dates of Service	14%
Non-Covered Benefit for this Plan	10%
Duplicate Claim	9%
This is a Capitated Service	5%
% Total of all denials	**64%**

Claims Received By Month

Claims Received Through	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Claims Rec'd in HEALTHsuite	177,483	167,057	175,441	162,201	162,433	185,738



Provider Relations Dashboard March 2022

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

Provider Relations Dashboard March 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%									
Benefits	4.1%	3.4%	3.1%									
Claims Inquiry	40.2%	41.5%	40.8%									
Change of PCP	2.4%	4.0%	4.8%									
Complaint/Grievance (includes PDR's)	4.9%	5.3%	4.8%									
Contracts	0.5%	0.7%	0.8%									
Correspondence Question/Followup	0.0%	0.1%	0.1%									
Demographic Change	0.1%	0.3%	0.0%									
Eligibility - Call from Provider	25.3%	23.2%	22.6%									
Exempt Grievance/ G&A	0.0%	0.1%	0.0%									
General Inquiry/Non member	0.0%	0.0%	0.0%									
Health Education	0.0%	0.0%	0.0%									
Intrepreter Services Request	0.8%	0.4%	0.8%									
Kaiser	0.0%	0.1%	0.1%									
Member bill	0.0%	0.2%	0.0%									
Mystery Shopper Call	0.0%	0.0%	0.0%									
Provider Portal Assistance	4.5%	5.4%	4.9%									
Pharmacy	1.2%	0.3%	0.3%									
Provider Network Info	0.1%	0.1%	0.2%									
Transferred Call	0.0%	0.0%	0.0%									
All Other Calls	12.3%	10.8%	13.4%									
TOTAL	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

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

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS

Practitioners		AHP 406	PCP 361	SPEC 629	PCP/SPEC 14
AAH/AHS/CHCN Breakdown		AAH 388	AHS 298	CHCN 443	COMBINATION OF GROUPS 281
Facilities	**295**				

VENDOR SUMMARY
Credentialing Verification Organization, Symply CVO

	Number	Average Calendar Days in Process	Goal - Business Days	Goal - 98% Accuracy	Compliant
Initial Files in Process	19	23	25	Y	Y
Recred Files in Process	20	14	25	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**39**				

CAQH Applications Processed in February 2022

	Invoice not received
Standard Providers and Allied Health	

March 2022 Peer Review and Credentialing Committee Approvals

Initial Credentialing	Number
PCP	9
SPEC	14
ANCILLARY	3
MIDLEVEL/AHP	12
	38
Recredentialing	
PCP	7
SPEC	12
ANCILLARY	1
MIDLEVEL/AHP	5
	25
TOTAL	**63**

March 2022 Facility Approvals

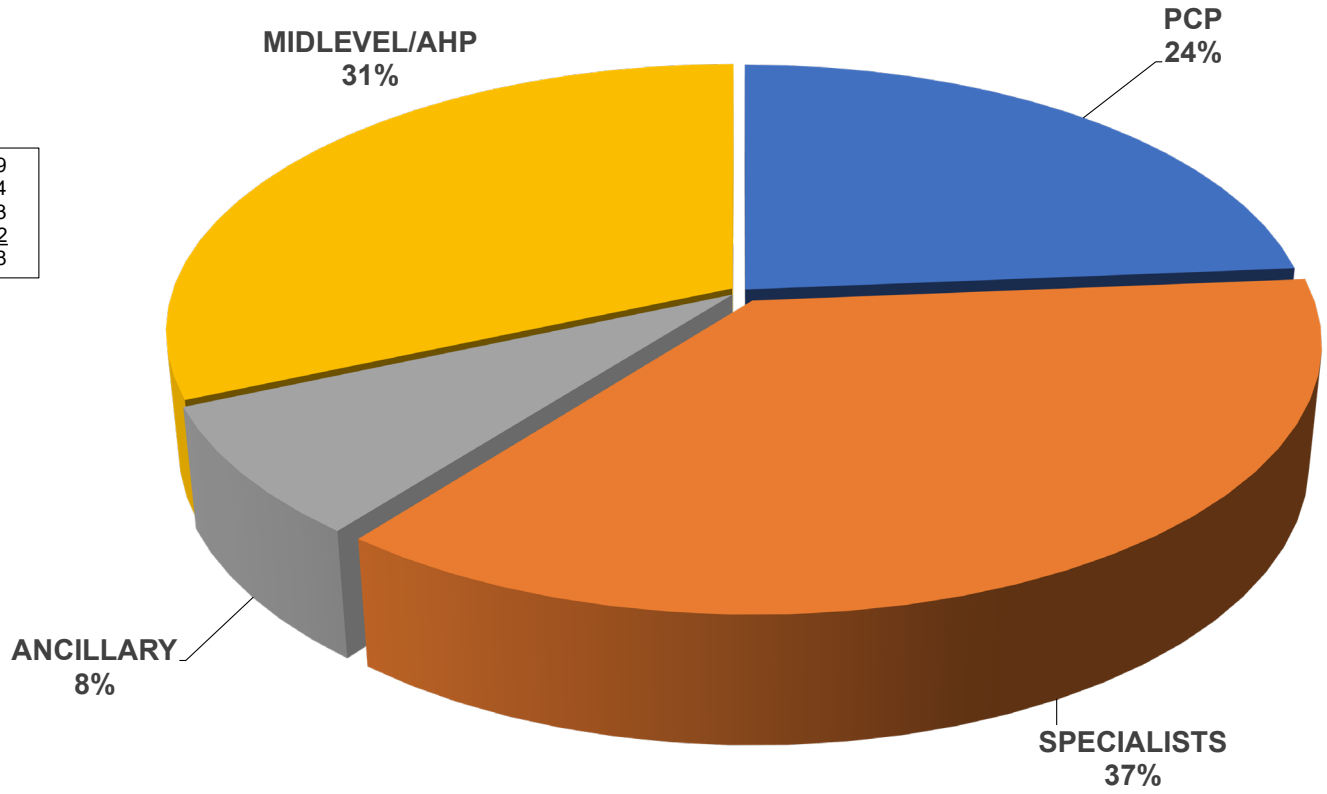
Initial Credentialing	1
Recredentialing	6
	7
Facility Files in Process	**28**

March 2022 Employee Metrics	4	
File Processing	Timely processing within 3 days of receipt	Y
Credentialing Accuracy	<3% error rate	Y
DHCS, DMHC, CMS, NCQA Compliant	98%	Y
MBC Monitoring	Timely processing within 3 days of receipt	Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Aggarwal	Sonal	Primary Care Physician	Initial	3/15/2022
Altshuler	Anna	Specialist	Initial	3/15/2022
Alvarez-Nutting	Mary	Allied Health	Initial	3/15/2022
Antwi-Badu	Philip	Allied Health	Initial	3/15/2022
Bowens	LaTonya	Allied Health	Initial	3/15/2022
Bunker-Alberts	Michele	Allied Health	Initial	3/15/2022
Carrillo	America	Allied Health	Initial	3/15/2022
Concepcion	Noel	Specialist	Initial	3/15/2022
Currie	Peter	Specialist	Initial	3/15/2022
Czestochowski	Stefan	Primary Care Physician	Initial	3/15/2022
Do	Tri	Primary Care Physician	Initial	3/15/2022
Feldman	Gary	Primary Care Physician	Initial	3/15/2022
Fernandez	Maiyu	Ancillary	Initial	3/15/2022
Golden	Donald	Primary Care Physician	Initial	3/15/2022
Hart	Britton	Allied Health	Initial	3/15/2022
Huang	Erika	Allied Health	Initial	3/15/2022
Jacka	Ciaran	Specialist	Initial	3/15/2022
Jothi	Sumana	Specialist	Initial	3/15/2022
Khan	Tanveer	Specialist	Initial	3/15/2022
Kleinsinger	Fredrick	Primary Care Physician	Initial	3/15/2022
Marroquin-Lopez	Madeline	Allied Health	Initial	3/15/2022
Mikkineni	Karthik	Specialist	Initial	3/15/2022
Patel	Krushangi	Specialist	Initial	3/15/2022
Peterson	Michael	Specialist	Initial	3/15/2022
Pyle	Lorna	Allied Health	Initial	3/15/2022
Ramachandra	Srinivas	Specialist	Initial	3/15/2022
Richmond	Stephen	Primary Care Physician	Initial	3/15/2022
Riordan	Nolli	Specialist	Initial	3/15/2022
Roitshteyn	Misha	Primary Care Physician	Initial	3/15/2022
Shrader	Kathleen	Allied Health	Initial	3/15/2022
Silvis	Janelle	Ancillary	Initial	3/15/2022
Slome	Sally	Primary Care Physician	Initial	3/15/2022
Sterkina	Viktoriya	Allied Health	Initial	3/15/2022
Toma	Marissa	Specialist	Initial	3/15/2022
Uchiyama	Merry	Specialist	Initial	3/15/2022
Valliani	Salimah	Specialist	Initial	3/15/2022
Vargas	Berenise	Ancillary	Initial	3/15/2022
Waterstraut	Carly	Allied Health	Initial	3/15/2022
Bonnel	Galadriel	Allied Health	Recred	3/15/2022
Carper	John	Primary Care Physician	Recred	3/15/2022
Chan	Vanessa	Specialist	Recred	3/15/2022
Devane	Matthew	Specialist	Recred	3/15/2022
Dugoni	William	Specialist	Recred	3/15/2022
Enteen	Lauren	Allied Health	Recred	3/15/2022
Farahmand	Guity	Specialist	Recred	3/15/2022
Georgis	Martha	Allied Health	Recred	3/15/2022
Hopson	Christina	Specialist	Recred	3/15/2022
Ito	Timothy	Specialist	Recred	3/15/2022
Jain	Aditya	Primary Care Physician and Specialist	Recred	3/15/2022
Kim	Jin	Primary Care Physician and Specialist	Recred	3/15/2022
Knight	Lynmarie	Allied Health	Recred	3/15/2022
Lam	Felicia	Primary Care Physician	Recred	3/15/2022
Law	Abraham	Primary Care Physician	Recred	3/15/2022
Le-Tran	Vivian	Specialist	Recred	3/15/2022
Lenoir	Michael	Primary Care Physician and Specialist	Recred	3/15/2022
Leung	Man	Specialist	Recred	3/15/2022
Lomeli-Loibl	Cadelba	Allied Health	Recred	3/15/2022
Pierce	Lasha	Specialist	Recred	3/15/2022
Reynolds	Kerisimasi	Specialist	Recred	3/15/2022
Ullal	Monish	Primary Care Physician	Recred	3/15/2022
Van Tassel	Jason	Specialist	Recred	3/15/2022
Wei	Wei Jane	Ancillary	Recred	3/15/2022
Xu	Weiwei	Specialist	Recred	3/15/2022

MARCH PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY

PCP	9
Specialists	14
Ancillary	3
MIDLEVEL/AHP	12
Total	38



Provider Dispute Resolution
February 2022 and March 2022

METRICS

PDR Compliance	Feb-22	Mar-22
# of PDRs Resolved	815	1,028
# Resolved Within 45 Working Days	815	1,025
% of PDRs Resolved Within 45 Working Days	100.0%	99.7%

PDRs Received	Feb-22	Mar-22
# of PDRs Received	709	788
PDR Volume Total	**709**	**788**

PDRs Resolved	Feb-22	Mar-22
# of PDRs Upheld	580	729
% of PDRs Upheld	71%	71%
# of PDRs Overturned	235	299
% of PDRs Overturned	29%	29%
Total # of PDRs Resolved	**815**	**1,028**

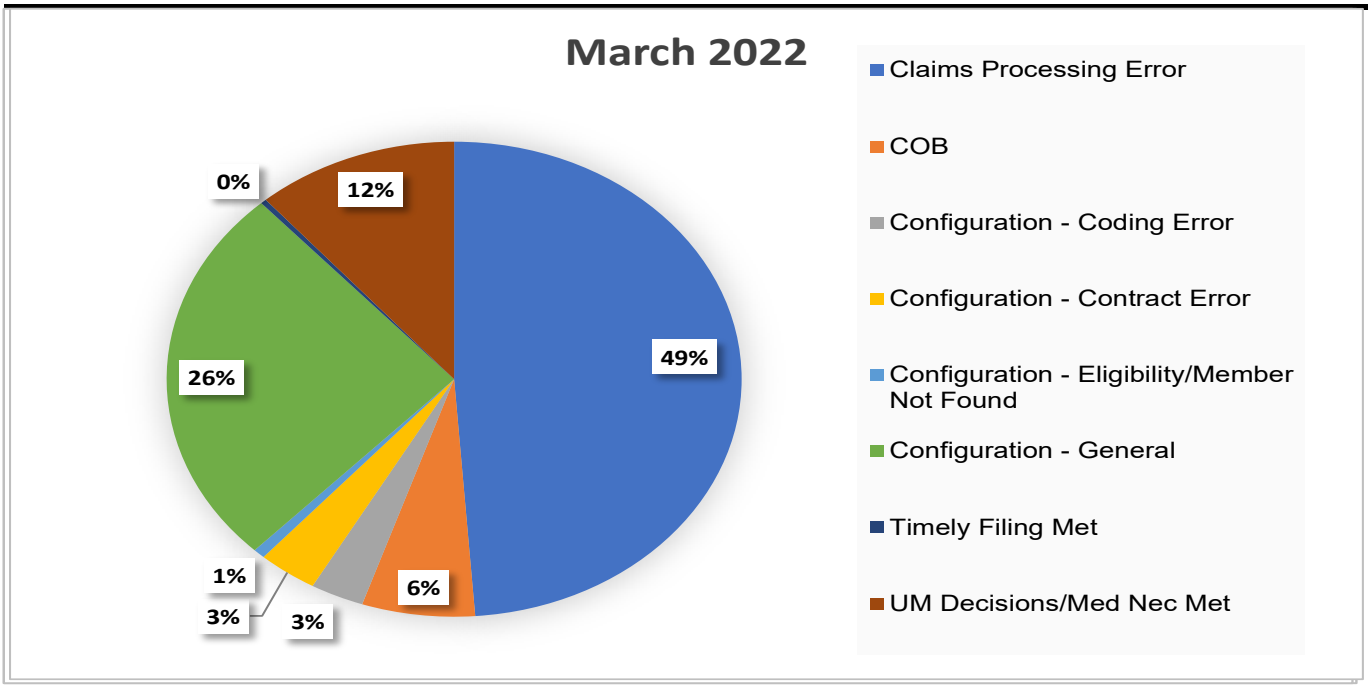
Average Turnaround Time	Feb-22	Mar-22
Average # of Days to Resolve PDRs	31	27
Oldest Unresolved PDR in Days	45	45

Unresolved PDR Age	Feb-22	Mar-22
0-45 Working Days	905	889
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**905**	**889**

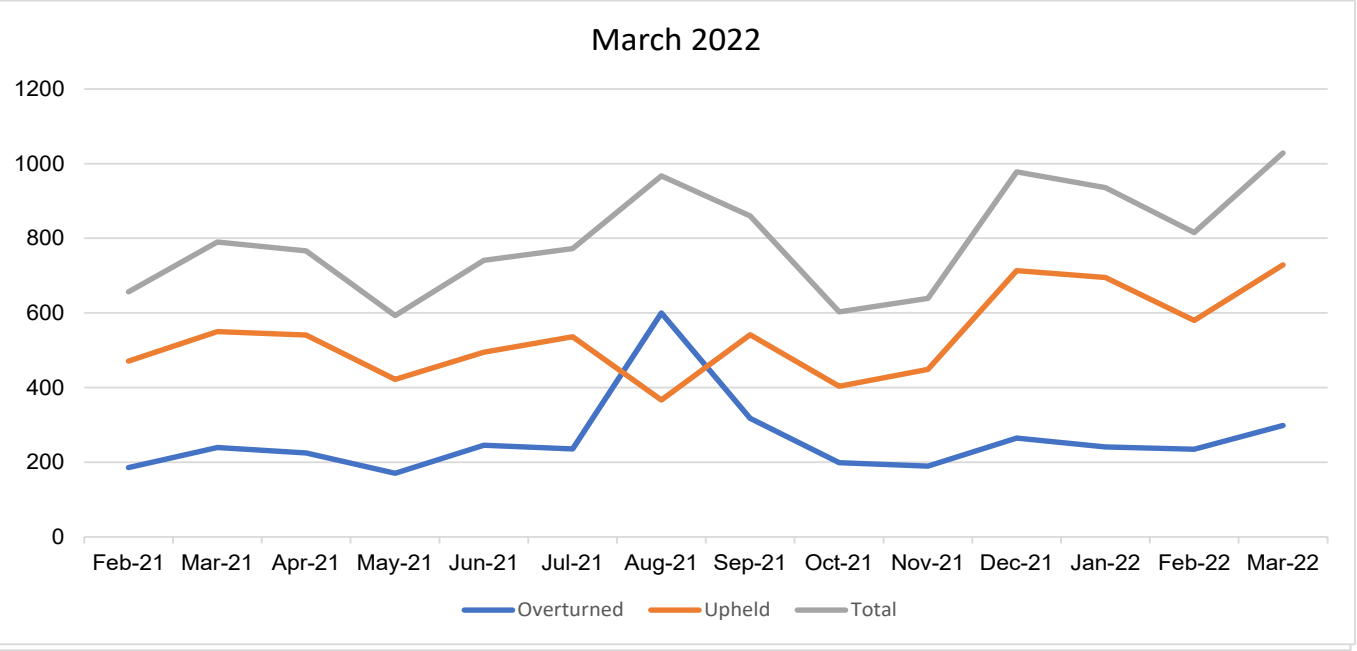
Provider Dispute Resolution
February 2022 and March 2022

Mar-22

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Between January 2022 and March 2022, the Alliance completed **1,013**-member orientation outreach calls and conducted **309** member orientations (**31%-member** participation rate). In addition, in Q3 2022, the Outreach team completed **255** Alliance website inquiries.

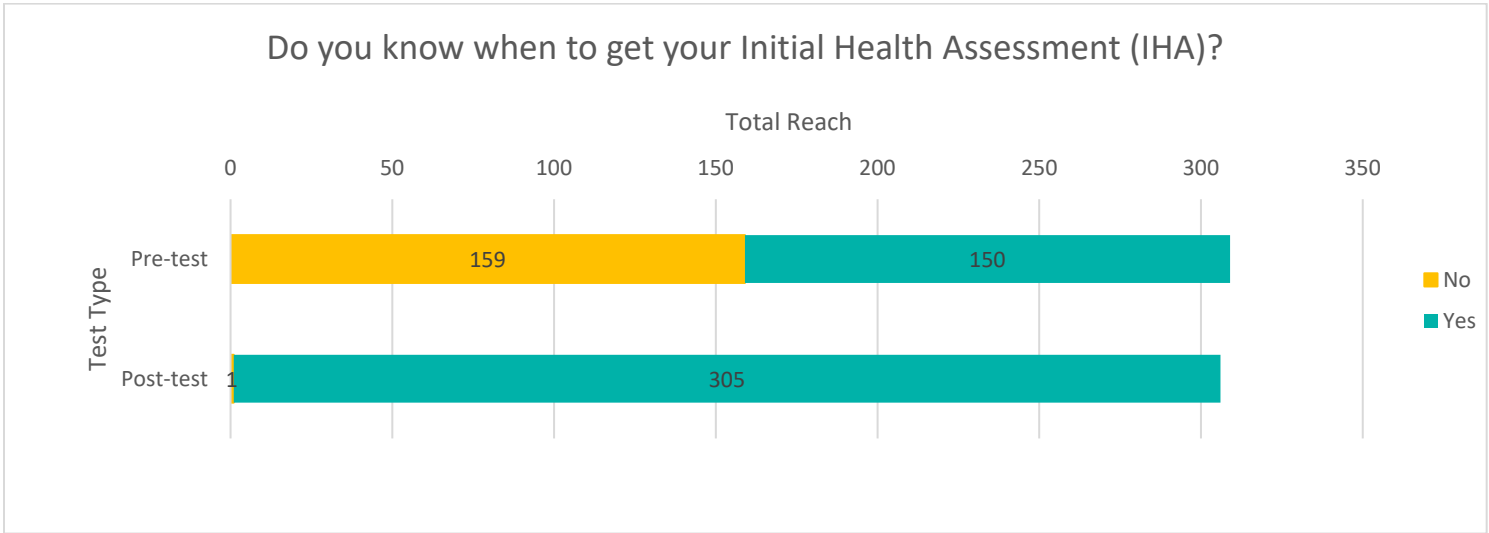
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **24,898** self-identified Alliance members have been reached during outreach activities.

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 the 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 March 31st, 2022, the Outreach Team completed **17,970**-member orientation outreach calls and conducted **5,073** member orientations (**28%-member** participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18, 2020, through March 31, 2022) – **5,073** members completed our MO program by phone.

After completing a MO **99.7%** of members who completed the post-test survey in Q3 FY 21-22 reported knowing when to get their IHA, compared to only **48.5%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 21-22\Q3\3. March 2022**

Q3 FY 2021-2022 TOTALS

0	VIRTUAL COMMUNITY EVENTS	0	TOTAL REACHED AT VIRTUAL COMMUNITY EVENTS
0	MEMBER EDUCATION EVENTS	0	TOTAL REACHED AT MEMBER EDUCATION EVENTS
309	MEMBER ORIENTATIONS	309	TOTAL REACHED AT MEMBER ORIENTATIONS
0	MEETINGS/ PRESENTATIONS	0	TOTAL REACHED AT MEETINGS/PRESENTATIONS
0	TOTAL INITIATED/INVITED EVENTS	0	TOTAL MEMBERS REACHED AT EVENTS
309	TOTAL EVENTS	309	TOTAL REACHED AT ALL EVENTS

ALAMEDA
ALBANY
BERKELEY
CASTRO VALLEY
DUBLIN
FREMONT
HAYWARD
LIVERMORE
NEWARK
OAKLAND
PLEASANTON
SAN LEANDRO
SAN LORENZO
UNION CITY

TOTAL REACH 19 CITIES

**Cities represent the mailing addresses for members who completed a Member Orientation by phone. The italicized cities are outside of Alameda County. The following cities had <1% reach during Q3 2022: Elk Grove,* Emeryville, *Los Angeles, Portland, Minneapolis, Richmond, and San Francisco. The C&O Department started including these cities in the Q3 FY21 Outreach Report.*

$0

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

Compliance

Richard Golfin III

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

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

Date: **April 8th, 2022**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2022 DHCS Routine Medical Survey:
  - The 2022 DHCS Routine Medical Survey is currently underway. The audit began on April 4th, 2022 and will run through April 15th, 2022. The review period is April 1st, 2021, through March 31st, 2022. The Plan is being evaluated in the following areas:

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

  - To assist Staff in audit preparation, the Compliance Department conducted a series of 10 mock interview sessions, each session lasted from 1-1.5 hours. The Mock interview sessions took place from March 23rd, 2022, through March 31st, 2022. The sessions focused on the 6 DHCS areas of review bulleted above. Following each interview session, the Compliance Department distributed to Staff packets of information that contained audit tips, resources, and actual questions from the interviews. The supplemental packets will further support staff in their audit preparation over the coming weeks.

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

- 2022 DMHC Behavioral Health Investigation:
  - In 2021, the DMHC began investigating full-service commercial health plans to evaluate and assess barriers providers experience in providing behavioral health services. The DMHC has announced it plans to conduct on average, 5-investigations per year with the first five plans having been investigated in 2021. Earlier this year, the DMHC announced the Plan would be a part of the Year 2 group of Plans investigated in the reviews. At

present, details on the scope of the audit are scant, however, Plans have been assured that the review will exclude Medi-Cal members.

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

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

- 2020 DHCS Kindred Focused Audit:
  - On October 23rd, 2020, the DHCS sent notice to the Plan of a focused audit involving the Plan's delegate, CHCN, and Kindred facilities. The Plan submitted its CAP response and available supporting documents to the DHCS on April 6th, 2021. The Plan is currently tracking towards its stated CAP milestones which involves Audits of the delegate's Concurrent Review Process and Notice of Action letters. The Plan anticipates its next follow-up audit will take place in early May 2022.

Delegation Oversight Audit Activity Updates

- The Delegation Oversight Committee met on March 15th, 2022. In this meeting the following topics and performance metrics were discussed:
  - All delegates met program performance metrics for Q4, 2021.
  - In order to accommodate the 2022 DHCS Full Medical Survey, the final audit reports for CHCN and Beacon have been delayed until after the audit. The reports are expected to be issued by May 6th, 2022.
  - The 2022 Delegation Audit Schedule was reviewed and discussed.
  - The 2022 Delegation Audit Grid was reviewed and discussed.

Compliance Activity Updates

- 2021 DMHC Measurement Year (MY) Timely Access Survey:
  - The DMHC requires health plans to measure timely access in an annual assessment, due to the DMHC by March 31st of each year. Due to DMHC's observance of Caesar Chavez Day on March 31st, 2022, the due date has been extended to April 1st, 2022. The annual submission is a multi-departmental effort that takes more than 8-weeks to complete. As of March 31st, 2022, the Plan was approximately 95% complete.

- 2021 DHCS Annual Network Certification & Subcontractor Network Certification:

- On March 22nd, 2022, the DHCS notified the Plan of its approval of the Subcontractor Network Certification (SNC) Readiness Plan. Through this notification, the Department asserts that the Plan's subcontracted network meets the requirements outlined in the 2021 Network Certification Rules. The timeline for the ANC will change in 2022. New filing requirements are expected in the coming months.

Compliance

Supporting Documents

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

2022 APL/PL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
10	DHCS	22-002	3/14/2022	ALTERNATIVE FORMAT SELECTION FOR MEMBERS WITH VISUAL IMPAIRMENTS	MEDI-CAL & GROUP CARE	The purpose of this All Plan Letter (APL) is to provide information about the Department of Health Care Services' (DHCS) processes to ensure effective communication with members with visual impairments or other disabilities requiring the provision of written materials in alternative formats, by tracking members' alternative format selections (AFS).
11	DMHC	22-009	3/16/2022	PROVIDER DIRECTORY ANNUAL FILING REQUIREMENTS	MEDI-CAL & GROUP CARE	California Health and Safety Code section 1367.27, subdivision (m), requires health care service plans to annually submit provider directory policies and procedures to the Department of Managed Health Care (Department).
12	DMHC	22-010	3/17/2022	GUIDANCE REGARDING AB 1184 - CONFIDENTIALITY OF MEDICAL INFORMATION	MEDI-CAL & GROUP CARE	On September 22, 2021, Governor Gavin Newsom signed AB 1184, which amends the Confidentiality of Medical Information Act to require plans to take specified steps to protect the confidentiality of a subscriber's or enrollee's medical information.
13	DHCS	22-003	3/17/2022	MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITY TO PROVIDE SERVICES TO MEMBERS WITH EATING DISORDERS	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with clarification and guidance regarding their responsibility to coordinate and provide medically necessary services for members who are diagnosed with feeding and eating disorders and are currently receiving Specialty Mental Health Services (SMHS) from a county Mental Health Plan (MHP). Corresponding guidance to MHPs is contained in Behavioral Health Information Notice (BHIN) 22-009.
14	DHCS	22-004	3/17/2022	STRATEGIC APPROACHES FOR USE BY MANAGED CARE PLANS TO MAXIMIZE CONTINUTIY OF COVERAGE AS NORMAL ELIGIBILITY AND ENROLLMENT OPERATIONS RESUME	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide instruction to Medi-Cal managed care health plans (MCPs) about strategies that must be used by MCPs in collaboration with counties to help ensure eligible beneficiaries retain coverage in Medi-Cal and ease transitions for individuals eligible for coverage through Covered California as the Department of Health Care Services (DHCS) prepares for the resumption of normal operations after the end of the COVID-19 Public Health Emergency (PHE).
15	DMHC	22-011	3/21/2022	NO SURPRISES ACT (NSA) GUIDANCE	GROUP CARE	Effective for plan years beginning on or after January 1, 2022, the NSA prohibits surprise balance billing, as specified, and establishes other consumer protections. To date, the federal government has issued four rulemaking packages, issued guidance, and established a dedicated web page, No Surprises to implement the NSA.
16	DMHC	22-012	3/24/2022	SECTION 1357.503 COMPLIANCE AND MEWA REGISTRATION	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to inform health care service plans (Plans) and association of employers defined as multiple employer welfare arrangement (MEWA) of the requirements of SB 255 (Portantino, Ch. 725, Stats. 2021) and SB 718 (Bates, Ch. 736, Stats. 2021), including California Health and Safety Code section 1357.503. This APL discusses the requirements of Section 1357.503, including requirements of Plans, registration of MEWAs, and other requirements.
17	DHCS	22-005	3/30/2022	NO WRONG DOOR FOR MENTAL HEALTH SERVICES POLICY	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCP) with guidance and clarification regarding the No Wrong Door for Mental Health Services policy. This policy ensures that members receive timely mental health services without delay regardless of the delivery system where they seek care and that members are able to maintain treatment relationships with trusted providers without interruption.

ALAMEDA Alliance FOR HEALTH

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

Health Care Services

Steve O'Brien, MD

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

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

Date: **April 8th, 2022**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

- DHCS 2022 audit: The team has submitted all requested documents and case files for review by DHCS and is receiving clarifying questions from DHCS. The Team is now preparing for interviews with DHCS.

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

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

- Progress continues with UM/Claims/Configuration alignment. Standardization improves accuracy and timeliness of claims payment through appropriate data integration between the authorization process and the claims processing. This results in fewer instances of accrued interest because of claim payment delays.

- The carve in of Major Organ Transplant/Bone Marrow Transplant (MOT/BMT) went live on 1/1/2022. So far, 65 members in various stages of the Transplant process are being managed, and the systems developed to coordinate care are working well.

- CCS process enhancements are underway to integrate into a larger EPSDT strategy. Reports on shared members and workflows are being refined and will be used to enhance the coordination of care between AAH and CCS on our mutual members under age 21.

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

Outpatient Authorization Denial Rates			
Denial Rate Type	**Jan 2022**	**Feb 2022**	**March 2022**
Overall Denial Rate	**4.2%**	**4.1%**	**3.5%**
Denial Rate Excluding Partial Denials	**3.6%**	**3.6%**	**2.9%**
Partial Denial Rate	**0.6%**	**0.5%**	**0.6%**

Turn Around Time Compliance			
Line of Business	**Jan 2022**	**Feb 2022**	**March 2022**
Overall	**97%**	**98%**	**98%**
Medi-Cal	**97%**	**98%**	**98%**
IHSS	**99%**	**100%**	**100%**
Benchmark	***95%***	***95%***	***95%***

Utilization Management: Inpatient

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

- Inpatient department continues to track COVID admissions which have dropped precipitously, consistent with Alameda County data. There are also fewer Intensive Care days than in the earlier time periods.

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

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

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

Inpatient Med-Surg Utilization to Update Total All Aid Categories **Actuals (excludes Maternity)**			
Metric	**Dec 2021**	**Jan 2022**	**Feb 2022**
Authorized LOS	**5.6**	**5.4**	**4.8**
Admits/1,000	**56.4**	**52.1**	**51.5**
Days/1,000	**316.3**	**283.9**	**248.4**

Pharmacy

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

Decisions	Number of PAs Processed
Approved	17
Denied	31
Closed	59
Total	**107**

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

- Medications for pain, diabetes, hypercholesterolemia, nausea, hepatitis B, antifibrinolytic, antirheumatic, and dry eye disease are the top 10 categories for denials, as outlined in the table below.

Rank	Drug Name	Common Use	Common Denial Reason
1	LIDOCAINE 5% PATCHES	Pain	Criteria for approval not met
2	JARDIANCE 10 MG TABLET	Diabetes	Criteria for approval not met
3	BASAGLAR 100 UNIT/ML KWIKPEN	Diabetes	Criteria for approval not met
4	JANUVIA 50 MG TABLET	Diabetes	Criteria for approval not met
5	ZYPITAMAG 4 MG TABLET	Hypercholesterolemia	Criteria for approval not met
6	SCOPOLAMINE 1 MG/3 DAY PATCH	Nausea	Criteria for approval not met
7	VEMLIDY 25MG TABLET	Hepatitis B	Criteria for approval not met
8	TRANEXAMIC ACID 650 MG TABLET	Antifibrinolytic	Criteria for approval not met
9	HYALGAN 20 MG/2 ML SYRINGE	Antirheumatic	Criteria for approval not met
10	XIIDRA 5% EYE DROPS	Dry Eye Disease	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 March 11, Medi-Cal Rx has:
        - Processed more than 22.84 million point-of-sale pharmacy paid claims with a sub second response time to participating pharmacies totaling more than $2.6 billion in payments
        - Processed more than 152,000 prior authorizations. PA continues to decline with a reduction by over 70%.
        - Answered 241,000 calls and 100 percent of virtual hold calls and voicemails have been returned.
        - The most edits/PA/limitations have been removed/lifted with no definite date until the DHCS decides otherwise.
    - AAH has been communicating with its Medi-Cal providers to keep them up to date via fax blast, quarterly packets and through its provider portal to help ensure that they have the most updated information as things evolve with Carve Out.
    - Our PBM, PerformRX, is closing out submitted Medi-Cal PAs and informing doctor offices to submit to Magellan:
        - Jan 2022: 169
        - Feb 2022: 44
        - March 2022: 31

    - The AAH Pharmacy department is collaborating with the IT and analytics department to organize the data we receive from the state in useable report formats that allow us to execute clinical initiatives to help better serve our Medi-Cal members.

- Pharmacy Services continues to collaborate with other Health Care Services teams for monitoring members use of opioids and/or benzodiazepines.

- The AAH Pharmacy Department is continuing to grow its new TOC (Transition of Care) program with the AAH Case Management Disease Management (CMDM) Department to reduce the number of re-hospitalizations after members are discharged from hospitals through education to the members as well as filling potential gaps between providers and their patients.

- As a result of an AAH population needs assessment, Pharmacy Services, QI, HealthEd and Case Management worked together to improve drug adherence for 200 Black adults with asthma between 21 to 44 years of age with asthma medication possession rate of 50% or below.

    - Our poster will be presented at the 2022 CMS Quality Conference Virtual Gallery Walk. This poster will also be provided in the:
        - DHCS QI toolkit due to DHCS specific request (will also be shared with other MCPs)
        - DHCS DUR Board Meeting
    - Our third group of member outreach calls are about complete.
    - Efforts to include asthma affinity survey as TruCare assessment is in motion.
    - Smoking cessation questionnaire will be included in TOC pharmacy consultation assessment.

- Pharmacy continues leading initiatives on PAD focused internal and external partnership and biosimilar optimization.

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

Case and Disease Management

- Population health-driven, disease-specific case management bundles (standard sets of actions developed to address the specific needs of members with significant diseases) continue development. Major Organ Transplant (MOT) CM bundle was deployed on 1/1/22, and the volume is higher than anticipated, (65 cases YTD) The processes to support the members is working well.

- Dialysis CM bundle work has begun with the DaVita Shared Patient Care Coordination, (SPCC) program. CM works with DaVita on very high-risk members to ensure wrap around support so that the member can successfully manage their dialysis needs.

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

- DHCS audit: Action Plans on CM findings from the DHCS audit is being monitored and continues to demonstrate consistent compliance with requirements. The CM team expects to field questions on the annual DHCS audit on these findings.

- NCQA 2022: CM team is gathering documents that address the NCQA PHM standards for submission to NCQA in June 2022.

Case Type	New Cases Opened in Jan 2022	Total Open Cases as of Jan 2022	New Cases Opened in Feb 2022	Total Open Cases as of Feb 2022
Care Coordination	223	503	278	541
Complex Case Management	15	54	27	62
Transitions of Care (TOC)	262	525	254	489
ECM	TBD	1024	TBD	1004

Enhanced Case Management and Community Supports Services

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

- Community Supports: CS services are cost-effective services 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 CS policy and procedures and workflows have been configurated into TruCare CM software and staff trained on their roles. The planned staff for the CS program have been hired and are in training.

- Members are starting to receive services through the program, and increased volume is starting to be seen. Outcomes will be closely tracked and reported to the State.

Community Supports	Services Started in Jan 2021	Services Started in Feb 2021
Housing Navigation	8	10
Housing Deposits	0	1
Housing Tenancy	4	13
Asthma Remediation	1	5
Medical Food	24	16
Medical Respite	10	1

Grievances & Appeals

- All standard grievance cases were resolved within the goal of 95% within regulatory timeframes; however, expedited grievances were not resolved within our goal of 95%.

    - Expedited Grievances: During the month of March, 59 complaints came from members that were originally logged as expedited and all but 5 were de-expedited within the required timeframe.

      Of the remaining 5 cases, 3 were not adjudicated within expedited timeframes and were out of compliance:

        - Two cases were originally logged as standard and then identified as expedited by the G&A Department after the 72-hour timeframe for resolution had passed. Action: Staff training has been provided that explains the process for identifying and logging expedited cases.

        - One case was changed from expedited to standard in error by G&A Department staff. Action: A change was made in our G&A system, Quality Suite, to only allow access to update the priority of a case to certain level of employees in the G&A Department.

- Total grievances resolved in March were 6.02 complaints per 1,000 members.

- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of March 2022; we did not meet our goal at 38.1% overturn rate.

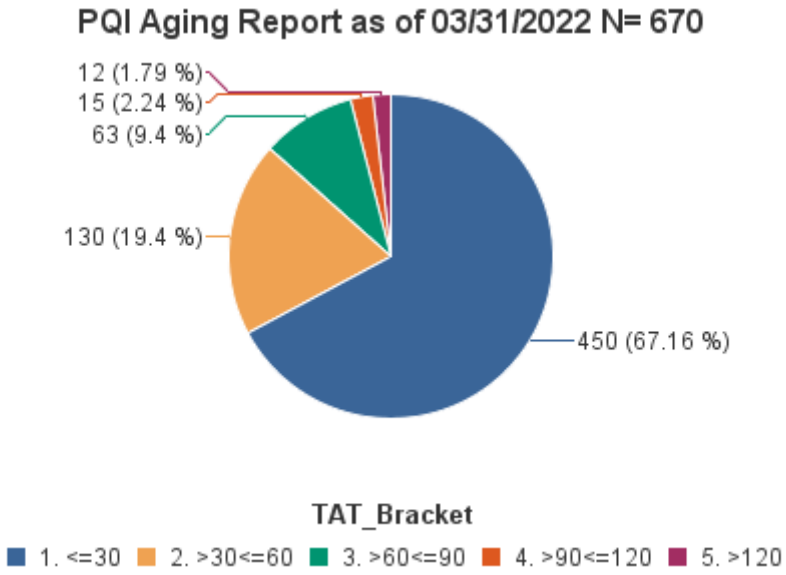
March 2022 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	625	30 Calendar Days	95% compliance within standard	597	95.5%	2.04
Expedited Grievance	5	72 Hours	95% compliance within standard	2	40.0%	0.02
Exempt Grievance	1,196	Next Business Day	95% compliance within standard	1,196	100.0%	3.90
Standard Appeal	21	30 Calendar Days	95% compliance within standard	20	95.2%	0.07
Expedited Appeal	0	72 Hours	95% compliance within standard	NA	NA	NA
Total Cases:	1,847		95% compliance within standard	1,815	98.3%	6.02

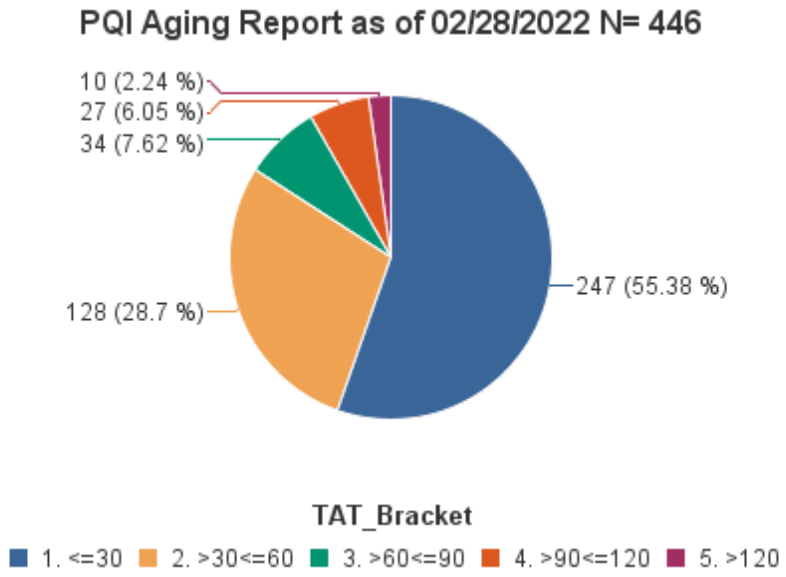
*Calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1000.

- 2022 NCQA Accreditation Resurvey:
    - We are being surveyed against the 2021 Health Plan Standards and Guidelines with a look back period of up to June 2019 through June 2022.
    - Both Lines of Business, Medi-Cal and Commercial, will be surveyed for Health Plan Accreditation.
    - Pre-submission deliverables due on April 26th, 2022.
    - Submission Date on June 7th, 2022.
    - Onsite Survey: File Review and Closing Conference Presentation on July 25th, 2022 through July 26th, 2022.

Quality

- Potential Quality Issues: Quality continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our aging report month-to-month goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records. PQI cases open > 120 days made up 1.79% of total cases for March with a noted increase of 224 cases in March when compared to February. Cases open for >120 days are primarily related to delay in submission of medical records by specific providers. Medical record procurement TAT greatly improved month-over-month due to increase staff outreach and return response by providers. Quality continues to work with providers to identify operations barriers in medical record procurement to maintain a TAT goal of < 5% for cases open >120 days. March also noted that TAT for cases open >90 days decreased by 3.81% from February. Increase in PQI TAT case closure is also due to a return to adequate RN review nurse staffing numbers.


PQI Aging Report as of 03/31/2022 N= 670
12 (1.79 %)
15 (2.24 %)
63 (9.4 %)
130 (19.4 %)
450 (67.16 %)
TAT_Bracket
1. <=30
2. >30<=60
3. >60<=90
4. >90<=120
5. >120


PQI Aging Report as of 02/28/2022 N= 446
10 (2.24 %)
27 (6.05 %)
34 (7.62 %)
128 (28.7 %)
247 (55.38 %)
TAT_Bracket
1. <=30
2. >30<=60
3. >60<=90
4. >90<=120
5. >120

Cultural and Linguistic Services

- The Alliance 2021 Cultural and Linguistic Services Program Evaluation highlights:

    - Added Tagalog as a threshold language.
    - Supported over 40,000 in person, telephonic, and video health care interactions with interpreter services. Services were offered in 85 languages by 4 different vendors.
    - Averaged 98% fulfillment rate for all interpreter services, exceeding our goal of 95%.
    - Made over 200 provider contacts to provide support and education regarding interpreter services.
    - Maintained a positive response on the Member Satisfaction Survey, CG-CAHPS to the survey question: "*Were you able to communicate with your doctor and clinic staff in your preferred language?*"

Favorable Response Rate	2020	2021
Adult	83.7%	84.4%
Child	91.4%	93.0%

    - Maintained a favorable count of members per PCP by language throughout 2021 for both Medi-Cal and Group Care.

        - For Medi-Cal, Vietnamese has the highest ratio (451 members per PCP).
        - For Group Care, Chinese has the highest ratio (19 members per PCP).

    - Implemented the annal Cultural Sensitivity Training for 99% of Alliance staff and distributed a provider version to the Alliance provider network. The 2021 training received input from a broad diversity of staff and included multi-cultural presenters.

- Cultural and linguistic Services Program 2022 Workplan highlights:

    - The Member Advisory Committee (MAC) has several member vacancies to be filled. The Alliance will be recruiting for at least three new MAC members focusing on recruitment of men, members ages 19 – 44, members with English as a Second Language, and members of diverse cultures.
    - Although the current Cultural and Sensitivity Training meets regulatory requirements, further training opportunities are needed to meet organizational goals for diversity, equity, and inclusion.
    - COVID-19 has increased the use of video conferencing for medical appointments. The Alliance plans to continue to provide interpreters for video appointments and expand capacity in this area.

ALAMEDA Alliance FOR HEALTH

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

Information Technology

Sasikumar Karaiyan

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

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

Date: **April 8th, 2022**

Subject: **Information Technology Report**

Call Center System Availability

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

Office 365 Initiative

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

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

- We plan to sunset our old solutions (Jabber Messenger and WebEx within 60 to 90 days based on adoption rate), and we are encouraging the staff to use Microsoft Teams as the primary application for chat and meetings.

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

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

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

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

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

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

Disaster Recovery and Business Continuity

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

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

- The project kicked-off on the 2nd week of March 2022.

- Discovery meetings has been scheduled to capture and document the network infrastructure and end to end application workflows for each application under the tier 1 group.

IT Security Program

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

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

- Cyber Security is at 38% complete, M365 is at 83% complete, and Azure 73% and overall, 58% complete for high-severity items.

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

    - **Key initiatives include:**

        - Remediating issues from security assessments. (e.g. Cyber, Microsoft Office 365, & Azure Cloud).

- Create, update, and implement policies and procedures to operationalize and maintain security level after remediation.

- Set up extended support for monitoring, alerting and supplementary support in cases of security issues.

- Implement Security Information and Event Management (SIEM) tool for the enterprise to provide real-time visibility across the organization's information security systems.

Encounter Data

- In the month of March 2022, the Alliance submitted 128 encounter files to the Department of Health Care Services (DHCS) with a total of 304,317 encounters.

Enrollment

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

HealthSuite

- A total of 197,664 claims were processed in the month of March 2022 out of which 163,706 claims auto adjudicated. This sets the auto-adjudication rate for this period to 82.8%.

- Experienced a partial application service outage with HealthSuite on March 21st that lasted 2 hours. This impacted backend claims processing jobs, but the system was available for users and all the remaining functions were working as expected.

TruCare

- A total of 13,916 authorizations were loaded and processed in the TruCare application.

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

- The Alliance has started the process of upgrade to TruCare Clinical Management platform 9.1 version. This upgrade is expected to go-live before end of June 2022. This version has additional features and is also compatible with Milliman Care Guideline v25. However, the plan is also to have the latest version of Milliman Care Guideline v26 by August 2022. Support for this version is being released by the vendor in July 2022.

Consumer and the Alliance Public Portal

- The provider and member consumer portal utilization for the month of February 2022 remains consistent with prior months.

Data Warehouse

- The Data Warehouse project is aimed at bringing all critical health care data domains to the Data Warehouse and enabling the Data Warehouse to be the single source of truth for all reporting needs and requirements.

- In the month of March 2022, the scope to add the Case Management data domains to the Data Warehouse was resumed and the project is expected to complete in May 2022.

Secure File Transfer Protocol (SFTP) Server Upgrade (Data Exchange)

- Secure File Transfer Protocol (SFTP) is a network protocol that provides file access, file transfer (data exchange), and file management over any reliable data stream.

- The Secure File Transfer Protocol (SFTP) Server Upgrade which is designed to expand its capabilities and provide redundancy for improved availability is now 100% completed. Final cleanup and decommission efforts of the old server has completed.

- Configuration and implementation of the Disaster Recovery (DR) environment for the new Secure File Transfer Protocol (SFTP) Server has been successfully completed in the last reporting period in February 2022.

- This project has been completed and the File Transfer Protocol Disaster Recovery (FTP DR) failover testing will be linked to the Disaster Recovery (DR) project which is anticipated to start by the 2nd week of March 2022.

Information Technology

Supporting Documents

Enrollment

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

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
March	300,911	4,460	2,276	5,824	135	108

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 March 2022

Auto-Assignments	Member Count
Auto-assignments MC	1,412
Auto-assignments Expansion	1,133
Auto-assignments GC	47
PCP Changes (PCP Change Tool) Total	2,714

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of March 2022”.
- There were 13,916 authorizations processed into TruCare application.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

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

Transaction Type	Inbound EDI Auths	Errored	Total Auths Loaded in TruCare
EDI	4441	449	4399
Paper to EDI	3230	2126	1447
Provider Portal	2654	515	2478
Manual Entry	N/A	N/A	1562
Total			9886

Key: EDI – Electronic Data Interchange

Web Portal Consumer Platform

- The following table 3-1 is a supporting document from the Web Portal summary section.

Table 3-1 Web Portal Usage for the Month of February 2022

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	5,141	3,245	143,566	362
MCAL	81,056	2,580	6,112	953
IHSS	3,024	102	233	31
AAH Staff	158	36	709	0
Total	**89,379**	**5,963**	**150,620**	**1,346**

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

Top 25 Pages Viewed		
Category	**Page Name**	**February - 22**
Provider	Member Eligibility	796,235
Provider	Claim Status	148,629
Provider	Auth Submit	7,167
Member My Care	Member Eligibility	3,549
Provider	Auth Search	2,908
Member Help Resources	Find a Doctor or Hospital	1,601
Provider	Member Roster	1,506
Member Help Resources	ID Card	1,499
Member Help Resources	Select or Change Your PCP	1,150
Member My Care	MC ID Card	789
Member Help Resources	Request Kaiser as my Provider	771
Member My Care	My Claims Services	760
Provider - Provider Directory	Provider Directory	559
Member My Care	Authorization	373
Member My Care	My Pharmacy Medication Benefits	371
Member Help Resources	FAQs	345
Provider - Home	Forms	323
Member Help Resources	Forms Resources	281
Member My Care	Member Benefits Materials	264
Member Help Resources	Contact Us	216
Member Help Resources	Authorizations Referrals	202
Provider - Provider Directory	Instruction Guide	190
Provider	Pharmacy	140
Provider - Provider Directory	Manual	139
Member My Care	My Pharmacy	131

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

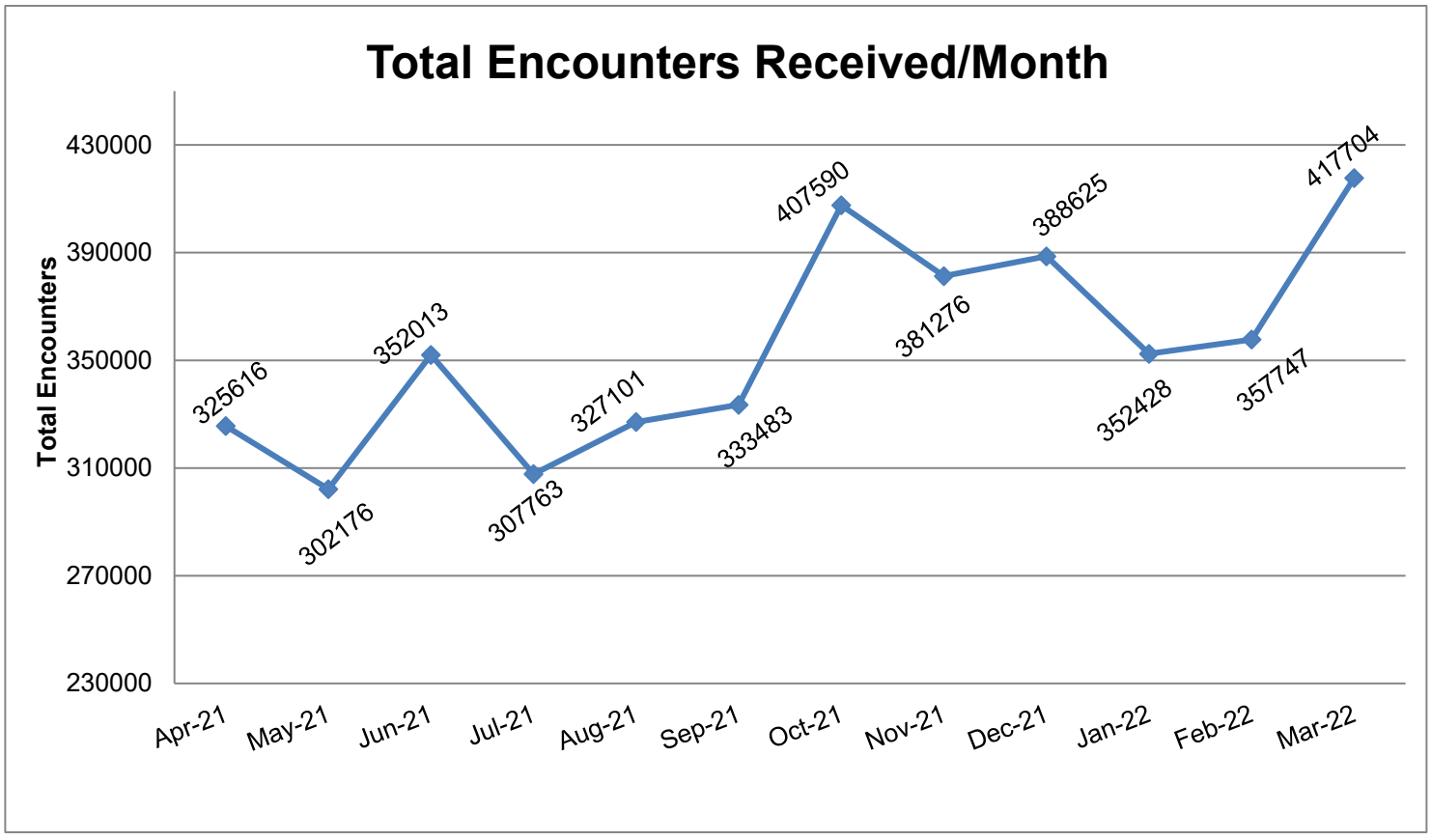
Member Portal Preferred Languages		
Member Group	**# of Individual User Accounts Accessed**	**Total Logins**
MCAL - English	2,554	6,046
MCAL - Spanish	10	15
MCAL - Vietnamese	0	0
MCAL - Tagalog	0	0
MCAL - Chinese	16	51
IHSS - English	101	228
IHSS - Spanish	0	0
IHSS - Vietnamese	0	0
IHSS - Tagalog	0	0
IHSS - Chinese	1	5
Total	**2,682**	**6,345**

Encounter Data from Trading Partners 2022

- **AHS**: March weekly files (6,215 records) were received on time.
- **BAC**: March monthly file (12 records) were received on time.
- **Beacon**: March weekly files (16,088 records) were received on time.
- **CHCN**: March weekly files (79,363 records) were received on time.
- **CHME**: March monthly file (4,778 records) were received on time.
- **CFMG**: March weekly files (13,522 records) were received on time.
- **Docustream**: March monthly files (2,130 records) were received on time.
- **HCSA**: March monthly files (3,630 records) were received on time.
- **PerformRx**: March monthly files (21 records) were received on time.
- **Magellan**: March monthly files (301,837 records) were received on time.
- **Kaiser**: March bi-weekly files (68,530 records) were received on time.
- **LogistiCare**: March weekly files (19,841 records) were received on time.
- **March Vision**: March monthly file (3,559 records) were received on time.
- **Quest Diagnostics**: March weekly files (14,268 records) were received on time.
- **Teladoc**: March monthly files (30 records) were received on time.

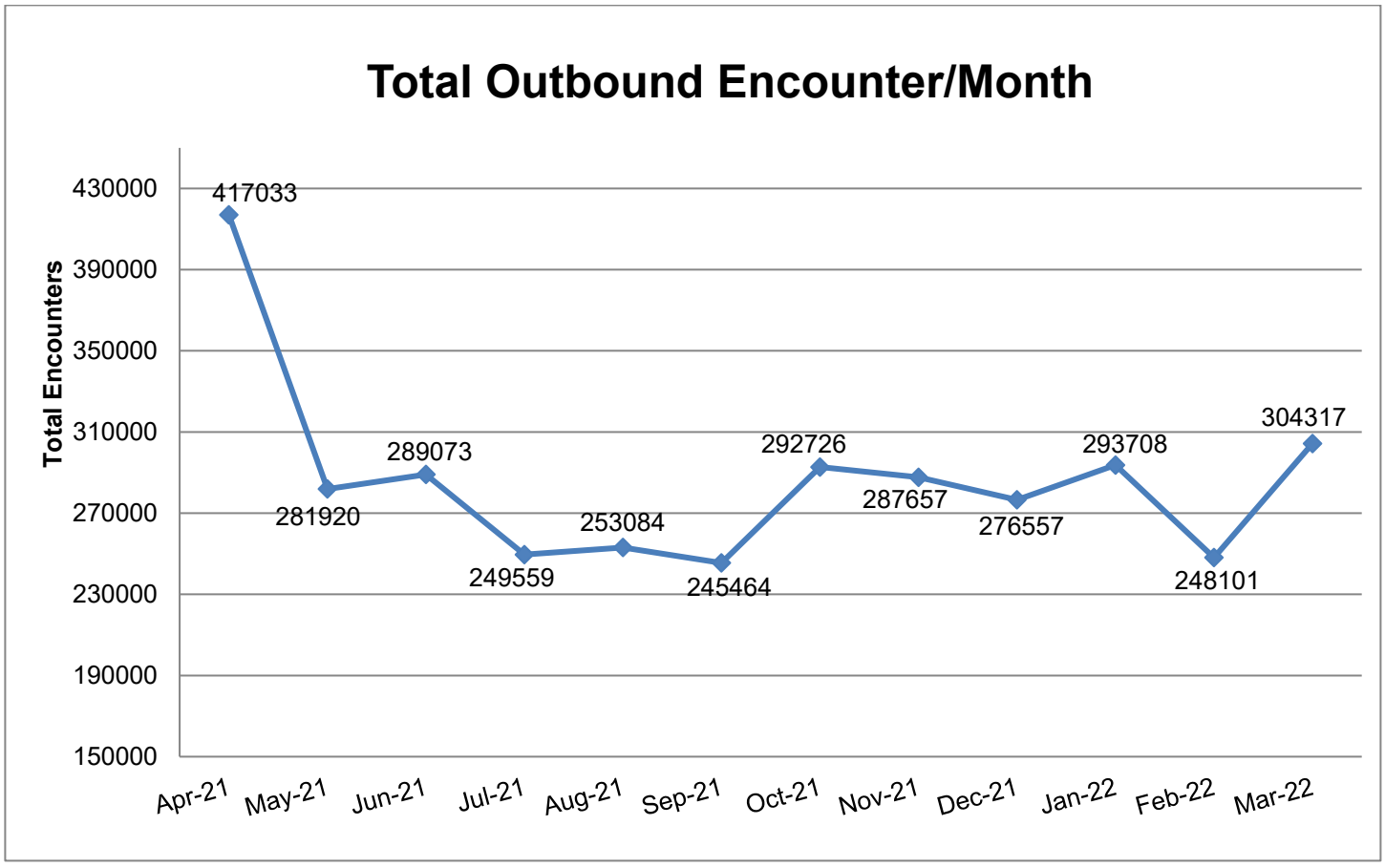
Trading Partner Medical Encounter Inbound Submission History

Trading Partners	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
HealthSuite	143171	140678	129847	136687	133958	139079	159558	177483	167057	175441	162201	162433	185738
AHS	9326	11166	9074	10138	8913	7869	7640	10625	8791	9314	6944	5630	6215
BAC												34	12
Beacon	13002	19247	14951	17079	15236	13320	14618	13693	12456	14899	9796	10966	16088
CHCN	89453	69080	66260	82211	63905	80862	60227	71581	99117	73269	75302	77276	79363
CHME	5776	5497	4885	4700	4960	4926	5393	4814	5003	4908	9254	4706	4778
Claimsnet	10905	8835	10834	8129	9774	7712	9880	15598	11032	12410	8643	13228	13522
Docustream	935	1166	1445	1218	1296	1568	1594	1474	1185	1586	1703	1304	2130
HCSA													3630
Kaiser	112545	39632	30039	60081	39398	35165	44366	75112	38085	63939	46458	52179	68530
Logisticare	16924	12945	14399	15473	14415	17306	13803	16977	22403	17125	16536	16393	19841
March Vision	2230	3156	3708	3306	3303	3531	3297	3377	3584	3220	2872	1445	3559
Quest	14699	14203	16718	12979	12563	15746	13084	16841	12542	12494	12696	12121	14268
Teladoc	13	11	16	12	42	17	23	15	21	20	23	32	30
Total	418979	325616	302176	352013	307763	327101	333483	407590	381276	388625	352428	357747	417704



Outbound Medical Encounter Submission

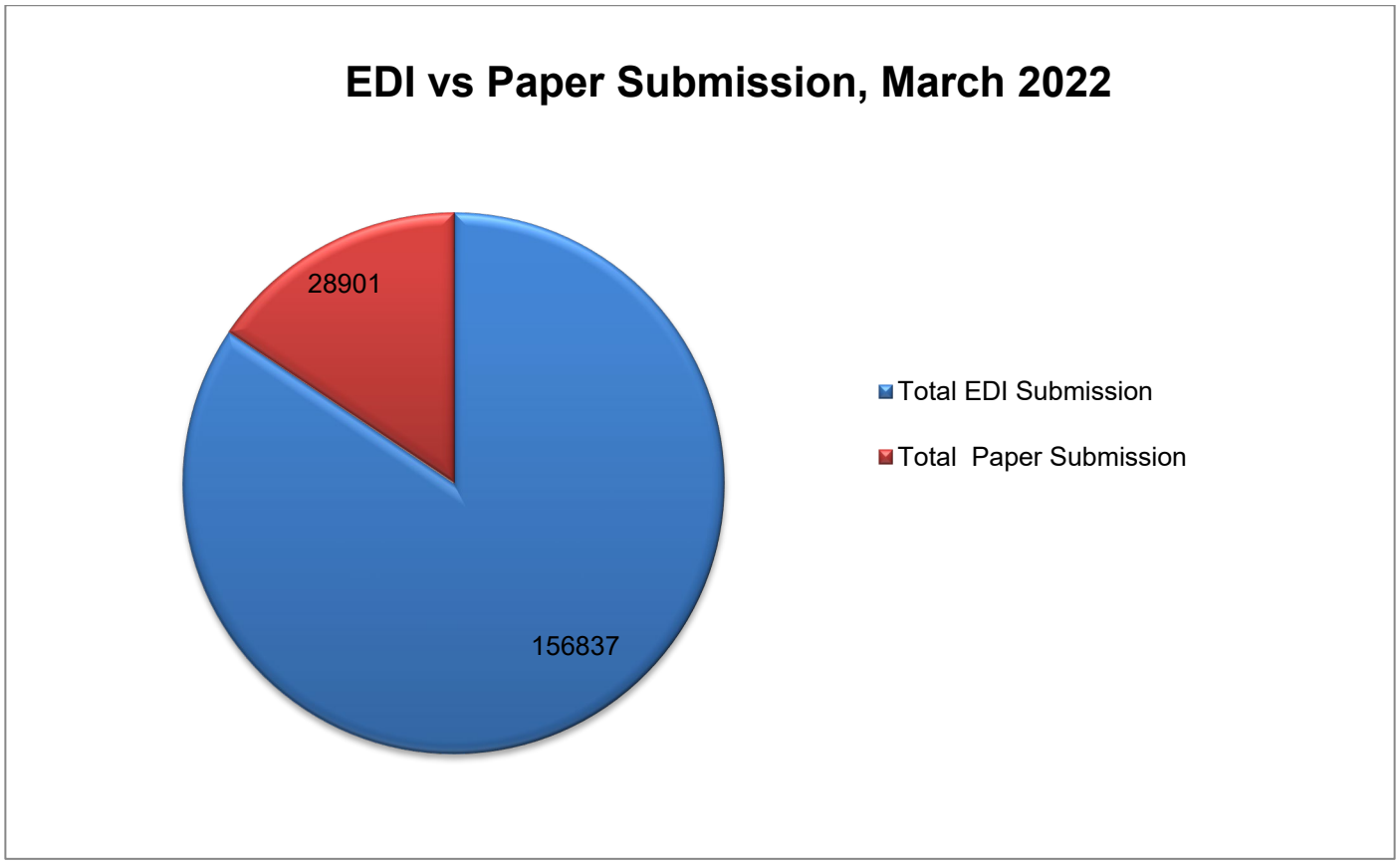
Trading Partners	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
HealthSuite	84220	216640	130885	128980	85346	109070	83690	100925	114507	95489	139452	97141	103843
AHS	8655	8812	10762	9912	7163	9172	7476	10176	8541	7728	7943	5524	6142
BAC												34	12
Beacon	10171	14881	12347	11746	12684	10959	9355	11423	9969	12659	7566	8140	12332
CHCN	64275	49446	48573	58519	45338	46573	54958	49171	67383	49080	52531	44745	58795
CHME	5283	5136	4767	4586	4753	4820	5280	4587	4849	4691	4496	4585	4702
Claimsnet	7964	6489	8110	5993	5625	7335	7452	10829	7406	8465	6114	9917	9677
Docustream	860	1070	1286	1016	1120	1273	1209	1094	981	1185	1176	66	72
HCSA													3112
Kaiser	59157	89295	29570	38443	59215	33798	43779	73264	37473	63433	44248	51831	67559
Logisticare	16652	9705	17299	15178	14008	12751	17657	16231	19240	19787	16309	16242	19700
March Vision	1930	2455	2850	2624	2596	2665	2483	2608	2831	2490	2175	1072	2724
Quest	16169	13093	15455	12066	11711	14632	12102	12403	14457	11531	11676	8774	15620
Teladoc	11	11	16	10	0	36	23	15	20	19	22	30	27
Total	275347	417033	281920	289073	249559	253084	245464	292726	287657	276557	293708	248101	304317



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
22-Mar	156837	28901	185738

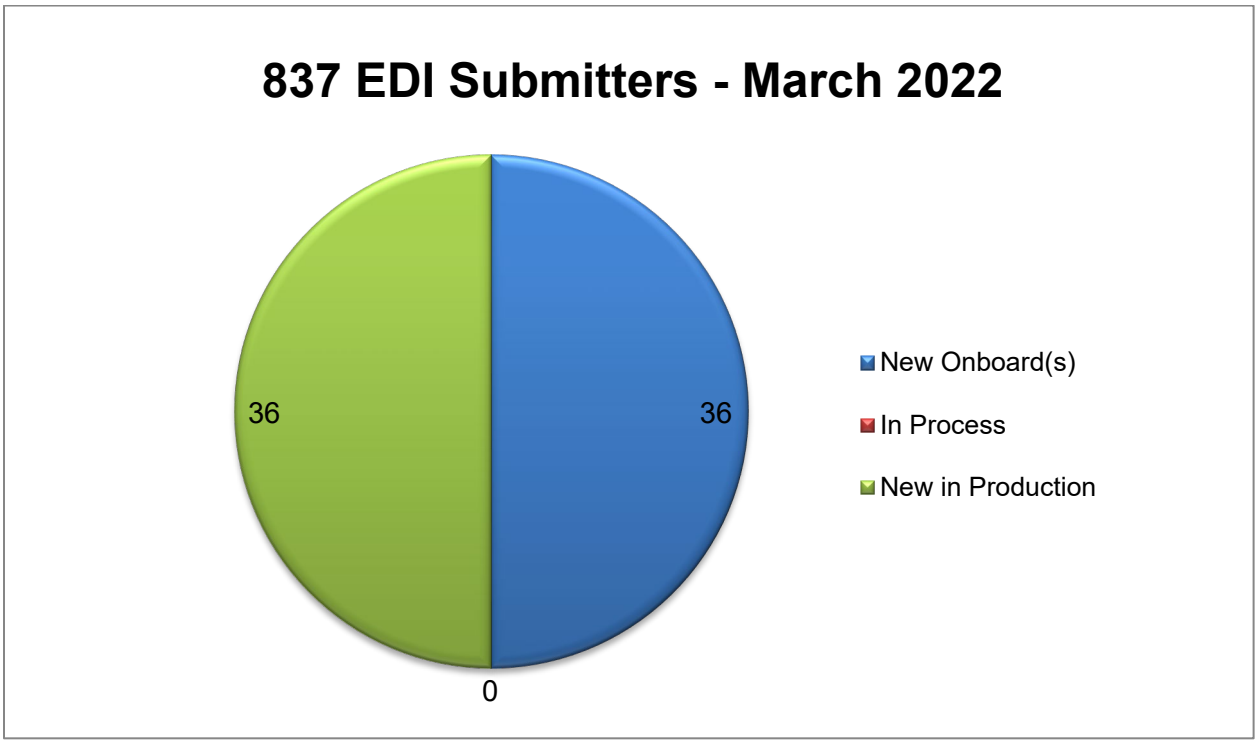
Key: EDI – Electronic Data Interchange

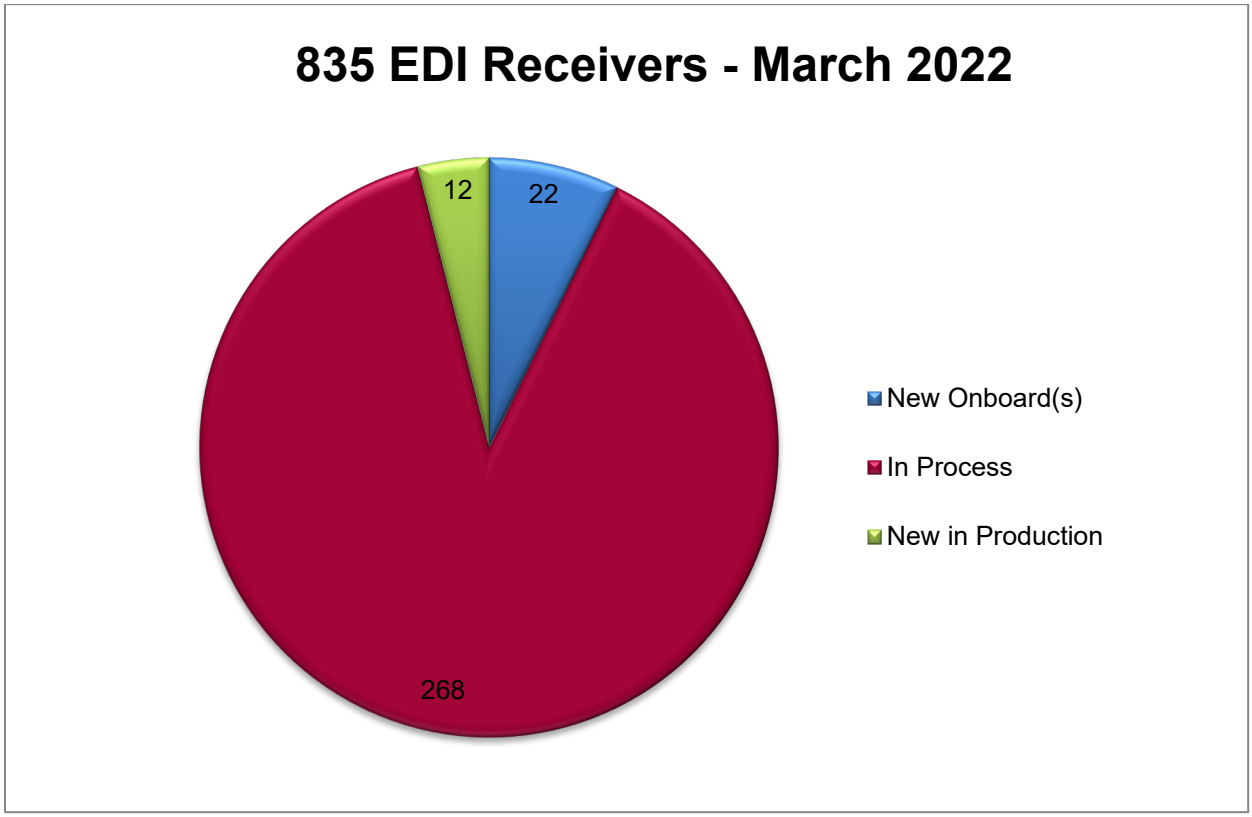


Onboarding EDI Providers - Updates

- March 2022 EDI Claims:
  - A total of 1325 new EDI submitters have been added since October 2015, with 36 added in March 2022.
  - The total number of EDI submitters is 2057 providers.
- March 2022 EDI Remittances (ERA):
  - A total of 414 new ERA receivers have been added since October 2015, with 12 added in March 2022.
  - The total number of ERA receivers is 441 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
Apr-21	5	0	5	1830	20	126	11	317
May-21	32	0	32	1862	20	134	12	329
Jun-21	13	0	13	1875	17	136	15	344
Jul-21	30	3	27	1902	14	138	12	356
Aug-21	17	0	17	1919	47	178	7	363
Sep-21	21	1	20	1939	15	193	0	363
Oct-21	17	0	17	1956	30	205	18	381
Nov-21	14	0	14	1970	19	210	14	395
Dec-21	8	0	8	1978	18	223	5	400
Jan-22	29	1	28	2006	44	253	14	414
Feb-22	17	2	15	2021	20	258	15	429
Mar-22	36	0	36	2057	22	268	12	441


837 EDI Submitters - March 2022
36
36
0
New Onboard(s)
In Process
New in Production


835 EDI Receivers - March 2022
12
22
268
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 March 2022.

File Type	Mar-22
837 I Files	23
837 P Files	105
NCPDP	2
Total Files	130

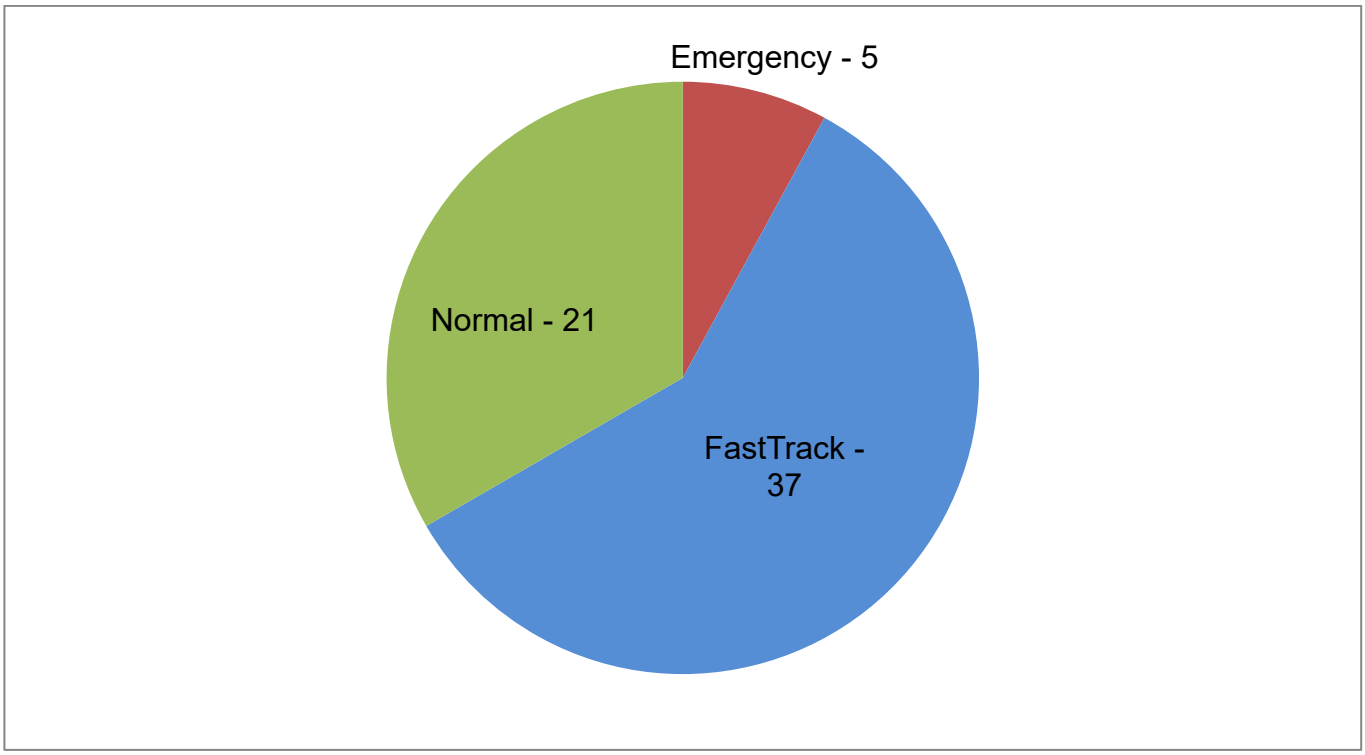
Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Mar-22	Target
Timeliness-% Within Lag Time – Institutional 0-90 days	95%	60%
Timeliness-% Within Lag Time – Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time – Professional 0-90 days	91%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

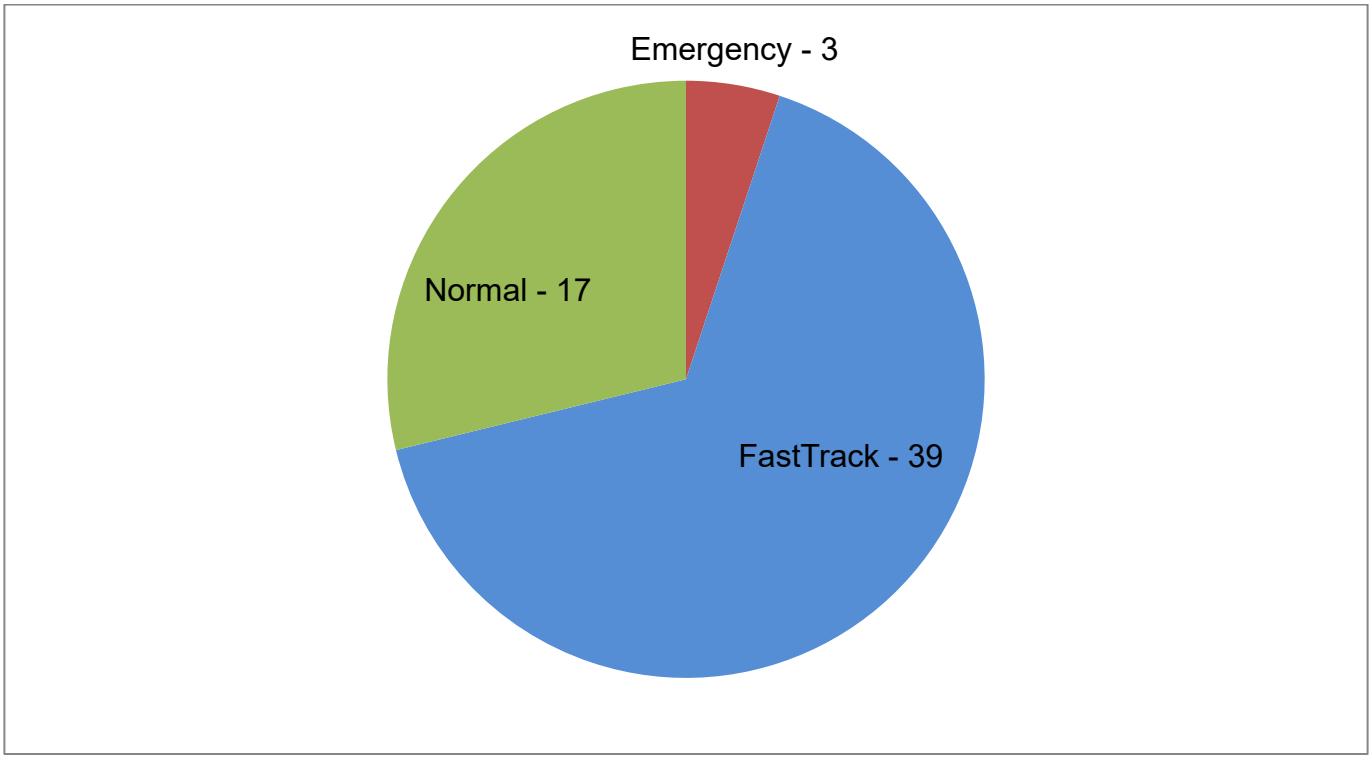
Change Management Key Performance Indicator (KPI)

- Change Request Overall Summary in the month of March 2022 KPI:
  - 63 Changes Submitted.
  - 59 Changes Completed and Closed.
  - 126 Active Change Requests in pipeline.
  - 6 Change Request Cancelled or Rejected.

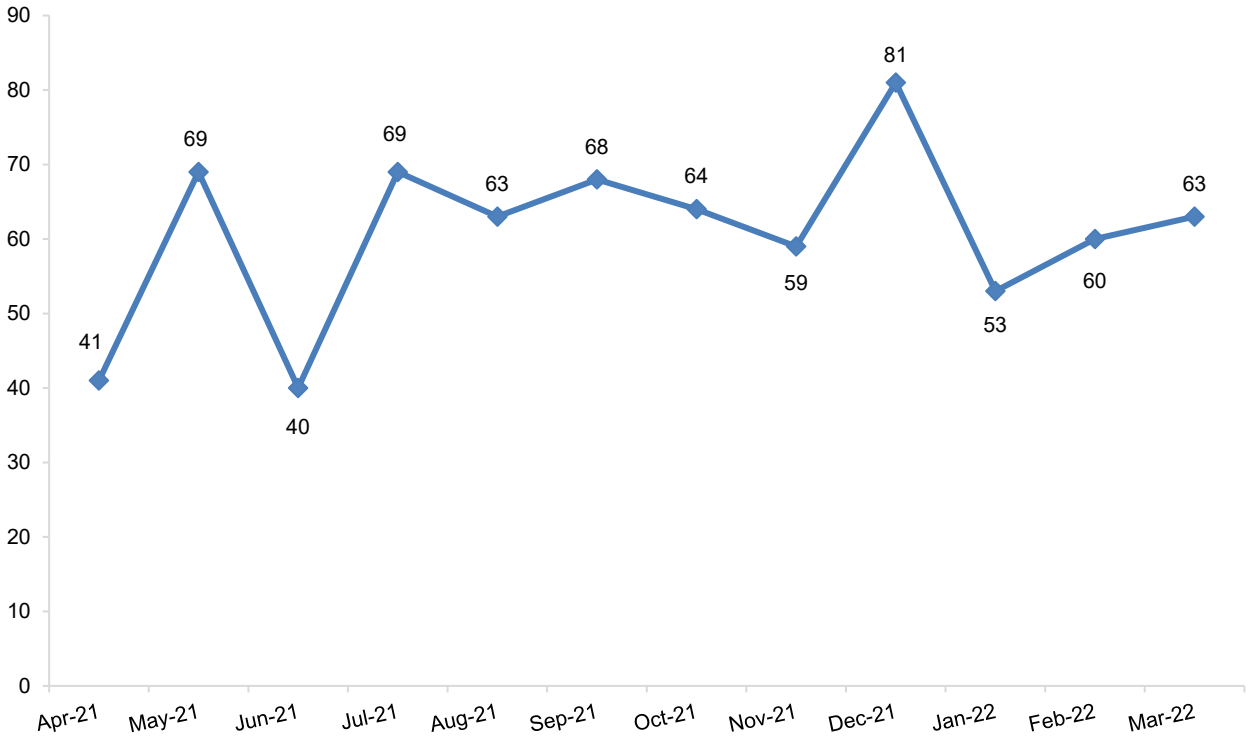
- 63 Change Requests Submitted/Logged in the month of March 2022



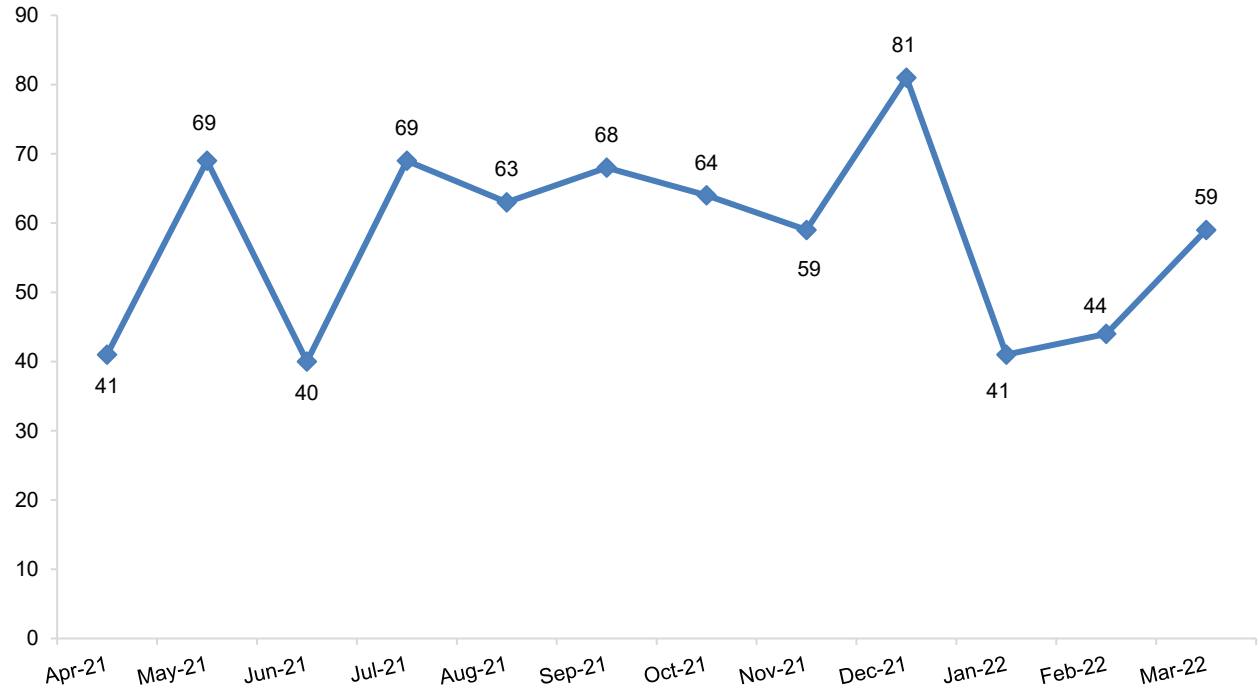
- 59 Change Requests Closed in the month of March 2022



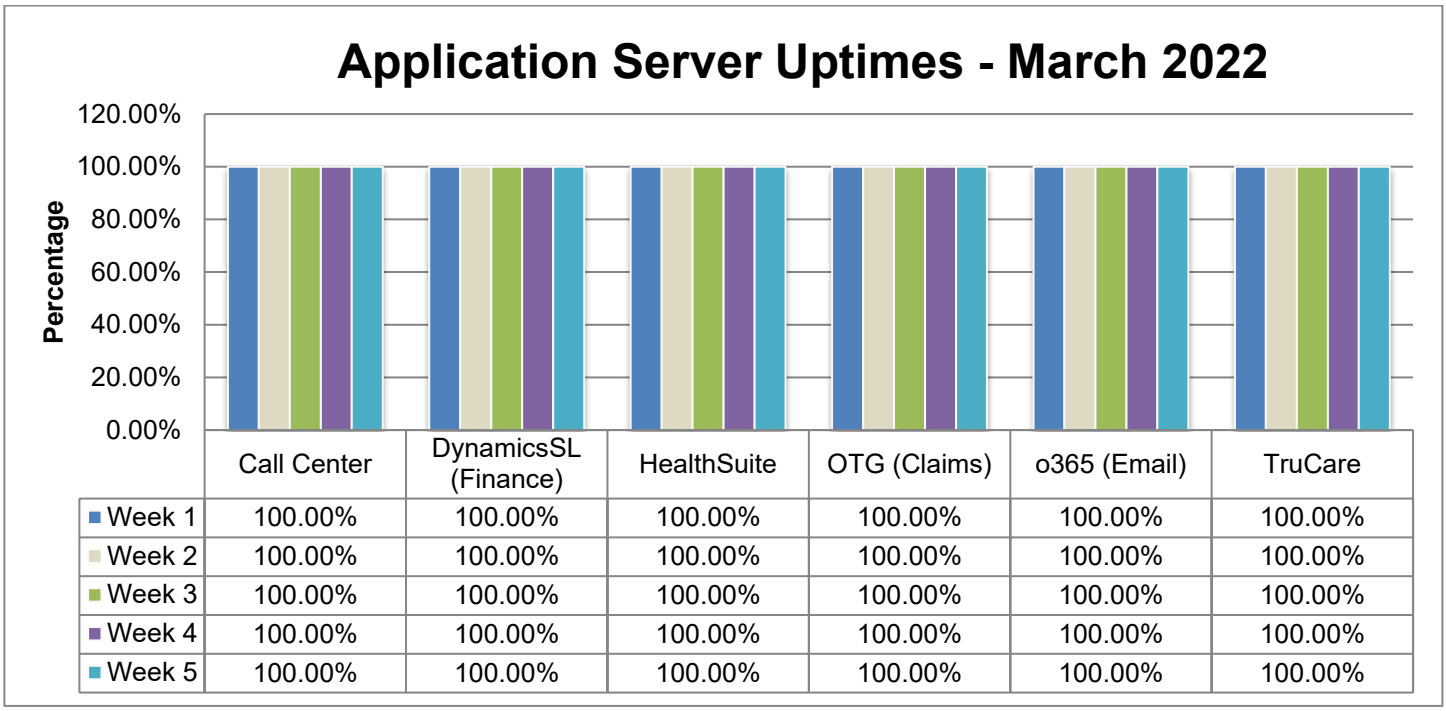
- Change Requests Submitted: Monthly Trend



- Change Requests Closed: Monthly Trend



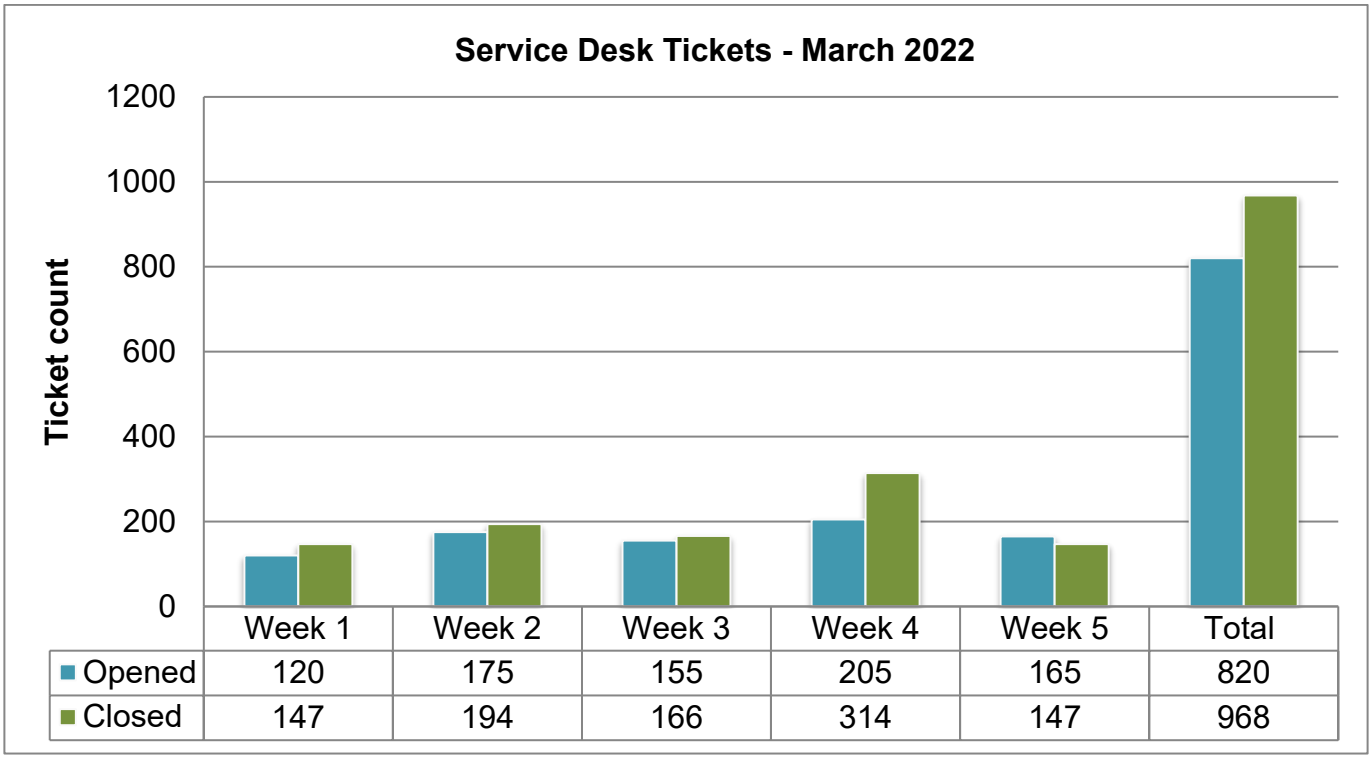
IT Stats: Infrastructure



	Call Center	DynamicsSL (Finance)	HealthSuite	OTG (Claims)	o365 (Email)	TruCare
Week 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 2	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 3	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 4	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- All mission critical applications are monitored and managed thoroughly.
- There were no major outages experienced in the month of March 2022 despite supporting 97% of staff working remotely.
- Experienced a partial application service outage with HealthSuite on March 21st, 2022, that lasted 2 hours. This impacted claims processing functionality only. The system was available and did not impact all other functional areas.

- 820 Service Desk tickets were opened in the month of March 2022, which is 19.3% higher than the previous month and 968 Service Desk tickets were closed, which is 27.1% higher than the previous month.



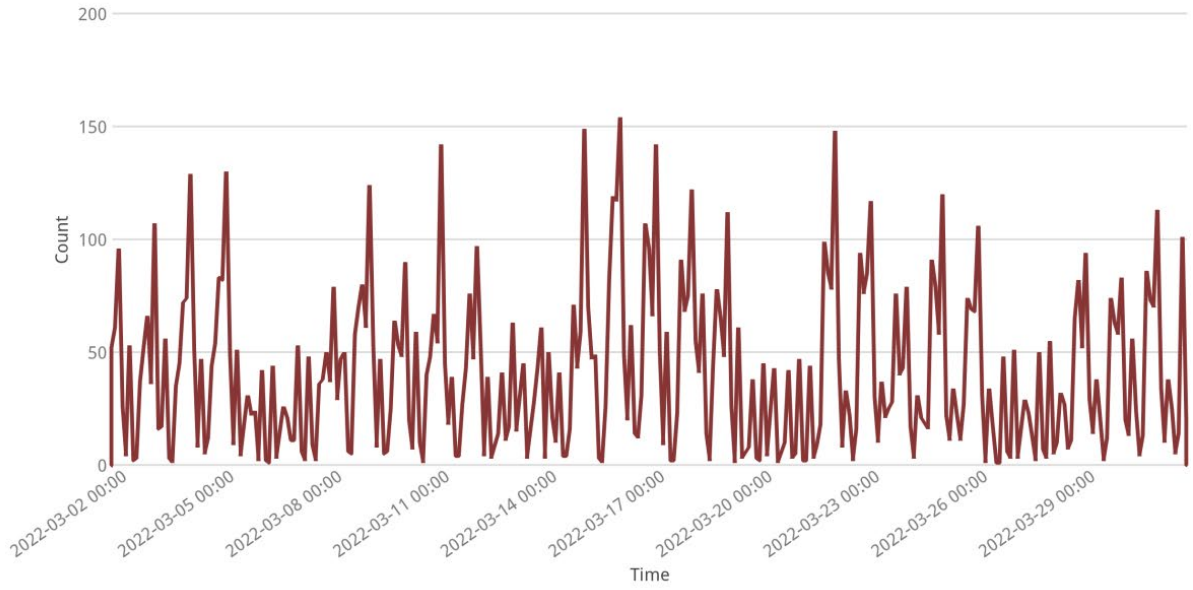
	Week 1	Week 2	Week 3	Week 4	Week 5	Total
Opened	120	175	155	205	165	820
Closed	147	194	166	314	147	968

- The open ticket count for the month of March is higher than the previous 3-month average of 750.

- Increased tickets related to MAC's (Moves, Adds and Changes) such as new hires, terminations and department changes were captured for this reporting period. The IT Service Desk ticket increase is back to full-strength and has been focusing on new hires and equipment standardization rollout in preparation for return to work.

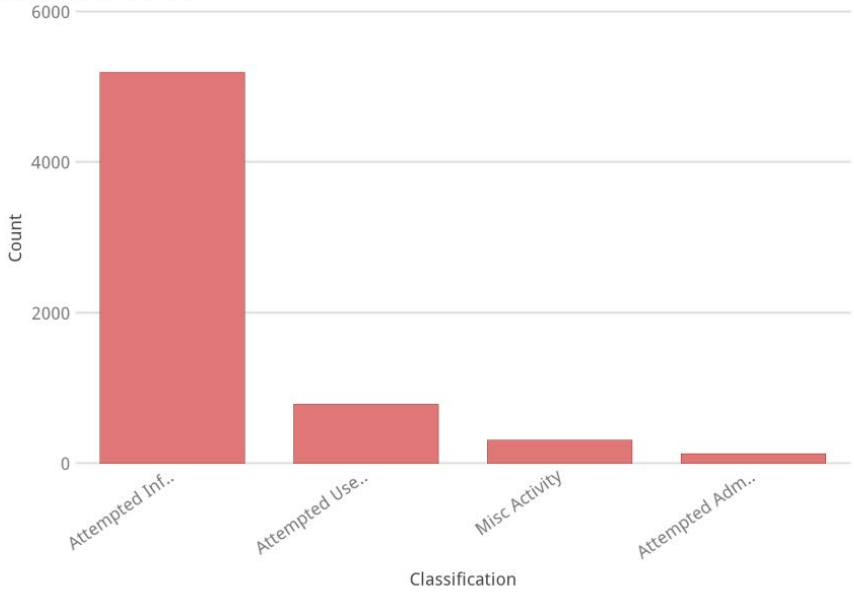
All Intrusion Events

Time Window: *2022-03-01 09:29:00 - 2022-03-31 09:29:00*



Dropped Intrusion Events

Time Window: *2022-03-01 09:30:00 - 2022-03-31 09:30:00*
Constraints: *Inline Result = dropped*



Classification	Count
Attempted Information Leak	5,192
Attempted User Privilege Gain	789
Misc Activity	308
Attempted Administrator Privilege Gain	132

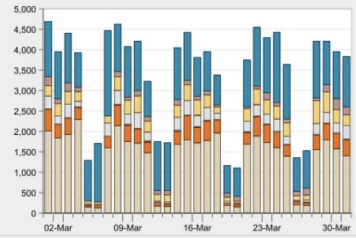
IronPort Email Security Gateways

Email Filters

MX4

01 Mar 2022 00:00 to 31 Mar 2022 23:59 (GMT -07:00) — Data in time range: 100.0 % complete

Overview > Incoming Mail Graph



Export...

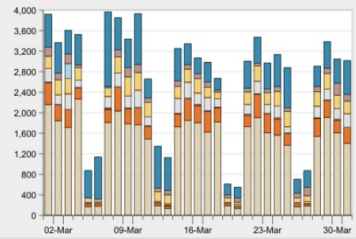
Overview > Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	33.9%	35.8k
Stopped by Domain Reputation Filtering	3.3%	3,444
Stopped as Invalid Recipients	0.1%	67
Spam Detected	7.8%	8,188
Virus Detected	0.0%	1
Detected by Advanced Malware Protection	0.0%	2
Messages with Malicious URLs	0.0%	32
Stopped by Content Filter	0.0%	21
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**45.1%**	**47.6k**
Marketing Messages	6.2%	6,522
Social Networking Messages	0.5%	524
Bulk Messages	8.7%	9,234
Total Graymails:	**15.4%**	**16.3k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	39.5%	41.7k
Total Attempted Messages:		**105.6k**

MX9

01 Mar 2022 00:00 to 31 Mar 2022 23:59 (GMT -07:00) — Data in time range: 100.0 % complete

Incoming Mail Graph



Export...

Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	20.6%	17.0k
Stopped by Domain Reputation Filtering	3.7%	3,042
Stopped as Invalid Recipients	0.4%	322
Spam Detected	8.3%	6,867
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	9
Stopped by Content Filter	0.0%	18
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**33.0%**	**27.3k**
Marketing Messages	6.6%	5,415
Social Networking Messages	0.5%	448
Bulk Messages	9.4%	7,728
Total Graymails:	**16.5%**	**13.6k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	50.5%	41.7k
Total Attempted Messages:		**82.6k**

Stopped By Reputation	60.7k	79.9k	65.4	78.8k	62.7k	43.1k	41.5k	24.3k	39.3k	69.7k	42.4k	329.9k	***52.8k***
Invalid Recipients	384	1,776	99	1,982	742	185	132	82	92	153	185	69	***389***
Spam Detected	19.2k	19.2k	18	17.4k	27	12.8k	10.8k	5.6k	9,684	13.2k	10.3k	10.3k	***15k***
Virus Detected	3	5	2	2	9	14	14	0	1	1	5	13	***1***
Advanced Malware	0	6	6	0	1	3	2	0	0	9	0	4	***2***
Malicious URLs	14	0	264	30	12	9	7	6	43	39	16	89	***41***
Content Filter	56	151	264	167	78	58	89	27	27	8	371	54	***39***
Marketing Messages	68	6,707	6,366	6,357	6,256	6,710	7,383	4,489	9,221	6,147	8,864	9,588	***8,864***
Attempted Admin Privilege Gain	89	96	95	109	101	129	157	128	124	116	103	116	***132***
Attempted User Privilege Gain	64	10	1	0	3	7	6	6	13	49	117	663	***789***
Attempted Information Leak	3	20	18	38	15	32	3,700	7,782	9,376	13.7k	13.7k	5,813	***5,192***
Potential Corp Policy Violation	0	0	0	0	0	0	0	0	0	0	0	0	***0***
Network Scans Detected	0	0	0	0	0	0	0	0	0	0	0	0	***0***
Web Application Attack	24	11	0	3	1	0	0	0	0	0	0	1	***0***
Attempted Denial of Service	0	1	0	0	0	0	0	0	0	0	0	0	***0***
Misc. Attack	6,870	4,395	3,851	1,516	975	446	5,733	8,550	76	161	275	626	***308***

- All security activity data is based on the current month's metrics as a percentage. This is compared to the previous three month's average, except as noted.
- Email based metrics currently monitored have increased with a return to a reputation-based block for a total of 52.8k.
- Attempted information leaks detected and blocked at the firewall is at 5,192 for the month of March 2022.
- Network scans returned a value of 0, which is in line with previous month's data.
- Attempted User Privilege Gain is higher at 789 from a previous six-month average of 142.

Projects and Programs

Ruth Watson

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

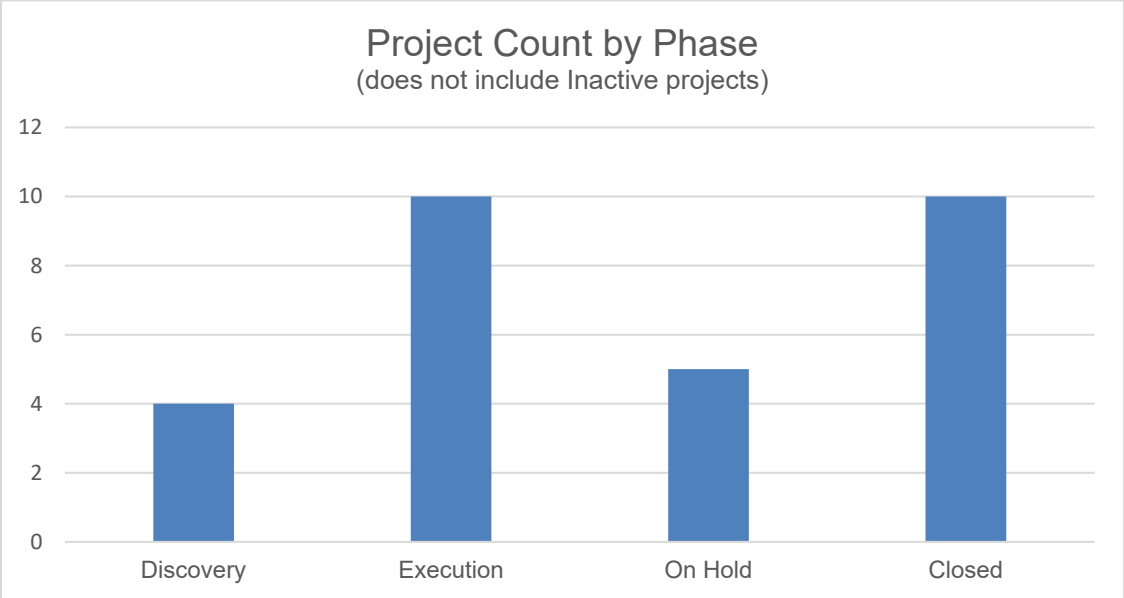
From: **Ruth Watson, Chief Projects and Programs Officer**

Date: **April 8th, 2022**

Subject: **Projects & Programs Report**

Project Management Office

- 36 projects currently on the Alliance enterprise-wide portfolio:
  - 14 Active projects (discovery, initiation, planning, execution, warranty)
  - 5 On Hold projects
  - 10 Closed projects
  - 7 Inactive projects (**not included on chart as Inactive is not a phase**)



Integrated Planning

- CalAIM Enhanced Care Management (ECM) and Community Supports (CS):
  - Launched ECM and CS on January 1st.
  - ECM portion of the Model of Care (MOC) fully approved by DHCS on March 8th.
  - CS portion of the MOC fully approved for Parts 1 and 2 and conditionally approved for Part 3.
    - DHCS requested additional information to previous responses on March 15th; AAH responded to DHCS on March 22nd and is awaiting final approval.
  - Operational Readiness Activities – Day 2 (30/60/90 days).

        - Sprint planning and execution continues in two-week increments to complete identified activities over the next 60 days.
    - Long-term planning continues for 2022 Q2 / Q3 / Q4 including:
        - Implementation of additional ECM Populations of Focus effective January 2023 and July 2023; will require submission of updated MOCs.
        - Identification and timing of additional CS services to be offered.
        - Automation of Day 1 manual processes.

- CalAIM Major Organ Transplants (MOT):
    - Submitted response to DHCS on January 7th regarding the Corrective Action Plan (CAP) received on December 10th for lack of a certified MOT network; CAP will remain in place until AAH has an executed contract with a transplant program that is a Center of Excellence (COE) for adult kidney-pancreas transplants.

- CalAIM Incentive Payment Program – three-year DHCS program to provide funding for the support of ECM and CS in the following areas:
    - 1) Delivery System Infrastructure
    - 2) ECM Provider Capacity Building
    - 3) Community Supports Provider Capacity Building and Community Supports Take-Up
    - Received approval from DHCS on March 29th for all 1,000 points.
    - Program Year 1 (PY1), Payment 1 (50% of PY1 funding) expected from DHCS no later than April 27th.

- Mental Health (Mild to Moderate/Autism Spectrum Disorder) Insourcing – services currently performed by Beacon Health Options will be brought in-house as of October 1st, 2022.
    - Planning activities, which were suspended due to the initial phase of CalAIM implementation, have re-started.
    - Senior Director, Behavioral Health has been hired and will be the project driver for this initiative.
    - Updated cost estimates are being prepared and will be presented at the May 2022 Board of Governors meeting.

- Behavioral Health Integration (BHI) Incentive Program – DHCS pilot program commenced January 1st, 2021 and continues through December 31st, 2022.
    - PY1 Annual Performance Measure reports submitted to DHCS on March 29th.

- Student Behavioral Health Incentive Program (SBHIP) – finalized contract for consulting services to assist with implementation of the program.
    - Initial meeting with Alameda County Office of Education (COE) and HCSA staff, including the Center for Healthy Schools and Communities, held on February 25th.

    - Partners Form which identifies which entities, including Local Education Agencies (LEAs), are interested in participating was submitted to DHCS on March 15th.
    - Individual meetings with identified Partners commenced on March 30th.

- Housing and Homelessness Incentive Program (HHIP):
    - Reviewed Alameda County and City of Oakland Homeless Housing, Assistance and Prevention (HHAP) Round 2 Grant applications.
    - Reviewed Home Together 2026, which is Alameda County's community implementation plan designed to reduce homelessness and improve outcomes and racial disparity.
    - Drafted HHIP Letter of Intent (LOI) which is due to DHCS on April 4th.

Recruiting and Staffing

- Project Management Open position(s):
    - Recruitment completed for Business Analyst, Integrated Planning; employee started on March 7th.
    - Recruitment to commence/continue for the following positions:
        - Manager, Project Management Office (PMO)
        - Senior Business Analyst
        - Project Manager

Projects and Programs

Supporting Documents

Project Descriptions

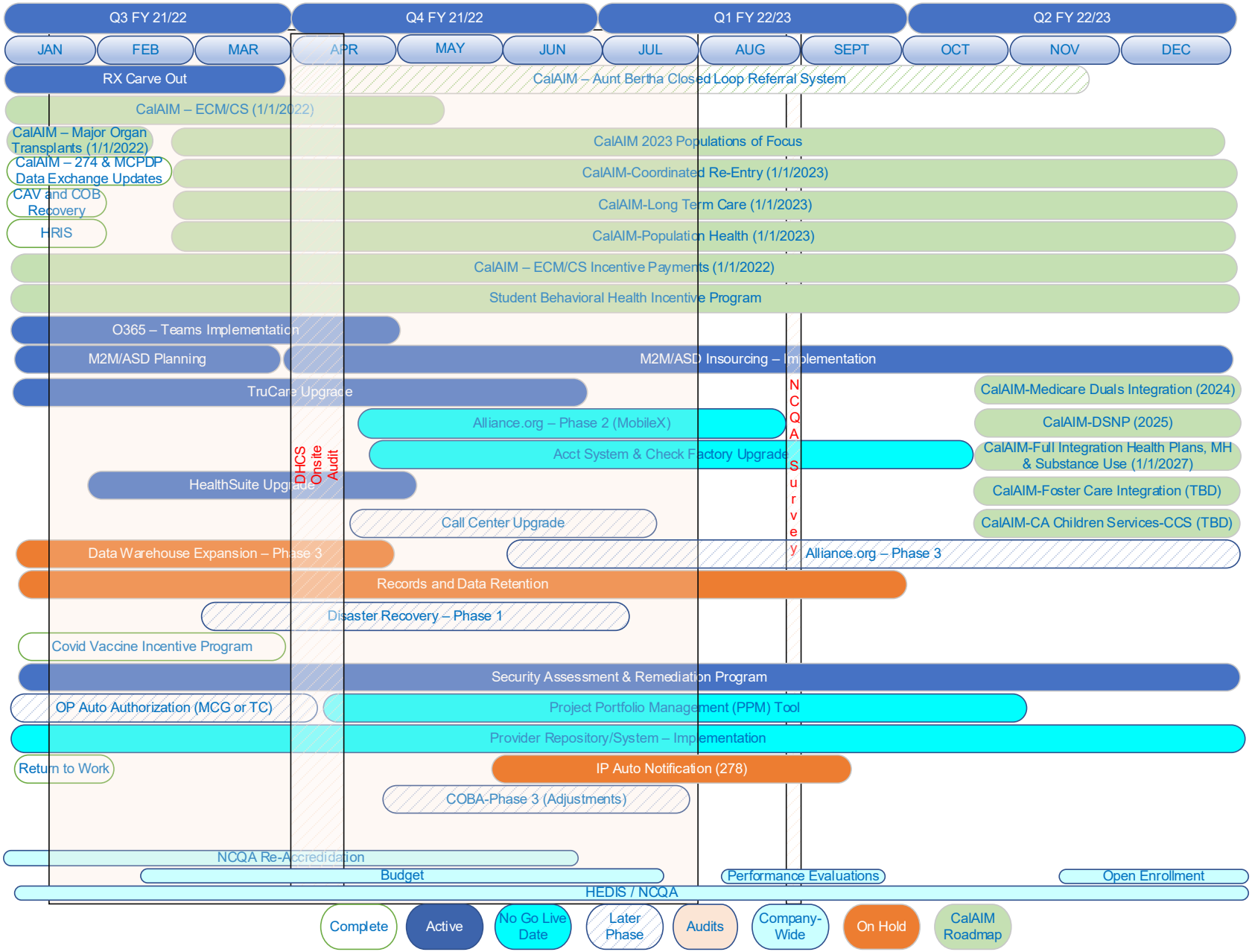
Key projects currently in-flight:

- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs
    - Enhanced Care Management (ECM) – ECM will target seven (7) specific populations of vulnerable and high-risk children and adults.
        - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022.
        - Three (3) additional PoFs will become effective on January 1st, 2023.
        - Final PoF will become effective on July 1st, 2023.
    - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays.
        - Six (6) Community Supports were implemented on January 1st, 2022
    - 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 adults; also applicable to children for transplants not covered by California Children's Services.
    - CalAIM Incentive Payment Program (IPP) – The CalAIM ECM and CS programs will require significant new investments in care management capabilities, ECM and CS infrastructure, information technology (IT) and data exchange, and workforce capacity across MCPs, city and county agencies, providers and other community-based organizations. CalAIM incentive payments are intended to:
        - Build appropriate and sustainable ECM and ILOS capacity.
        - Drive MCP investment in necessary delivery system infrastructure.
        - Incentivize MCP take-up of ILOS.
        - Bridge current silos across physical and behavioral health care service delivery.
        - Reduce health disparities and promote health equity.
        - Achieve improvements in quality performance.
    - Long Term Care - currently not within the scope of many Medi-Cal managed care plans (MCPs); will be carved into all MCPs effective January 1st, 2023.
    - Justice Involved/Coordinated Re-Entry – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release effective January 1st, 2023.
    - Population Health Management (PHM) – all Medi-Cal managed care plans will be required to develop and maintain a whole system, person-centered population health management strategy effective January 1st, 2023.
        - PHM is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes.
- Return to Work – assessment of current state work environment and recommendations for future configurations (remote/onsite/hybrid).

- Pharmacy Carve-Out – transition of the pharmacy benefit for Medi-Cal members from managed care plans to the State occurred on January 1st, 2022.
- Project Portfolio Management (PPM) Tool – vendor demonstrations complete.
- APL 20-017 Managed Care Program Data Improvement.
    - DHCS will require Managed Care Plans (MCPs) to report program data using new, standardized reporting formats.
        - Additional requirements for data reporting related to grievances, appeals, monthly Medical Exemption Requests (MER) and other continuity of care requests, out-of-Network requests, and Primary Care Provider (PCP) assignments for all MCPs.
        - MCPs are required to meet all requirements in this APL no later than July 1st, 2021.
- Accounting & Enterprise Resource Planning (ERP) System Upgrade – upgrade current system to supported platform.
- Student Behavioral Health Incentive Program (SBHIP) – program launched in January 2022 to support new investments in behavioral health services, infrastructure, information technology and data exchange, and workforce capacity for school-based and school-affiliated behavioral health providers. Incentive payments will be paid to Medi-Cal managed care plans (MCPs) to build infrastructure, partnerships and capacity, statewide, for school behavioral health services.
    - Letter of Intent submitted to DHCS on January 27th.
    - Partners Form submitted to DHCS on March 15th.
    - Meetings will be scheduled in February with the Alameda County Office of Education and Center for Healthy Schools and Communities to begin work to identify which of the fourteen (14) targeted interventions are a priority for Alameda County.
- Housing and Homelessness Incentive Program (HHIP) – program launched in January 2022 and is part of the Home and Community-Based (HCBS) Spending Plan. It will enable Managed Care Plans (MCPs) to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health. MCPs must collaborate with local homeless Continuums of Care (CoCs) and submit a Local Homelessness Plan (LHP) to be eligible for HHIP funding. The LHP is expected to be in alignment with local Homeless Housing, Assistance and Prevention (HHAP) grant applications. In counties with more than one MCP, MCPs need to work together to submit one LHP per county.

Key Projects on Hold:

- In Patient (IP) Auto Notification (278 Data File) – pilot hospitals are not ready to start implementation.
- Records and Data Retention – on hold due to internal resource constraints re-directed to regulatory required projects.


Q3 FY 21/22
Q4 FY 21/22
Q1 FY 22/23
Q2 FY 22/23
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEPT
OCT
NOV
DEC
RX Carve Out
CalAIM – Aunt Bertha Closed Loop Referral System
CalAIM – ECM/CS (1/1/2022)
CalAIM – Major Organ Transplants (1/1/2022)
CalAIM 2023 Populations of Focus
CalAIM – 274 & MCPDP Data Exchange Updates
CalAIM-Coordinated Re-Entry (1/1/2023)
CAV and COB Recovery
CalAIM-Long Term Care (1/1/2023)
HRIS
CalAIM-Population Health (1/1/2023)
CalAIM – ECM/CS Incentive Payments (1/1/2022)
Student Behavioral Health Incentive Program
O365 – Teams Implementation
M2M/ASD Planning
M2M/ASD Insourcing – Implementation
TruCare Upgrade
NCQA Survey
CalAIM-Medicare Duals Integration (2024)
Alliance.org – Phase 2 (MobileX)
CalAIM-DSNP (2025)
DHCS Onsite Audit
Acct System & Check Factory Upgrade
CalAIM-Full Integration Health Plans, MH & Substance Use (1/1/2027)
HealthSuite Upgrade
CalAIM-Foster Care Integration (TBD)
Call Center Upgrade
CalAIM-CA Children Services-CCS (TBD)
Data Warehouse Expansion – Phase 3
Alliance.org – Phase 3
Records and Data Retention
Disaster Recovery – Phase 1
Covid Vaccine Incentive Program
Security Assessment & Remediation Program
OP Auto Authorization (MCG or TC)
Project Portfolio Management (PPM) Tool
Provider Repository/System – Implementation
Return to Work
IP Auto Notification (278)
COBA-Phase 3 (Adjustments)
NCQA Re-Accreditation
Budget
Performance Evaluations
Open Enrollment
HEDIS / NCQA
Complete
Active
No Go Live Date
Later Phase
Audits
Company-Wide
On Hold
CalAIM Roadmap

Analytics

Tiffany Cheang

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

From: **Tiffany Cheang, Chief Analytics Officer**

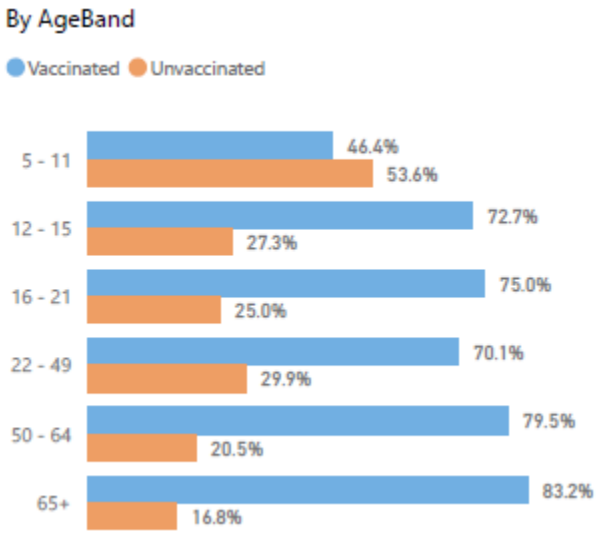
Date: **April 8th, 2022**

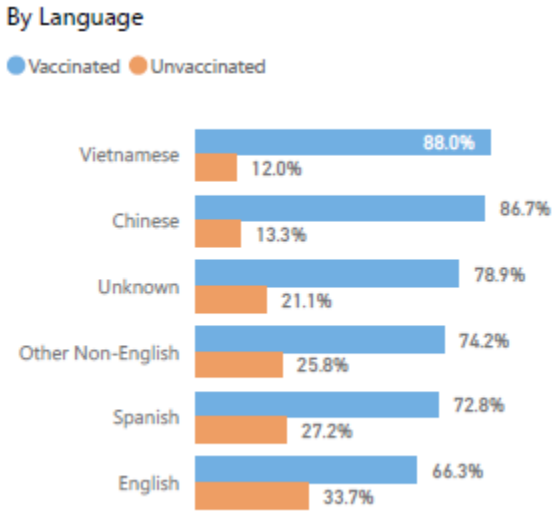
Subject: **Performance & Analytics Report**

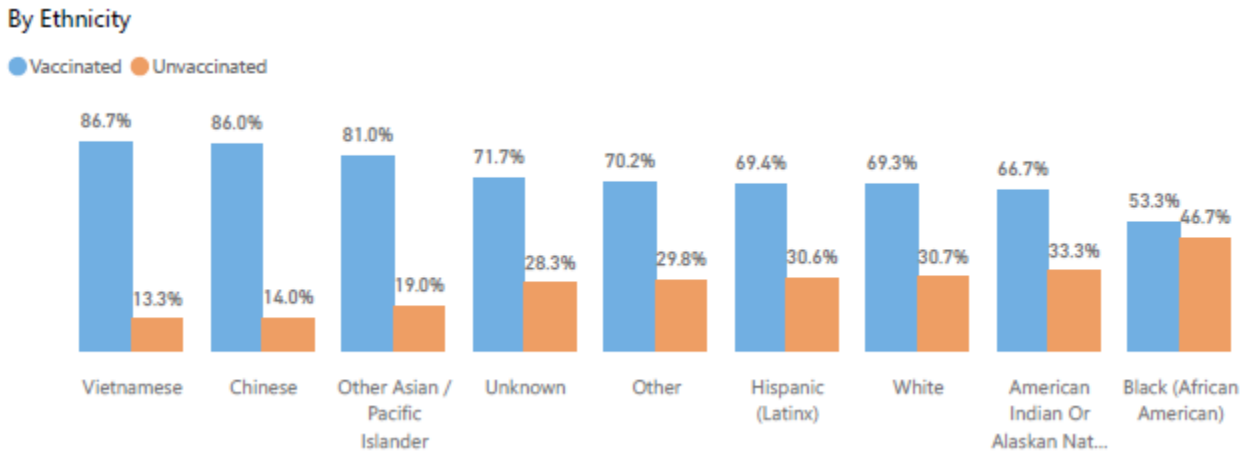
COVID-19 Vaccination Rate

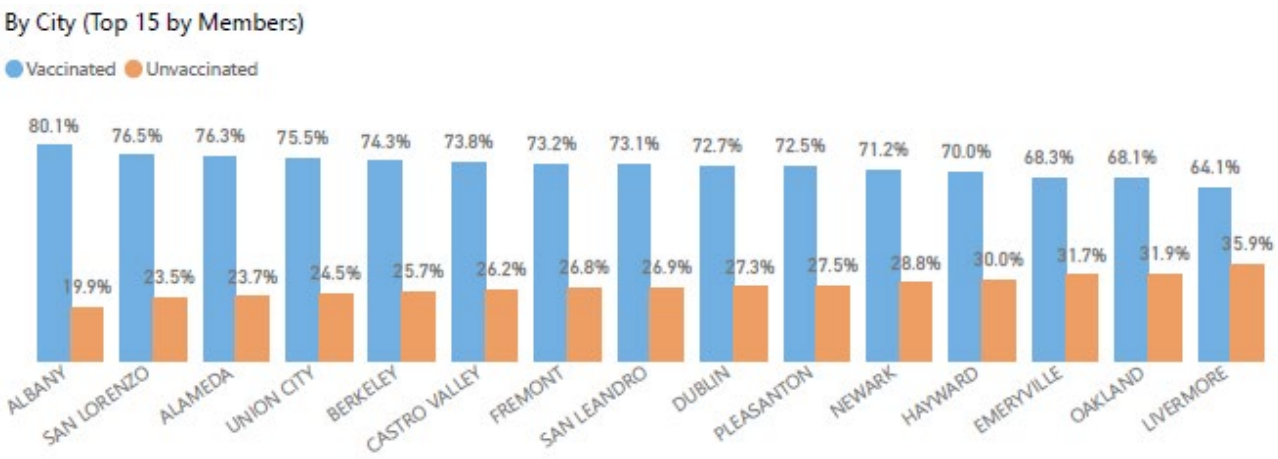
- The Alliance COVID-19 Vaccination rate is 70.7% for fully and partially vaccinated members aged **5** years and older.
  - 66.4% are fully vaccinated
  - 4.3% are partially vaccinated

A comparison of the Alliance's vaccinated vs unvaccinated members (29.3%) shows the following demographic results:









Member Cost Analysis

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

- For the Current reporting period, the top 8.6% of members account for 83.8% of total costs.

- In comparison, the Prior reporting period was lower at 7.9% of members accounting for 83.6% of total costs.

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

  - The SPD (non duals) and ACA OE categories of aid saw no change to account for 59.9% of the members, with SPDs accounting for 26.9% and ACA OE's at 33.1%.
  - The percent of members with costs >= $30K slightly increased from 1.7% to 1.9%.
  - Of those members with costs >= $100K, the percentage of total members remained consistent at 0.4%.
    - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, slightly increasing to 49.2%.

- Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.

- However, the age distribution of the top 8.6% is more concentrated in the 45-66 year old category (40.3%) compared to the overall population (20.4%).

Analytics

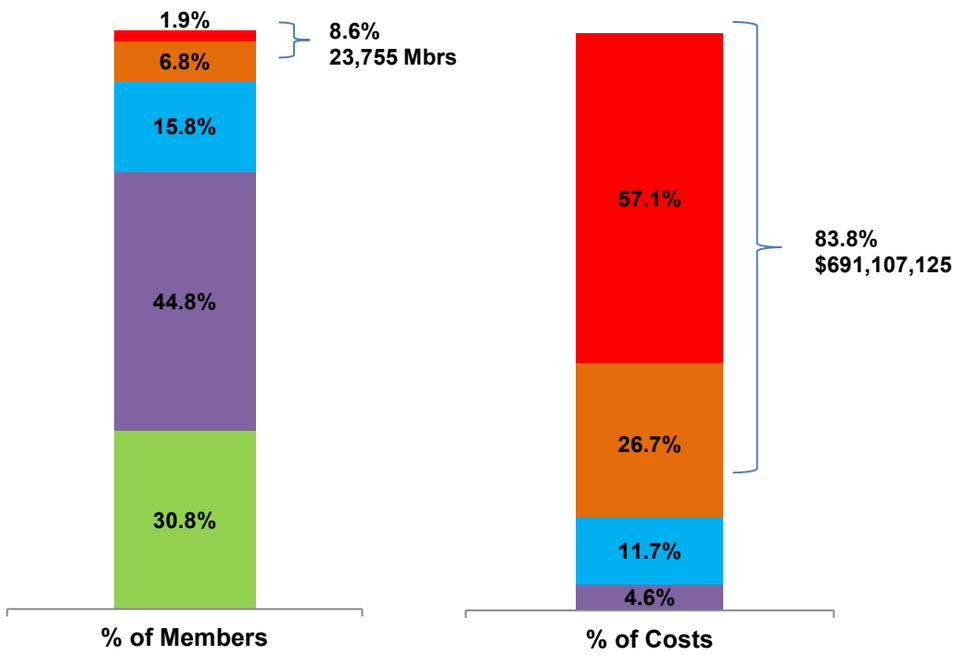
Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jan 2021 - Dec 2021

Note: Data incomplete due to claims lag

Run Date: 03/30/2022

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	5,176	1.9%	$ 470,652,785	57.1%
$5K - $30K	18,579	6.8%	$ 220,454,341	26.7%
$1K - $5K	43,260	15.8%	$ 96,095,302	11.7%
< $1K	122,901	44.8%	$ 37,565,170	4.6%
$0	84,709	30.8%	$ -	0.0%
Totals	**274,625**	**100.0%**	**$ 824,767,597**	**100.0%**

Top 8.6% of Members = 83.8% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	1,227	0.4%	$ 260,197,504	31.5%
$75K to $100K	622	0.2%	$ 53,442,084	6.5%
$50K to $75K	1,282	0.5%	$ 78,490,557	9.5%
$40K to $50K	790	0.3%	$ 35,272,147	4.3%
$30K to $40K	1,255	0.5%	$ 43,250,493	5.2%
SubTotal	***5,176***	***1.9%***	***$ 470,652,785***	***57.1%***
$20K to $30K	2,457	0.9%	$ 59,786,235	7.2%
$10K to $20K	6,784	2.5%	$ 94,214,662	11.4%
$5K to $10K	9,338	3.4%	$ 66,453,444	8.1%
SubTotal	***18,579***	***6.8%***	***$ 220,454,341***	***26.7%***
Total	**23,755**	***8.6%***	**$ 691,107,125**	***83.8%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Dec 2021	252,145	$ 731,012,254
Dis-Enrolled During Year	22,480	$ 93,755,343
Totals	**274,625**	**$ 824,767,597**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
8.6% of Members = 83.8% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jan 2021 - Dec 2021
Note: Data incomplete due to claims lag
Run Date: 03/30/2022

8.6% of Members = 83.8% of Costs
26.9% of members are SPDs and account for 32.6% of costs.
33.1% of members are ACA OE and account for 32.5% of costs.
6.8% of members disenrolled as of Dec 2021 and account for 12.8% of costs.

Highest Cost Members; Cost Per Member >= $100K
36.9% of members are SPDs and account for 36.3% of costs.
30.5% of members are ACA OE and account for 32.7% of costs.
19.6% of members disenrolled as of Dec 2021 and account for 19.9% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	136	587	723	3.0%
MCAL	MCAL - ADULT	580	3,562	4,142	17.4%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	217	1,520	1,737	7.3%
	MCAL - ACA OE	1,641	6,219	7,860	33.1%
	MCAL - SPD	1,821	4,559	6,380	26.9%
	MCAL - DUALS	110	1,188	1,298	5.5%
Not Eligible	Not Eligible	671	944	1,615	6.8%
Total		**5,176**	**18,579**	**23,755**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	22	1.8%
MCAL	MCAL - ADULT	110	9.0%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	5	0.4%
	MCAL - ACA OE	374	30.5%
	MCAL - SPD	453	36.9%
	MCAL - DUALS	22	1.8%
Not Eligible	Not Eligible	241	19.6%
Total		**1,227**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 9,489,402	$ 6,639,592	$ 16,128,993	2.3%
MCAL	MCAL - ADULT	$ 44,636,246	$ 41,857,041	$ 86,493,286	12.5%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 10,179,047	$ 17,535,281	$ 27,714,328	4.0%
	MCAL - ACA OE	$ 152,548,682	$ 72,172,121	$ 224,720,803	32.5%
	MCAL - SPD	$ 169,666,614	$ 55,814,651	$ 225,481,265	32.6%
	MCAL - DUALS	$ 8,003,359	$ 14,427,417	$ 22,430,776	3.2%
Not Eligible	Not Eligible	$ 76,129,436	$ 12,008,238	$ 88,137,674	12.8%
Total		**$ 470,652,785**	**$ 220,454,341**	**$ 691,107,125**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 3,922,972	1.5%
MCAL	MCAL - ADULT	$ 20,423,060	7.8%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 1,041,286	0.4%
	MCAL - ACA OE	$ 85,122,785	32.7%
	MCAL - SPD	$ 94,419,589	36.3%
	MCAL - DUALS	$ 3,613,446	1.4%
Not Eligible	Not Eligible	$ 51,654,366	19.9%
Total		**$ 260,197,504**	**100.0%**

% of Total Costs By Service Type

Breakout by Service Type/Location

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	8%	0%	0%	12%	57%	1%	14%	5%	2%	7%
$75K to $100K	7%	0%	1%	18%	44%	3%	9%	5%	8%	12%
$50K to $75K	7%	0%	1%	17%	42%	4%	7%	7%	9%	15%
$40K to $50K	7%	1%	1%	16%	46%	5%	9%	5%	2%	17%
$30K to $40K	13%	0%	1%	15%	37%	14%	7%	7%	1%	19%
$20K to $30K	7%	2%	1%	18%	34%	11%	10%	8%	1%	19%
$10K to $20K	1%	0%	1%	21%	33%	6%	13%	10%	1%	16%
$5K to $10K	0%	0%	0%	24%	18%	9%	13%	16%	0%	19%
Total	**6%**	**0%**	**1%**	**16%**	**44%**	**5%**	**12%**	**7%**	**3%**	**13%**

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

ALAMEDA Alliance FOR HEALTH

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

Human Resources

Anastacia Swift

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

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

Date: **April 8th, 2022**

Subject: **Human Resources Report**

Staffing

- As of April 1st, 2022, the Alliance had 371 full time employees and 1-part time employee.

- On April 1st, 2022, the Alliance had 52 open positions in which 11 signed offer acceptance letters have been received with start dates in the near future, resulting in a total of 41 positions open to date. The Alliance is actively recruiting for the remaining 41 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by department:

Department	Open Positions April 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	11	2	9
Operations	23	7	16
Healthcare Analytics	3	0	3
Information Technology	6	1	5
Finance	1	0	1
Regulatory Compliance	3	1	2
Human Resources	4	0	4
Projects & Programs	1	0	1
Total	52	11	41

- Our current recruitment rate is 12%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in March 2022 included:
    - 5 years:
        - Ramon Tran Tang (Pharmacy Services)
    - 6 years:
        - Sonia Spears (Quality Analytics)
        - Kristel Rusiana (Utilization Management)
        - Maria Radona (Utilization Management)
        - Tanisha Lipscomb-Shepard (Regulatory Affairs & Compliance)
        - Junaid Godil (IT Operations & Quality Apps Management)
        - Remy Sagayo (Finance)
    - 7 years:
        - Paris Hawkins (Claims)
        - Janese Jacques-Davis (Projects & Programs)
        - Christine Marie Rosal (Utilization Management)
    - 10 years:
        - Christine Rattray (Quality Improvement)
        - Elsa Guzman (Case & Disease Management)
    - 12 years:
        - Marlowe West (Claims)
        - Latrina Brodnax (Claims)
    - 13 years:
        - Tyisha Pierce (Claims)
    - 14 years:
        - Ed Sanares (IT Infrastructure)
    - 20 years:
        - Mandy Gutierrez (Community Relations)
    - 21 years:
        - Teresa Corral (Claims)