Board of Governors

Regular Meeting

Friday, June 14th, 2024
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 South Loop Road, Alameda, CA 94502

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, June 14th, 2024
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

1 Market Place
San Diego, CA 92101

7272 MacArthur Blvd.
Oakland, CA 94605

PUBLIC COMMENTS: Public Comments can be submitted for any agendized item or for any item not listed on the agenda, by mailing your comment to: "Attn: Clerk of the Board," 1240 S. Loop Road, Alameda, CA 94502 or by emailing the Clerk of the Board at brmartinez@alamedaalliance.org. You may attend meetings in person or by computer by logging in to the following link: Click here to join the meeting. You may also listen to the meeting by calling in to the following telephone number: 1-510-210-0967 conference id 728716599#. If you use the link and participate via computer, you may use the chat function, and 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, please submit your comments to the Clerk of the Board at the email address listed above or by providing your comments during the meeting at the end of each agenda item. Oral comments to address the Board of Governors are limited to three (3) minutes per person. Whenever possible, the board would appreciate it if public comment communication was provided prior to the commencement of the meeting.

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.

1. CALL TO ORDER

(A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on June 14th, 2024, at 12:00 p.m. in Alameda County, California, by Rebecca Gebhart, Presiding Officer. This meeting is to take place in person and by video conference call)

2. ROLL CALL

3. AGENDA APPROVAL

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) MAY 7th, 2024, FINANCE COMMITTEE MEETING MINUTES

b) MAY 10th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

c) MAY 10th, 2024, BOARD OF GOVERNORS MEETING MINUTES

d) 2023 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM EVALUATION

e) 2024 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM DESCRIPTION

f) 2023 UTILIZATION MANAGEMENT PROGRAM EVALUATION

g) 2024 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

h) 2023 QUALITY IMPROVEMENT – PROGRAM EVALUATION

i) 2024 QUALITY IMPROVEMENT – PROGRAM DESCRIPTION

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

b) FINANCE COMMITTEE

7. CEO UPDATE

8. BOARD BUSINESS

a) REVIEW AND APPROVE APRIL 2024 MONTHLY FINANCIAL STATEMENTS

b) REVIEW AND APPROVE FY25 DRAFT BUDGET PRESENTATION

c) MEDICARE PRESENTATION

9. STAFF UPDATES

10. UNFINISHED BUSINESS

11. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

12. PUBLIC COMMENT (NON-AGENDA ITEMS)

13. CLOSED SESSION

a) **CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION**
Significant exposure to litigation, one (1) potential case.
(Paragraph (2) or (3) of subdivision (d) of GOV. CODE, § 54956).

b) **PUBLIC EMPLOYEE PERFORMANCE EVALUATION: CHIEF EXECUTIVE OFFICER (GOV.CODE SECTION 54957).**

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: www.alamedaalliance.org

Board of Governors meetings are regularly held on the second Friday of each month at 12:00 p.m., unless otherwise noted. This meeting is held both in person and as a video conference call. Meeting agendas and approved minutes are kept current on the Alameda Alliance for Health's website at www.alamedaalliance.org.

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 items 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.

Supplemental Material Received After the Posting of the Agenda: Any supplemental materials 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 it to "Attn: 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, Brenda Martinez, at (510) 747-6160 at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodations to attend or participate in meetings on a regular basis.

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org by June 11th, 2024, by 12:00 p.m.

Brenda Martinez, Clerk of the Board

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EXECUTIVE SUMMARY APPENDIX

Please click on the hyperlink(s) below to direct you to corresponding material for each item.

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PRESENTATIONS APPENDIX

Please click on the hyperlink(s) below to direct you to corresponding material for each item.

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SUPPORTING MATERIALS APPENDIX

Please click on the hyperlink(s) below to direct you to corresponding material for each item.

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Consent Calendar

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Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

May 7th, 2024
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted in-person and by Teleconference.

Committee Members in-person: Dr. Rollington Ferguson, Yeon Park, Gil Riojas
Committee Members on Conference Call: James Jackson

Board of Governor members in-person and on Conference Call: Rebecca Gebhart, Colleen Chawla, Andrea Ford

Alliance Staff in-person and on Conference Call: Matt Woodruff, Tiffany Cheang, Sasi Karaiyan, Richard Golfin III, Anastacia Swift, Lao Paul Vang, Ruth Watson, Shulin Lin, Carol van Oosterwijk, Linda Ly, Brenda Martinez, Renan Ramirez, Danube Serri, James Zhong Xu, Christine Corpus

CALL TO ORDER, ROLL CALL, AND INTRODUCTIONS

Dr. Ferguson called the Finance Committee meeting to order at 8:00 am. A roll call was then conducted.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

There were no modifications to the Consent Calendar, and no items to approve.

a.) CEO UPDATE

Matt Woodruff provided updates to the committee on the following:

- **Audit**
  Matt informed the committee that our annual DHCS Audit is scheduled for June 17th through June 28th. We received our file pull on Friday, May 3rd, and the team is performing an internal audit on the file pull which will be reviewed at next week's Senior Leadership meeting. Matt will provide an update at next month's Compliance Committee meeting, ahead of the audit. Of particular interest, DHCS has pulled more files than usual, and specifically from departments they have not pulled from before such as Transportation, and Behavioral Health.

- **New Board Members**
  On Friday we will see two new Board Members for the Alliance. The last two open seats that we have had since we became a Single Plan Model will be filled. We have two nominees coming forward for the Hospital Council seat, both very qualified.

- **Finance**
  From a Finance perspective, the Alliance is still doing very well. Projections indicate a positive Net Income for the year, slightly above the Board reserve ratio of 1%. The financial outlook suggests that we are on track to end the year on a positive note.

  Matt provided insight into the ongoing growth of enrollment within the Alliance. This topic will be further elaborated upon in an upcoming presentation scheduled for Friday.

Matt emphasized the significance of this enrollment growth, attributing it to changes implemented by the Alameda County Social Services Agency. These changes were made last fall following state allowances for county-level adjustments. Matt commended the Social Services Agency for their efforts, noting the positive impact these changes have had on Alameda County.

Matt underscored the importance of this growth, acknowledging the collaborative efforts between the Alliance and the county in achieving this outcome.

Informational update to the Finance Committee. Voting is not required.

b.) REVIEW AND APPROVE FEBRUARY AND MARCH MONTHLY FINANCIAL STATEMENTS

Gil provided the following update prior to reviewing the monthly financial statements:

- Budgeting Process: Gil informed the committee about the ongoing efforts in the finance department regarding budgeting for the upcoming fiscal year. He mentioned that the team is currently working on the second pass of the budget, which involves refining the initial draft. In the first pass, all requests from different departments, including their FTEs (Full-Time Equivalents) and operating expenses, were received. Additionally, the finance team has been modeling medical expense trends for the next fiscal year, with enrollment being a significant factor influencing projections. Gil noted the second pass of the budget should be complete by the end of the week. The preliminary budget will then be presented to the Finance Committee first, followed by presentation to the full board in June.
- Audit Engagement: Gil shared that the Alliance has recently engaged Moss Adams for audit services by signing an engagement letter. Moss Adams is scheduled to conduct their audit typically in August or September, with the results expected in October.

FEBRUARY 2024 Financial Statement Summary

Enrollment:

As Matt mentioned, our Enrollment unexpectedly increased by 1,700 members. By category of aid, we saw increases in our Child, Adult, and Optional Expansion. We also saw slight increase in our Group Care category, with SPD and Duals remaining relatively flat.

Net Income:

For the month ending February 29th, 2024, the Alliance reported a Net Income of $5.4 million (versus budgeted Net Income of $3.4 million). The favorable variance is attributed to higher than anticipated Premium Revenue and lower than anticipated Administrative Expense. This was offset somewhat by higher than anticipated Other Expense, Medical Expense, and net MCO Tax. For the year-to-date, the Alliance recorded a Net Income of $32.8 million versus a budgeted Net Income of $20.0 million.

Premium Revenue:

For the month ending February 29th, 2024, actual Revenue was $165.9 million vs. our budgeted amount of $161.5 million. This slight positive variance is primarily due to the timing of revenue recognition. Our actual year-to-date Revenue is currently at $1.2 billion versus budgeted Revenue of $1.1 billion.

Gil provided a comprehensive explanation of the new term "Premium Revenue" in relation to Targeted Rate Increases (TRI). These TRI represent a State initiative aimed at allocating additional revenue to healthcare providers, particularly focusing on specific services, notably Primary Care.

For the Alliance, this initiative involves several operational tasks at the plan level. Essentially, the TRI serves as a mechanism for the State to enhance funding for critical healthcare services, relying on plans such as the Alliance to facilitate the transfer of funds to the relevant providers.

However, it's important to note that despite the implementation of TRI, and the reflection of it in our stated Revenue, the State has not yet provided guidance on how plans are expected to execute this. Therefore, while the Alliance is prepared to comply with this initiative, further clarification and guidance from the State are needed to ensure smooth and effective implementation.

Medical Expense:

Actual Medical Expenses for the month of February were $152.7 million, vs. our budgeted amount of $152.2 million. For the year-to-date, actual and budgeted Medical Expenses were $1.1 billion. Drivers leading to the slight favorable variance can be seen on the tables on pages 14, with further explanation on pages 14 and 15.

Medical Loss Ratio:

Our MLR ratio for this month was reported at 92.0%. Year-to-date MLR was at 93.4%.

Administrative Expense:

Actual Administrative Expenses for the month ending February 29th, 2024 were $6.4 million vs. our budgeted amount of $8.4 million. Our Administrative Loss Ratio (ALR) is 3.8% of our Revenue for the month, and 5.1% of Net Revenue for year-to-date.

Other Income / (Expense):

As of February 29th, 2024, our YTD interest income from investments show a gain of $20.4 million.

YTD claims interest expense is $493,000.

Managed Care Organization (MCO) Provider Tax:

For the month ending February 29th, 2024, we reported $159.8 million unbudgeted MCO Tax Revenue, and $162.5 million unbudgeted MCO Tax Expense.

Tangible Net Equity (TNE):

For the month of February, the DMHC required that we have $55.3 million in TNE, and we reported $356.7 million, so the excess of that is $301.4 million. As a percentage, we are at 645% of required, which remains very healthy.

Cash and Cash Equivalents:

We reported $530.5 million in cash; $225.1 million is uncommitted. Our current ratio is above the minimum required at 1.56 compared to regulatory minimum of 1.0.

Capital Investments:

We have spent $1.2 million in Capital Assets year-to-date. Our annual capital budget is $1.6 million.

Question: Dr. Ferguson inquired about staff returning to the office and its impact on our lease at the 1320 building. Matt, in response, provided an update on the lease status, stating that the lease for the 1320 building is set to expire in May 2025, and the decision has been made not to renew it. He indicated that discussions regarding securing a new building will be forthcoming.

Matt also elaborated on the company's stance regarding staff returning to the office, emphasizing that remote work can continue to be the company practice as long as operational metrics are met. He clarified that there won't be a necessity for the full staff to return to the office on a full-time basis.

MARCH 2024 Financial Statement Summary

Enrollment:

As previously mentioned, in March, the Alliance continued to experience increases in enrollment. Enrollment increased by 1,682 members since February, to 403,941 members, with primary increases in our Child, Adult, and Optional Expansion Categories of Aid. SPD and Duals remained flat, and for the second month in a row we saw a slight increase in our Group Care line of business.

Net Income:

For the month ending March 31st, 2024, the Alliance reported a Net Loss of $3.3 million (versus budgeted Net Loss of $2.3 million). The unfavorable variance is attributed to higher than anticipated Medical and Administrative Expenses, as well as the unbudgeted accrual for MCO Tax. For the year-to-date, the Alliance recorded a Net Income of $29.5 million versus a budgeted Net Income of $17.7 million.

Premium Revenue:

For the month ending March 31st, 2024, actual Revenue was $169.7 million vs. our budgeted amount of $159.9 million. The positive variance is primarily due to favorable Medi-Cal Capitation Rate variance due to the new Targeted Rate Increase, favorable CalAIM Incentive revenue due to an additional award for Housing and Homelessness Incentive Program (HHIP). These were slightly offset by the 2022 Acuity Adjustment reserve. Our actual and budgeted year-to-date Revenue is currently at $1.3 billion.

Gil discussed the state's consideration of acuity adjustments, which retroactively impact revenue back to 2022. Rebecca Gebhart inquired whether non-utilizing members affect the acuity score, suggesting that encouraging them to undergo basic wellness checks might help reverse the situation. Gil affirmed this and explained that non-utilizers do impact the acuity level, which in turn affects rates. Efforts to engage non-utilizers in healthcare can enhance the accuracy of acuity levels in rate calculations. Matt added that the acuity adjustment was part of a statewide initiative, noting that the Alliance was relatively less affected compared to other plans.

Yeon Park then asked about the frequency of reassessment and whether there was an outreach plan. Gil responded that over the last several years, the state typically reassesses member acuity annually based on information provided by plans. This reassessment involves reviewing data and coding to determine if initial assumptions were correct and allows for adjustments to be made accordingly. Matt confirmed that there are outreach plans in place, with initiatives starting as early as last summer and additional ones scheduled for the first quarter of the current calendar year. These outreach efforts target specific measures that impact our HEDIS scores, particularly focusing on well-child visits. The aim is to identify non-utilizers and engage with them effectively. Overall, we have already initiated some outreach plans and have more in progress.

Medical Expense:

Actual Medical Expenses for the month were $163.3 million, vs. budgeted amount of $156.2 million. For the year-to-date, actual and budgeted Medical Expenses were $1.2 billion. Drivers leading to the favorable variance can be seen on the tables on page 49, with further explanation on pages 49 and 50.

Medical Loss Ratio:

Our MLR ratio for this month was reported at 96.2%. Year-to-date MLR was at 93.9%.

Administrative Expense:

Actual Administrative Expenses for the month ending March 31st, 2024 were $9.8 million vs. our budgeted amount of $8.5 million. Our Administrative Loss Ratio (ALR) is 5.8% of our Revenue for the month, and 5.2% of Net Revenue for year-to-date.

There were a couple of changes implemented this month. There was a modification to the fixed asset methodology, resulting in an increase in the fixed asset limit. Consequently, fewer items were classified as assets, leading to more being categorized as expenses. This adjustment caused an increase in administrative expenses for the current month. However, it is believed that this change better aligns with industry standards and provides a more accurate reflection of the fixed asset number. It's anticipated that these adjustments will normalize in the upcoming months, thus avoiding significant changes in administrative expenses in the future.

Other Income / (Expense):

As of March 31st, 2024, our YTD interest income from investments show a gain of $23.3 million.

YTD claims interest expense is $555,000.

Managed Care Organization (MCO) Provider Tax:

For the month ending March 31st, 2024, we reported $113.6 million unbudgeted MCO Tax Revenue, and $116.3 million unbudgeted MCO Tax Expense.

Tangible Net Equity (TNE):

For March, the DMHC requires that we have $56.3 million in TNE, and we reported $353.4 million, leaving an excess of $297.2 million. As a percentage we are at 628% which remains a very healthy number.

Cash and Cash Equivalents:

We reported $765.4 million in cash; $508.2 million is uncommitted. Our current ratio is above the minimum required at 1.58 compared to regulatory minimum of 1.0.

Capital Investments:

We have spent $1.2 million on Capital Assets year-to-date. Our annual capital budget is $1.6 million.

Motion: A motion was made by Yeon Park, and seconded by Dr. Rollington Ferguson, to accept and approve the February 2024, and March 2024 Financial Statements.

Motion Passed

No opposed or abstained.

c.) INVESTMENT PORTFOLIO UPDATE

Gil provided a PowerPoint presentation on the Investment Portfolio. In summary:

- As of the end of March, the total investment portfolio stood at $784 million. The majority, 92%, was invested in short-term investments with maturities ranging from 0 to 90 days, while the remaining 8% was in investments maturing over 90 days.
- The average yield of the investments was 5.36%, benefiting from the increase in interest rates over the past 12 to 18 months.
- The estimated return for the fiscal year is projected to be approximately $24 million, a significant increase from the previous fiscal year's return of $8 million.
- Investments are focused on high-quality and highly liquid assets, ensuring quick cash-out if necessary, in compliance with California Government Code 53600.
- Regarding Environmental, Social, and Governance (ESG) investments, the organization has divested from companies conflicting with ESG principles, such as Lockheed Martin.
- Currently, $17.5 million is invested in green investments aimed at financing renewable energy, energy efficiency, clean air, clean water, and pollution control projects.

- The yield from ESG investments in the longer-term portfolio is slightly higher than the regular portfolio, at 5.51% versus 5.43%. Plans are underway to increase the ESG investment portfolio from $17.5 million to $20 million by the end of the calendar year.
- Market update: There is growing confidence in a soft landing, with expectations of slow growth without entering a recession. The initial anticipation of multiple interest rate cuts has been tempered to one or two cuts for the year, which could benefit investments. The focus remains on shorter-term investments but there is consideration to venture into longer-term investments given potential rate changes.

Informational update to the Finance Committee. Voting is not required.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 9:02 a.m.

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Compliance Advisory Committee Meeting Minutes

COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes
Friday, May 10, 2024
10:30 a.m. – 11:30 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

CALL TO ORDER

Committee Members Attendance: Byron Lopez, Dr. Kelley Meade, Rebecca Gebhart

Committee Members Remote: Richard Golfin III

Committee Members Excused: None

1. CALL TO ORDER

The regular Compliance Advisory Committee meeting was called to order by Dr. Kelley Meade at 10:30 am.

2. ROLL CALL

A roll call was taken of the Committee Members, quorum was confirmed.

3. AGENDA APPROVAL OR MODIFICATIONS

There were no modifications to the agenda.

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

None

5. CONSENT CALENDAR

a) March 8th, 2023, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

Motion: A motion was made by Richard Golfin, III and seconded by Byron Lopez to approve Consent Calendar Agenda Items (a) through (c).

Vote: Motion unanimously passed.

No opposition or abstentions.

6. COMPLIANCE MEMBER REPORTS

a) COMPLIANCE ACTIVITY REPORT

i. Plan Audits and State Regulatory Oversight

1. Status Updates on State Audit Findings and Plan Responses

    a. 2024 DHCS Routine Medical Survey

        - The virtual interview sessions for the 2024 DHCS Full Medical Survey are scheduled from June 17th through June 28, 2024. The lookback period is from June 1st, 2023, through May 31st, 2024. The Plan has already submitted its pre-audit materials that was done on April 24th and then on April 29th we made a submission of Addendum E. The DHCS has reached out with clarifying questions and additional information related to the pre-audit submission. The Plan is in the process of providing that additional information.
        - 2024 Mock Audits
            - The Compliance Division held Mock Audit interviews with the subject matter experts at the Plan from April 22nd through May 3rd. There were a total of 16 mock audits with Plan staff, and two mock audit interviews with delegates. The SMEs were prepared and asked clarifying questions, and the Plan now feels prepared for the audit sessions with DHCS.

    Question: Which two delegates participated in the mock audits?

    Answer: CHCN and ModivCare. R*egulators tend to select those delegates for further review. ModivCare, because they have focused oversight on transportation across the state and CHCN because they are our larges partner. For the past few years, the state has selected these delegates, and now that we have behavioral health insourced and administered by the plan, that was also the primary focus of the Plan, but since there's no delegate there, they'll just ask those questions of us during our normal interviews.*

2. Compliance Dashboard

    a. No Update Due to 2024 DHCS Routine Full Medical Survey.

        - We have no update as we are on the cusp of beginning our 2024 routine full medical survey.
        - The state has recently closed our 2023 audit
        - We're ready for the 2024 audit with no open engagements with the state.

    Question: What are the dates for the 2024 audit?

    Answer: The onsite days are June 17 through June 28.

        - We expect for the post-audit exercises to last from June 28th through early August. Following the onsite, there will be 60 to 75 days of back and forth with the state on any potential findings, and then we can anticipate getting a preliminary report in August, with a final report issued towards January 2025. If everything goes well, the audit will then close as we approach the June 2025 audit. So even though this audit happens over 2 weeks, it's really a year-round engagement the Audits team works throughout the year, either in closing the audit of the current year or in preparing the audit for the coming year.

ii. Compliance Risk Assessment Results and Plan Progress

1. RGP Compliance Risk Assessment (CRA)

a. There were total of 14 areas of opportunity that were identified with the risk assessments and there were 20 different findings.
b. As of today, we have 52% of recommendations complete and 48% are in progress.
c. We are on track with our goal of completing all findings by the end of Q4 2024
d. Recently, we completed the triage protocols for the Compliance Hotline. These triage protocols help us determine what to do with the calls that come in the hotline, whether they are compliance related, or need to be referred to other departments.

Question: As I recall, we had one single hotline that lumped many activities together, and now this one is pulled out specifically for Compliance?

Answer: The only hotline we have so far is the Compliance Hotline. We are working with our Chief Human Resources Officer and her team to develop a separate anonymous reporting hotline that will be for human resources-related complaints. That is a project that is still in process and we are very close to closing that.

e. Along with the recommendations that we're looking for in completing this risk assessment, we also developed additional actions, they go beyond the RGP recommendations, so they are going to mature our Compliance Program.
    - There's a total of 22 additional actions that align with the 22 different findings.
    - We have completed 9% of the additional actions so far, including:
        1. A partnership with Regulatory Affairs Team and Integrated Planning team here at the Alliance to help support ongoing projects related to the regular price changes.
        2. Creation of a policy template to help guide what is included in policies and procedures and to make sure they all have the same format.
        3. Development of a workflow for approving policies to help ensure that policies are being reviewed by the appropriate people, and they’re being reviewed annually.
f. Some recommendations and areas of opportunity that are still in progress, include:
    - Creating desktop procedures for completing internal audits. We've created desktop procedures, they’re still in rough form, we're finalizing them.
    - Creating a separate Human Resources hotline
    - We have started the process of creating an Enterprise Risk Management program. We have a consultant now and we've kicked off this enterprise-wide risk assessment that started on March 26th. The consultant has gotten documents from us, such as policies and procedures, what our current risk reporting is, and now they're interviewing various departments on their processes.
    - We have enhanced our delegation dashboard reporting. We're gathering feedback from stakeholders on our corrective action plan process for delegates as well as the information that we’re presenting on the dashboard to ensure that we're providing a full view of the metrics are delegates and such.

- We've completed a Fraud Waste Abuse training plan and workflows so incidents are reported timely and then this is just a small piece of the compliance training we're developing to help provide a better understanding of the points of compliance here at the Alliance. This Fraud, Waste, and Abuse piece has to do with the DHCS finding we had about our timeliness in reporting Fraud, Waste, and Abuse, and it is important to continue training annually.
- The Privacy team has started partnering with our Vendor Management team on data sharing agreements, privacy and security incident investigation and Vendor Management has also started developing a vendor playbook which the privacy team is weighing in on.

Question: I'm curious about item number 11 in this Q4 section. For timely reporting of of Fraud, Waste, and Abuse—are the triage protocols going to help in the hotline, going to help with that item? Are they related?

Answer: Yes. we are in the second year of a compliance program transformation here at the Alliance. Our CEO has a vision and we've taken that vision through assistance from our third-party consultants. We've gone through a compliance program, effectiveness on it. We've got 22 recommendations and from those 22 recommendations we've implemented almost 50 improvements to our compliance program, all in pursuit of improving the way our compliance program operates within our plan. Written policies and procedures have been updated and developed, effective training and education has been distributed across the enterprise. We've improved our lines of communication with our operational units across the enterprise. As you've seen, our internal monitoring and auditing that Miss Robertson, and Miss Sisto, have led us through from start to finish in this transformation has been tremendous and we've improved the way that we enforce our standards and we've been attentive to shaping our ability to be proactive rather than reactive, we still have some reactionary aspects of our compliance program. But as you saw in the in the changes that we're working towards by the end of Q4 2024, we will have more proactivity and proactive ways of identifying risks in the plan. And I think that's an excellent transition into our next section, which is our enterprise risk management program, which is going to holistically allow us to identify the risks and proactively address them.

iii. Introduction to Enterprise Risk Management (ERM)
   a. The Plan would like to provide an update that we are currently engaging with Protiviti, a third-party consultant, to assist with the roll out of holistic approaches to risk management and risk stratification across the enterprise.
   b. The purpose of this enterprise risk assessment is to identify risks or potential risk areas and provide more opportunities of improvement for the Alliance.
   c. Currently, weekly status meetings are held with Protiviti and the Team to provide progress and milestones. The collaboration between Protiviti and the Plan will focus on 19 specific departments and risk types identified in the enterprise risk assessment in order to further the ERM project milestones.

d. These milestones will include gaining and assessing and understanding of risk identification, prioritization, integration and planning to evaluate risk management practices as well as opportunities for improvement and gap identification, industry risk and organization risk assessment, and as part of the process, currently 19 stakeholder interviews are scheduled with leaders across the plan to discuss the risk assessment, with a final report anticipated in June 2024.

Question: How long have we been engaged with this vendor, Protiviti?

Answer: End of March.

Question: So it is a new relationship.

Answer: It is. This endeavor came out of the compliance program effective review we had through another third party assessment which was in the last update that Roberta and Katie provided. So first we had a third party evaluate our compliance program and provide us feedback and then now the second phase of that is to have a third party provide us an assessment and evaluation on risk management as a whole across the enterprise. And so one has fed into the other and we're hoping to leverage the feedback from this secondary review to really take our organization to the next level from a risk management perspective. So we've done internal audits, but internal audits doesn't give you the whole risk picture in an organization. So this is aligned with our organizational maturity over the past decade or so.

Question: We had internal feedback from our original vendor-consultants. Is this new vendor privy to that feedback to understand some of the issues we want to have them address?

Answer: Yes, they do have all that feedback, but that feedback, if you look at it from a 50,000 foot perspective, the first vendor provided this feedback just on the compliance program and then this vendor is providing us feedback on the organizational risk, risk appetite, risk structure, risk methodology, and approach to risk management. One was like looking just at a Compliance vertical and this one is looking at all aspects from operational and Governance committee structure, hiring practices, so it's looking at everything, not just in the compliance vertical. For an almost 30 year organization, we are beyond due for not having an organizational risk assessment. So this is just falling in line with where we are in our in our organizational growth path.

b) MEDI-CAL PROGRAM UPDATES

None

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a) None

8. STAFF UPDATES

None

9. UNFINISHED BUSINESS

None

10. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

None

11. ADJOURNMENT

Chair Dr. Kelley Meade adjourned the meeting at 11:30 am.

ALAMEDA Alliance FOR HEALTH

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Board of Governors Meeting Minutes

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, May 10th, 2024
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Jody Moore, Yeon Park, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam

Board of Governors Remote: Andie Martinez-Patterson, Dr. Noha Aboelata (Vice-Chair)

Board of Governors Excused: Andrea Ford, James Jackson, Natalie Williams

Alliance Staff Present: Matthew Woodruff, Dr. Donna Carey, Gil Riojas, Anastacia Swift, Ruth Watson, Sasi Karaiyan, Tiffany Cheang, Michelle Lewis, Lao Paul Vang

Chair Gebhart called the regular Board of Governors meeting to order at 12:02 p.m.

2. ROLL CALL

Roll call was taken and a quorum was established.

3. AGENDA APPROVAL OR MODIFICATIONS

There were no modifications to the agenda.

4. INTRODUCTIONS

Cory Woods was introduced.

5. CONSENT CALENDAR

a) MARCH 8th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

b) MARCH 8th, 2024, BOARD OF GOVERNORS MEETING MINUTES

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Dr. Kelley Meade to approve the Consent Calendar Agenda Items 5a through 5b.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Jody Moore, Yeon Park, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

Dr. Kelley Meade provided an update on the Compliance Advisory Committee meeting that took place on May 10th. The 2023 dashboard is being closed out with near 100% completion and getting ready for the plan's audit season for 2024. The mock audits have gone well, and the plan is currently auditing all the requested files and preparing for2024 state audit. The compliance risk assessment and overall strategy were also discussed.

Question: The governor is suggesting that many unopened positions will be eliminated and wondering if it's going to affect the state's interaction with us on audits and compliance.

Answer: It will not affect us. Our audit is scheduled, and we have the same auditors as last year.

b) FINANCE COMMITTEE

Dr. Rollington Ferguson provided an update on the Finance Committee meeting held on May 7th, 2024. During the meeting, they discussed the financial reports for February 2024 and March 2024. One of the key topics was the Target Rate Increase, which is intended to directly benefit our providers and improve the overall network. This increase in funding mainly comes from the MCO tax and will have an impact on the overall revenue. Our enrollment numbers are showing improvement, and our MLR (Medical Loss Ratio) is above 90%. Both the revenue and medical expenses have increased, while the Tangible Net Equity decreased in February but is back on an upward trend.

Question: What percentage of Medicare are our current rates?

Answer: It varies. We pay anywhere from Medi-Cal to Medicare, and it depends on the specialty. It is a very wide range.

7. CEO UPDATE

In the CEO Update, Matthew Woodruff expressed his gratitude to everyone involved in planning and participating in the Spring Social. He also provided an update on the April Financials, stating that revenue was $169.7 million in March 2024 and $1.3 billion Year-To-Date (YTD). The total enrollment in March 2024 was 403,941.

Another topic of discussion was automation. The Alliance is currently undergoing a major exploration of all the processes that can be automated. The provider recruiting program is set to go live, with the application being finalized and slated for posting on the Alliance website. Additionally, the DHCS audit is scheduled for the last two weeks in June. At the June Compliance Committee meeting, a review of performance expectations will take place.

There was also an update on the pay equity salary survey, revealing positive progress since August. Internal changes have been implemented, thanks to HR's substantial contributions. While there are a few areas that need adjustment, the overall improvements have been notable since last August. These adjustments will be addressed during the merit review process in July, making the organization more equitable overall.

The Alliance met with CMS, DHCS and DMHC to review D-SNP readiness and filings and the agencies were pleased with the Alliance progress. We have already started submitting documents, so we're well on our way for all of our different filings.

Comment: The Board is interested in hearing more about how we're funding the Unsatisfied Immigration Status (UIS) population.

8. BOARD BUSINESS

a) REDETERMINATION PRESENTATION

Tammy Lue & Juan Ventanilla, Medi-Cal Program Specialists, Ruth Watson and Tiffany Cheang provided a presentation on Medi-Cal Re-Evaluations. Highlights of the presentation include:

Medi-Cal Re-Evaluation Data

- From March 2020 to March 2023, Medi-Cal beneficiaries remained enrolled in the program, with a moratorium on annual redetermination processing due to the continuous coverage requirement for Medi-Cal throughout the duration of the public health emergency.
- April 2023 – Renewal processing began with the auto-renewal process.
- July 1st – First discontinuances
- Counties have 12 months from the end of the continuous coverage requirement to initiate Medi-Cal redeterminations and an additional two months to complete processing these redeterminations.
- June 2023 – March 2024 – 138,091 packets sent.
- # of REs received: 117,137
    - REs Processed: 91,158
    - REs not processed: 25,981
    - REs not received: 51,426
    - # of cases discontinued: 39,293
    - # of cases discontinued for no RE: 31,090

Alliance Net Change Enrollment

- January 2024 – Transitioned to a Single Plan model in Alameda County.
- Anthem members transitioned to the Alliance.

ACSSA Plan for Re-Evaluation Process

- ACSSA continues implementation of the Health Enrollment Navigators Project until June 2025 via Senate Bill (SB) 154 by partnering with 7 CBOs to conduct outreach and assist community members with completing Medi-Cal applications or re-evaluation.
- ACSSA has integrated unwinding activities into the CBO partners' implementation of the project and the targeted multimedia marketing campaign.

Medi-Cal Re-Evaluation Waivers

- Reasonable Compatibility Threshold Increase
- Hard-to-Reach Population Waiver
- Reasonable Explanation
- 100% FPL Waiver
- Stable Income Waiver

Alliance & ACSSA Collaboration

- Coordination with Alameda Alliance for Health
- MOU between ACSSA and Alliance was finalized and ACSSA is currently sharing Medi-Cal renewal due dates for outreach to plan members.
- Alliance has provided funding of $50,000 to each of ACSSA's partnering CBOs and $75,000 to ACSSA to assist with renewal efforts.

Question: Why is there a net negative on the duals?

Answer: We have been trying to figure that out since it happened in January. Originally, we had been reporting that Anthem had 8000 duals, but those 8000 members who were supposed to come to us didn't materialize. The question then arises: where did they go? We don't have the answer at this point. Technically, they could have gone to Kaiser, but Kaiser didn't grow significantly; they only gained a couple of hundred members in January. We saw our duals decrease from 43,000 to 40,000, and we've been holding steady at 40,000 since. The question remains: where did those 8000 duals go? At this point, we don't really understand where those 8,000 went, but we suspect that there may not have been 8000 duals there in the first place. There seem to be a lot of discrepancies in the data.

Question: If an adult member is cognitively disabled, how will they be communicated with to redetermine their membership? Will they be dropped if they don't respond?

Answer: If someone is an authorized representative on their case, we'll communicate with them so they're both aware that their redetermination is due or if they need to turn in anything to redetermine their eligibility. Depending on what information is requested, they might be dropped. If there's no response from the client or the authorized representative, we do give individuals or their beneficiaries thirty days to respond to any requests for verification.

Question: Is the funding of $50,000 to CBOs and $75,000 to ACSSA a one-time or annual contribution?

Answer: It was one-time funding to assist with the redetermination period due to the frequent reiterations occurring this year.

Question: Why is enrollment higher than what was previously projected?

Answer: We worked with the State and the County to determine enrollment projections. We were expecting a 36% auto adjudication rate, which is among the highest in the counties. Based on this rate and the processing capacity of the County, we initially projected approximately 6,000 disenrollments a month. However, the County made some significant changes that impacted the enrollment numbers. Without those changes, we would likely still be around the 36% mark. Comparatively, counties that did not implement similar changes are experiencing lower rates than we are.

Question: The Alameda Health Consortium stated that they saw a decline in the reevaluation, which contrasts with the data in this report. They mentioned that some of this decline is due to limited access to CalSAWS. Can you elaborate?

Answer: Compared to other counties, Alameda County had more information available about eligibility and enrollment. However, the switch to CalSAWS restricted our access, resulting in lower application processing capability. This is not anyone's fault but simply bad timing. We hope for better access in the future. We have also seen an unexpected increase in redeterminations, which is a positive outcome. Despite these challenges, we are hopeful that we can improve the situation over time.

Informational Item Only.

b) HEDIS DATA PRESENTATION

Tiffany Cheang provided an update on the Healthcare Effectiveness Data and Information Set (HEDIS). Highlights of the presentation include:

Oversight & Accountability

- DHCS Medi-Cal Accountability Set (MCAS)
- DMHC Health Equity & Quality Measure Set (HEQMS)
- NCQA Accreditation – Health Plan
- NCQA Accreditation – Health Equity
- Future: CMS and Stars Measures

DHCS Medi-Cal Accountability Set (MCAS)

- Measures held to MPL fall into 4 domains:
    - Behavioral Health
    - Children's Health
    - Chronic Disease
    - Reproductive Health
    - Cancer Prevention
- Report Only measures include 3 new LTC measures
- Majority of the measures are NCQA HEDIS, but also include several from other measure stewards.
- HEQMS includes:
    - 15 HEDIS measures
    - CAHPS Health Plan survey results
- MY 2023 and MY 2024: All measures overlap with DHCS MCAS except one
- Potential corrective action and or administrative penalties not until 2027

AAH MCAS Performance – MY2022

- Five (5) measures did not meet MPL
    - Controlling High Blood Pressure
    - Cervical Cancer Screening
    - Lead Screening in Children
    - Well Child Visits in the First 15 months
    - 30-day follow-up after ED Visit for Mental Illness
- Comparison to MY 2021
    - Rates improved in 9 of the measures

    - MY 2021 had 3 measures that did not meet MPL
- DHCS sanction imposed ($80,000)
    - Triggered by 2 measures within a single domain (Children's Health)

AAH MCAS Performance – MY2023

- As of 4/26/2024, 3 measures are not meeting MPL
- Medical Record Retrievals (MRR) are 96% closed
- Comparison to MY 2022
    - Rates improved in 14 out of 18 measures
- NCQA and DHCS HEDIS audits passed successfully
- Change Healthcare impact on the abstraction process mitigated
- Rates will be finalized in June 2024
- Anticipate a DHCS sanction based on the current methodology

Question: Where are we with the other three MPLs, which are cervical cancer screening, high blood pressure, and child visits?

Answer: We have now met the targets for cervical cancer screening, which we did not achieve last year. Additionally, we have met the targets for well-child visits and blood pressure, and we are actually above the minimum practice level for them. This is great news for us!

Question: Many of us in the healthcare industry are learning from Kaiser and using their system to prevent heart attacks and strokes. Do we provide something similar to them here at the Alliance to help us achieve the best possible outcomes?

Answer: At the moment, we don't have any programs for our providers in that area. We are focusing on our members with high blood pressure and sending them reminder letters to check their blood pressure. We are also making sure they understand the importance of managing and controlling their high blood pressure. As of now, we don't have anything specifically for the providers.

Comment: There is a tool that the Alliance has invested in along with the County and the Social Health information exchange and the Community Health record, which does provide more real-time information about patient encounters that we could leverage further for systems.

Comment: Chair Gebhart mentioned that the Board is interested in learning more about the follow-up process after an emergency. They would like to discuss the possibility of using the social health information exchange for real-time information and suggested having an offline conversation about promoting its use with our providers or exploring how to integrate it more internally.

Informational item only.

c) REVIEW AND APPROVE FEBRUARY 2024 AND MARCH 2024 MONTHLY FINANCIAL STATEMENTS

For the month ended February 29th, 2024, the Alliance continued to experience increases in enrollment, bringing total enrollment to 402,000 members. Net income of 5.4 million was reported in February. The plan's February medical expenses represented 92% of revenue. Alliance reserves increased to 645% of what was required and remained well above minimum requirements.

Motion: A motion was made by Dr. Evan Seevak and seconded by Yeon Park to approve the Financial Statements.

Vote: The motion was passed unanimously.

Ayes: Colleen Chawla, Dr. Rollington Ferguson, Byron Lopez, Dr. Marty Lynch, Andie Martinez-Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

d) REVIEW AND APPROVE HOSPITAL COUNCIL OF NORTHERN AND CENTRAL CA HOSPITAL SEAT NOMINEE(S)

By roll call vote, the Board selected Nominee Tosan Boyo.

Motion: A motion was made by Yeon Park and seconded by Dr. Kelley Meade to approve the Resolution appointing Tosan Boyo to the Hospital Seat.

Vote: The motion was passed unanimously.

Ayes: Colleen Chawla, Dr. Rollington Ferguson, Byron Lopez, Dr. Marty Lynch, Andie Martinez-Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

e) REVIEW AND APPROVE RESOLUTION NOMINATING WENDY PETERSON FOR APPOINTMENT TO DESIGNATED LONG TERM SERVICES AND SUPPORTS (LTSS) SEAT

Motion: A motion was made by Dr. Marty Lynch and seconded by Dr. Evan Seevak to appoint Wendy Peterson to the LTSS Seat.

Vote: The motion was passed unanimously.

Ayes: Colleen Chawla, Dr. Rollington Ferguson, Byron Lopez, Dr. Marty Lynch, Andie Martinez-Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

f) REVIEW AND APPROVE THE RESOLUTION ESTABLISHING THE COMMUNITY ADVISORY SELECTION COMMITTEE, SEATS, AND CHARTER.

Motion: A motion was made by Supervisor Lena Tam and seconded by Dr. Evan Seevak to approve Resolution establishing the Community Advisory Selection Committee, Seats and Charter.

Vote: The motion was passed unanimously.

Ayes: Colleen Chawla, Dr. Rollington Ferguson, Byron Lopez, Dr. Marty Lynch, Andie Martinez-Patterson, Dr. Kelley Meade, Yeon Park, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

9. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE

Dr. Carey gave an update on the Peer Review and Credentialing Committee's meeting held on April 16th. Out of the 120 applicants, 40 were recredentialed providers, and 80 were behavioral health providers.

b) QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE

Dr. Carey gave an update on the Pharmacy & Therapeutics committee meeting held on March 19th. During the meeting, they reviewed the efficacy, safety, cost, and utilization profiles of nine therapeutic categories and drug monographs. They made seventeen formulary modifications, most of which modified the drugs so that there was a step therapy. They also completed twenty-three prior authorization guidelines.

10. STAFF UPDATES

There were no staff updates.

11. UNFINISHED BUSINESS

None.

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

14. ADJOURNMENT

Chair Gebhart adjourned the meeting at 1:58 p.m.

Case Management/Care Coordination, Complex Case Management & Disease Management Program Evaluation

2023

Case Management/Care Coordination, Complex Case Management & Disease Management
2023 Program Evaluation

Signature Page

_____	_____
Date	Allison Lam, MHL, RN Senior Director, Health Care Services
_____	_____
Date	Donna Carey, MD, MS Medical Director, Case and Disease Management
_____	_____
Date	Sanjay Bhatt, M.D., MS, MMM Senior Medical Director Vice Chair, Quality Improvement Health Equity Committee
_____	_____
Date	Lao Paul Vang Chief Health Equity Officer
_____	_____
Date	Donna Carey, MD, MS - Interim Chief Medical Officer, Medical Management Chair, Quality Improvement Health Equity Committee
_____	_____
Date	Matthew Woodruff Chief Executive Officer
_____	_____
Date	Rebecca Gebhart Board Chair

Table of Contents

2023
Case Management Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors, senior management and the Quality Improvement Health Equity Committee (QIHEC), the Health Care Services 2023 Case Management Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the Case Management (CM) program activities, which include care coordination, care management, complex case management and disease management.

The processes and data reported covers activities conducted from January 1, 2023 through December 31, 2023.

Membership and Provider Network

The Alliance products include:

- Medi-Cal Managed Care: serving beneficiaries eligible through one of several Medi-Cal programs, including Temporary Assistance for Need Families (TANF), Seniors and Persons with Disabilities (SPD), Medi-Cal Expansion and Dually Eligible Medi-Cal members who do not participate in California's Coordinated Care Initiative (CCI). For dually eligible beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

- Alliance Group Care (commercial product): an employer-sponsored plan providing low-cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Covered services are provided to beneficiaries via Alliance's direct network or one of Alliance's contracted provider networks. In 2023, The Alliance's contracted provider networks included

Alameda Health System (AHS), Children First Medical Group (CFMG), Community Health Center Network (CHCN), and Kaiser Permanente. The below figures show membership trends throughout 2023.

Figure 1a. 2023 Membership - by Category of Aid

Category of Aid Trend							
Category of Aid	Dec 2023	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	52,174	15%	10,629	9,872	790	22,025	8,858
Child	101,634	29%	8,380	9,382	32,231	33,788	17,853
SPD	30,848	9%	10,020	4,407	1,148	13,052	2,221
ACA OE	119,669	35%	19,524	36,581	1,231	47,077	15,256
Duals	40,976	12%	24,440	2,463	1	9,784	4,288
LTC	135	0%	134	1	-	-	-
LTC-Dual	951	0%	950	-	-	-	1
Medi-Cal	346,387		74,077	62,706	35,401	125,726	48,477
Group Care	5,622		2,164	842	-	2,616	-
Total	**352,009**	**100%**	**76,241**	**63,548**	**35,401**	**128,342**	**48,477**
Medi-Cal %	98.4%		97.2%	98.7%	100.0%	98.0%	100.0%
Group Care %	1.6%		2.8%	1.3%	0.0%	2.0%	0.0%
	Network Distribution		*21.7%*	*18.1%*	*10.1%*	*36.5%*	*13.8%*
			% Direct:	**40%**		**% Delegated:**	**60%**

Figure 1b. 2023 Membership - by Age Group

Age Category Trend			
	Members		
Age Category	Jan 2022	Jan 2023	Dec 2023
Under 19	101,615	104,152	104,062
19 - 44	109,198	120,648	121,694
45 - 64	61,651	69,127	72,612
65+	30,709	35,887	53,641
Total	**303,173**	**329,814**	**352,009**

Figure 1c. 2023 Membership – by Provider Network

Network Trend						
	Members			% of Total (ie.Distribution)		
Network	Jan 2022	Jan 2023	Dec 2023	Jan 2022	Jan 2023	Dec 2023
Independent (Direct)	57,046	53,870	76,241	18.8%	16.3%	21.7%
AHS (Direct)	58,927	66,052	63,548	19.4%	20.0%	18.1%
CFMG	32,689	33,741	35,401	10.8%	10.2%	10.1%
CHCN	109,878	126,433	128,342	36.2%	38.3%	36.5%
Kaiser	44,633	49,718	48,477	14.7%	15.1%	13.8%
Total	**303,173**	**329,814**	**352,009**	**100.0%**	**100.0%**	**100.0%**

Figure 1d. 2023 Membership – by Provider Network (Delegated vs. Direct Trend)

Delegation vs Direct Trend						
	Members			% of Total (ie.Distribution)		
Members	Jan 2022	Jan 2023	Dec 2023	Jan 2022	Jan 2023	Dec 2023
Delegated	187,200	209,892	212,220	61.7%	63.6%	60.3%
Direct	115,973	119,922	139,789	38.3%	36.4%	39.7%
Total	**303,173**	**329,814**	**352,009**	**100.0%**	**100.0%**	**100.0%**

In 2023, The Alliance membership increased by 22,195 members by year-end. The largest membership increase was seen in the population age 65 and older. The Alliance direct network experienced the largest membership gains, with an increase of 19,867 members by the end of 2023. This trend aligns with increases in Medi-Cal Enrollment overall, including dual-eligible members and Long-Term Care members receiving custodial level of care in Skilled Nursing Facilities in January 2023.

Case Management Program Scope and Structure

CM Program Scope

The Alliance provides person-centered case management services through multidisciplinary teams that address medical conditions, behavioral, functional, and psychosocial issues occurring throughout the continuum of care, including in between medical office visits. Case management activities are performed telephonically. The underlying premise of the program is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, and the overall health care delivery systems (including physicians, hospitals, and the various payer sources).

The case management program was established to provide case management processes and procedures that enable The Alliance to improve the health and health care of its membership. Members from both Alliance products (Managed Medi-Cal and Alliance Group Care) are eligible for participation in the program. The fundamental components of The Alliance case management services encompass member identification and screening; member assessment; care plan development, care plan implementation and management; evaluation of the member care plan; and appropriate closure of the case. Case management interventions are organized to promote quality care, member satisfaction and cost-effectiveness using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

CM Program Structure

The structure of the CM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of The Alliance health care delivery network and community resources. Additionally, the structure is designed to enhance communication and collaboration on CM issues that affect all departments and disciplines within

the organization. The CM Program is evaluated on an on-going basis for efficacy and appropriateness of content by The Alliance staff and oversight committees.

Responsibility, Authority and Accountability / Governing Committee

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 19-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of The Alliance programs and is responsible for approving the Quality Improvement, Utilization Management and Case Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to The Alliance Chief Medical Officer (CMO) and the Quality Improvement Health Equity Committee (QIHEC) and provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management and Case Management Programs. Utilization Management oversight is the responsibility of the QIHEC. Utilization Management and Case Management activities are the responsibility of The Alliance Health Care Services staff under the guidance of the Medical Director for Care Management, the Medical Director for Utilization Management, and the Senior Director, Health Care Services, in collaboration with The Alliance CMO.

Committee Structure

The Board of Governors appoints and oversees the QIHEC, the Peer Review and Credentialing Committees, and the Pharmacy and Therapeutics Committee (P&TC) which, in turn, provide the authority, direction, guidance, and resources to enable The Alliance staff to carry out the Quality Improvement, Utilization Management and Case Management Programs. Committee membership consists of provider representatives from The Alliance contracted networks and the community, including those who provide health care services to populations served by The Alliance (for example: Seniors and Persons with Disabilities, Dual-eligible members, and members with Chronic conditions).

The QIHEC provides oversight, direction, makes recommendations, and has final approval of the UM and CM Programs. Committee meeting minutes are maintained to summarize committee activities and decisions with appropriate signatories and dates.

QIHEC charters a sub-committee called the Utilization Management Committee (UMC), which meets at least once every 2 months. UMC serves as a forum for The Alliance to evaluate current CM activities, processes, and metrics, including case management/care coordination, complex case management, transitional care services, population health, integration of medical and behavioral health, regulatory compliance, and oversight for delegated CM activities. The UMC also evaluates the impact of CM programs on key stakeholders in other departments, including Compliance, Member Services, and Grievance and Appeals. Input from UMC members is included in continuous CM program monitoring, evaluation, and design of interventions.

In 2023, the UMC had 10 meetings. The 2022 CM Program Evaluation and 2023 CM

Program Description and Workplan were presented for review and approval at the March 31, 2023 QIHEC meeting, and documented in the minutes for Board of Directors approval. The committee was chaired by the Chief Medical Officer with support of the Senior Director of Quality Management, external physicians, and key organizational staff.

Integration of Medical and Behavioral Health

Effective April 1, 2023, Behavioral health was insourced by the Alliance. CM participated in the planning for the insourcing with the Director of BH services, and in the training of new BH staff in CM processes and practices. This has allowed for further integration of behavioral and medical health within the Alliance. The Alliance provides access to mental health services for the Medi-Cal and Commercial membership in several ways:

- Basic mental health care needs are provided by Primary Care Providers
- Medi-Cal members with "mild to moderate" impairments in mental, emotional, or behavioral functioning were referred to the contracted behavioral health delegate, Beacon Health Options (Beacon) through 3/31/23. Effective 4/1/23, the Medi-Cal members were referred to the Alliance's network for behavioral health care.
- Medi-Cal members diagnosed with a severe persistent mental health disorders and Substance Use Disorders are carved-out and managed by Alameda County Behavioral Health Care Services Department (ACBHCS).
- Commercial members accessed mental health/SUD benefits through the contracted BH delegate, Beacon Health Options (Beacon) through March 31, 2023. Effective April 1, 2023, commercial members were referred to the Alliance's network for behavioral health care.

Increasing access to care and increasing utilization was a primary driver of the Alliance's decision to insource the management of behavioral health services. The Behavioral Health Program includes a care coordination program staffed by licensed clinicians and behavioral health navigators.

- The mental health team consists of 4 licensed clinicians and the ABA team consists of 3 licensed clinicians.
- The clinical teams are supported by 5 behavioral health navigators.
- A behavioral health manager was hired in Q4 2023 to further support the growth and visibility of the behavioral health program at the Alliance.
- The Alliance behavioral health program operates under the leadership of a Senior Director of Behavioral Health and Medical Director.

Involvement of senior-level physician and behavioral healthcare practitioners

The Board of Governors delegates oversight of Quality and Case Management functions to The Alliance Chief Medical Officer (CMO). The CMO provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the Case Management Program. The CMO delegates senior level physician involvement in appropriate committees to provide clinical expertise and guidance to program development. Dr. Peter

Currie, Ph.D., Senior Director, Behavioral Health Services, provides leadership to behavioral health care at the Alliance, further supporting the integration of behavioral health care with medical care. Together, the senior-level physician and behavioral health practitioners are involved in the CM program by:

- Establishing CM policies (for medical and behavioral healthcare services)
- Reviewing and consulting on complex CM cases (for medical and behavioral healthcare services)
- Participating in various clinical and stakeholder committees (including UMC and QIHEC)
- Evaluating the overall effectiveness of the CM Program (for medical and behavioral healthcare services)

Case Management Resources

The Alliance CM Department is staffed with physicians, nurses, social workers, and non-clinical support staff, including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2023 CM Program Description.

In 2023, the CM leadership structure was designed to meet the needs of the program and the staff, including Enhanced Care Management and Community Supports:

- 1.0 FTE Medical Director of Case Management
- 1.0 FTE Senior Director, Health Care Services
- 1.0 FTE Director, Social Determinants of Health
- 1.0 FTE Manager, CM
- 1.0 FTE Supervisor of CM
- 1.0 FTE Non-Clinical Supervisor of CM
- 1.0 FTE Lead CM
- 1.0 FTE Clinical Manager, Enhanced Care Management (ECM)
- 1.0 FTE Supervisor of Community Supports (CS)

With insourcing Behavioral Health in April 2023, additional leadership was added to support Behavioral Health case management:

- 1.0 FTE Senior Director, Behavioral Health Services
- 1.0 FTE Manager, Behavioral Health

The adequacy of case management resources is continuously evaluated to ensure appropriate staffing levels to manage programmatic changes and workload volumes, accounting for variations in members' health status and complexities of coordination of care needs. For example, in 2024, the Community Supports team will transition to the Long-Term Services and Supports Director, allowing for continued expansion and optimization of Community Supports services.

Delegated Case Management

The Alliance delegates case management (CM) activities to contracted health plan, provider groups, vendor networks and healthcare organizations that meet delegation agreement standards. The contractual agreements between The Alliance and delegated groups specify the responsibilities of both parties, including:

- the functions or activities that are delegated;
- the frequency of reporting on those functions and responsibilities;
- how performance is evaluated; and
- corrective action plan expectations, if applicable.

The Alliance conducts pre-contractual evaluations of delegated functions to ensure a delegates' abilities to meet standards and requirements. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with CM department, and other departments, to conduct the annual delegation oversight audits. When delegation occurs, The Alliance requires the delegated entity to comply with the NCQA standards and present quarterly reports of services provided to Alliance members. The Alliance's Compliance Department completes an annual performance evaluation of delegated CM operations. Results of the annual evaluation, and any audit results, are reviewed by the Compliance and Delegation Oversight Committee, and shared with the delegates.

In 2023, Alliance delegated CM activities to the following entities:

Figure 2. Delegated Entities (CM activities only)

Delegate Name	**Provider Type**	**Delegated Activity-** Care Coordination/Case Management	**Delegated Activity-** Complex Case Management
Kaiser	Health Maintenance Organization (HMO)	Yes	Yes
CHCN	Managed Care Organization (MCO)	Yes	No
Beacon / College Health IPA* (through 3/31/23)	Managed Behavioral Healthcare Organization (MBHO)	Yes	Yes

*In April 2023, Mental Health/Behavioral Health services were insourced into The Alliance and Beacon/College Health IPA was a delegate only through March 31, 2023. Efforts in Q1 2023 were focused on transitioning the impacted members from Beacon to The Alliance.

Case Management Information Systems

The CM Department uses a clinical information system, TruCare®, as the case management platform. TruCare® is a member-centric application that automates the entire clinical, administrative, and technical components of case management into a single platform. The system supports case management with algorithmic clinical intelligence and best practices to guide case managers through assessments, development of care plans, and ongoing management of members. The system includes assessment templates to drive consistency in the program. Care plans are generated within the system and are individualized for each member and include short and long-term goals, interventions, and barriers to goals. The clinical information system includes automated features that provide accurate documentation for each entry; record actions or interactions with members, caregivers, and providers; and create automatic date, time, and user stamps. To facilitate care planning and management, the clinical information system includes features to set prompts and reminders for next steps or follow-up contact. Optimization of TruCare® continued into 2023, including improving assessments to automatically trigger care plan elements (including problems, goals, interventions, and barriers). Thorough vetting processes are established between clinical and IT teams to ensure any enhancements and upgrades to the platform are amenable to all system users. System optimization and upgrades are ongoing as standard practices, including staff training to ensure competence in using the platform and alignment on best practice workflows.

Clinical Decision Support Tools

Evidence-based clinical guidelines are available to support the Case Managers in conducting assessments, developing care plans, and managing care. The clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the Alliance will involve board certified specialists in the development of the appropriate guidelines, as well as medical and behavioral healthcare specialty societies and/or Alliance Clinical Practice Guidelines.

Case Management Process

Case Management Referral and Identification

The Alliance's Care Management program adopts a person-centered design, ensuring all care management activities align with members' needs, preferences, and goals. Members are identified as candidates for care management services through a variety of data sources and referrals. This includes, but is not limited to:

- Health Risk Assessment (HRA)
- Health Information Forms/Member Evaluation Tool (HIF/MET)
- Data sources such as Utilization reports and Admission, Transfer and Discharge (ADT) Feeds

- Population Health Reports - *In 2023, the Population Health initiatives at the Alliance were strengthened and further integrated into ongoing Alliance care management identification activities. A stratification of member acuity was developed, ranging from low-risk members who may need health promotion/education, to the highest risk, most vulnerable members needing full wraparound Enhanced Care Management services.*
- Self-referrals from members/authorized representatives
- Direct referrals from provider networks
- Internal referrals (including Utilization Management, Member Services, Appeals and Grievance, Leadership)
- Predictive modeling

The HRA and HIF/MET processes are essential components of the care management process, allowing members to self-report their health care needs and goals.

Health Risk Assessments (HRA)

The Alliance arranges for the assessment of every new Senior and Person with Disabilities (SPD) member through a process that stratifies all new members into an assigned risk category based on self-reported or available utilization data. Based on the results of the health risk stratification, the Alliance administers a Health Risk Assessment (HRA) survey to all newly enrolled SPD members within:

- 45 days of enrollment for members identified as high-risk.
- 105 days of enrollment for members identified as lower-risk.

The Alliance outreaches to SPD members to administer the HRA and to develop a Care Plan. SPD members are re-assessed annually on the anniversary month of their enrollment. The responses from the HRA may result in the members being re-stratified as high risk or low risk (for some members, risk-level based on their HRA responses may be different from their earlier stratification based on the stratification tool/data). In addition, the HRA includes specific Long-Term Services and Supports (LTSS) referral questions. These questions are intended to assist in identifying members who may qualify for and benefit from LTSS services. These questions are for referral purposes only and are not meant to be used in stratifying members as high risk or low risk. After completion of the HRA, the Alliance develops Individualized Care Plans (ICPs) for members found to be high risk and coordinates referrals for identified LTSS, as needed.

CM staff is responsible for ensuring the Individualized Care Plan is completed, shared with the Member and PCP, and is accompanied by relevant community and health resources. For Members whose completed HRA results in a final stratification of Low Risk, CM staff review Member HRA responses to identify Member needs (i.e., resources for transportation, in home support services (IHSS), durable medical equipment (DME), food resources). The CM staff generates the standardized low risk care plan, attaches the relevant resources, and prepares it for mailing. For Members whose completed HRA results in a final stratification of High Risk, clinical CM staff outreach to the Member and

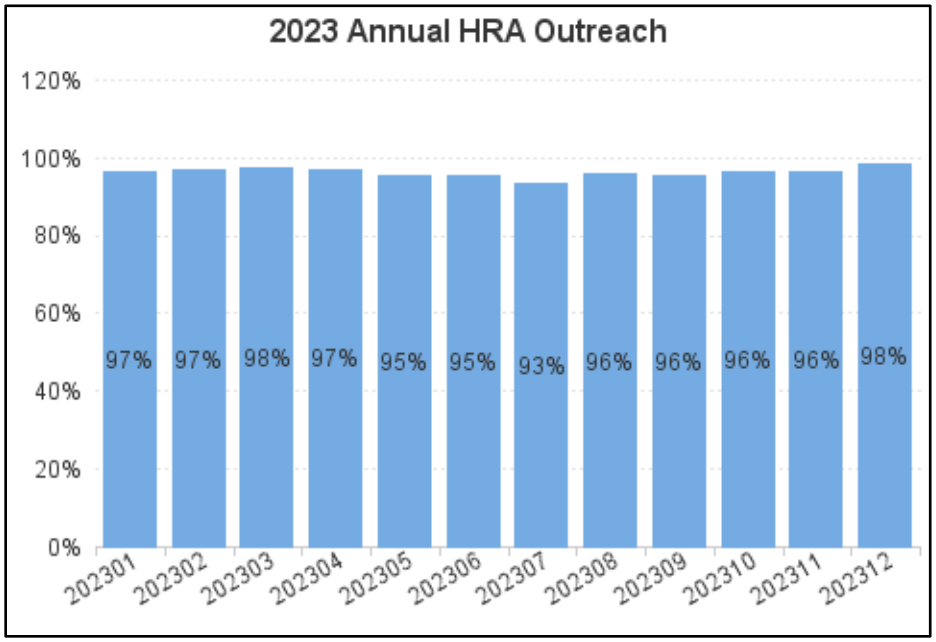
reviews Member HRA responses with the member to identify Member needs. The CM staff generate the standardized high-risk care plan and include additional health education resources and materials based on the conversation with the Member. If the member remains Unable to Contact (UTC), a standardized care plan is sent to the member. This is sent to members, even if they do not complete the HRA and return it to the plan.

Copies of the care plans, for both High Risk and Low Risk members, are mailed to the Member, the Primary Care Provider, and the Delegate Group if applicable.

The Alliance uses Interactive Voice Response (IVR) calls to remind and encourage Low Risk Members to complete an HRA. The Alliance's internal IT team makes Interactive Voice Response (IVR) calls to members. These IVR calls are made to members so that the Alliance can give members every opportunity to complete the HRA and have the results acted upon by the CM department. High Risk Member receive calls from CM staff to remind and encourage completion of the HRA.

Below figures show 2023 HRA outreach and completion rates for the SPD population.

Figure 3. HRA Outreach for SPD Members



The average outreach rate for 2023 was 96%, reflecting the engagement of the Alliance IT team's IVR to assist with the HRA process by reminding members to return HRAs in a timely manner.

Figure 4a. New HRA completion for SPD Members

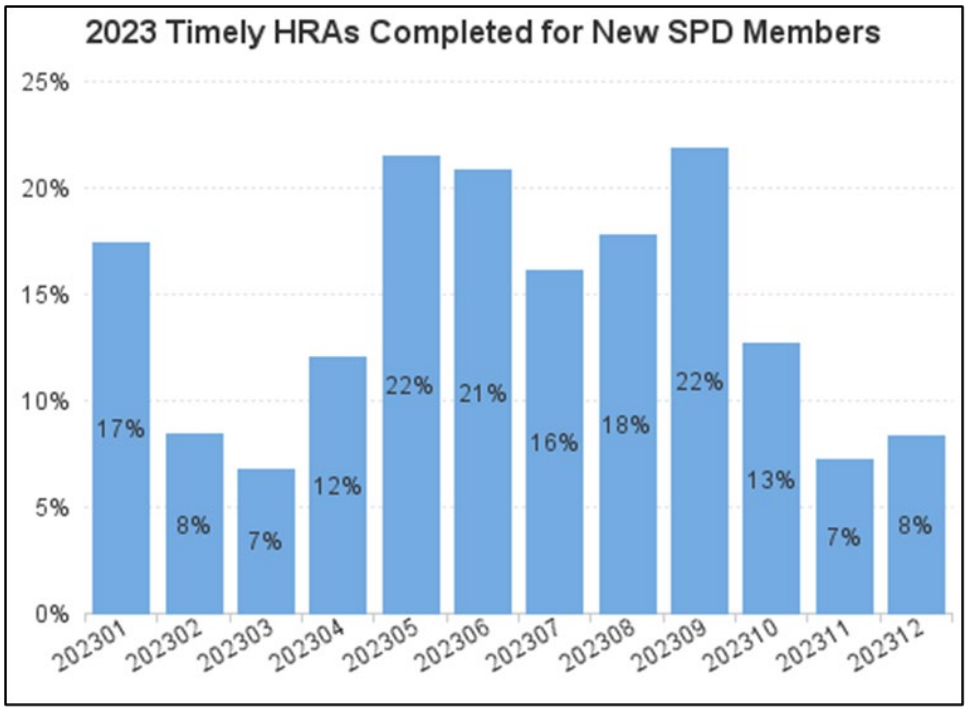
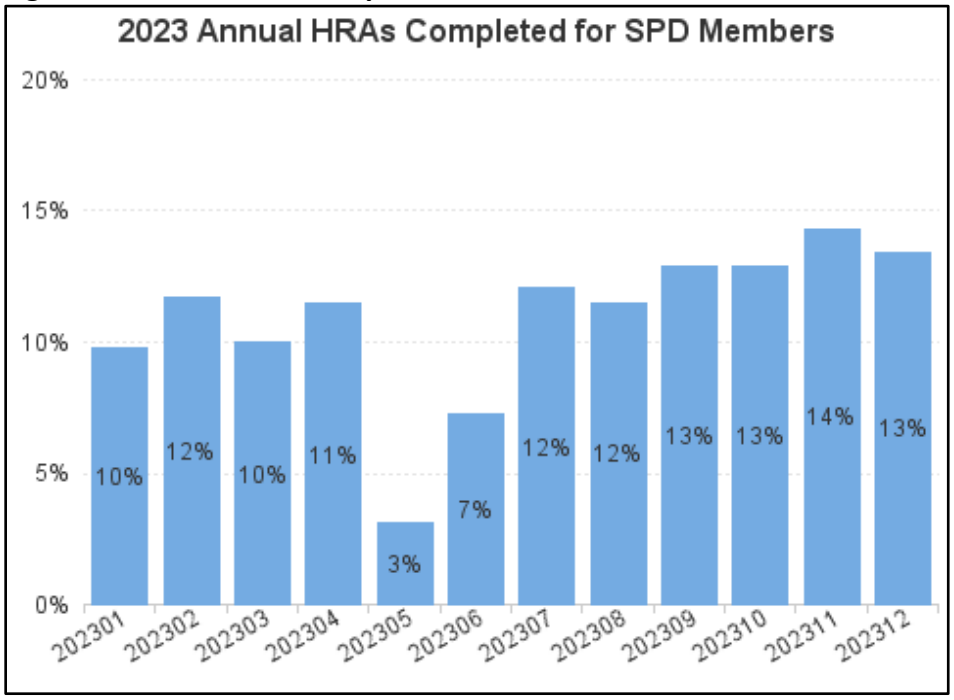


Figure 4b. Annual HRA completion for SPD Members



In 2023, the average combined completion rate for new and annual HRAs was 12%, representing a 2% decrease compared to the 14% completion rate in 2022. In 2023, the highest monthly completion rate was 22%.

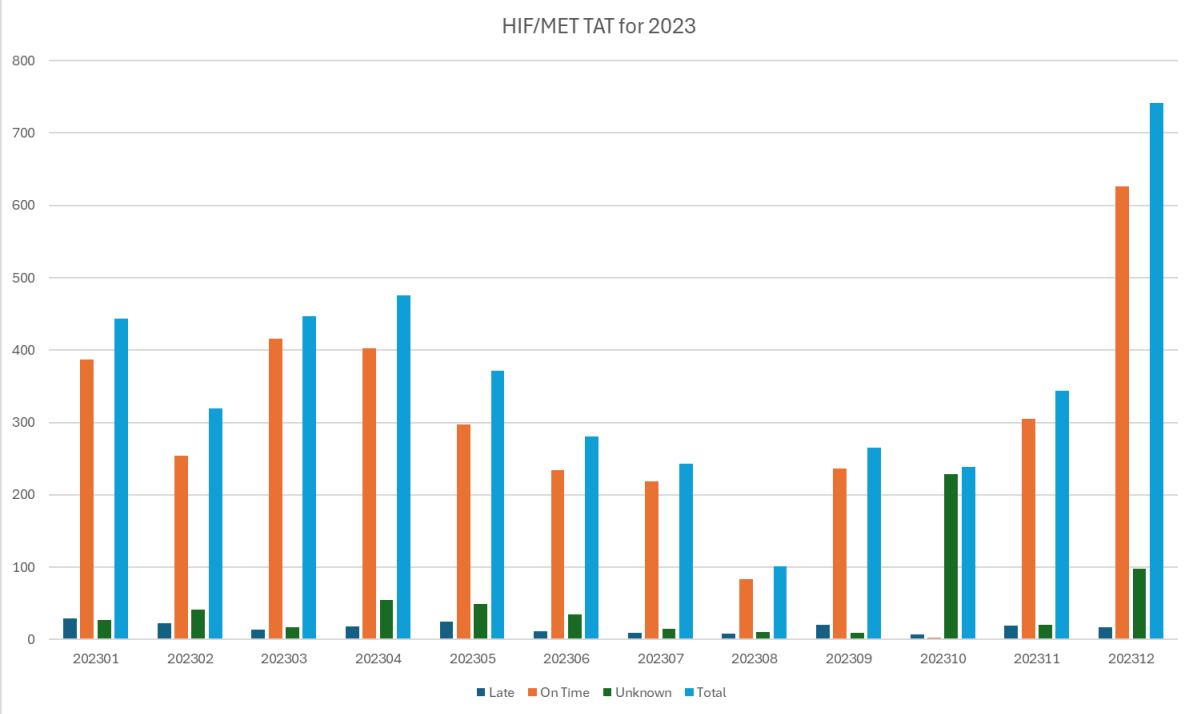
Health Information Forms/Member Evaluation Tools (HIF/MET)

The Alliance arranges for the assessment of every new member to the Alliance, and for members returning to the Alliance after a gap in coverage (with the Alliance) of 6 months or more. The HIF/MET is a brief federal initial screening requirement that is used to identify general member needs and to determine if a new member requires expedited care upon joining or returning to the Alliance.

HIFMETs are mailed in the new member packet for any member not stratified as a Senior and Persons with Disability (SPD). The responses from the HIF/METs are entered into the Case Management system of record (TruCare). Monthly reports are run to identify any positive responses to inform members' assigned PCPs of the results. PCPs provide follow up, as necessary.

The Alliance uses Interactive Voice Response (IVR) calls to encourage members to complete the HIF/METs. The Alliance's internal IT team makes the IVR calls to members so that the Alliance can give every opportunity to complete the HIF/MET and have the results acted upon by the members' assigned PCP.

Figure 5. 2023 Total Completed HIF/METs



In 2023, we saw an increase in HIF/METs through the end of Q1. Q4 showed a sharp increase in HIF/METs as members were no longer assigned to Anthem past October 1, 2023. The Q4 spike is likely related to members preparing for the Anthem Transition on January 1, 2024.

Referral Assignment

All CM referrals are reviewed by the CM Lead who makes daily assignments, considering referral data, pre-existing or historical CM cases, type of request, and acuity of request. The CM Lead verifies the appropriate CM staff to support the member (including Health Navigators, Social Workers, or Nurses) and assigns to corresponding CM staff. Members are deemed ineligible if the member's Alliance eligibility is inactive, the member has expired, or is receiving duplicative services.

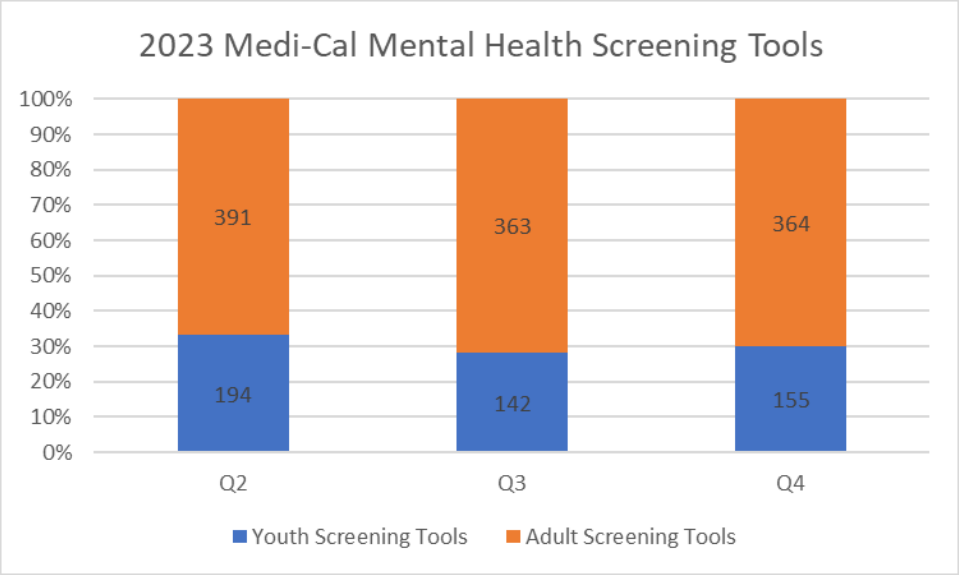
Behavioral Health CM Referrals

Also in 2023, as part of increased efforts to integrate BH and medical services, the Alliance worked closely with ACBHCS to identify members who may benefit from co-management of medical and behavioral health services and/or specialty and non-specialty mental health services. The Behavioral Health (BH) Department maintained the relationship with ACBHCS to ensure eligible Medi-Cal members receive services through the ACBHCS linked mental health programs. The focus of the activities is to ensure contracted providers continue to identify and refer members with serious persistent mental health/SUD conditions to the appropriate ACBHCS programs, as well as to facilitate coordination activities for co-existing medical and behavioral health disorders to assist with their treatment access and follow-up care.

DHCS issued a No Wrong Door policy in December 2022, which required AAH and ACBHS to utilize a standardized screening tool between both entities to determine which system of care Medi-Cal members are referred into. The Alliance and ACBHCS worked to implement the DHCS required age-appropriate screening and care transitions tools that went into effect on January 1, 2023. AAH and Beacon participated in joint meetings with ACBHCS through March 31, 2023. After insourcing, The Alliance continued regular meetings with ACBHCS to facilitate coordination of care and identify potential duplication of services.

The graph below represents the number of adult and child DHCS MH screening tools that were completed by the Alliance Q2-Q4 2023 for Medi-Cal.

Figure 6. 2023 Medi-Cal Mental Health Screening Tools



Care Coordination/Care Management Services and Supports

Upon identification and receipt of appropriate care management referrals, the Alliance provided the following Care Coordination and Care Management services and supports in 2023. Service categories are aligned with the DHCS Population Health Management (PHM) Policy Guide that governs the Alliance's PHM Strategy.

- **Basic Population Health Management** (replaces DHCS' "Basic Case Management" requirements, includes Care Coordination and Disease Management, also includes Basic Case Management delegated to CHCN)
- **Care Management Programs:**
  - Complex Care Management (CCM)
  - Enhanced Care Management (ECM)
  - Targeted Case Management (TCM)
- **Transitional Care Services**
- **Specialized Services:**
  - Continuity of Care
  - Community Supports
  - Transportation

Also in 2023, after the insourcing of BH services, the care management teams worked on integration efforts between medical and behavioral health services, including:

- Enhancing CCM outreach to the chronically ill.
- Improve coordination of care by increasing clinical oversight and co-management with the medical management teams.
- Continued efforts toward improving communication between the primary care physician and behavioral health providers.

- Attendance by the Alliance's behavioral health team at the Interdisciplinary Care (IDT) Team meetings to collaborate, advise, refer, and provide additional insight into medical CCM cases.

Below is a summary of care management cases managed in 2023, categorized by target diagnoses identified as part of the population health management strategy.

Figure 7. Volume of CM cases in Population Health Target Diagnoses in 2023

Diagnoses	Numbers with Disease State in the last 12 months	Care Coordination (Currently Enrolled)	Transitional Care Services (Currently Enrolled)	Complex Case Management (Currently Enrolled)	Enhanced Care Management (Currently Enrolled)
CAD	7900	65	58	12	209
CHF	5202	56	71	9	246
Cervical CA	444	3	1	0	8
Lung CA	407	5	3	1	8
Emphysema	4683	41	43	9	183
ESRD	1232	28	15	4	62
Schizophrenia	3867	24	40	2	118
Sickle Cell Disease	118	0	0	0	2
Hepatitis C	879	3	11	0	21
Tuberculosis	217	0	0	0	5
SUD	9607	75	102	9	386
Asthma	16180	66	50	8	347
Breast CA	1312	11	7		15
Hyperlipidemia	47672	184	108	17	462
Hypertension	49637	239	173	27	749
Diabetes	26211	138	97	16	404
Obesity	30275	128	74	11	406
Pregnancy	6129	19	48	2	43
Gingivitis	7285	17	6	2	51
Burns-1st degree	422	3	4		7
Tobacco	9607	75	102	9	386

Total Unique Members any DX	**500199**	**2196**	**1693**	**246**	**7593**

The highest volume of members with a Population Health target diagnoses are served by Enhanced Care Management (ECM), representing the most vulnerable members with complex physical, social, and emotional risk factors. The next highest volume are those members receiving Care Coordination, representing the volume of work assisting members to navigate the health care system. Transitional Care Services are provided to members transitioning between settings of care, including those discharging from a hospital to a skilled nursing facility or to a home. Complex CM (CCM), the lowest volume of enrolled members, is an opt-in program for members with multiple and/or complex health conditions, requiring member consent and participation in care planning and goal setting to appropriately self-manage their conditions. If a member declines Complex CM, the member is offered care coordination services.

Each CM service category, and its impacts, are further evaluated below.

Basic Population Health Management

Basic Population Health Management (BPHM) is available to all The Alliance members, regardless of risk tier, and includes ensuring access to primary care, care coordination, navigation and referrals across health and social services (including Community Supports), information sharing and referral support infrastructure, services provided by Community Health Workers (CHWs) under the new CHW benefit, wellness and preventions programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children.

The Primary Care Provider (PCP) is responsible for Basic Population Health Management for his/her assigned members and is supported by the Provider Group CM team. The PCP is responsible for ensuring that members receive an initial screening and health assessment (IHA), which initiates Basic Medical Care Management. The PCP conducts an initial health assessment upon enrollment, and through periodic assessments provides age-appropriate periodic preventive health care according to established, evidence-based, preventive care guidelines. The PCP also makes referrals to specialists, ancillary services, and linked and community services as needed based on the member's Individual Care Plan (ICP). When additional care management assistance is needed, the PCP works with the Provider Group's CM department to facilitate coordination. For members enrolled in the Direct Network, the PCP works with the Alliance CM and UM teams to facilitate coordination.

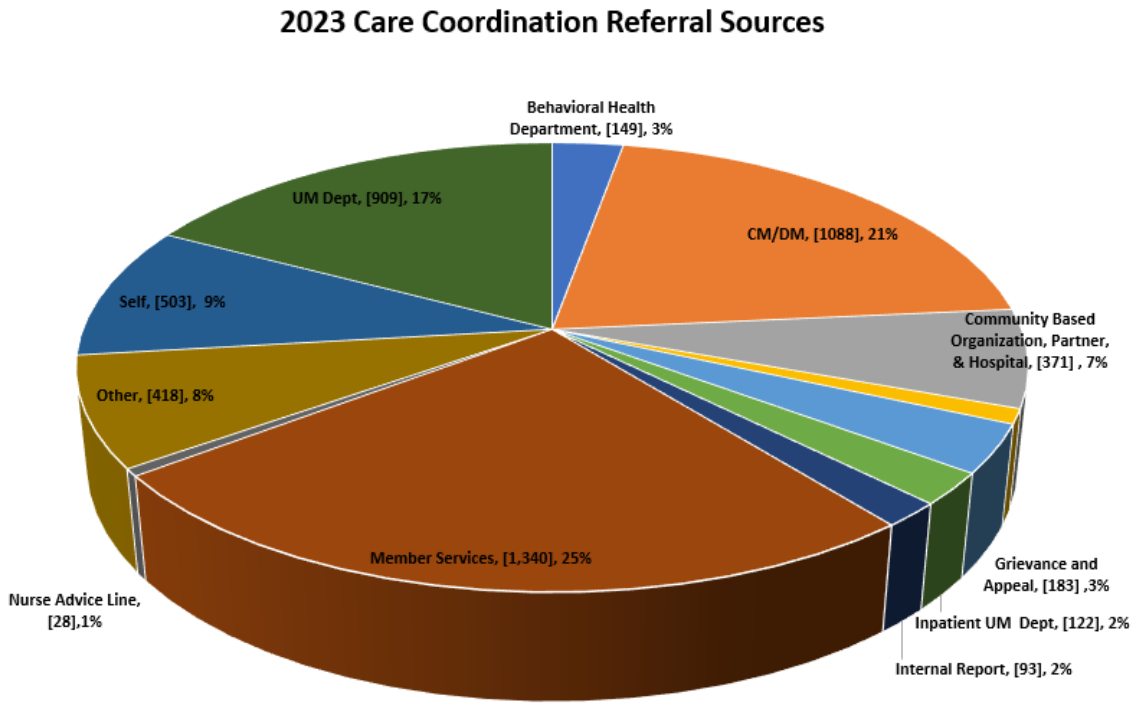
Care Coordination – Medical Services

Care coordination is provided by the CM staff for members needing assistance in coordinating their health care services. Interventions may include referral coordination, focused disease management programs, and/or making arrangements for linked and carved-out services, programs, and agencies. The Alliance uses non-clinical staff called Health Navigators to support care coordination. Health Navigators have extensive

training in facilitation and coordinating services both internally and with outside agencies (for example: Alameda County Public Health and other community resources). They are equipped to manage most care coordination cases, including those involving access to care and continuity of care.

Below figures show 2023 Care Coordination program outcomes by referral source, open/active volumes, and case closure reasons.

Figure 8. 2023 Care Coordination Program by Referral Source

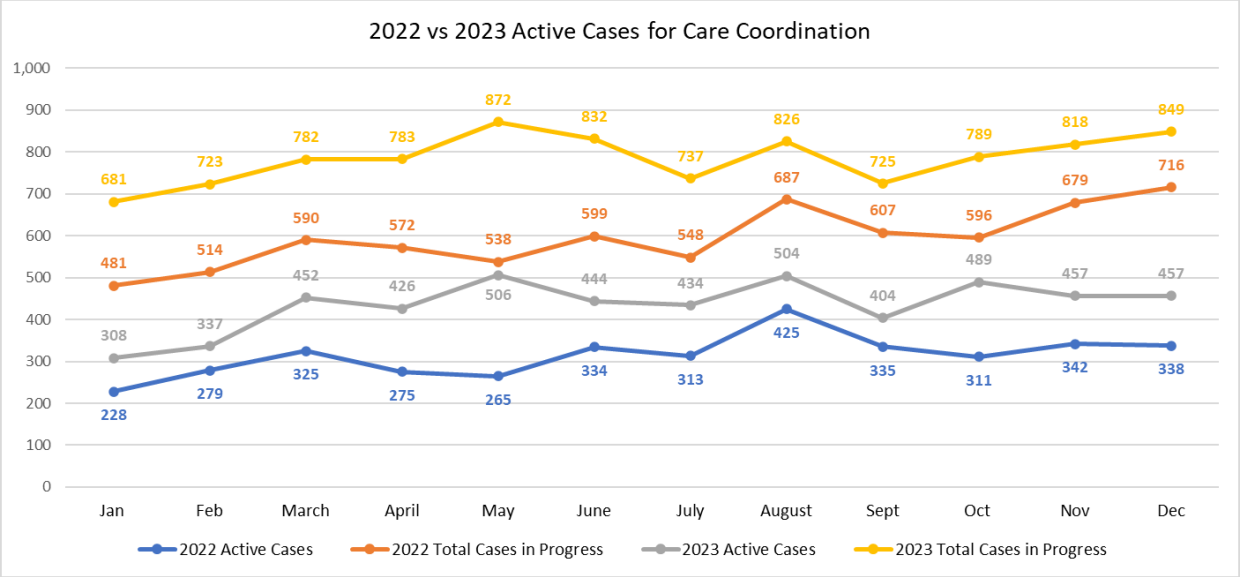


In 2023, the top three referral sources for Care Coordination cases were Member Services (1340 referrals), CM/DM department (1088 referrals), and the UM Department (909 referrals).

- The Member Services Department is the top referral source leading to care coordination cases because Member Services is the main entry point for members contacting the Alliance. Member Services also processes exempt same-day grievances, referring to CM for any care coordination needs related to grievances that cannot be resolved by a member services representative on the same day of the member's call.
- CM/DM referrals are comprised of referrals for members being referred within the care management team (for example, a nurse may refer care coordination tasks to a health navigator), thus demonstrating the collaboration among the team and the resulting continuity of care management support to members.

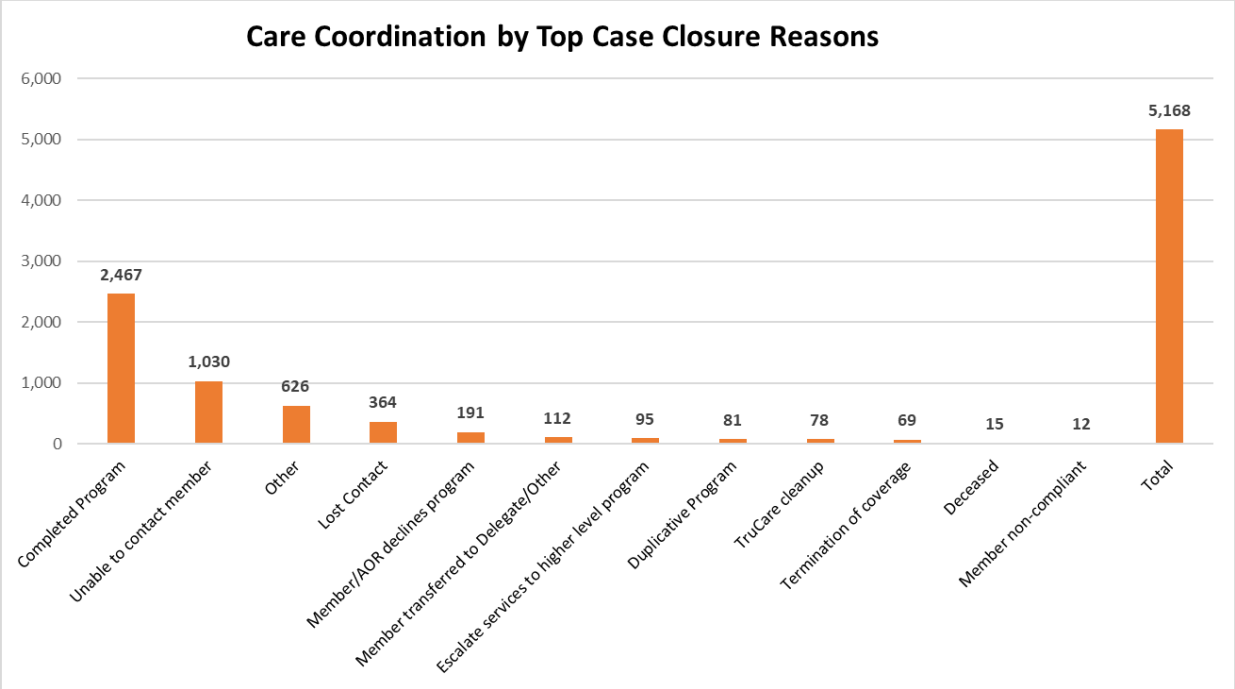
- The UM Department is a top referral source leading to care coordination cases showing the essential collaboration between UM and CM teams. Common referrals from UM include support with accessing and navigating care with in-network providers and facilitating continuity of care with out-of-network providers, when appropriate.

Figure 9. 2022 vs. 2023 Care Coordination Program by Active Cases



In 2023, there was a monthly average of 434 open/active care coordination cases. This was a year-over-year increase of 120 cases per month, compared to the monthly average of 314 open/active care coordination cases in 2022.

Figure 10. 2023 Care Coordination Program by Case Closure Reason



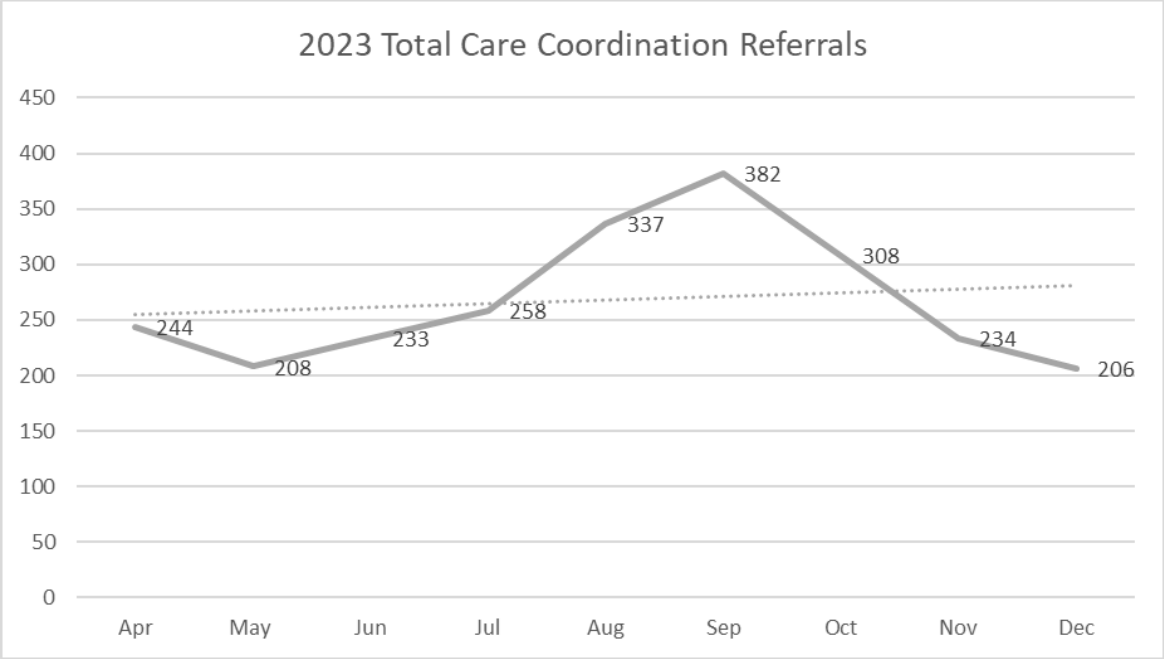
In 2023, the top three reasons for case closure were Completed Program (2,467 cases), Unable to Contact Member (1,030 cases), and Other (626 cases). Cases closed with reason of "Other" including free text by staff describing case closure reasons that could have been categorized by other options in drop-down menu. This presents an opportunity for retraining CM staff and updating the drop-down menu options. Leadership is considering removal of "Other" as an option, as many cases would have fit into more appropriate closure categories.

While nearly 20% of cases were closed due "unable to contact" member, it should be noted that when a referral is made from other departments or data sources besides member "self-referral," the member is not expecting a phone call from CM, and therefore, less likely to respond to contact attempts (including voicemails and letters).

Care Coordination – Behavioral Health Services

The Alliance received an average of 147 care coordination referrals. These are referrals from PCPs, and mental health clinicians and members themselves requesting assistance with coordination of behavioral health care. The graph below represents referrals for behavioral health and autism-related services.

Figure 11. 2023 Total Care Coordination Referrals



When the Alliance insourced behavioral health treatment/applied behavioral analysis and related diagnostic assessments from Beacon, the care coordinators inherited a backlog of members waiting for connection to care. These were mostly members with developmental delay referred for diagnostic evaluations and related treatments. Locally and nationally, there has been a significant increase in the numbers of children identified and later diagnosed with developmental delays, mostly autism. The number of treatment providers has not grown at a comparable rate. This has resulted in longer than expected wait times for access to care. As a result, the Alliance has a high-touch care coordination program to support the members and their families in accessing care. In addition, the Alliance has taken action to increase network capacity. The care coordination program has also increased communication with primary care providers to keep them abreast of the status of referrals.

The graphs below represent the number of cases open in each month and the number that are successfully closed.

Figure 12. 2023 BHT Case Closures Volumes

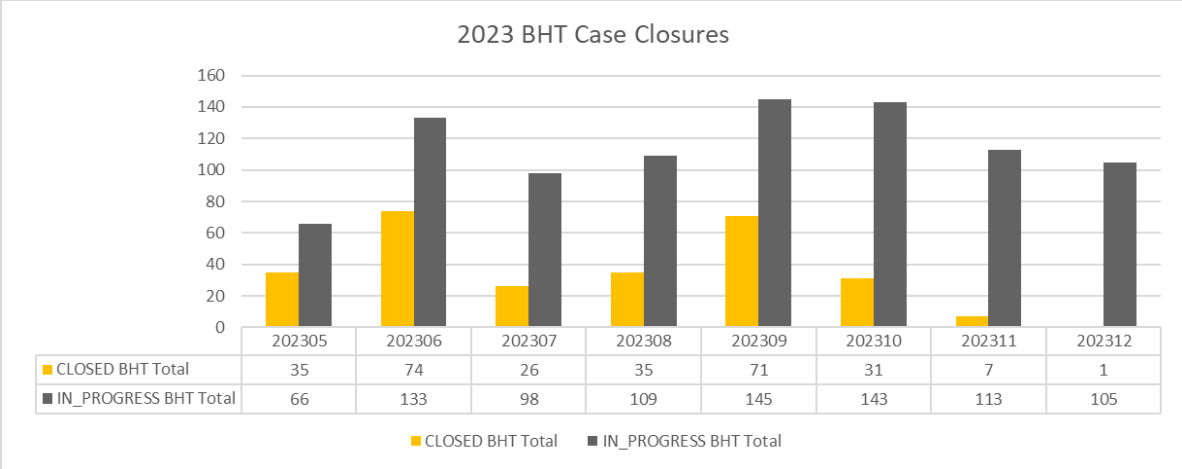
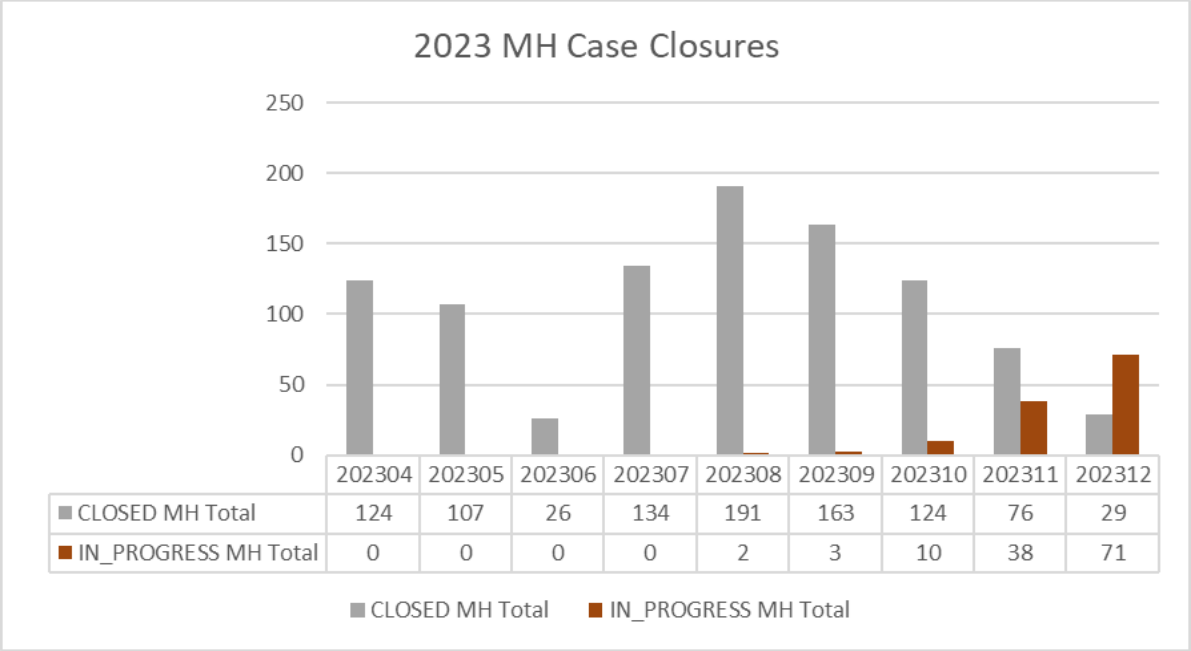


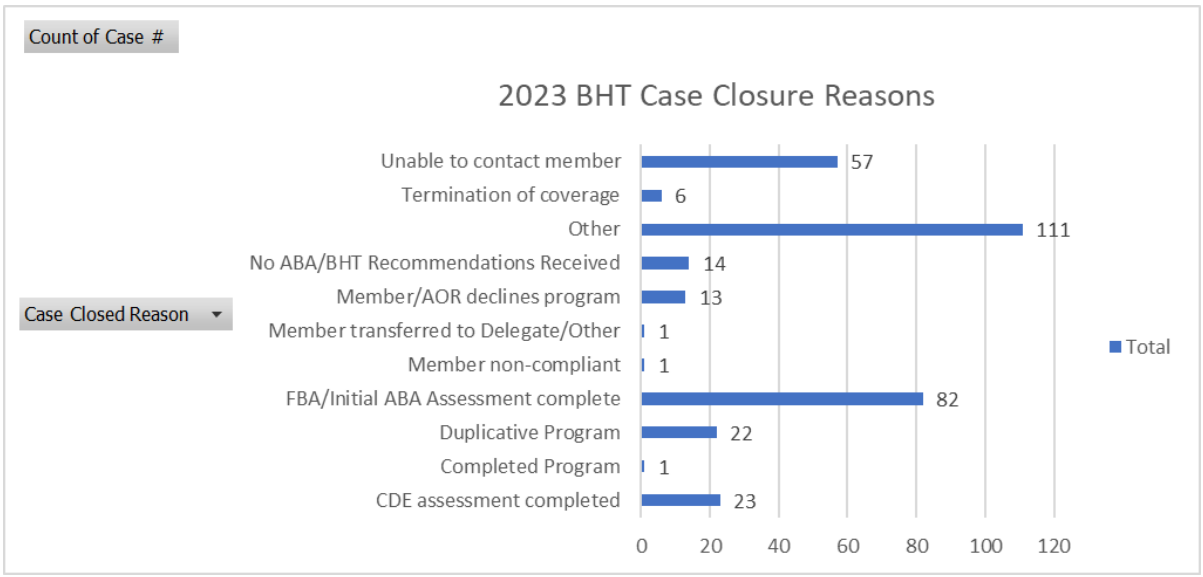
Figure 13. 2023 MH Case Closure Volumes

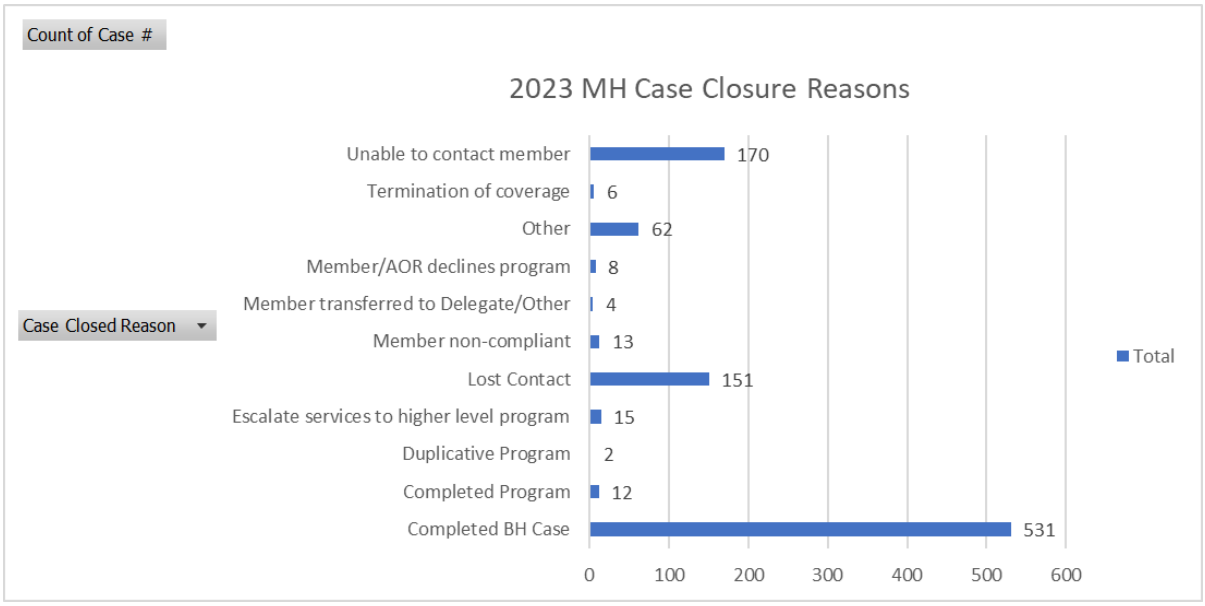


The challenges in connecting members to care is reflected in the ratio of closed to in progress cases, particularly with the BHT cases. The mental health care coordination team has been able to close cases more readily. However, the uptick in care coordination referrals is noted in the Q32023.

The graph below represents case closure reasons for both the mental health and BHT/ABA care coordination cases.

Figure 14. 2023 BHT & MH Case Closure Reasons





Cases are predominantly closed because the member has been successfully connected to care. It is noted that there is a significant number of BHT/ABA case closure reason categorized as other. This category was initially utilized in our case coordination program until more specific case closure reasons were developed and implemented.

In addition to the focus on reducing barriers to accessing mental health services, the Alliance behavioral health team is committed to facilitate coordination of care between mental health and primary care providers. To enable coordinated care, we deployed the Mental Health Initial Evaluation and the Mental Health Coordination of Care Update forms on our provider portal. These forms are designed to be an efficient and secure process whereby Mental Health providers log into the Alliance provider portal after evaluating a member to then enter the presenting problems, their findings and diagnosis

as well as their treatment plan with the mental health treatment modalities they recommend. The Mental Health provider is also provided information about the member's Primary Care Physician and the pharmacy information including all the medications the member has received from prescribers. The Mental Health provider is also able to include a message to the Primary Care Physician and make referrals to other mental health providers and to Alameda County Behavioral Health for specialty mental health services. This new mental health treatment report will help the Alliance connect mental health providers with co-treating providers and Primary Care Physicians to establish coordinated care that integrates behavioral and physical health care.

Disease Management

The Alliance Disease Management (DM) program is an Alliance Case Management and Health Education collaboration. Disease Management provides interventions for members with targeted chronic conditions. Interventions include case management for higher risk members and health coaching, care coordination and condition self-management education for lower risk members. The Alliance Population Health Assessment identified asthma for children and diabetes for adults as priority diagnoses affecting the Alliance membership at a disproportionate rate and/or with significant utilization. The Alliance Disease Management program collaborates with community partners, such as Alameda County Public Health's Asthma Start Program for children with asthma, and hospital-based Diabetes Self-Management Training (DSMT) programs to provide services for members with diabetes.

Figure 15. Members Served for Disease Management Services

Disease Management Services	Members Served
Asthma Start - Child care-management, health education and asthma remediation	128
Diabetes - Health Coaching	17
Diabetes - Diabetes Self-Management Training (DSMT)	497

With the release of the Population Health Management Policy Guide in 2023, additional work was done to expand disease management services to include cardiovascular disease and depression by 2024.

Basic Population Health Management (including Care Coordination for Medical and Behavioral Health Services and Disease Management) - Recommended Actions for 2024:

- Increase engagement in care coordination for medical services by continuing efforts to find alternative contact information for members through Electronic Health Records (EHR), PCP clinics, and Community Health Record (CHR)
- Work with Healthcare Analytics department to further enhance population analysis and program interventions to evaluate program efficacy
- Work with IT department to identify additional opportunities to automate processes administrative CM processes

- Further solidification of case coordination processes for behavioral health services to increase efficiency and uniformity of practice
- Further collaboration with Alameda County Behavioral Health to ensure member's needs are met across systems of care
- Further collaboration Alameda County Office of Education to coordinate school-based services
- Initiate bi-directional coordination of care between physical health and mental health providers, including deployment of PCP referral to Mental Health Web Form, enabling PCPs to communicate more completely the needs of the members they refer for mental health services that can be passed on to the Mental Health Provider to enhance their evaluation
- Behavioral Health Treatment/Applied Behavioral Health Treatment plan deployed on the Alliance Provider Portal to enable Autism Service Providers to submit their assessments and treatment plans securely, that can then be shared with referring pediatricians and PCPS.
- Continued identification of data sharing pathways between PCPs and Behavioral Health Practitioners
- Increase member engagement into Alliance Disease Management programs through member mail and call campaigns and provider education

Care Management Programs: Complex Case Management (CCM)

Complex Case Management (CCM) is an opt-in program, provided to members who consent to participate. It is a collaborative process between the Primary and/or Specialty Care Providers, member, and Care Manager; and the Care Manager's role is to support the member with person-centered planning, coordinating, and monitoring options and services to meet the member's health care goals.

Members meeting criteria for CCM may have conditions in which the degree and complexity of illness or conditions is severe, the level of management necessary is intensive, and the number of resources required for member to regain optimal health or improved functionality is extensive. Eligibility criteria are subject to change, based on findings from the population needs assessment and/or community and stakeholder committees, but typically support Members with at least one of the following clinical features:

- Complex diagnoses such as End-Stage Renal Disease (ESRD), Chronic Heart Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD)
- High risk scores
- Multiple comorbidities
- Multiple Emergency Department (ED) visits in a year
- Multiple hospitalizations in a year

A clinician (CM nurse or social worker) may deem a member eligible for CCM if they feel a member could benefit from CCM services. The Alliance also employed proactive strategies to identify members meeting criteria for CCM.

Predictive Model Application

The Alliance uses a predictive model application, CareAnalyzer, to aggregate utilization data (including behavioral health and pharmacy data) to identify members who may be at risk and could benefit from CM interventions. CareAnalyzer's unique analytic approach stems from the integration of The Johns Hopkins University Adjusted Clinical Group (ACG) System, a comprehensive set of predictive modeling tools based on series of mutually exclusive, health status categories defined by morbidity, age, and sex. ACGs offer a person-focused method of categorizing patients' illnesses; over time, each person develops numerous conditions, and based on the pattern of these morbidities, the ACG approach assigns each individual to a single ACG category. The Johns Hopkins Resource Utilization Bands (RUBs) were added to the data sets to improve the sensitivity and specificity of the member data. In addition, the tool was enhanced to capture the Relative Risk Score (RRS) to apply predictability to the data. The enhancement identifies current and predictive changes based on utilization data.

Population Health Report

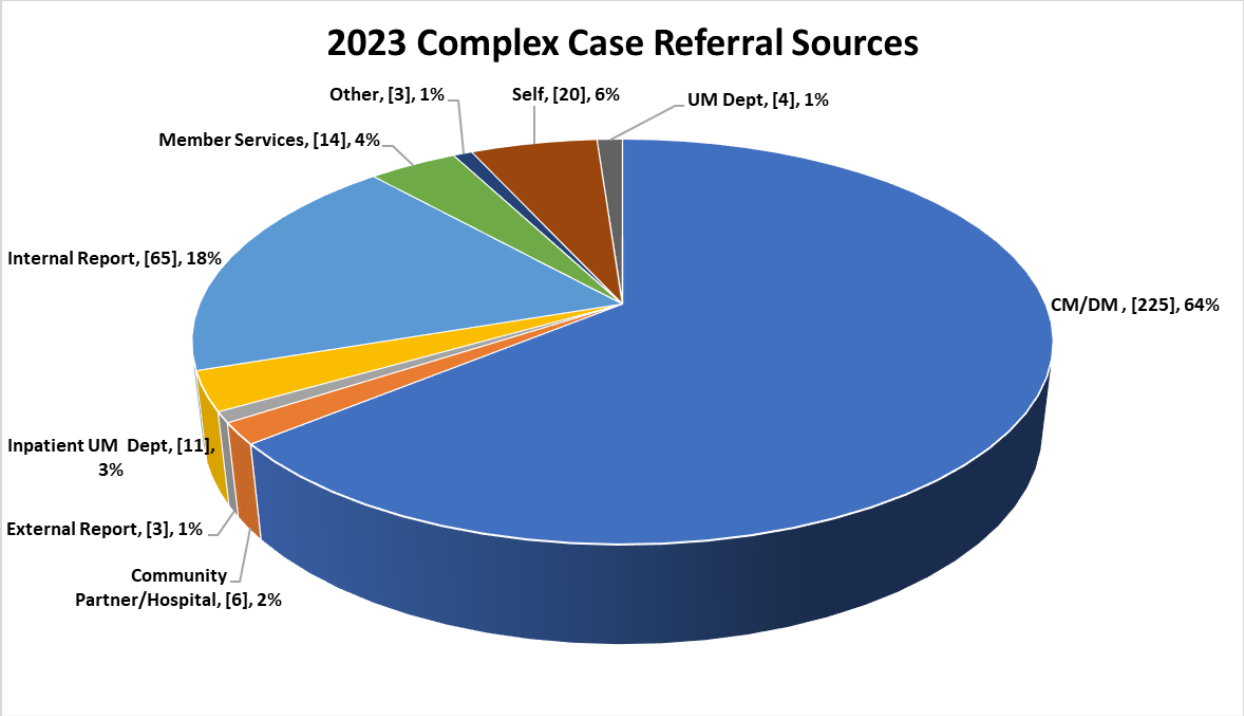
CM also worked with Healthcare Analytics to develop a Population Health Report based on claims, utilization data and the predictive modeling application, CareAnalzyer. Members identified on the report were contacted and offered CCM services.

In 2023, 166 members were identified to meet criteria for CCM and contacted by a non-clinical team member to offer CCM. Of those contacted, 11 members (about 7%) consented to participate in CCM.

The CM Department monitors CCM referral sources, case volumes and outcomes, and staff operational metrics to assess the effectiveness of the program, as well as, to identify patterns for potential program and process improvements.

The below chart shows members referred to Complex Case Management, categorized by referral source.

Figure 16. 2023 Complex Case Management – Referrals by Source

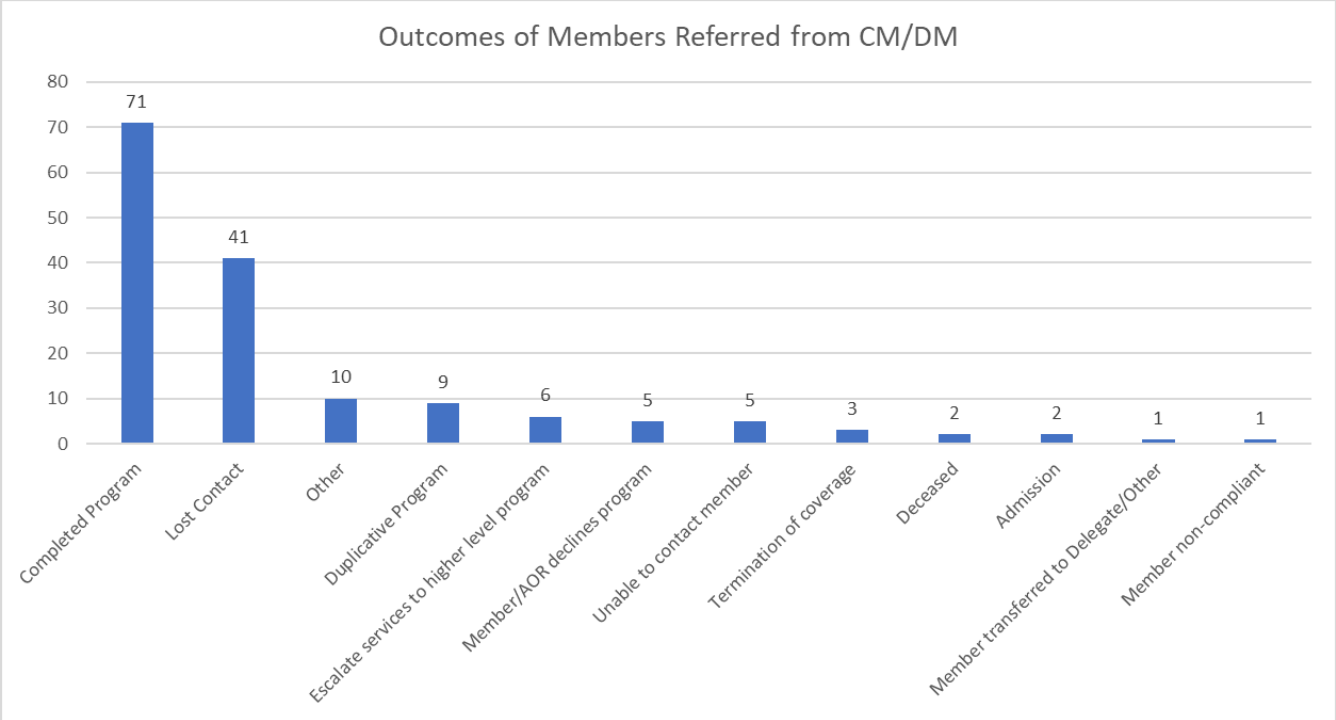


Referrals into CCM increased from 193 referrals in 2022 to 352 referrals in 2023, for a total increase of 159 cases. This may be attributed to increasing the CCM productivity standard for RN Complex Case Managers, encouraging more members to participate in CCM.

For 2023, the top three referral sources were CM/DM (225 referrals), Internal Report (65 referrals), and Self (20 referrals).

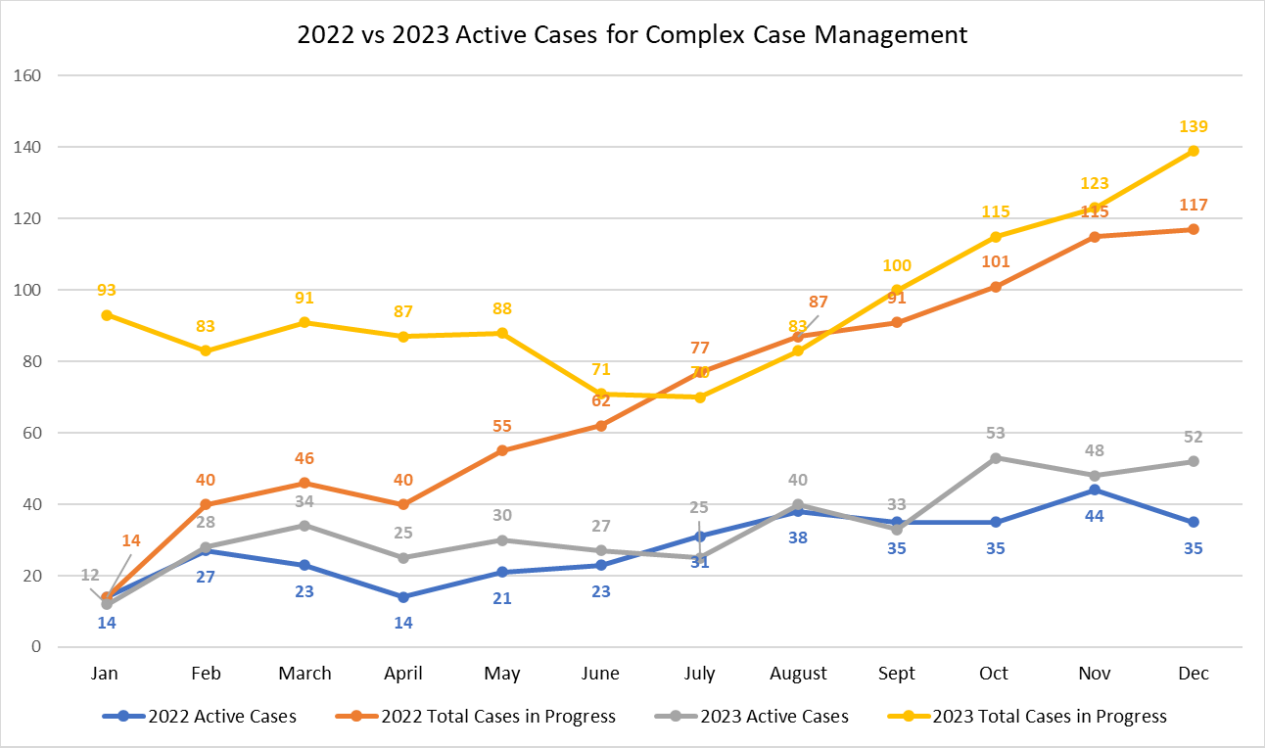
Some cases managed as care coordination may have indicators for CCM, but cannot be enrolled in CCM until the member consents. After member consent is received, a referral is made to enroll in Complex Case Management. In 2023, CM continued to monitor CCM productivity standard for CCM RNs, providing coaching sessions to practice motivational interviewing skills to increase consent from members to participate in CCM. This resulted in more CM staff referring members to CCM from a lower level-of-care CM program, like care coordination. The below table shows outcomes of members referred from lower-level CM interventions to CCM.

Figure 17. Outcome of Members Referred from CM/DM



In 2023, the CM/DM team was the largest source of CCM referrals. This means the members were already working with the CM/DM team and agreed to the more intensive case management program. Of the total CCM referrals, 32% of members completed the program and 18% lost contact with staff. The other 50% of cases were closed for reasons including (but not limited to): escalating to a high level of care, the member was already enrolled in a more intensive case management program, or the member/AOR declined the program.

Figure 18. 2022 vs. 2023 CCM Active Cases



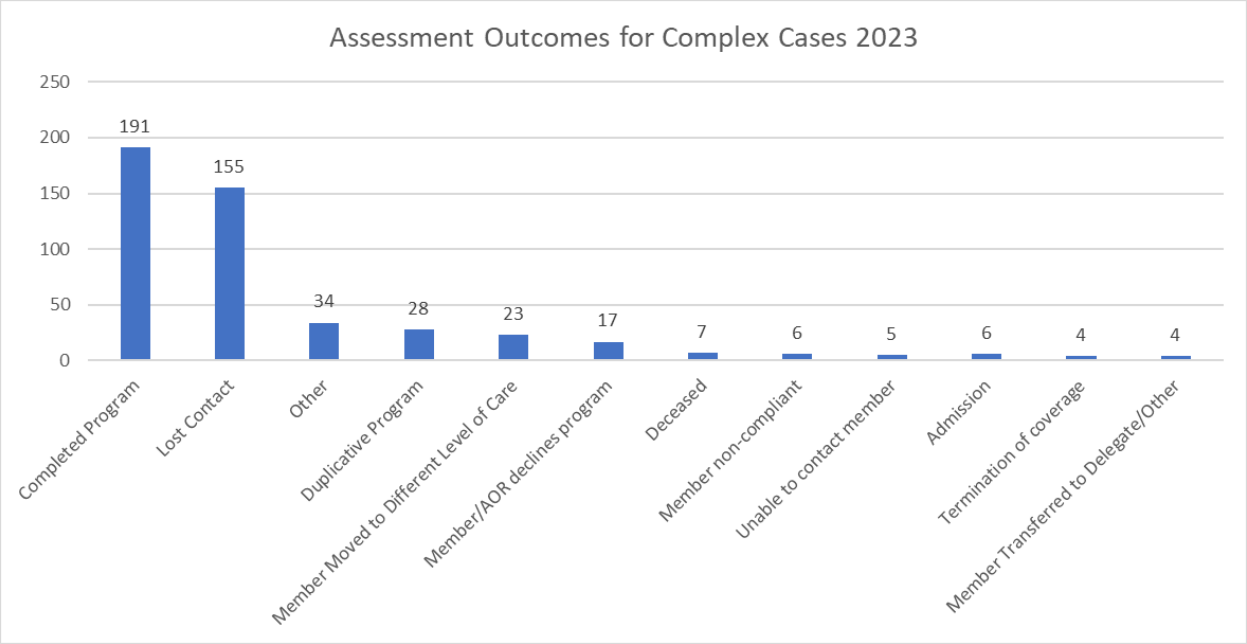
In 2023, there was a monthly average of 34 open/active CCM cases. This was a year-over-year increase of 6 cases per month, compared to the monthly average of 28 open/active CCM cases in 2022.

There has been improvement in identification and engagement of members with potential need for CCM from the Internal Reports. Referral and identification from internal staff continues to be the largest driver for CCM enrollment, indicating the importance of continued staff training to increase referrals into CCM. Monthly CCM productivity standards have promoted increased identification of and engagement of members into CCM.

To evaluate the effectiveness and quality of CCM interventions, CCM assessment and Interdisciplinary Care Team presentations were evaluated for outcomes and completion timeliness. Case closures outcomes and staff operational metrics were also evaluated.

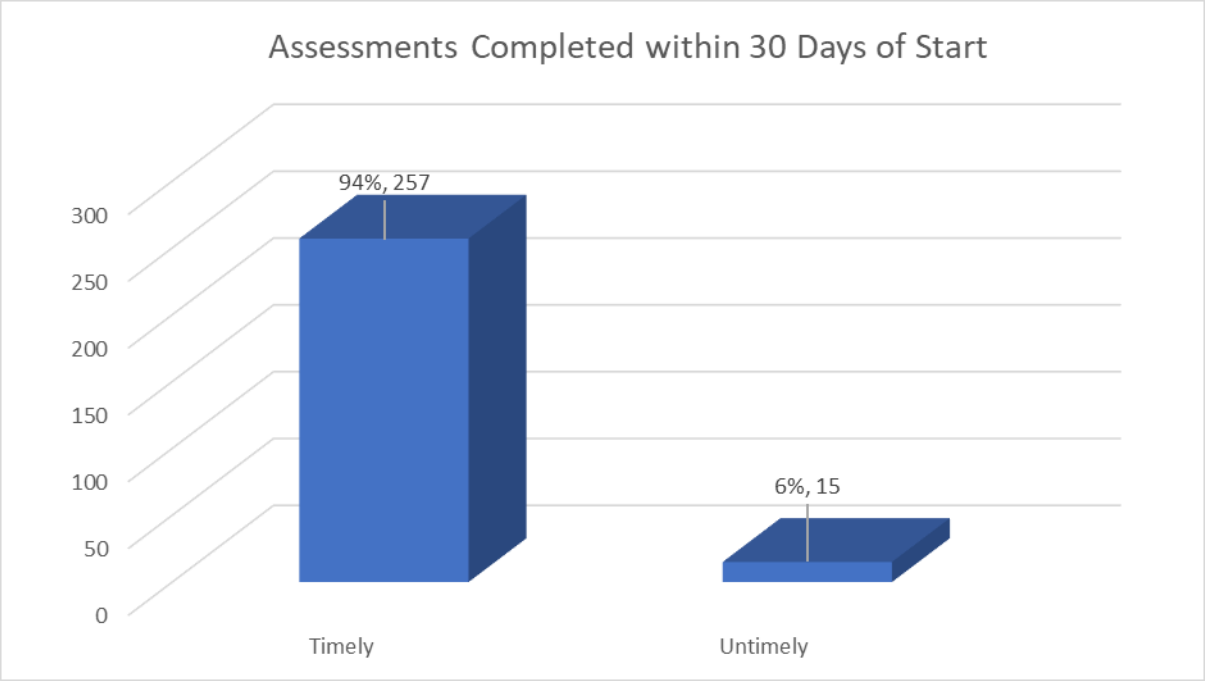
The below figures show CCM assessment trends in 2023:

Figure 19a. 2023 Assessment Outcomes for Complex Cases



In 2023, 70% of CCM assessments were completed, compared to 56% in 2022. Unable to reach rates decreased to 2% in 2023, compared to 19% in 2022.

Figure 19b. 2023 Assessment Completion Timeliness



In 2023, a total of 272 assessments were completed. This was an increase from 199 total completed assessments in 2022. Out of the 272 completed assessments, 257 were started within 30 days, meeting the timeliness goal at 95.0%. Of the 15 assessments that did not get completed within 30 days, all 15 were completed (100%) within 60 days. Assessments that were not started within 30 days were due to care coordination needs taking priority to starting the assessment, and difficulty re-engaging the member.

Complex Cases Open >90 days

An essential component of CCM is involvement of the Interdisciplinary Care Team (IDT). Members' cases are presented to the IDT at IDT Rounds to elicit insight from multiple disciplines, ensuring comprehensive problem-solving to achieve the most optimal health outcomes. IDT Rounds are held bi-weekly and using the Daily Aging Report. So that staff meet the deadline to present a case at IDT Rounds by the 90th day the case is open, staff are notified of cases that are open at the 60-day mark, ensuring the case is ready to be presented before the 90th day deadline. The timeliness of case managers presenting cases during IDT Rounds was evaluated, pulling data from all cases that had been open for 90 days or more.

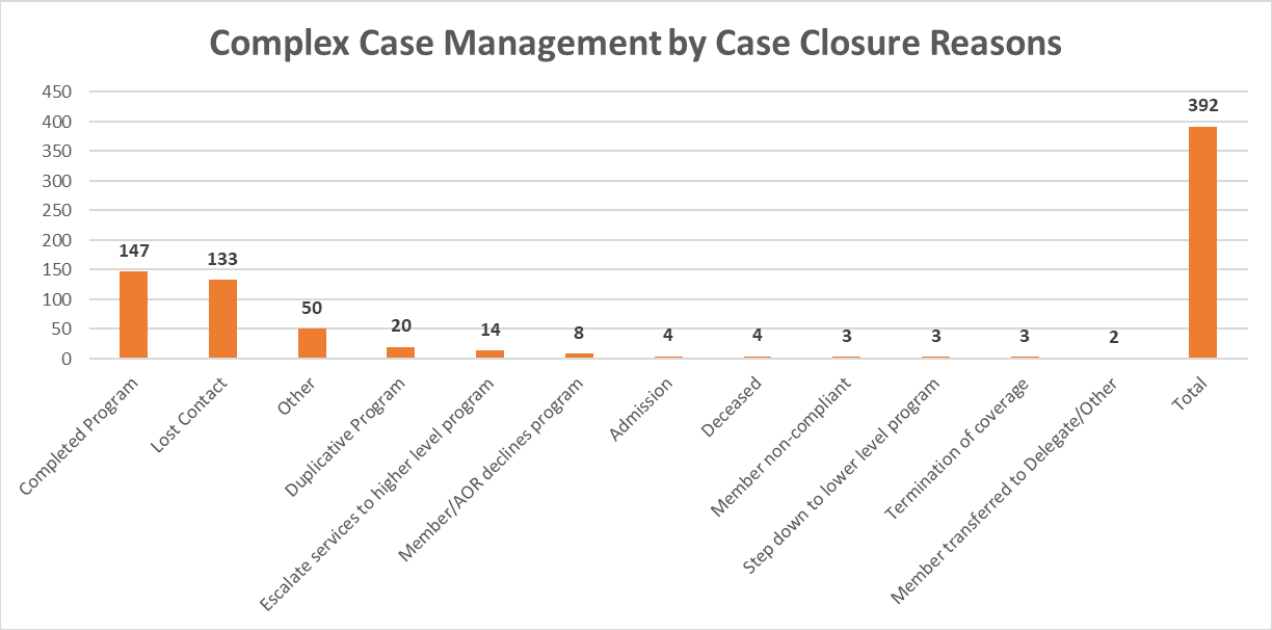
Figure 20: 2023 Results for IDT Rounds

Complex Cases ≥ 90days	Outcome of IDT	% of Timely IDT based on Report
0	No IDT	0%
18	Timely	100%
0	Untimely	0%

In 2023, 18 CCM cases were identified to be open for at least 90 days, and 100% of cases were presented at IDT meetings within 90 days of the case being opened.

Upon completion of care plan goals, including addressing all barriers, case closure is discussed with members to ensure they feel prepared to self-manage their health. The below figure shows CCM case closure reasons.

Figure 21. 2023 Complex Case Management Case Closures by Reason



In 2023, the top three reasons for case closure were Completed Program (147 cases), Lost Contact (133 cases), and Other (50 cases). Cases closed with reason of "Other" including free text by staff describing case closure reasons that could have been categorized by other options in drop-down

menu. This presents an opportunity for retraining of CM staff and updating the drop-down menu options.

There was increase in case closure reason "Completed Program" to 147, compared to 67 in 2022. This continues to show 2023 had both a higher volume of CCM cases and higher rate of program completion (31% in 2022, 38% in 2023). Lost contact case closure reason continues to be addressed via multiple telephone attempts and sending member a "Lost Contact" Letter.

The Alliance maintains operational performance measures for the complex case management program to maximize member health, wellness, safety, satisfaction, and cost efficiency while ensuring quality care. The Alliance selects measures that have significant and demonstrable bearing on the entire complex case management population or a defined subpopulation. The Alliance annually measures the effectiveness of its complex case management program based on the following performance goals and corresponding measures:

Figure 22. 2023 CM Performance Measures

	Goal	Measure	Measurement	Performance Goal	2023 Rate	Goal Met?
#1	Achieve and maintain high level of satisfaction with CM services.	Member Satisfaction Rates	High level of satisfaction with CM services	90%	100%	Yes
#2	Improve member outcomes	All-Cause readmission Rate	Readmission rates for all causes for members in CCM with admission within 6 months of enrollment in CCM	*Report in development*		N/A
#3	Improve member outcomes	Emergency Room Visit Rate	ER rates for members enrolled in CCM	*Report in development*		N/A
#4	Achieve optimal member functioning.	Health Status	% of members in CCM responding that their health status improved because of CCM	90%	100%	Yes

Of the four measures, two had an established benchmark. For 2023, CM continued to achieve the goal of achieving and maintaining high level of satisfaction with CM services at 100%. Also, 100% of members in CCM responded that their health status had improved because of CCM. Reports are being developed to evaluate the remaining two measures.

In summary, for 2023, the following strategies resulted in an increased volume of members engaged in CCM and increased identification of members for the program:

- Continued review and revisions of the Population Health Report and the CM Daily Aging Report
- Department trainings to improve consistency in member outreach, improving the staff process to offer services to members and streamlining documentation in the electronic system of record.
- Continued collaborative efforts with hospital partners to identify eligible members, including implementing alternatives to member outreach
- Continued review of productivity standard with a goal of increasing outreach to members who may be eligible for CCM.
- Staff identifying members they are already working at a lower level of care for CCM through increased training for staff on proper identification
- Motivational interviewing of members to assist in staff gaining more information that could qualify member for CCM and to assist in increasing member consent into CCM program

Complex Case Management - Recommended Actions for 2024:

- Continue to identify, implement, and evaluate different avenues to continue to increase member engagement.
- Continue SMART goal for:
  - Collaborative efforts with partnered hospitals
  - Productivity standard of Complex member outreach and engagement
  - Obtaining accurate member contact information.
  - Continue the use of the CHR and PCP for alternate phone numbers for member engagement

Care Management Programs: Enhanced Care Management (ECM)

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. ECM coordinates all care for Members who receive it, including across the physical and behavioral health delivery systems. ECM offers comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members, with the overarching goals of:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Addressing social determinants of health (SDOH);
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

The ECM program has evolved since its transition from the Health Homes Program (in 2021).

- In January 2022, The Alliance successfully launched ECM for homeless, high utilizer, and Serious Mental Health (SMI)/Substance Use Disorder (SUD) populations of focus.

- In September 1, 2022, Alameda County Behavioral Health (ACBH) became an ECM Provider.
- In January 2023, the Alliance launched programs to support two new ECM populations of focus (Adults Living in the Community at Risk for Institutionalization & Adult Nursing Facility Residents Transitioning to the Community).
- In July 2023, after DHCS re-structured ECM to further breakdown eligibility criteria for children and youth, The Alliance onboarded ECM providers to specifically support the children and youth populations.

As of 12/31/2023, the ECM program had served 1,341 members at the 24 ECM sites in Alameda County. The below table shows the number of members served in each Population of Focus.

Figure 23a. 2023 ECM Populations of Focus Enrollment

ECM Populations of Focus		Adults	Children & Youth
1	Individuals Experiencing Homelessness	115	140
2	Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly "High Utilizers")	486	116
3	Individuals with Serious Mental Health and/or SUD Needs	171	45
4	Adults Living in the Community and At Risk for LTC Institutionalization	198	
5	Adult Nursing Facility Residents Transitioning to the Community	2	
6	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		30
7	Children and Youth Involved in Child Welfare		38
	TOTAL	**972**	**369**
	COMBINED TOTAL	**1341**	

Also in 2023, the ECM team worked diligently to assist with network expansion as the final two (2) Populations of Focus went live on January 1, 2024 (Justice Involved and Birth Equity). The Alliance is also incorporating Street Medicine into ECM in alignment with DHCS' APL.

Figure 23b. ECM Populations of Focus – Implementation Dates

ECM Populations of Focus		Adults	Children & Youth
1a	Individuals Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experience Homelessness	✓	
1b	Individuals Experience Homelessness: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly "High Utilizers")	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	Go-Live January 1, 2024	
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	Go-Live January 1, 2024	

In 2023, many ECM providers continue to have challenges understanding authorizations and requirements for ECM. The Clinical Manager of ECM has leaned in to assist with process improvements, restructuring and engaging every ECM provider in regular meetings. With the current staff of five (5) Health Navigators, two registered nurses and a Physician Champion, the CM Medical Director, the team is renewing collaboration and further developing relationships with the ECM providers to understand their capacity to support additional members. ECM program graduation will be a focus area in 2024, providing additional insight/education to providers on various programs (lower levels of case management services, Community Supports services, etc.) and working towards increasing enrollment (and graduation) of members enrolled in ECM.

Enhanced Care Management - Recommended Actions for 2024:

- Continue to develop, train, and maintain the ECM Provider network, in preparation for further expansion to support all ECM populations of focus.
- Provide consistent/routine monthly in-person and virtual provider audits and respective in-services to ensure ECM compliance and optimal use of ECM benefits.
- Work closely with ECM providers in monthly IDT meetings to provide guidance with the ECM graduation process.

Care Management Programs: Targeted Case Management (TCM)

Targeted Case Management is provided to members by Local Governmental Agencies (LGAs). The Alliance facilitates access to TCM for eligible members by ensuring referrals are appropriately made to the LGAs, so they can evaluate members for TCM services. Alliance staff follow preset guidelines and collaborate with primary care providers when necessary to identify members eligible for TCM services.

Members eligible for TCM services have generally been identified as moderate or high risk. Once a member is identified and referred to an LGA for potential TCM, they are assigned to an Alliance

Case Manager, who ensures screening, referrals, care planning, and all other care coordination activities are coordinated between the member, their providers, the LGA, and The Alliance. Data exchange occurs between the Alliance and the various TCM LGAs, to ensure non-duplication of services. Collaboration with the LGA also ensures members who are no longer eligible for TCM are appropriately linked with alternate resources to support any ongoing health needs.

Transitional Care Services

The Alliance's Transitions of Care (TOC) Program has evolved since its inception in 2019. The TOC care model had always provided support to members at hospital discharge, using any individual or combination of the Case Management disciplines: Nurse Case Managers, Social Workers or non-clinical staff, Health Navigators. In 2022, the Alliance redesigned the TOC care model to align with DHCS' Transitional Care Services (TCS), as described in the Population Health Management Policy guide.

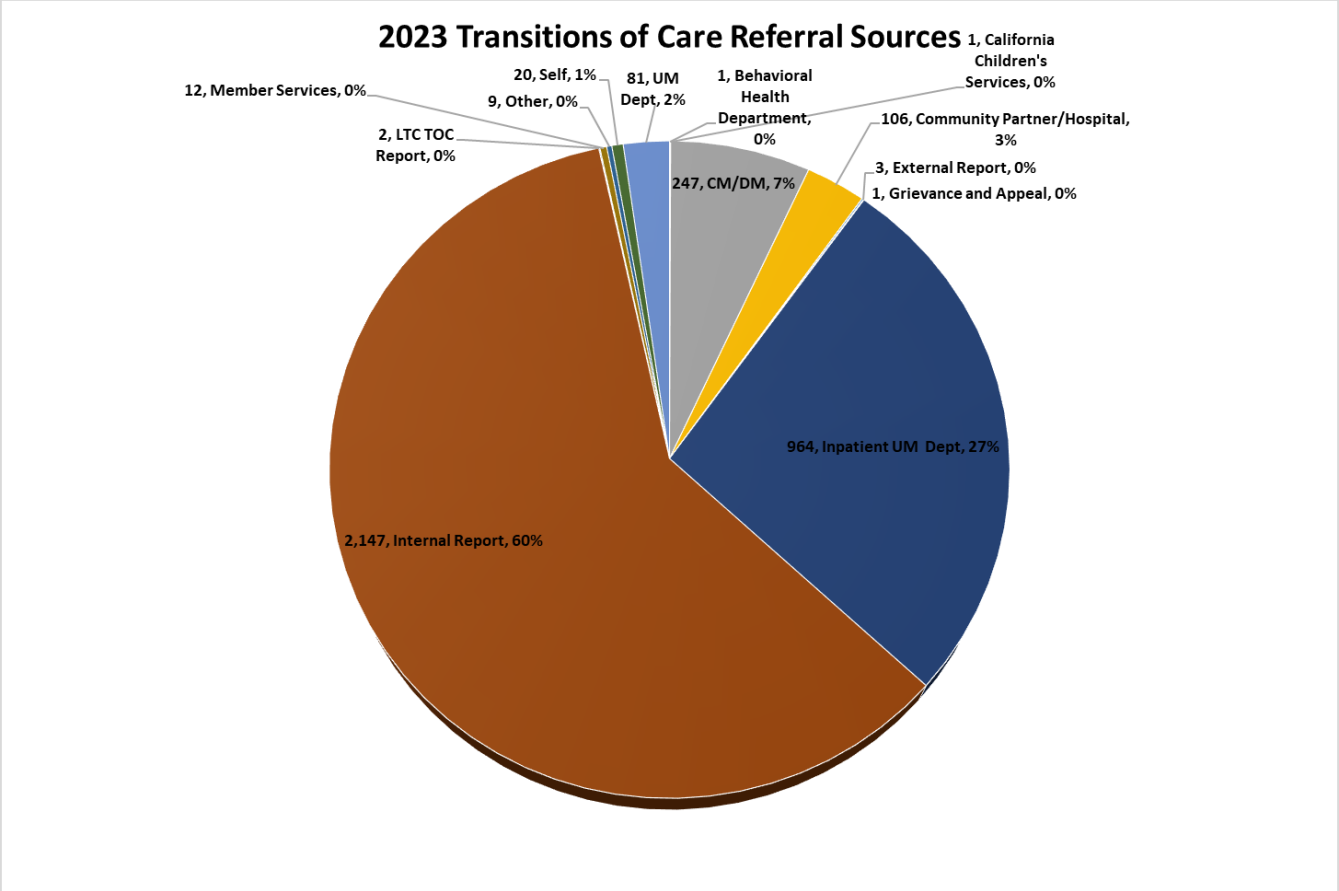
In January 2023, The Alliance implemented TCS for all high-risk members transitioning from one setting or level of care to another. These transitions include, but are not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings. The Alliance has established partnerships with hospitals and network providers, like Alameda Health Systems (AHS), to effectively implement TCS, ensuring members have access to supports across the continuum from admission to discharge.

Also, in 2023, the Alliance prepared for the expanded requirement of providing TCS to all members, regardless of risk stratification, starting January 2024.

The Alliance delegates TCS to CHCN for members assigned to the CHCN network – these members are supported via CHCN's Care Transitions Registered Nurse (CTRN) program. The CM team provides oversight and monitoring of the delegated TCS activities to ensure compliance with all DHCS requirements.

The below data represents TCS outcomes in 2023, including referral sources, case volumes, and case closure reasons.

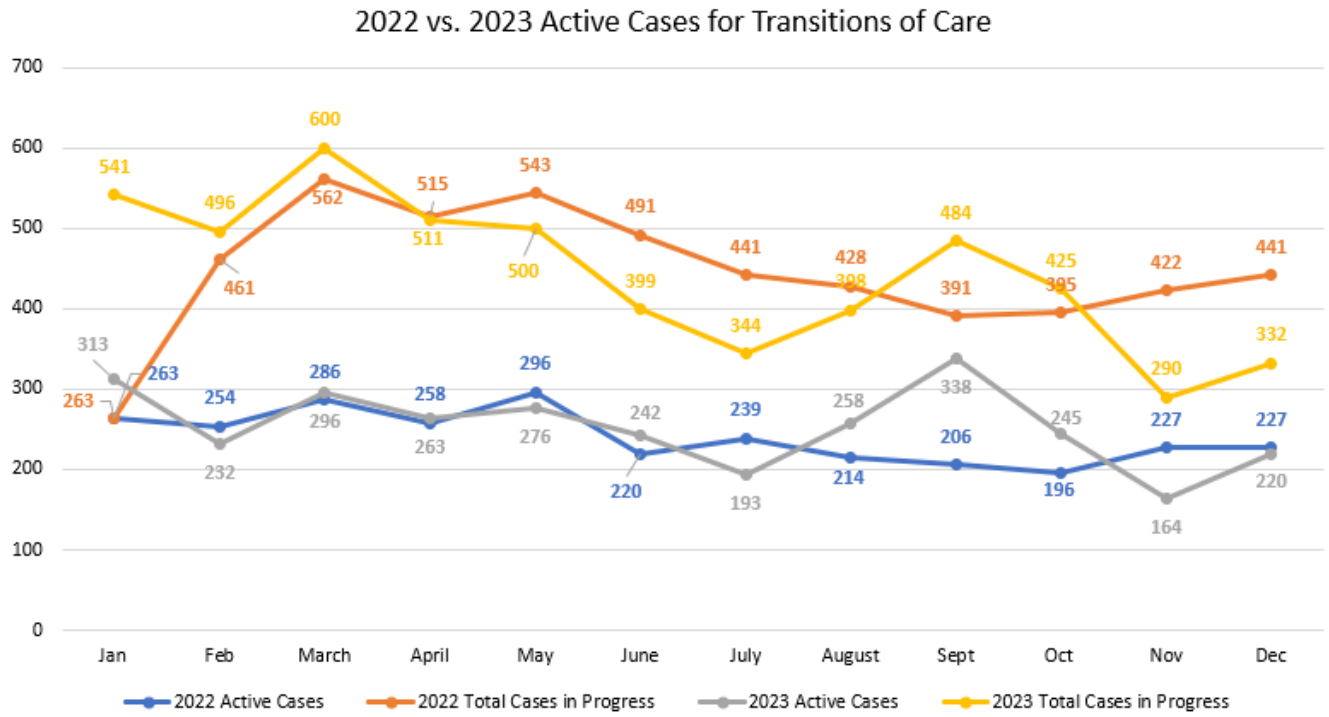
Figure 24. 2023 Transitional Care Services Referrals



In 2023, the top three sources of TCS referrals were Internal Report (2,147 cases), the Inpatient UM Dept (964 cases), and CM/DM (247 cases).

The Internal Reports refer to the ADT Feed, in which cases are created automatically via ADT data received from hospitals who have agreed to provide ADT. The significant increase in TCS referrals is due to implementation of the DHCS requirement for all members stratified as high-risk.

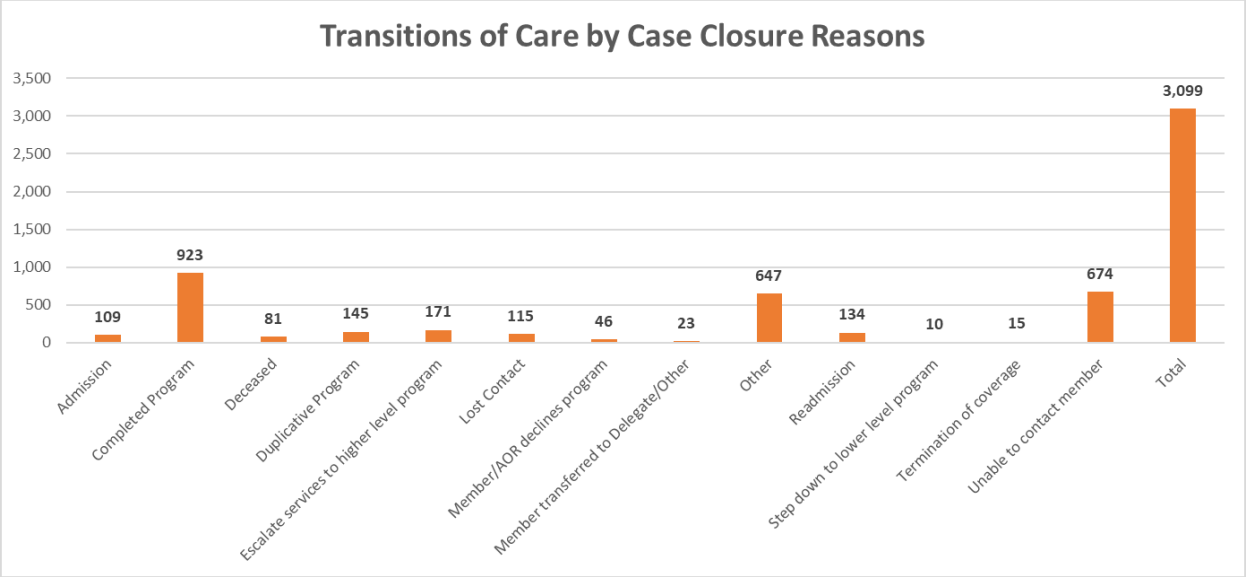
Figure 25. 2022 vs. 2023 Transitional Care Services Active Cases



In 2023, there was a monthly average of 253 open/active CCM cases. This was a year-over-year decrease of 13 cases per month, compared to the monthly average of 240 open/active TCS cases in 2022. The decrease from 2022 to 2023 was due to new requirements from DHCS beginning in 2023, including that TCS in 2023 was only required for members stratified as high risk. CM updated workflows of its previous Transitions of Care (TOC) pilot to comply with these formalized TCS requirements.

The higher volume of TCS cases in Q1 2023 was related to supporting ECM providers with training and reminders to deliver Transitional Care Services to members enrolled in ECM. The ECM team worked with various ECM providers to ensure they were able to identify ECM members who had been hospitalized. Once ECM providers understood how to track and manage their members who were hospitalized, they were able to effectively deliver TCS, thus stabilizing the TCS referral volume noted in the remainder of 2023.

Figure 26. 2023 Transitional Care Services Case Closures



In 2023, the top three (3) reasons for TCS Case Closure were Completed Program (923 cases), Unable to Contact Member (674 cases), and Other (647 cases). Cases closed with reason of "Other" including free text by staff describing case closure reasons that could have been categorized by other options in drop-down menu. This presents an opportunity for retraining of CM staff and updating the drop-down menu options.

The number of members who completed TCS increased year-over-year to 923 cases, compared to 794 cases in 2022. In 2023, the CM team implemented member outreach while the member was still in the hospital, likely contributing to this increase in successful outcomes.

Transitional Care Services - Recommended Actions for 2024:

- Continued efforts to improve member engagement rate will continue in 2024 via finding alternate phone numbers through CHR, and PCP office.
- Increased partnerships with hospital systems.
- Increased partnerships with PCP offices in collaborating on TCS, particularly post discharge appointments.
- Increased focused on specific TCS populations such as OB and FFS Medicare Part A members.

Specialized Services

Continuity of Care

The CM Department collaborates with the UM Department and Member Services on facilitating members' timely access to care and any appropriate continuity of care. CM is responsible assisting members who are redirected to In-Network Providers after their continuity of care period ends and assisting members whose initial request did not qualify for continuity of care. Continuity of Care referrals are sent to CM via direct referrals from UM and Member Services. The UM department also identifies and refers members to CM

who have exhausted a benefit, who are aging out of a benefit (i.e., California Children Services), or have needs beyond those provided by partner agencies. CM supports these members with access to alternate resources.

In Q4 2023, the Alliance worked with DHCS and other managed care plans to prepare for the transition of about 100,000 members into The Alliance, due to The Alliance becoming a single-plan county. The Alliance effectively executed the specialized Continuity of Care requirements for this transitioning population, proactively outreaching to providers and members, when appropriate.

Community Supports

Community Supports (CS) services were initiated as part of CalAIM and include a variety of services not typically covered by managed care plans. These services were intended to provide additional cost-effective support to members in lieu of higher-level services. In 2023, the Alliance provided eleven (11) CS Services:

- Housing Navigation
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Recuperative Care (Medical Respite)
- Medically Tailored Meals/Medically Supportive Food
- Asthma Remediation (for children under 19 years of age)
- Environmental Accessibility Adaptations (Home Modifications)
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care & Homemaker Services
- (Caregiver) Respite Services

The below table shows the number of members receiving Community Supports in 2023.

Figure 27. Number of Members Receiving Community Support Services

CS Service Type	CS Providers	Members Served	Number of Authorizations
Housing Deposits	Healthcare Service Agency (HCSA)	241	406
Housing Tenancy and Sustaining Services	Healthcare Service Agency (HCSA)	1594	1648
Housing Transition/Navigation Services	Healthcare Service Agency (HCSA)	870	968
Medically-Supportive Food/Medically Tailored Meals	Project Open	734	922
	Healthcare Service Agency (HCSA) - Recipe 4 Health	823	1447

Asthma Remediation	Health Care Service Agency (HCSA) - Asthma Start	182	189
Community Transition Services/Nursing Facility Transition to a Home	East Bay Innovation (EBI)	4	5
Environmental Accessibility Adaptations	East Bay Innovation (EBI)	0	6
Nursing Facility Transition/Diversion to Assisted Living Facilities	East Bay Innovation (EBI)	10	15
Personal Care/Homemaker Services	24 Hour Home Care	81	130
Recuperative Care/Medical Respite	Cardea Health	120	134
	Adeline Lifelong	76	92
	Bay Area Community Services (BACS)	24	27
Respite Services	224 Hour Home Care	1	2

The Alliance continued to work with the current providers of the current services, and onboarded new providers and new services in 2023. Significant effort was made to further expand the CS services that the Alliance offers, and to prepare for further network expansion of the current CS services in Jan 2024. The CS team met regularly with all CS providers, discussing utilization, member support/cases and building rapport with the CS provider network. Oversight and monitoring began in 2023 with the providers who had been contracted with the Alliance for 12 months (or more).

Community Supports - Recommended Actions for 2024:

- Transition the operational oversight of Community Supports to LTSS Director
- Launch the last two CS services (Short-Term Post-Hospitalization Housing and Day Habilitation Programs) by January 1, 2025.
- Continue to broaden CS provider network, as appropriate.
- Increase staff where appropriate as department expands to better meet needs of members and providers.

- Continue to build relationships with billing to assist providers with receiving timely payments.
- Continue to work with Analytics to further enhance a dashboard for CS services
- Continue development of accurate and reliable closed loop referral process with Community Supports providers, in alignment with the DHCS requirement by January 1, 2025; establish mechanism for CS providers to confirm members are being serviced after authorizations have been issued
- Provide training to all CS providers to promote best practices while working with our members and to continue to build rapport with CS providers

Transportation

Ensuring access to adequate and timely transportation to medical appointments is an essential care management intervention to address this social determinant of health barrier. In 2023, the Alliance's dedicated CM Transportation Coordinators provided oversight and management of the Transportation benefit. Specifically, they assumed responsibility for obtaining completed Physician Certification Statement (PCS) forms prior to coordinating Non-Emergency Medical Transportation (NEMT), collaborating with the vendor management department to ensure that Transportation processes aligned with the requirements of APL 22-008 for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT).

Additionally, the Alliance continued to monitor the performance of its transportation subcontractor, ModivCare, in the provision of the Transportation benefit by conducting weekly joint operational meetings, quarterly joint operational meetings (JOM), weekly grievances meetings, weekly potential quality issue (PQI) meetings, and other ad-hoc meetings as needed. The below figure show ModivCare's key performance indicators.

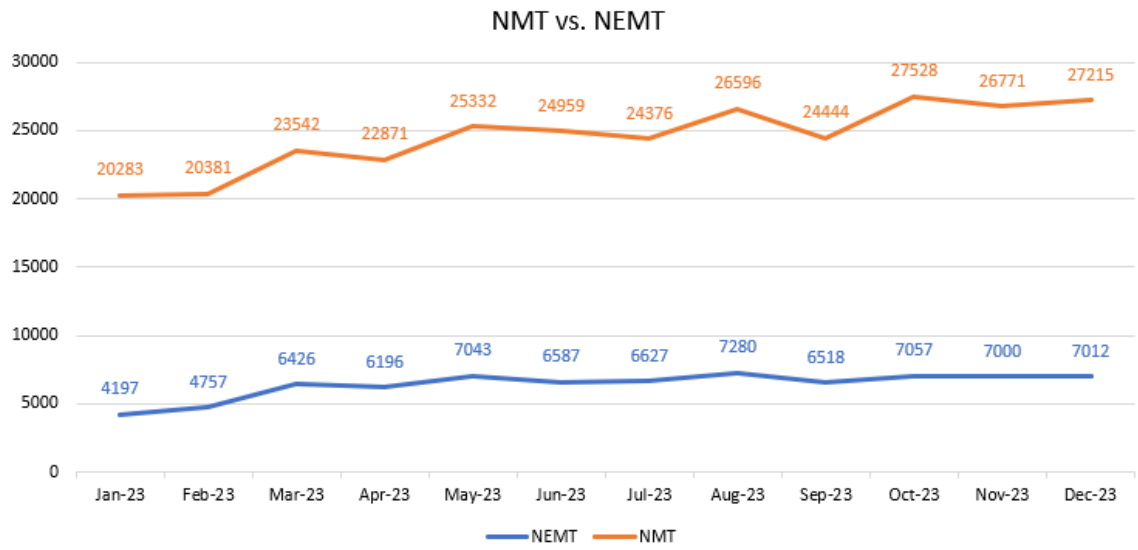
Figure 28. ModivCare Key Performance Indicators

	Description		1st QTR Total	1st QTR Average	% of Total	2nd QTR Total	2nd QTR Average	% of Total	3rd QTR Total	3rd QTR Average	% of Total	4th QTR Total	4th QTR Average	% of Total	YTD	YTD Totals
Members	Members Served	Number of unique members utilizing transportation		2,207			2,468			2,621			2,747		2,511	2,511
	Enrollment	Total number of eligible members		344,985			359,293			352,593			352,225			
Advance Notice	Same Day Trips	Trips scheduled with less than 24 hr notice	875	292	1.5%	1091	364	1.6%	1755	585	2.5%	3819	1273	5.7%	2.9%	7,540
	Standing Orders	Standing Order Trips	33066	11022	55.2%	40932	13644	60.0%	41220	13740	59.8%	37406	12469	55.9%	57.8%	152,624
Utilization	Utilization Rate	Transportation utilization rate (completed trips/total enrollment)		5.8%			6.3%			6.5%			6.3%		6.25%	
Call Center	Calls Received	Measures number of Reservations calls received	9,565	3,188		9,465	3,155		9,978	3,326		8,588	2,863		3,133	37,596
	Average Hold Time	Average hold time should be less than 3 min for 90% of calls		0:00:44			0:00:39			0:00:32			0:00:20		00:34	
	Service Level	Goal: 80% of calls answered within 30 seconds		82.0%			83.9%			73.6%			88.5%		82.0%	
Timeliness	On Time Performance*	Goal: 90% on time for all legs		77.7%			84.2%			89.5%			91.1%		85.6%	
	Will Call On Time	Goal: 90% on time for Will Call Legs		97.6%			98.0%			98.5%			98.6%		98.1%	

The below figure shows total NMT vs. NEMT trip volume in 2023.

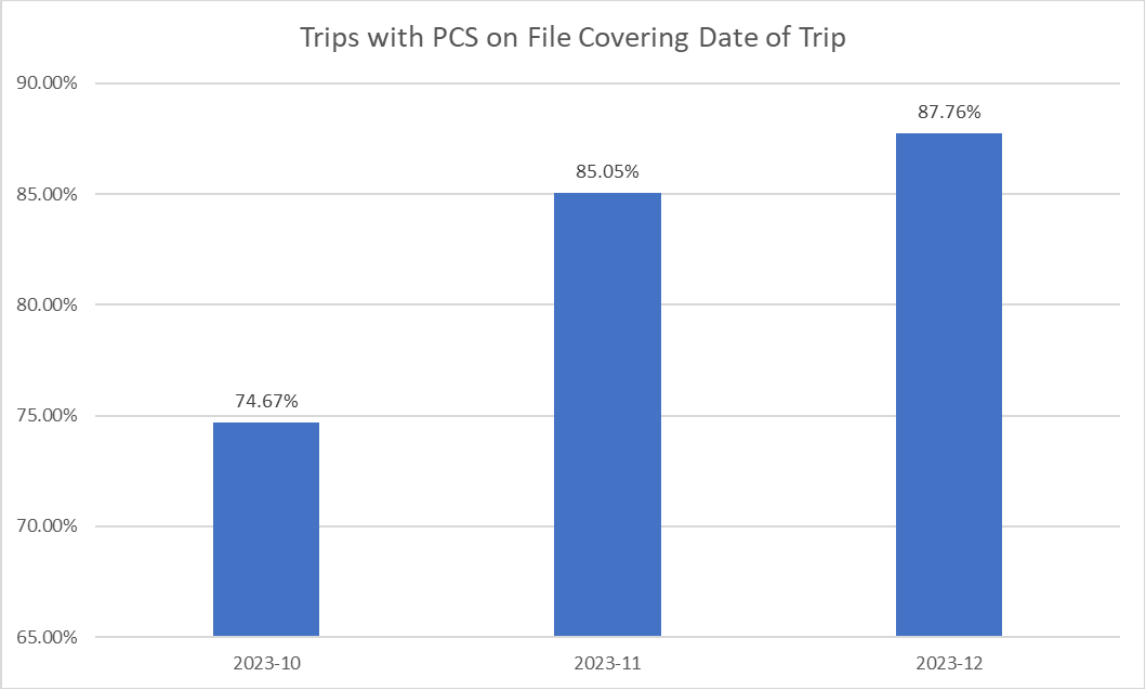
Figure 29. Total NMT vs. NEMT trip volume

NMT vs. NEMT												
	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
NEMT	4197	4757	6426	6196	7043	6587	6627	7280	6518	7057	7000	7012
	17.14%	18.92%	21.44%	21.32%	20.88%	21.36%	21.38%	21.49%	21.05%	20.40%	20.73%	20.49%
NMT	20283	20381	23542	22871	25332	24959	24376	26596	24444	27528	26771	27215
	82.86%	81.08%	78.56%	78.68%	78.25%	79.12%	78.62%	78.15%	78.95%	79.60%	79.27%	79.51%



In 2023, ModivCare scheduled a monthly average of 6,392 NEMT trips and 24,525 NMT trips. Around 6% of Alliance members utilized the transportation benefit, with the top reason for transportation continuing to be transport to dialysis for members with End Stage Renal Disease.

Figure 30. NEMT trips with PCS on file



In 2023, the Alliance completed the insourcing of the acquisition of Physician Certification Statement (PCS) forms, previously done by the Alliance's transportation subcontractor, Modivcare. The insourcing included creation and hiring of a new position, transportation coordinators. CM leverages its relationships with PCP offices and dialysis centers to ensure timely completion of PCS forms. The Alliance worked with its analytics department to better track PCS compliance, defined as having a valid PCS form on the day of a member transportation trip. Figure 31 shows compliance hovering around 88% by end of 2023, up from an estimated 30%-50% compliance when PCS was still managed by the transportation subcontractor.

Coordination with Compliance Department

The Alliance CM Department works closely with the Compliance Department to prepare for regulatory audits. In April 2023, the department participated in DHCS' annual audit. There were two findings related to the care management program:

1) A repeat finding related to The Alliance not ensuring required Physician Certification Statement (PCS) Forms were on file for members receiving Non-Emergency Medical Transportation (NEMT) services. The CM department implemented DHCS' recommendation to ensure policies and procedures for obtaining and maintaining PCS forms in members' files and worked with the transportation vendor to reinforce requirements.
2) The Alliance did not ensure members' behavioral health treatment plans contained all required elements. The finding involved Beacon Health Options, given delegation of behavioral health treatment services through March 2023. With the insourcing of BH services in April 2023, the behavioral health department implemented DHCS'

recommendation to ensure members' behavioral health treatment plans contain all the required elements.

To maintain the integrity of The Alliance's CM processes, ongoing auditing and monitoring of key operational functions will continue, ensuring compliance with all federal, state, regulatory, contractual and accreditation standards.

Member Satisfaction with the CM Process

Annually, CM evaluates member experience with the CCM Program by obtaining member feedback with the use of satisfaction surveys and continuous monitoring of member complaints. The information obtained assists The Alliance in measuring how well the complex case management program is meeting members' expectations and identifying areas for improvement.

The Alliance's goal is to obtain a 90% or greater overall satisfaction with the CCM program. Satisfactory results are defined as those that fall under the following categories:

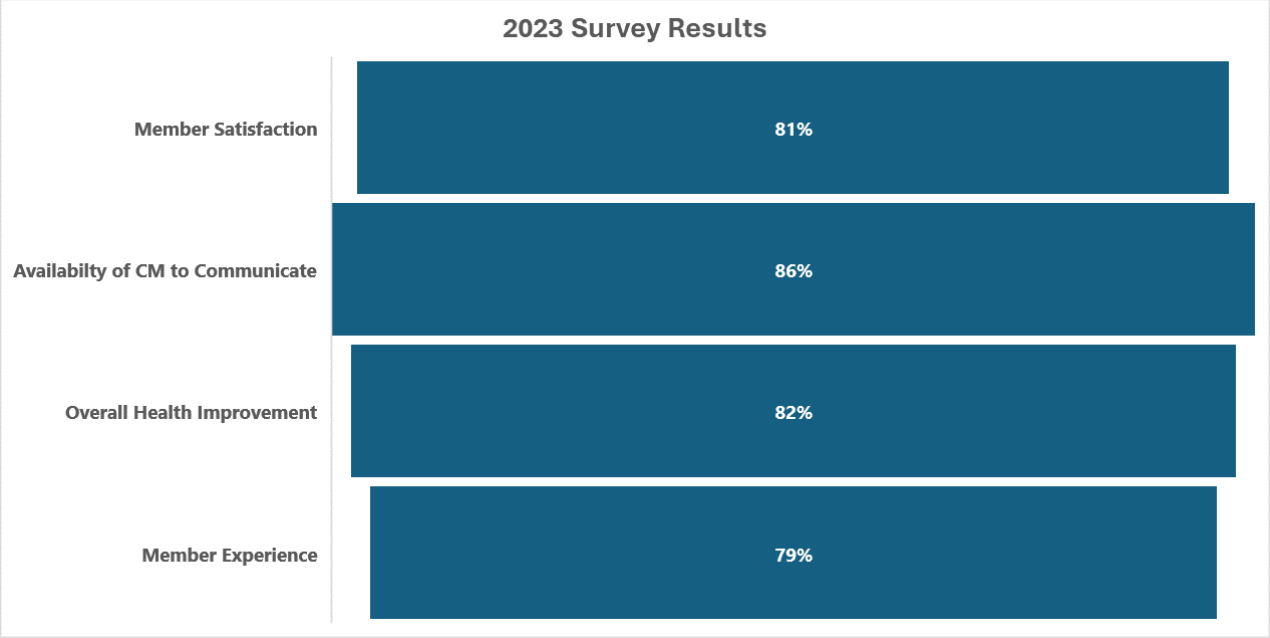
- Very Satisfied
- Much Improved
- Always True
- Highly Likely

Figure 31. 2023 CM Member Satisfaction Survey Questions

Member Satisfaction
Are you satisfied with the amount of time spent with your care manager throughout the program? How satisfied were you with the care manager listening to and understanding your concerns? How satisfied were you with the information you received in managing your health?
Availability of CM to Communicate
When you called with questions about your health care needs, were you able to speak to your care manager?
Overall Health Improvement
Are you able to better manage your health condition since receiving care management services? Please rate how much the Alliance Program helped your overall health and well-being.
Member Experience
How do you rate your overall experience with the Alliance Program? How likely are you to recommend the services of this organization to your family and friends?

In 2023, CM Department received a total of 14 surveys. Below are the results:

Figure 32. 2023 CM Member Satisfaction Survey Results



The overall satisfaction rate was 82%, thus not meeting the goal of 90%.

Member experience is also assessed by reviewing grievances filed against Case Management. Below are grievances filed in 2023:

Figure 33. 2023 Complaints Filed Regarding CM Process

Total Non-Exempt Grievances Against CM	G&A Decision – In Favor or Member	G&A Decision – Neutral	G&A Decision – In Favor of Plan
38	23	15	0

In 2023, there were 38 non-exempt grievances against CMDM, with 23 grievances resolved in the members' favor. Notable trends included:

- Members dissatisfied with turnaround time for returning member calls
- Members dissatisfied with ability to assist in changing decision by a provider office

Member Satisfaction with CM - Recommended Actions for 2024:

- Increasing the return rate of satisfaction surveys. Satisfaction surveys are attached to case closure letters, which are sent to all members who complete their CM case. CM will work on ensuring members are educated that they will receive a survey upon case closure to increase return rate.
- Continue educating members on care management process, including establishing communication plan with member and establishing mutually-agreed upon scheduled calls
- Continue educating members on effective strategies for working with provider offices, including setting realistic expectations about provider treatment protocols

Evaluation of Delegated Case Management Activities

The Compliance Department is responsible for monitoring and tracking the overall performance of delegates, including completion of annual audits. CM department staff review the CM components of the annual audit, which includes a review of delegates' policies and procedures and member case files. The CM team also reviews the delegated entities' annual work plans/evaluations, and semi-annual reporting. The Compliance Department is responsible for finalizing the audit findings. For entities that do not meet thresholds, a corrective action plan may be issued and tracked to ensure adequate resolution of the deficiency. All audit findings are reported to the Compliance Committee and the QIHEC.

In 2023, the Compliance Department conducted annual audits on the 2 delegates with delegated CM responsibilities. The threshold for CM audit compliance was 90%. In 2023, delegate audit results for CM activities included:

- Kaiser passed the CM audit (≥ 90.0%)
- CHCN had findings and required corrective actions.

Figure 34. 2023 Delegate Annual Audit Results (CM components only)

Delegate Name	**Provider Type**	**Delegated Activity-** Care Coordination/Case Management	**Delegated Activity-** Complex Case Management	**2023 Audit Results**	**Corrective Action Required**
Kaiser	Health Maintenance Organization (HMO)	Yes	Yes	No deficiencies found	None
CHCN	Managed Care Organization (MCO)	Yes	No	1 finding File Review (91% score) *This is a preliminary finding*	Retraining of staff already addressed in 2022 audit.
Beacon / College Health IPA (through 3/31/23)	Managed Behavioral Healthcare Organization (MBHO)	Yes	Yes	No audit*	No audit*

*In April 2023, Mental Health/Behavioral Health services were insourced into The Alliance and Beacon/College Health IPA was a delegate only through March 31, 2023. Efforts in Q1 2023 were focused on transitioning the impacted members from Beacon to The Alliance.

NOTE: Calendar year 2023 was the last year Kaiser Permanente remained a delegate with The Alliance. Kaiser Permanente contracted directly with the Department of Health Care Services

(DHCS), effective January 2024. In 2023, Kaiser and The Alliance worked together to prepare for this transition to ensure minimal disruption in care to the impacted membership.

Delegated Case Management - Recommended Actions for 2024:

- Partner with the Compliance Department to evaluate audit tools and establish metrics that align with The Alliance's key performance indicators.
- Provider regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance's Population Health Management strategy

Conclusion

Overall, the 2023 CM Program continued to develop into an effective program, maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The CM program activities have met most of the established targets, including a reduction in regulatory findings. The Alliance leadership has played an active role in the CM Program structure by participating in various committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements. To ensure that the Alliance used a comprehensive approach to designing the CM program structure, practicing physicians provided input through QIHEC. The CM program continues to analyze internal benchmarks to further enhance progress and provide quality service to the Alliance membership.

CM Program Recommendations for 2024

As a result of the 2023 program evaluation, opportunities for improvement have been identified and will be incorporated into the 2024 CM Program and Work Plan. A summary of process improvement opportunities is noted below:

Operational Efficiency and Compliance

Basic Population Health Management (including Care Coordination for Medical and Behavioral Health Services and Disease Management):

- Increase engagement in care coordination for medical services by continuing efforts to find alternative contact information for members through Electronic Health Records (EHR), PCP clinics, and Community Health Record (CHR)
- Work with Healthcare Analytics department to further enhance population analysis and program interventions to evaluate program efficacy
- Work with IT department to identify additional opportunities to automate processes administrative CM processes
- Further solidification of case coordination processes for behavioral health services to increase efficiency and uniformity of practice

- Further collaboration with Alameda County Behavioral Health to ensure member's needs are met across systems of care
- Further collaboration Alameda County Office of Education to coordinate school-based services
- Initiate bi-directional coordination of care between physical health and mental health providers, including deployment of PCP referral to Mental Health Web Form, enabling PCPs to communicate more completely the needs of the members they refer for mental health services that can be passed on to the Mental Health Provider to enhance their evaluation
- Behavioral Health Treatment/Applied Behavioral Health Treatment plan deployed on the Alliance Provider Portal to enable Autism Service Providers to submit their assessments and treatment plans securely, that can then be shared with referring pediatricians and PCPS.
- Continued identification of data sharing pathways between PCPs and Behavioral Health Practitioners
- Increase member engagement into Alliance Disease Management programs through member mail and call campaigns and provider education

Complex Case Management:

- Continue to identify, implement, and evaluate different avenues to continue to increase member engagement.
- Continue SMART goal for:
  - Collaborative efforts with partnered hospitals
  - Productivity standard of Complex member outreach and engagement
  - Obtaining accurate member contact information.
  - Continue the use of the CHR and PCP for alternate phone numbers for member engagement

Enhanced Care Management:

- Continue to develop, train, and maintain the ECM Provider network, in preparation for further expansion to support all ECM populations of focus.
- Provide consistent/routine monthly in-person and virtual provider audits and respective in-services to ensure ECM compliance and optimal use of ECM benefits.
- Work closely with ECM providers in monthly IDT meetings to provide guidance with the ECM graduation process.

Transitional Care Services:

- Continued efforts to improve member engagement rate will continue in 2024 via finding alternate phone numbers through CHR, and PCP office.
- Increased partnerships with hospital systems.
- Increased partnerships with PCP offices in collaborating on TCS, particularly post discharge appointments.
- Increased focused on specific TCS populations such as OB and FFS Medicare Part A members.

Community Supports:

- Transition the operational oversight of Community Supports to LTSS Director
- Launch the last two CS services (Short-Term Post-Hospitalization Housing and Day Habilitation Programs) by January 1, 2025.
- Continue to broaden CS provider network, as appropriate.
- Increase staff where appropriate as department expands to better meet needs of members and providers.
- Continue to build relationships with billing to assist providers with receiving timely payments.
- Continue to work with Analytics to further enhance a dashboard for CS services
- Continue development of accurate and reliable closed loop referral process with Community Supports providers, in alignment with the DHCS requirement by January 1, 2025; establish mechanism for CS providers to confirm members are being serviced after authorizations have been issued
- Provide training to all CS providers to promote best practices while working with our members and to continue to build rapport with CS providers

Quality Improvement

Member Satisfaction with CM:

- Increasing the return rate of satisfaction surveys. Satisfaction surveys are attached to case closure letters, which are sent to all members who complete their CM case. CM will work on ensuring members are educated that they will receive a survey upon case closure to increase return rate.
- Continue educating members on care management process, including establishing communication plan with member and establishing mutually-agreed upon scheduled calls
- Continue educating members on effective strategies for working with provider offices, including setting realistic expectations about provider treatment protocols

Delegated Case Management:

- Partner with the Compliance Department to evaluate audit tools and establish metrics that align with The Alliance's key performance indicators.
- Provider regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance's Population Health Management strategy

Case Management/Care Coordination, Complex Case Management & Disease Management Program Description

2024

Case Management/Care Coordination, Complex Case Management & Disease Management
2024 Program Description

Signature Page

_____ Date	_____ Allison Lam, MHL, RN Senior Director, Health Care Services
_____ Date	_____ Donna Carey, MD, MS Medical Director, Case and Disease Management
_____ Date	_____ Sanjay Bhatt, M.D., MS, MMM Senior Medical Director Vice Chair, Quality Improvement Health Equity Committee
_____ Date	_____ Lao Paul Vang Chief Health Equity Officer
_____ Date	_____ Donna Carey, MD, MS - Interim Chief Medical Officer, Medical Management Chair, Quality Improvement Health Equity Committee
_____ Date	_____ Matthew Woodruff Chief Executive Officer
_____ Date	_____ Rebecca Gebhart Board Chair

Table of Contents

I. Background

Alameda Alliance for Health (the Alliance) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to citizens most in need in Alameda County. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for Alameda County residents and reflects the cultural and linguistic diversity of the community. In addition, Alliance providers, employees, and Board of Governors live in areas that the health plan serves.

The Alliance provides health care coverage to over 300,000 children and adults in Alameda County through the Medi-Cal and Group Care programs. Through active partnerships with healthcare providers and community partnerships, the Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan Members.

The Alliance offers an array of care management services to support a collaborative patient and provider treatment process, and to improve the health of the Member population. The comprehensive case management program assists Members and providers in aligning effective healthcare services and appropriate community resources. The activities of the comprehensive case management program support Alliance Members and providers to attain the highest level of functioning available to the Member in relation to their overall health condition. The CM Program ensures parity between medical/surgical care and behavioral health care throughout all structures and functions. The Alliance oversees and maintains the following case management services in the comprehensive case management program:

- Health Risk Assessments
- Basic Population Health Management (inclusive of Care Coordination and Disease Management)
- Complex Case Management (CCM)
- Enhanced Care Management (ECM)
- Targeted Case Management (TCM)
- Transitional Care Services
- Specialized Services (including Community Supports, Continuity of Care, California Children's Services, Major Organ Transplants, and Transportation)

This comprehensive case management program description includes a discussion of program scope, objectives, structure and resources, population assessment, clinical information systems, care coordination and case management services, and monitoring and oversight processes that ensure quality assurance of CM program interventions.

II. Program Purpose and Scope (including Goals and Objectives)

The purpose of the Alliance comprehensive case management program is to provide case management processes and structures to Members who may have complex health needs. Case management is defined by the Case Management Society of America (CMSA) as:

"a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes."

The Alliance provides person-centered case management services through multidisciplinary teams that address medical conditions, behavioral, functional, and psychosocial issues occurring throughout the continuum of care, including in between medical office visits. Case management activities are performed telephonically. The underlying premise of the program is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, and the overall health care delivery systems (including physicians, hospitals, and the various payer sources).

The case management program was established to provide case management processes and procedures that enable The Alliance to improve the health and health care of its membership. Members from both Alliance products (Managed Medi-Cal and Alliance Group Care) are eligible for participation in the program. The fundamental components of The Alliance case management services encompass member identification and screening; member assessment; care plan development, care plan implementation and management; evaluation of the member care plan; and appropriate closure of the case. Case management interventions are organized to promote quality care, member satisfaction and cost-effectiveness using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

Goals for the CM program include:

- Maximize the quality of life and promote a regular source of care for patients with chronic conditions
- Improve Member engagement as active participants in the care process
- Improve health, including behavioral health, outcomes
- Support the foundational role of the primary care physician and care team to achieve high-quality, accessible, and efficient health care
- Coordinate with community services to promote and provide Member access to available resources in the Alliance service area
- Provide person-centered support, education, and advocacy to Members in collaborative communications and interactions
- Engage the provider community as collaborative partners in the delivery of effective healthcare
- Develop and implement a program that meets all regulatory compliance and NCQA accreditation standards

Objectives of the CM program are stated to support concrete measurements that assess effectiveness and progress toward the overall program goal of making high quality health care services accessible and affordable to the Alliance Membership. The objectives of the program include:

- Promote appropriate utilization of services for Members enrolled in case management.
- Achieve and maintain Member's high levels of satisfaction with case management services as measured by Member satisfaction rates.
- Improve functional health status and sense of well-being of comprehensive case management Members as measured by Member self-reports of health condition.

III. Program Structure

The structure of the CM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of The Alliance health care delivery network and community resources. Additionally, the structure is designed to enhance communication and collaboration on CM issues that affect all departments and disciplines within the organization. The CM Program is evaluated on an on-going basis for efficacy and appropriateness of content by The Alliance staff and oversight committees.

A. Board of Governors

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 19-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of The Alliance programs and is responsible for approving the Quality Improvement, Utilization Management and Case Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to The Alliance Chief Medical Officer (CMO) and the Quality Improvement Health Equity Committee (QIHEC) and provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management and Case Management Programs. Utilization Management oversight is the responsibility of the QIHEC. Utilization Management and Case Management activities are the responsibility of The Alliance Health Care Services staff under the guidance of the Medical Director for Care Management, the Medical Director for Utilization Management, and the Senior Director, Health Care Services, in collaboration with The Alliance CMO.

The QIHEC and UMC are responsible for the review and assessment of the CM program performance against objectives during the annual program evaluation, and if appropriate, provide recommendations for improvement activities or changes to objectives.

B. Quality Improvement Health Equity Committee (QIHEC)

The QIHEC provides oversight, direction, makes recommendations, and has final approval of the CM Program. Committee meeting minutes are maintained to summarize committee activities and decisions with appropriate signatories and dates. A full description of the QIHEC Committee responsibilities can be found in the most recent Quality Improvement Program Description.

The QIHEC provides the external physician involvement to oversee The Alliance QI and UM Programs. The QIHEC includes a minimum of four (4) practicing physician representatives with active, unrestricted licenses to practice in the State of California. The composition includes the Senior Director of Behavioral Health and/or a Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized

criteria, development of policies and procedures, and case review, as needed.

The QIHEC functional responsibilities for the CM Program include:

- Annual review and approval of the CM Program Description
- Annual review and approval of CM Policies and Procedures
- Oversight and monitoring of the CM Program, including:
  - Define the strategies direction for population health
  - Define the goals and measures to the target population
  - Integration of medical and behavioral health activities
  - Assist in identifying populations at high-risk for poor health outcomes, along with potential programs/services to be provided
  - Recommend policy decisions
  - Oversight of interventions to the provision of the programs and services
  - Recommend necessary actions

C. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a sub-committee of QIHEC. The UMC promotes the optimum utilization of health care services, while protecting and acknowledging Member rights and responsibilities, including their right to appeal denials of service. The sub-committee is multidisciplinary and provides a comprehensive approach to support the CM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to Members. UMC activities are reported to QIHEC, integrating CM activities into the Quality Improvement system.

UM Committee Membership

The UMC is chaired by the Chief Medical Officer. Members of the UM Committee include:

- The Alliance Chief Analytics Officer
- The Alliance Medical Director, UM
- The Alliance Medical Director, CM
- The Alliance Medical Director, Quality Improvement
- The Alliance Senior Director, Quality Improvement
- The Alliance Senior Director, Pharmacy
- The Alliance Senior Director, Health Care Services
- The Alliance Senior Director, Behavioral Health
- The Alliance Senior Director, Healthcare Analytics
- The Alliance Director, Compliance
- The Alliance Director, Member Services
- The Alliance Director, Provider Relations and Provider Contracting
- The Alliance Director, Quality Assurance
- The Alliance Director, Social Determinants of Health
- The Alliance Director, Utilization Management
- The Alliance Director, Long-Term Supports and Services (LTSS)
- The Alliance Manager, Case Management

- The Alliance Clinical Manager, Enhanced Care Management
- The Alliance Manager, Utilization Management
- The Alliance Manager, Long-Term Care (LTC)
- The Alliance Manager, Grievance & Appeals

UMC Voting Privileges
For the purposes of voting, only physician and Director-level members of the UMC may vote.

UMC Quorum
A quorum is established when fifty one percent (51%) of voting Members are present.

UMC Meetings
The UMC meets at least once every 2 months, but as frequently as necessary. The meeting dates are established and published each year.

UMC Minutes
All meetings of the UMC are formally documented in transcribed minutes which include discussion of each agenda topic, follow-up requirements, and recommendations to the QIHEC. All minutes are considered confidential. Draft minutes of prior meetings are reviewed and approved by the UMC with noted corrections. These minutes are then submitted to the QIHEC for review and approval.

UMC Functions
The UMC is a forum for facilitating clinical oversight and direction. Its purpose is to:

- Improve quality of care for the Alliance Members
- Evaluate and trend enrollment data for medical and behavioral health services provided to Alliance Members and benchmarks for care management program utilization.
- Provide a feedback mechanism to drive quality improvement efforts.
- Increase cross-functional collaboration and provide accountability across all departments in Health Care Services.
- Provide mechanism for oversight of delegated CM functions, including review and trend CM reports for delegated entities to identify improvement opportunities
- Identify behaviors, practices, patterns, and processes that may contribute to fraud, waste, and abuse with a goal to support the financial stability of providers and network
- Maintain the annual review and approval of the CM Program & Evaluations, CM Policies/Procedures, CM Criteria, and other pertinent CM documents such as the CM Delegation Oversight Plan.
- Review and analysis of utilization data for the identification of trends
- Assist in monitoring performance of CM activities and recommend appropriate actions when indicated.

The UMC also evaluates the impact of CM programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes.

D. Staff Resources

The Alliance's Case Management Department (see Appendix A) is responsible for comprehensive case management programs and activities. The Behavioral Health Department (see Appendix B) is responsible for behavioral health case management activities, including triage, referral, and participation on the multi-disciplinary case management teams. The following are the primary staff with roles and responsibilities in the implementation of the comprehensive case management program:

Chief Medical Officer

The Chief Medical Officer (CMO) is the designated Board Certified in his/her specialty and California licensed physician with responsibility for development, oversight, and implementation of the comprehensive case management program. The CMO provides guidance for all clinical aspects of the program. The CMO serves as the chair of the HCQC and makes periodic reports to the HCQC regarding comprehensive case management program activities and the annual program evaluation. The CMO works collaboratively with the Alliance network physicians to continuously improve the services that the comprehensive management program provides Members and providers.

Medical Director

The Medical Director of CM, a licensed physician, provides clinical leadership and stewardship to the Case and Disease Management programs and staff. The Medical Director provides guidance to clinical program design and clinical consultation of Members enrolled in the case and disease management programs. The Medical Director works collaboratively with the Alliance network physicians to continuously improve the services that the case and disease management programs provide Members and providers.

Senior Director, Health Care Services

The Senior Director of Health Care Services, a Registered Nurse, provides operational leadership to the Case and Disease Management programs and staff. The Senior Director provides additional guidance to the programs' designs with a focus on analytics, operations, and regulatory adherence. The Senior Director also ensures the collaboration of the programs with other internal and external stakeholders. The Senior Director provides leadership for case management accreditation and regulatory activities, and works with the Director to evaluate and achieve program goals.

Senior Director, Behavioral Health Services

The Senior Director, Behavioral Health Services is a licensed Psychologist and is responsible for the overall Behavioral Health department operations, staff training, and coordination of services between departments. The Senior Director's management responsibilities include:

- Develop and maintain the Behavioral Health (BH) Program in collaboration with the Senior Medical Director of Quality and the CMO.

- Coordinate BH activities with the Quality, UM, Case Management, Member Services Departments, as well as other Alliance units.
- Maintain compliance with the regulatory standards.
- Maintain professional collaboration with Alameda County Behavioral Health Care Services (ACBHCS) to coordinate care and care transitions across behavioral health care systems.
- Coordinate interventions with the Senior Medical Director and the CMO to address under and over utilization concerns when appropriate.
- Develop and monitor data and activities for clinical and utilization studies; and maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies.
- Monitor for consistent application of utilization criteria by BH staff, for each level and type of UM decision.
- Monitor for consistent application of Triage and Referral criteria by BH staff for each type of behavioral health service

Director, Social Determinants of Health

The Director of Social Determinants of Health provides operational leadership to the Case and Disease Management and Enhanced Care Management programs and staff. The Director provides guidance to the various programs with a focus on analytics, operations, and regulatory adherence. The Director assists with collaboration of the programs with other stakeholders. The Director develops the programs' goals and operationalizes processes needed to successfully commence and complete the desired goals.

Director, Long Term Services and Supports

The Director of Long-Term Services and Supports provides operational leadership to the Long-Term Services and Supports and Community Supports programs and staff. The Director provides guidance to the various programs with a focus on analytics, operations, and regulatory adherence. The Director assists with collaboration of the programs with other stakeholders. The Director develops the programs' goals and operationalizes processes needed to successfully commence and complete the desired goals.

Manager, Case Management and Disease Management

The Manager of Case and Disease Management provides daily oversight over the comprehensive case management program. Under the supervision of the Director of Social Determinants of Health, the scope of responsibilities of the Manager of Case and Disease Management includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the comprehensive case management program activities and presents regular reports to the UMC and HCQC.

Manager, Behavioral Health

The Manager of Behavioral Health is responsible for the daily oversight of the care coordination program for behavioral health. This includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the comprehensive case management program activities and presents regular reports to the UMC and HCQC. This position was newly created in Fall 2023 to further support the care coordination efforts within Behavioral Health.

Clinical Manager of Enhanced Care Management

The Clinical Manager of Enhanced Care Management is responsible for the provision of daily oversight of components of the case management program, including programs between the Alliance and contracted Community Based Organizations (CBOs). Under the supervision of the Director of Social Determinants of Health, the scope of responsibilities of the Clinical Manager of Enhanced Care Management includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the comprehensive case management program activities and presents regular reports to the UMC and HCQC.

Supervisor of Case Management and Disease Management

The Supervisor of Case and Disease Management is a licensed California registered nurse who provides daily oversight over the comprehensive case management program. Under the supervision of the Manager of Case Management and Disease Management, the scope of responsibilities of the Supervisor of Case and Disease Management includes supervision of department clinical staff; allocation and management of program resources; and accountability for the quality of care and services.

Non-Clinical Supervisor of Case Management and Disease Management

The Non-Clinical Supervisor of Case and Disease Management provides daily oversight over the comprehensive case management program. Under the supervision of the Manager of Case Management and Disease Management, the scope of responsibilities of the Non-Clinical Supervisor of Case and Disease Management includes supervision of department non-clinical staff; allocation and management of program resources; and accountability for the quality of care and services.

Supervisor of Community Supports

The Supervisor of Community Supports provides daily oversight over the Community Supports services. Under the supervision of the Director of Long Term Services and Supports, the scope of responsibilities of the Supervisor of Community Supports include supervision of department staff; allocation and management of program resources; and accountability for the quality of care and services.

Lead Complex Case Manager, Nurse

The Lead Case Manager (CM) is a licensed California registered nurse, who acts as a daily resource to the case management, social work, and navigator staff. Under the supervision of the Manager of CM/DM, the scope of responsibilities of the Lead CM are to assist in identifying and resolving issues impeding the daily delivery of consistent CM services to meet regulatory and quality requirements, escalate issues unable to be resolved to upper leadership, carry a caseload of members, and assist in the coaching of staff in the standard work of the department.

Complex Case Manager, Nurse

The Alliance uses licensed California registered nurses in the role of the Complex Case Manager. The Complex Case Manager provides case management services for health plan Members with highly complex medical conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's disease conditions. Working within a multi-functional team, the Complex Case Manager coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes. The Alliance uses staffing guidelines to assign caseloads to each Complex Case Manager. Caseload assignments are made with the following considerations: current case load size; acuity level of case load; characteristics of Members, primary care provider, health plan product; and relevant case management responsibilities.

Enhanced Care Management, Nurse

The Alliance uses licensed California registered nurses in the role of the Enhanced Care Management, Nurse. The Enhanced Care Management nurse provides collaborative assistance for Enhanced Care Management (ECM) providers. The ECM nurse participates in regular interdisciplinary team rounds with each ECM provider clinic site and offers clinical support and recommendations to ECM providers to assist with members enrolled in ECM. The ECM nurse also assists with clinical review for ECM authorizations.

Community Supports, Nurse

The Alliance uses licensed California registered nurses in the role of the Community Supports, Nurse. The Community Supports nurse provides collaborative assistance for Community Supports (CS) providers. The CS nurse participates in regular meetings with each CS provider and offers clinical support and recommendations to CS providers to assist with members receiving CS. The CS nurse assists with clinical review for all CS authorizations requiring a clinical review. If members need continued services past an expired authorization, the CS nurse reviews all requests and corresponding justification to determine whether services can be appropriately continued.

Social Worker

The Alliance employs Medical Social Workers to assist in the provision of services for Members enrolled in one of the comprehensive case management programs.

The Medical Social Worker is also responsible for coordinating medical, social and or behavioral health care needs with Alliance CM teams. Under general supervision from the Manager, Case and Disease Management, the Medical Social Worker is responsible to meet the day-to-day care coordination needs among assigned case management teams. Occasionally, the Social Worker may be required to support delegated Provider Group teams with care coordination and community resources.

Health Navigator

Under guidance from the Case Management Manager or the Clinical Manager, Enhanced Care Management, the Health Navigator supports clinical staff through the completion of components of case management, disease management, and wellness/health maintenance programs. The Health Navigator provides the Member with individualized, patient-centered support and education to assist and guide the Member across the continuum of the healthcare delivery system. The Health Navigator works with the Complex Case Manager to perform follow up case management activities and coordinate care and services for the Member with providers and community resources. The Health Navigator also coordinates care for Members not admitted to the complex case management program.

Community Supports Coordinator

Under guidance from the Supervisor of Community Supports, the Community Supports Coordinator works with Community Supports providers to process authorizations into AAH's information system of record. The Community Supports Coordinator works with the Medical Director and Supervisor to perform follow up management to meet specific turn-around times for authorizations. They also assist with coordination of weekly meetings with Community Supports providers and facilitate communication to meet appropriate authorization regulatory requirements.

Transportation Coordinator

Under guidance from the Manager of Case Management or the Supervisor of Case Management the Case Management Coordinator supports the case management department through assisting with ensuring that members receive transportation as needed to all covered services, acting as a coordinator between providers, the Transportation Vendor, members and AAH staff.

Case Management Coordinator

Under guidance from the Manager of Case Management or the Supervisor of Case Management the Case Management Coordinator supports the case management department through assisting with administrative duties. The Case Management Coordinator providers the member with individualized, patient-center support and assistance to help guide the member across the continuum of the healthcare delivery system.

Health Assessment Coordinator

Under the guidance of the Manager of Case and Disease Management, Health Assessment Coordinator is responsible for the non-clinical support of the Health Risk Assessments (HRAs) for Members identified as Low Risk. The Health Assessment Coordinator is responsible for the final processing of completed HRAs and providing the preventive health and community resources identified from the Member responses. Fulfillment also includes sending the HRA letter and resources to the Members and the Care Plans to the PCPs. The Health Assessment Coordinator is also responsible for the management of mailings and data entry of hardcopy documents received (HRAs and HIFs/METs) for entry into the clinical information system. s

Behavioral Health Triage Specialist

Under guidance from the Senior Director of Behavioral Health, Behavioral Health Triage Specialists provide the behavioral health case management components for members to enables integration of physical and behavioral health to address the member's whole person health needs.

The Alliance uses California Licensed Clinical Social Workers, Licensed Marriage and Family Counselors and Licensed Psychologists in the role of the Behavioral Health Triage Specialist. The Behavioral Health Triage Specialist provides case management services for health plan Members with highly complex behavioral health conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's conditions. Working within a multi-functional team, the Behavioral Health Triage Specialist coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes.

Behavioral Health RN Case Manager

Under guidance from the Senior Director of Behavioral Health, Behavioral Health RN Case Managers provide the behavioral health case management components for members to enables integration of physical and behavioral health to address the member's whole person health needs. Additionally, the Behavioral Health RN Case Manager participates in the multi-disciplinary case management team when there are psychiatric conditions impacting the members health outcomes to ensure psychiatric conditions are addressed in coordination with physical health conditions.

The Alliance uses California Licensed registered nurses who have specialized in psychiatric/mental health nursing in the role of the Behavioral Health RN Case Manager. The Behavioral Health RN Case Manager provides case management services for health plan Members with highly complex behavioral health conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's conditions. Working within a multi-functional team, the Behavioral Health RN Case Manager coordinates with the Member,

Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes.

Applied Behavioral Analysis (ABA) Analyst

Under guidance from the Senior Director of Behavioral Health, the ABA Analyst provides the behavioral health therapy/Applied Behavioral Analysis (ABA) case management components for members to ensure member under the age of 21 who need ABA services for the treatment of Autism or other developmental conditions receive medically necessary services.

The Alliance uses Board Certified Behavioral Analysts (BCBA) in the role of the ABA Analyst. The ABA Analyst provides case management services for health plan Members with Autism or other developmental conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's conditions. Working within the behavioral health team the ABA Analyst coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes.

Behavioral Health Navigator

Under the guidance of the Senior Director of Behavioral Health, the Behavioral Health Navigator is responsible for the non-clinical support of the Alliance Behavioral Health Department. The Behavioral Health Navigator is responsible for the non-clinical support of members who need assistance in accessing the behavioral health services they need. The Behavioral Health Navigator supports the Behavioral Health Department's clinical staff in following through on referrals and services to ensure member health care needs are met. The Behavioral Health Navigator is also responsible for the management of mailings and data entry of hardcopy documents received for entry into the clinical information system.

Liaisons

Liaisons are members of the care management team who have subject matter expertise with the population and/or entity they are assigned to. Liaison names and contact information are shared with DHCS, and their roles and responsibilities are as follows:

- California Children's Services (CCS) Liaison: serves as the primary point of contact responsible for the CCS members' care coordination. CCS liaisons must receive training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with counties, care management and authorization processes for CCS Children
- Foster Care Liaison: has expertise in Child welfare services, County Behavioral Health Services, and ensures appropriate ECM staff, including the ECM Lead Care Manager whenever possible, attend meetings of the Child and family teams, in

accordance W&I section 16501(a)(4); Ensure Covered services are closely coordinated with other services, including social services and Specialty Mental Health Care Services; Act as a resource to ECM Providers providing services to Child welfare-involved Children and youth, provide technical assistance to Contractor and ECM Provider staff as needed, and serve as a point of escalation for care managers if they face operational obstacles when working with County and community partners; Coordinate with foster care liaisons for other Medi-Cal managed care plans to notify them when Members cross county lines and/or change managed care plans; Serve as a family advocate.

- Justice-Involved (JI) Liaison: support correctional facilities, pre-release care management providers, and/or ECM providers in the re-entry planning process
- Regional Center Liaison: coordinate with each RC operating within Contractor's Service Area to assist Members with Developmental Disabilities (DD) in understanding and accessing services, and to act as a central point of contact for questions, access and care concerns, and problem resolution
- Dental Liaison: be available to Medi-Cal dental Providers to assist with referring the Member to other Covered Services, including but not limited to, laboratory services, and pre-admission physical examinations required for admission to an outpatient surgical service center, or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services)
- In-Home Support Services (IHSS) Liaison: day-to-day liaison with county IHSS agency; sufficiently trained on IHSS assessment and referral processes and providers, and how the Alliance and PCPs can support IHSS eligibility applications and coordinate care across IHSS, medical services, and long-term services and supports; includes training on IHSS referrals for Members in inpatient and SNF settings as a part of Transitional Care Service requirements, to support safe and stable transitions to home and community-based settings

IV. Population and Member Needs Assessment

The Alliance routinely assesses the characteristics and needs of the Member population, including relevant subpopulations. The Alliance analyzes available enrollment and census data, in combination other data sources, including but not limited to:

- Product lines and eligibility categories
- Language and subpopulations
- Race and ethnicity
- Age
- Gender
- High volume diagnoses
- Results of Health Risk Assessments (HRA)
- Chronic and co-morbid medical conditions
- Laboratory Reports

- Internal department data sources
- Utilization history (including claims and authorizations for medical, behavioral, and pharmacy services)

To effectively address Member needs, after the collection of Member population data, the CM Medical Director, Senior Director of Health Care Services, Senior Director of Behavioral Health, Director of Social Determinants of Health, and Manager of Case Management and Disease Management analyze and review the data to determine any necessary updates to the processes and resources of the comprehensive case management program. The information gathered in this process is used to further define and revise the program's structure and resources, including the following types of factors:

- **Department staffing** – by analyzing the data the Alliance revises staffing ratios and roles, for example adding nurse Case Managers or Behavioral Health Triage Specialists versus unlicensed social workers when the level of higher risk Members increases in the program.
- **Evidence-based guidelines** – as the mix of condition types increases the Chief Medical Officer assists in identifying clinical guidelines to be used in creating care plans for Members.
- **Member materials** – Alliance uses data, Case Manager feedback and patient satisfaction information to identify new types of materials or revise materials to support language and cultural needs.

V. Case Management Clinical Systems

A. Case Management Information Systems

The CM Department uses a clinical information system, TruCare®, as the case management platform. TruCare® is a member-centric application that automates the entire clinical, administrative, and technical components of case management into a single platform. The system supports case management with algorithmic clinical intelligence and best practices to guide case managers through assessments, development of care plans, and ongoing management of members. The system includes assessment templates to drive consistency in the program. Care plans are generated within the system and are individualized for each member and include short and long-term goals, interventions, and barriers to goals. The clinical information system includes automated features that provide accurate documentation for each entry; record actions or interactions with members, caregivers, and providers; and create automatic date, time, and user stamps. To facilitate care planning and management, the clinical information system includes features to set prompts and reminders for next steps or follow-up contact. Optimization of TruCare® continued into 2023, including improving assessments to automatically trigger care plan elements (including problems, goals, interventions, and barriers). Thorough vetting processes are established between clinical and IT teams to ensure any enhancements and upgrades to the platform are amenable to all system users. System

optimization and upgrades are ongoing as standard practices, including staff training to ensure competence in using the platform and alignment on best practice workflows.

B. Clinical Decision Support Tools

Evidence-based clinical guidelines are available to support the Case Managers in conducting assessments, developing care plans, and managing care. The clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the Alliance will involve board certified specialists in the development of the appropriate guidelines, as well as medical and behavioral healthcare specialty societies and/or Alliance Clinical Practice Guidelines (see Appendix C). Clinical guidelines are reviewed and approved by the UMC and QIHEC.

VI. Case Management Services

The Alliance maintains and oversees the delivery of the following case management services in the comprehensive case management program:

- Health Risk Assessments
- Basic Population Health Management (inclusive of Care Coordination and Disease Management)
- Complex Case Management (CCM)
- Enhanced Care Management (ECM)
- Targeted Case Management (TCM)
- Transitional Care Services
- Specialized Services (including California Children's Services, Community Supports, Continuity of Care, Major Organ Transplants, and Transportation)

To effectively deliver case management services, the Alliance's Care Management program adopts a person-centered design, ensuring all care management activities align with members' needs, preferences, and goals. Members are identified as candidates for care management services through various data sources and referrals. This includes, but is not limited to:

- Health Risk Assessment (HRA)
- Health Information Forms/Member Evaluation Tool (HIF/MET)
- Data sources such as Utilization reports and Admission, Transfer and Discharge (ADT) Feeds
- Population Health Reports
- Self-referrals from members/authorized representatives
- Direct referrals from provider networks
- Internal referrals (including Utilization Management, Member Services, Appeals and Grievance, Leadership)
- Predictive modeling

After members are identified as candidates for care management, they are aligned to the appropriate case management service. Each service component is described in further detail below.

A. Health Risk Assessment (HRA)

The Alliance arranges for the assessment of every new Senior and Person with Disabilities (SPD) member through a process that stratifies all new members into an assigned risk category based on self-reported or available utilization data. Based on the results of the health risk stratification, the Alliance administers a Health Risk Assessment (HRA) survey to all newly enrolled SPD members within:

- 45 days of enrollment for members identified as high-risk
- 105 days of enrollment for members identified as lower-risk

The Alliance uses a standardized HRA questionnaire (see appendix F) to identify member care needs and provide early interventions for Members at higher risk for adverse outcomes. The questions are focused on medical care needs, community resource needs, the appropriate level of caregiver involvement, timely access to primary and specialty care needs, identification of communication of care needs across providers as well as identifying any activities or services to optimize a member's health status, including a mental health screener. In addition to the standardized HRA questions, the DHCS LTSS questionnaire (see appendix G) is completed to identify whether a member is experiencing risk factors that make them a candidate for LTSS services that will help keep them in their home and community.

For members stratified as lower risk, members receive the HRA questionnaire via mail, and also receive interactive voice calls encouraging them to return the questionnaire to complete the HRA process. For members stratified as high-risk, CM staff initiate outreach to the member to attempt completion of the HRA over the phone. The responses from the HRA may result in the reclassification of Members as higher or lower risk (for some members, risk-level based on their HRA responses may be different from their earlier stratification based on the stratification tool/data). After completion of the HRA, the Alliance develops Individualized Care Plans (ICPs) for members found to be high risk and coordinates referrals for identified LTSS, as needed.

CM staff is responsible for ensuring the Individualized Care Plan is completed, shared with the Member and PCP, and is accompanied by relevant community and health resources.

For Members whose completed HRA results in a final stratification of Low Risk, CM staff review Member HRA responses to identify Member needs (i.e., resources for transportation, in home support services (IHSS), durable medical equipment (DME), food resources). The CM staff generates the standardized low risk care plan, attaches the relevant resources, and prepares it for mailing.

For Members whose completed HRA results in a final stratification of High Risk, clinical CM staff outreach to the Member and reviews Member HRA responses with the member to identify Member needs. The CM staff generate the standardized high-risk

care plan and include additional health education resources and materials based on the conversation with the Member.

If the member remains Unable to Contact (UTC), a standardized care plan is sent to the member. This is sent to members, even if they do not complete the HRA and return it to the plan. Copies of the care plans, for both High Risk and Low Risk members, are mailed to the Member, the Primary Care Provider, and the Delegate Group if applicable.

SPD members are reassessed annually in the month of their enrollment. All HRAs are reviewed by a Social Worker, whether a member is identified as Low-Risk or High-Risk, to determine needs or any changes in condition. For High-Risk Members, the assigned Care Manager is responsible for ensuring the HRA is completed, and the Care Plan updated accordingly. For Members identified as Low-Risk, the Alliance uses utilization data to re-stratify Members. Members that are re-stratified from Low to High-risk based on annual re-assessment activities are referred to a CM Nurse for further assessment and development of a Care Plan. If the member continues to be stratified as Low-Risk in the annual re-assessment, the member is provided a standardized care plan and informed of the availability of CM as needed.

B. Care Team Roles and Responsibilities

Case Management services are provided using a combination of care teams:

- The core care team is comprised of an RN Complex Case Manager, Health Navigator and Social Worker, working together to manage a group of Members with complex and care navigation needs.
- The extended care team supports specific needs of the core care team. The extended care team members work across functional areas to provide additional support and interventions, as needed. The extended care team may include Medical Directors, pharmacy, behavioral health, utilization management, long-term care and health education.

Care teams are assigned specific roles to address the needs of Members. The CM Nurse will serve as the medical lead for the team. The role of the CM Nurse is to ensure the CM assessments and follow-up are completed in a timely manner. The CM Nurse will communicate the outcomes of each assessment with the other team Members to ensure the team is knowledgeable on care needs and understands their role in the care plan. The Behavioral Health Triage Specialist or the Behavioral Health RN Case Manager is engaged in the Care Team when behavioral health conditions are identified. The teams are directed by defined workflows and serve as sources to identify and refer Members to other programs, including Enhance Care Management (ECM), Community Supports (CS), and behavioral health services. Communication is key to the effectiveness of the program, with the care team meeting daily to discuss member needs and expectations.

Extended Care Team Members are consultants to the core care team. As needed, the CM Nurse will coordinate care team discussions to address identified care needs. This may

include medication reconciliation or adherence issues, behavioral health concerns, social determinates of health best managed using community resources, or health literacy issues.

C. Basic Population Health Management Services

Basic Population Health Management (BPHM) is available to all Alliance members, regardless of risk tier, and includes ensuring access to primary care, care coordination, navigation and referrals across health and social services (including Community Supports), information sharing and referral support infrastructure, services provided by Community Health Workers (CHWs) under the new CHW benefit, wellness and preventions programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children.

The Primary Care Provider (PCP) is responsible for Basic Population Health Management for his/her assigned members and is supported by the Provider Group CM team. The PCP is responsible for ensuring that members receive an initial screening and health assessment (IHA), which initiates Basic Medical Care Management. The PCP conducts an initial health assessment upon enrollment, and through periodic assessments provides age-appropriate periodic preventive health care according to established, evidence-based, preventive care guidelines. The PCP also makes referrals to specialists, ancillary services, and linked and community services as needed based on the member's Individual Care Plan (ICP). When additional care management assistance is needed, the PCP works with the Provider Group's CM department to facilitate coordination. For members enrolled in the Direct Network, the PCP works with the Alliance CM and UM teams to facilitate coordination.

Basic Population Health Management services are provided by the primary care provider, in collaboration with the Alliance, and include the following elements:

- Initial Health Assessment (IHA) (including a history and physical evaluation sufficient to assess the acute, chronic, and preventive health needs of the Member)
- Identification of appropriate providers and facilities (such as medical rehabilitation, and support services) to meet Member needs.
- Direct communication between the provider and Member, family and/or caregiver.
- Member, caregiver and/or family education, including healthy lifestyle changes when warranted.
- Coordination of carved out and out of plan services, and referral to appropriate community resources and other agencies.

Care Coordination

Alliance Case Management staff maintains procedures to assist Members who are unable to secure and coordinate their own care because of functional, cognitive, or behavioral limitations, or the complexity of the community-based services. Members are assigned to a Case Manager, Social Worker, or Health Navigator to assist with short-term assistance with care coordination. Members, during program enrollment, will also be assessed for long-term care needs provided through Complex Case Management and Disease Management.

Members eligible for care coordination services have generally been identified as low or moderate risk, and meet the following criteria:

- Suffer from one or more acute or chronic conditions.
- Require case management services that are less intensive than services provided in CCM.
- Have medical, functional, and/or behavioral health conditions that require extra support but generally demand fewer resources to achieve or maintain stability than do Members enrolled in more intensive case management programs.
- Care requires moderate coordination with several providers involved.
- Member and/or caregiver education is needed to support self-management skills and strategies. Once available resources are accessed, successful self-management is achievable with moderate intensity of care coordination services.
- Issues may be acutely destabilized and time-limited OR chronic, ongoing but stable.

Once a member is identified and referred for care coordination, they are assigned to an Alliance lead Case Management unit for screening, referrals, care planning, and all other care coordination activities. Members are matched to the Case Management staff that is specialized based on the prominence of needs. Though there is one assigned "lead," the support and expertise of other units may be harnessed to provide collaboration and comprehensive, multidisciplinary care. This approach is most important for those Members who are diagnosed with medical, functional, cognitive, and psychosocial conditions. Health Navigators, Social Workers or Case Managers are responsible for the following services:

- Screening and enrollment
- Comprehensive clinical assessment
- Development and implementation of a "service plan."
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon assessment and care plan.
- Clear documentation of service delivery, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

Disease Management

The Alliance has four disease management programs as a part of the overall Population Health Management strategy. Disease Management (DM) programs provide health education interventions, seek to close care gaps, and focus on improving equity and reducing health disparities. Disease Management programs aim to improve the health

status of its participants through assessment, support with adherence to treatment plans, health coaching, and care coordination.

All program interventions are based on data-identified patient needs and are developed using evidence-based practice guidelines and care pathways. Members are identified for engagement by claims, pharmacy, and lab data and direct referrals from Alliance staff, physicians, and community partners. Current Alliance Disease Management programs address the following conditions:

- Diabetes
- Cardiovascular Disease
- Asthma
- Depression

The Alliance Disease Management (DM) Programs will:

- Provide disease management as an "opt-out" service meaning that all eligible members identified are enrolled unless they choose to decline participation.
- Ensure that all Alliance members are identified and stratified into appropriate levels for disease management services depending on risk.
- Provide DM services based on evidence-based guidelines and an individual assessment of gaps in care.
- Maintain documentation of program enrollment and provision of services using a Clinical Information System
- Promote DM to members and practitioners via written information about the program.

The Alliance delegates DM for a small proportion of its population. The delegates are required to follow NCQA standards.

Alliance Disease Management Programs

Disease state	Program name	Criteria	Key program offerings	Member outreach
Asthma	**Asthma Remediation Services**	Alliance Medi-Cal members ages 0-18 with poorly controlled asthma.	Asthma education, tools, and home modifications to improve asthma management.	Letter and telephonic outreach
Asthma	**Happy Lungs**	Members 18 years or younger with lower-risk asthma and their caregivers.	Opportunity to engage in pediatric asthma case	Educational letter and an invitation to engage in pediatric

Disease state	Program name	Criteria	Key program offerings	Member outreach
			management services.	asthma services.
Asthma	**Living Your Best Life with Asthma**	Members 19 years or older with lower risk asthma.	Opportunity to receive Alliance care management, health coaching, health education, care coordination or other services based on need.	Educational letter with an invitation to engage with the Alliance for additional resources.
Diabetes	**Living Your Best Life with Diabetes**	Members 19 years and older with diabetes.	Opportunity to receive Alliance care management, health coaching, health education, care coordination or other services based on need.	Members identified at lower risk will receive an educational letter and an invitation to engage with diabetes management programs. Members identified with diabetes at a higher risk of worsening outcomes will also receive an outreach call.
Hypertension	**Living Your Best Life with a Healthy Heart**	Members aged 18 – 85 years or older with high blood pressure.	Opportunity to receive Alliance care management, health coaching, health education, care coordination or other services based on need.	Educational letter and an invitation to engage with the Alliance for additional resources. Members identified with high blood pressure at a higher risk will also receive an outreach call.

Disease state	Program name	Criteria	Key program offerings	Member outreach
Depression	**Birthwise Wellbeing**	Members between the ages 18-50 who are pregnant, or have given birth within the past year	Opportunity to receive assessment, care coordination to access behavioral health services, and perinatal health education services.	An educational flyer in the Alliance Baby Steps packet of educational materials for a healthy pregnancy. Members identified as higher risk for depression may also receive an outreach call.

Identification and Screening

Disease Management (DM) services at the Alliance are provided to all Alliance members with a diagnosis of diabetes, asthma, hypertension, or depression who meet the age criteria specified in the above table and are identified as eligible based on clinical, pharmacy and utilization data or direct referral.

Members are identified for program eligibility through one of the following:

a. Monthly report from HealthCare Analytics department utilizing claims, encounter, and pharmacy data. The report is further risk stratified according to the program criteria (see below).
b. Health Risk Assessment (HRA) for Medi-Cal Seniors and Persons with Disability (SPD). Members are identified as eligible with the appropriate age and diagnoses eligible for the DM program, and have a score calculated from HRA answers that may impact the member's health. The list of members meeting these criteria will be provided to the Intake Department for further processing.

Additional referral sources include, but is not limited to, self-referral, caregiver, Primary Care Providers or Specialists, laboratory results, discharge planners at medical facilities and internal department referrals such as Utilization Management (UM), Case and Disease Management and Member Services.

The Alliance informs practitioners about the DM programs and how to refer members through multiple methods, including, Provider Services educational material, Alliance webpage, and Provider bulletins. The communication methods describe how to use disease management services and how the Alliance works with their patients enrolled in

DM. Training and/or targeted communications for key referral sources such as the CM department, UM department, Member Services, Hospital Discharge planners occur at least annually.

Information needed for a DM referral includes:

a. Referral or data source (name, affiliation, and contact information).
b. Date referral received by Intake. If secondary referral, document initial contact information and date.
c. Member information
d. Reason for referral
e. Diagnosis (asthma, diabetes, hypertension, or depression)
f. Level of urgency
g. Additional information, as necessary.

DM Risk Stratification

1. The CM/DM designee stratifies all members directly referred to the Alliance DM services into the appropriate DM program.
2. Data reports provided to the Case & Disease Management Department monthly are already stratified into levels according to the following risk criteria:

    1. **High Risk Diabetes:** Eligible age members with diagnosis of diabetes and other comorbidities and potentially significant risk factors, such as history of hospital or ER admission.
    2. **Moderate Risk Diabetes:** Eligible age members with diabetes and identified gaps in care. Members with a diagnosis of diabetes will be initially classified as Moderate Risk and referred to the Health Navigator to determine appropriate risk stratification.
    3. **Low risk Diabetes:** Eligible age members with diagnosis of diabetes and who do not fall into the high or moderate risk category.
    4. **High Risk Asthma:** Eligible age members identified with pediatric asthma, ER and hospital utilization, and asthma medications. Members with a diagnosis of asthma will be classified as High Risk and referred for outreach and follow up..
    5. **Low Risk Asthma:** Eligible age members not in the high-risk category.
    6. **High Risk Hypertension:** Eligible age members with at least one hypertension medication in the last year or whose blood pressure was not adequately controlled as defined by HEDIS Controlling High Blood Pressure (CBP) measure and frequent inpatient, emergency room visits or readmissions. Members with a diagnosis of hypertension will be classified as High Risk and referred to the Health Navigator for appropriate follow up and interventions.
    7. **Low Risk hypertension:** Eligible age members with a diagnosis of hypertension and at least one hypertension medication in the last year or whose blood pressure was not adequately controlled as defined by HEDIS Controlling High Blood Pressure (CBP) measure.

8. **High Risk Perinatal Depression:** Eligible age members identified as pregnant or having given birth within the past year and who have a prescription for anti-depressants or anti-psychotic medications in the past year. Members with a diagnosis of depression will be classified as High Risk and referred for outreach and follow up.
9. **At Risk Perinatal Depression:** Age-eligible members identified as pregnant or having given birth within the past year, not in the high-risk category.

DM referrals will be completed within the month of receipt of the request of the DM Identification and Stratification. If at any time, the CM/DM staff or the referral source believes that the case is of an urgent nature, priority will be given to the case to be completed as soon as possible.

Eligible members (or parents/guardians of minors) are sent letters about the availability of disease management program services. The letter will also inform them how to use the program, eligibility criteria and opt-in and opt out program aspects.

Upon receipt of the necessary information for a referral, the CM/DM designee documents the referral into Clinical Information System. Members assigned to a delegate entity that provides Disease Management will be referred to the delegate. If the member is no longer eligible for services, the case should be closed and the reason for case closure will be marked as transitioned to a lower level of care, or Other.

Enrollment

1. High-Risk and Moderate-Risk Programs. Referrals will be assigned to staff based on existing caseload and specialization.
    a. Case Managers (CMs) and Health Navigator staff assigned to the case will outreach to members for further engagement regarding disease management program enrollment and/or update the member's existing Care Plan with the new information.
    b. Case Management will document one of the following programs member is enrolled into, by opening an appropriately corresponding case:
        i. DM – Diabetes High Risk
        ii. DM – Diabetes Moderate Risk/Navigator
        iii. DM – Hypertension

2. Low Risk Programs: Members identified for the Low-Risk programs will be counted as enrolled by sending the appropriate DM low-risk Letter.

Assessment

1. Upon engagement from the member, staff will complete the appropriate intake assessment within the Clinical Information System.
2. Procedures for conducting assessments are addressed in *CM-001, CCM Identification, Screening, Assessment and Triage Policy*. Along with assessment questions regarding

co-morbidities, cognitive deficits, psycho-social issues, depression, physical limitations and health behaviors, additional questions specific to the disease management condition have been added to the DM High Risk assessments.

DM Plan Development and Management

1. The steps in developing the Care Plan involve:
   a. Development of case management goals, including prioritized goals
   b. Identification of barriers to meet the goals and complying with the plans
   c. Development of schedules for follow-up and communication with members
   d. Development and communication of member self-management plans
   e. Assessment of progress against CCM plans and goals, and modifications as needed

2. Condition monitoring (self-monitoring and medical testing) and adherence to the applicable chronic disease treatment plan will be an important component of the DM Plan of Care and goals should be set accordingly.

3. The Care Plan for the Diabetes DM Program is developed from evidence-based Standards of care for Diabetes Management. Goals will be set as short-term goals defined as achievable within 30 days. Goals can be extended by another 30 days, however, at the 60 day mark the member should be reviewed at Case Rounds. At any time, the member may be referred to CCM for ongoing case management needs.

4. Referrals for additional services and resources will be made as documented in the Plan of Care. Referrals will be made as necessary and timely (within 7 business days of identifying the need) and follow-up on these referrals will occur within 30 calendar days after the referral.

DM Case Evaluation and Closure

The DM program is structured where DM cases are closed either by meeting prescribed length in program criteria or by defined closure criteria.

High Risk Program enrollees will be evaluated for closure to DM services using *CM-003, Policy and Procedure, Complex Case Management Plan Evaluation and Closure Evaluation and Closure criteria.* Diabetes DM Program enrollees will also be evaluated for closure to DM services using CM-003 P&P criteria.

All closure actions will be documented in the Clinical Information System. At the time of case closure, a satisfaction survey, and a case closure letter if appropriate will be sent.

D. Complex Case Management (CCM)

Complex Case Management (CCM) is an opt-in program, provided to members who consent to participate. It is a collaborative process between the Primary and/or Specialty Care Providers, member, and Care Manager; and the Care Manager's role is to support the member with person-

centered planning, coordinating, and monitoring options and services to meet the member's health care goals. Complex Case Management includes at a minimum the following elements:

- Case Management services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team.
- Intense coordination of resources to ensure Member regains optimal health or improved functionality.
- With Member and PCP input, development of care plans specific to individual needs and updating at least annually.

The Alliance CCM process provides opportunities along the continuum of care to identify and address potential risks for medical errors and ensure patient safety. The CCM program includes the following activities to ensure and enhance Member safety:

- Completion of a comprehensive general assessment that supports proactive prevention or correction of patient safety risk factors.
- Active management of transitions of care to ensure that the Member's health condition will not be placed at risk for an unsafe situation that may result in a negative outcome.
- Care plan development that ensures individualized access to quality, safe, effective, and timely care.
- Monitoring of information exchanges across the provider continuum to ensure safety, prevent medical errors, and support effective continuity of care. Review of medication regimen to monitor drug utilization, interactions and side-effects that compromise patient health and safety
- Patient advocacy to ensure the care plan is followed by all providers. Annual evaluation of satisfaction with the complex case management program.

Identification of Eligible Members

Members meeting criteria for CCM may have conditions in which the degree and complexity of illness or conditions is severe, the level of management necessary is intensive, and the number of resources required for member to regain optimal health or improved functionality is extensive. Eligibility criteria (see Appendix D) are subject to change, based on findings from the population needs assessment and/or community and stakeholder committees. Criteria are developed under the guidance of the Chief Medical Officer, and routinely, but no less than annually, evaluated to ensure Members at high-risk of poor health outcomes receive the appropriate level of care management support. Typically, CCM supports Members with at least one of the following clinical features:

- Complex diagnoses such as End-Stage Renal Disease (ESRD), Chronic Heart Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD)
- High risk scores
- Multiple comorbidities
- Multiple Emergency Department (ED) visits in a year

- Multiple hospitalizations in a year
- Mental Health diagnosis
- Complex Psychosocial Needs (i.e., Homelessness)

Referral Process

Referrals to CCM can be made by members, caregivers, practitioners/providers (including PCPs and Specialists), hospitals or facilities, and internal departments (including UM, Member Services, Disease Management, Behavioral Health, and Grievance & Appeals). A CM clinician (nurse or social worker) may also deem a member eligible for CCM if they feel a member could benefit from CCM services.

The Alliance also employs proactive strategies to identify members meeting criteria for CCM, including but not limited to:

- Predictive Model Application – *the Alliance uses a predictive model application, CareAnalyzer, to aggregate utilization data (including behavioral health and pharmacy data) to identify members who may be at risk and could benefit from CM interventions*
- Inpatient census reports
- Hospital discharge reports
- Health Risk Assessments (HRA)
- Readmission Report
- Laboratory Results
- Claims and pharmacy data
- Admission, Transfer, Discharge (ADT) report

Program Interventions

Members referred for CCM are reviewed by CM triage nurses, taking into consideration the known information about the case from claims history, medical records that may be on file for UM purposes, and Member Services call history. The triage nurse verifies Member appropriateness for CM, and if determined as appropriate then a case is opened in the care management information system and assigned to a Case Manager. If the Member does not meet criteria for complex case management, the Member may be referred to the other Alliance program for coordination of care, assistance in managing risk-factors, referral to community services or assistance in identifying a primary care practitioner. Members are deemed ineligible if they do not have active Alliance eligibility or are receiving another duplicative CM service.

The Alliance considers a member enrolled in case management when they are given a program overview and provides verbal or written consent to program enrollment. The encounter establishing eligibility is tracked in the Clinical Information System as a CCM Consent Note. The Member may opt out of CCM services at any time during the process. Members who make the decision to opt out of CCM are offered the opportunity to enroll

again into CCM upon request or by outreach from The Alliance upon a new triggering event.

Once a member is enrolled in CCM, the Case Manager is responsible for the following services:

A. Identification of Care Needs

The Case Manager (and with periodic collaboration with a Social Worker) conducts a Comprehensive Assessment of the Member health, behavioral, functional, and psychosocial status specific to identified health conditions and comorbidities. The assessment also includes:

- Screening for presence or absence of comorbidities and their status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the Member's identification for complex case management.
- Assessment of current medications, including schedules and dosages.

An initial assessment is performed as expeditiously as the Member's condition requires (and may be completed by multiple calls), but always within 30 calendar days of the Member becoming eligible. At the time of the assessment, the Case Manager obtains consent to participate in the complex case management program and information about the Member's primary care practitioner, identifies short-term and long-term needs and initiates the care plan. If the Member declines complex case management services, the Member may be referred to the community services or assistance in identifying a primary care practitioner.

As part of the General Assessment, the Case Manager reviews and documents the member's clinical history, including disease onset; key events such as acute phases; inpatient stays; treatment history; and current and past medications, including schedules and dosages. All clinical documentation is collected and stored in a secure clinical information system and is organized in structured templates to facilitate efficient access and use of information. Assessment components are further detailed below, and information gathered in the assessment is used to identify care gaps and potential barriers to care.

- **Assessment of Activities of Daily Living** – evaluates Member functional status related to activities of daily living such as eating/feeding, bathing, dressing, going to the toilet, continence, transferring, and mobility.
- **Assessment of Behavioral Health Status Including Cognitive Functions** – evaluates mental health status, including psychosocial factors, cognitive functions, and depression; also includes evaluation of the member's ability to communicate, understand instructions, and their ability to process information about their illness. An alcohol and drug use screen are also included in the assessment, and

referrals are made to the behavioral health Triage Specialists or behavioral health RN Case Managers to collaborate with the Complex Case Management Team for Members, as needed.

- **Assessment of Social Determinants of Health –** evaluates for social determinants of health barriers, which are economic and social conditions that affect a wide range of health, functioning and quality of life outcomes and risks that may affect a member's ability to meet their health goals; assessment includes questions on:
    - Current living situation, such as homelessness
    - Issues related to obtaining or using medications.
    - Transportation issues in meeting healthcare needs
    - Overall financial concerns that impacts member's well-being

- **Assessment of Life-Planning Activities** – evaluates member preferences about healthcare and treatment decisions that may impact their care, including life planning activities (including wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life Sustaining Treatment (MOLST or POLST forms); life planning materials can also be mailed, as appropriate (e.g., advance directive)

- **Evaluation of Cultural and Linguistic Needs, Care Preferences or Limitations** – determines communication methods best suited for the Member, cultural and linguistic needs, care preferences or limitations; also includes assessment of any personal, religious, cultural preferences or any cultural restrictions to consider in a their care

- **Evaluation of Visual and Hearing Needs, Preferences or Limitations** – determines any visual and hearing needs, preferences or limitations, including details such as use of hearing aids and eyeglasses

- **Evaluation of Caregiver Resources and Involvement** – determines any family and/or caregiver involvement in decision-making about the member's care

- **Evaluation of Health Plan Benefits and Community Resources** – determines access to resources that may impact care, including caregiver, community, transportation, and financial resources delivered by local, county, and state agencies as well as disease-specific organizations, ECM, CS, and philanthropic groups to provide services such as community mental health, transportation, wellness organizations, palliative care programs, and nutritional support. United Way, Meals on Wheels and the American Cancer Society are examples of programs with available assistance.

B. Care Plan Development

Following the initial assessment, the Case Manager and/or Social Worker develops an Individualized Care Plan (ICP), consisting of goals and interventions. Case Managers must develop an ICP within 30 calendar days of completing an initial assessment. The Case

Management staff incorporate information from the initial assessment, as well as other assessments such as Health Risk Assessments, Pharmacy profile, specialized assessments, such as PHQ-9 or PHQ-2, that may be included in the Initial Assessment, HRA and Health Information Form/Member Evaluation Tool.

The Care Plan includes a personalized Person-Centered planning and treatment approach that is collaborative and responsive to meet Member specific health care needs. The ICP is a comprehensive, individualized, interdisciplinary action plan that includes varying types of goals such as clinical milestones, pain management, addressing care gaps, and Member self-management. The Person-Centered approach involves the development of the care management plan with Member input regarding preferences and choices in treatments, services, and abilities. Working with the Member, the Case Manager or Social Worker establishes and documents a set of prioritized goals.

Case Managers establish care plan goals with the following characteristics:

- Goals are relevant to the Member's condition with identified goals driving optimally coordinated care.
- Goals take into consideration the Member's or primary caregiver's goals and preferences, and desired level of involvement. These goals must be:
    - **Specific** - usually defining a maximum of four behaviors or measurable outcomes.
    - **Measurable** - so that it is easily understood when the goal is achieved.
    - **Achievable** - it does no good for the patient or for the manager to set unrealistic or unachievable goals. This is an invitation to frustration and disappointment for all involved parties.
    - **Relevant** - are the chosen goals the ones for which the greatest value can be achieved for the time, resources, energy expended?
    - **Time-dimensioned** - Is there a realistic timeframe in which the goal can be achieved?
- Goals are prioritized. A complex case may have many goals toward regaining optimal health or improved function; therefore, each goal is prioritized against other goals for dependencies. The Alliance designates goals on a scale of 1 to 10. 1 = High, 10 = Low.
- Goals have specific time frames for re-evaluation. Members with complex health concerns require ongoing assessment and management. When establishing a goal, the Case Management staff sets a specific date for follow-up on progress toward that goal. Upon re-evaluation the goal may be on track, may require revision, or may no longer be appropriate due to changes in conditions or circumstances. When a goal is retained as is or revised the Case Management staff establishes a next follow-up date in the case management system.
- Goals have identified resources to be utilized, including the appropriate level of care when applicable.
- Goals include documentation of any collaborative approaches to be used, including family participation, to achieve the goal. Goals have an assessment of

barriers. Barriers may be assessed at the individual goal level (such as limited transportation to physical therapist) or at the case level (such as Member is in denial about prognosis).

The Case Manager or Social Worker facilitates the participation of the Member, and any family, friends, and professionals of their choosing, to participate in any discussion or decisions regarding treatments, services, support, and education. The Case Manager or Social Worker ensures that the Member receives all necessary information regarding treatment and services so that the Member makes informed choices and input regarding care management, prioritized goals as high, medium, or low, and interventions. The Case Manager or Social Worker includes the Member in appropriate and regular updates to the care management plan that occur at a minimum on an annual basis.

The Case Manager also provides the Member or Member caregiver(s) instructions and/or materials to assist the Member with self-management of his or her complex medical condition. The development and communication of a self-management plan includes Member monitoring of key symptoms, activities, behaviors, and vital statistics as appropriate (i.e., weight, blood pressure and glucose levels). The Case Manager documents oral or written communication of self-management activities provided to the Member or caregiver(s).

Care plans also assess the level of care settings, i.e., home health, custodial care, adult, or child day care. Case Managers or Social Workers determine the appropriate setting, education and training required, and community network resources required to achieve a desired level of functioning/independence. In some cases, a specialist, or multiple specialists, in lieu of the Member's PCP, best positioned to provide the most appropriate care. In these situations, the care manager discusses this option with the Member's PCP and the specialist(s) and arranges for a standing referral to the specialist(s). The care manager notifies the Member that he/she will have direct access to the managing specialist for a specific period.

C. Identification of Barriers to Care

The CM identifies and addresses the Member's beliefs and concerns about their condition and any perceived or real barriers to their treatment such as access, transportation, and financial barriers to obtaining treatment. The Care Plan identifies barriers to care and interventions to reduce or resolve Member specific healthcare barriers. Additionally, cultural, religious, and ethnic beliefs are assessed that may impact the condition being managed. Based on the assessment of these psychosocial issues, interventions may be modified. Examples of such issues include:

- Beliefs or concerns about the condition or treatment.
- Perceived barriers to meeting treatment requirements.
- Access, transportation, and financial barriers to obtaining treatment.

D. Communication with Member

The PCP communicates directly with the Member to meet Member specific health care needs, and includes family, caregivers, and other appropriate providers in the case management process. The PCP facilitates the participation of the Member, and any family, friends, and professionals of their choosing, to participate in any discussion or decisions regarding treatments, services, support, and education. The PCP, in collaboration with Case Management staff, ensures that the Member receives all necessary information regarding treatment and services so that the Member makes informed choices regarding case management, prioritized goals, and interventions.

The Case Manager arranges follow-up interactions with members to review progress towards their care plan goals, including but not limited to, counseling, referral to disease management, education, or self-management support. The Case Manager also evaluates whether previously identified barriers to goals are impeding progress and may work with members to adjust their care plan and goals, as needed.

E. Coordination of Services

The Care Plan includes care coordination and follow-up activities to reduce or eliminate barriers for obtaining needed health care services. The PCP in collaboration with Alliance Case Management staff facilitate linkages between Members and community organizations to enhance access to community resources and ensure Members can utilize these resources. Case Management staff coordinate access to community services, monitor service delivery, advocate for Member needs, and evaluate service outcomes. A directory of community resources is available to Case Managers and Social Workers as they work with Members, caregivers, and providers. Case Management and Disease Management department staff regularly compile and document resources available in Alameda County and update the directory when necessary.

F. Monitoring of PCP Services

Alliance Case Management staff monitor the Member's condition, responses to case management interventions, and access to appropriate care. The Alliance ensures the PCP performs the necessary activities of case management services such as the IHA and identification of appropriate healthcare services.

G. Case Closure

The PCP in collaboration with Alliance Case Management staff terminate case management services for Members based on established case closure guidelines. For Members that do not meet the closure criteria with 90 calendar days of enrollment, the Case Management staff will present the case to the Inter-Disciplinary Care Team (ICT) to evaluate whether established goals are appropriate, and if additional goals are needed or referrals to additional services are warranted. The criteria for case closure include:

- Goals met
- Interventions not successful/All resources exhausted

- Loss of eligibility
- Unable to establish or maintain contact with Member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the Member
- Member not compliant with plan of care
- Determination by the Case Manager that the member is unable to appropriately and actively participate in the program

Inter-Disciplinary Care Teams

Complex Case Management staff cannot effectively work apart from the formal and informal circle of care that surrounds the Member. The Case Management staff integrates CCM program activities with all Members of the Interdisciplinary Care Team (ICT). CCM care plans are made available to the Member or Member representative and the ICT. Request for care plans from individuals other than the Member, Member representative, and ICT participants require consent of the Member or authorized representative. The Case Management staff collaborates with other licensed professionals on the care team, such as a social worker, clinical pharmacist, and health plan medical directors, and with external professionals in addition to the PCP such as specialty care practitioners. When indicated, the Case Management staff builds a co-management plan with a specially trained Behavioral Health Case Manager, Carve-Out Service CM team, a CM from a Community Based Organization, (CBO) or a CM from an Organ Transplant Center of Excellence (COE). The Case Management staff continually plans for the Member's developing and future needs, which includes ongoing interaction with other Alliance programs such as Disease Management.

The ICT is a team of healthcare professionals from various professional and care management disciplines who work together to manage the physical, psychological, and social needs of the Members. The ICT is always comprised of the CM Nurse, the PCP and the Member or caregiver. Internal ICTs are held to review care plans and provide guidance to the CM team caring for the Member. For CM, the core ICT is comprised of the CM Medical Director, Manager of CM and DM, the assigned CM. Ad-hoc Members of the team may be invited to attend based on the needs of the Member. This includes Pharmacy, Social Worker, or Behavioral Health Specialist. Formal ICTs are held with invitations to the Member/Member Caregiver and PCP/Specialist as needed.

ICTs are held bi-weekly to discuss complex care planning, and to provide support and direction to the dedicated care teams.

E. Enhanced Care Management (ECM)

ECM offers comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members, with the overarching goals of:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Addressing SDOH;
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

The Alliance has contracted with community-based agencies to deliver Enhanced Care Management (ECM). The purpose of the program is to build community infrastructure to improve integration, reduce unnecessary utilization of health services and improve health outcomes. The ECM providers include both clinic-based CBOs and social agencies (see Appendix H), and serve the below Populations of Focus:

1. Adults & Children/Youth Experiencing Homelessness
2. Individuals At Risk for Avoidable Hospital or ED Utilization
3. Individuals with Serious Mental Health and/or SUD Needs
4. Individuals Transitioning from Incarceration
5. Adults Living in the Community and At Risk for LTC Institutionalization
6. Adult Nursing Facility Residents Transitioning to the Community
7. Children and Youth Enrolled in California Children's Services (CCS) with Additional Needs Beyond the CCS Condition
8. Children and Youth Involved in Child Welfare
9. Birth Equity Population of Focus

ECM service includes:

- Outreach & Engagement
- Comprehensive Assessment & Care Plan
- Enhanced Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Member & Family Supports
- Coordination of & Referral to Community & Support Services

Program activities focus on transitioning from a fragmented and siloed approach provided by various health delivery systems, county/community programs and health plans to an integrated county-wide program focused on accessible shared health information, effective linkages to county resources, and access to high quality community case management services. The Alliance maintains regular communication and coordination with contracted ECM providers to ensure optimal delivery of ECM services, providing clinical consultative and liaison support to navigate the managed care plan.

F. Targeted Case Management (TCM)

Targeted Case Management is provided to members by Local Governmental Agencies (LGAs). The Alliance facilitates access to TCM for eligible members by ensuring referrals are appropriately made to the LGAs, so they can evaluate members for TCM services.

Identification of Eligible Members

Alliance staff follow preset guidelines and collaborate with primary care providers when necessary to identify members eligible for TCM services. The Alliance identifies Members that may be eligible for targeted case management services through admission review, concurrent review processes, provider referral, or at the request of the Member. Members eligible for TCM services have generally been identified as moderate or high risk, and meet the following criteria:

- Suffer from one or more acute or chronic conditions.
- Require case management services that are less intensive than services provided in CCM.
- Have medical, functional, and/or behavioral health conditions that require extra support but generally demand fewer resources to achieve or maintain stability than do Members enrolled in more intensive case management programs.
- Care requires moderate coordination with several providers involved.
- Member and/or caregiver education is needed to support self-management skills and strategies. Once available resources are accessed, successful self-management is achievable with moderate intensity of care coordination services.
- Issues may be acutely destabilized and time-limited OR chronic, ongoing but stable.

Referral Process

Once a member is identified and referred to an LGA for potential TCM, they are assigned to an Alliance Case Manager, who ensures screening, referrals, care planning, and all other care coordination activities are coordinated between the member, their providers, the LGA, and The Alliance. The LGA determines eligibility for TCM and assigns a Lead Case Manager to support the member once deemed eligible. For Members under the age of twenty-one (21) who are not accepted for TCM services, the Alliance ensures Member access to services comparable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) TCM services as well as California Children Services (CCS) for case management for Members with a qualified CCS condition.

Program Interventions

When enrolled in TCM, the LGA Lead Case Manager is responsible for the following services:

- **Screening and enrollment**: determines eligibility and obtains member consent to services
- **Comprehensive clinical assessment:** assesses the Member's health and psychosocial status to identify the specific needs of the Member, including

identification of barriers to care such as Member lack of understanding of condition, motivation, financial or insurance issues and transportation problems

- **Development and implementation of an Individualized Care Plan ("ICP") also referred to as a "service plan":** includes information from the Member assessment as well as Member input regarding preferences and choices in treatments, services, and abilities
- **Care coordination activities:** including facilitating communication, referrals, treatment/service authorizations, collaborating with Alliance Utilization and Case Management staff to assist Members with accessing services identified in the service plan
- **Crisis assistance:** collaborating with Alliance Case Management and Behavioral Health staff to coordinate and arrange crisis services or treatment for Members when immediate intervention is necessary or in situations that appear emergent in nature
- **Maintenance of comprehensive, written records:** including assessments, service plans and documentation of service delivery, provider communications, member interactions, etc.
- **Periodic review and evaluation of cases, including case closure, as appropriate**

Oversight

Alliance Case Management and Behavioral Health staff monitor the Member's condition, responses to case management interventions, and access to appropriate care. The Alliance ensures the TCM LGA performs the necessary activities of TCM services. Data exchange occurs between the Alliance and the various TCM LGAs, to ensure non-duplication of services. Collaboration with the LGA also ensures members who are no longer eligible for TCM are appropriately linked with alternate resources to support any ongoing health needs.

G. Transitional Care Services

Alliance Case Management staff maintains procedures to assist Members who transition from one setting or level of care to another. These transitions include, but are not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings. The Alliance has established partnerships with hospitals and network providers, like Alameda Health Systems (AHS), to effectively implement TCS, ensuring members have access to support across the continuum from admission to discharge.

The Alliance delegates TCS to CHCN for members assigned to the CHCN network – these members are supported via CHCN's Care Transitions Registered Nurse (CTRN) program. The CM team provides oversight and monitoring of the delegated TCS activities to ensure compliance with all DHCS requirements.

Regardless of risk level, members are assigned to a Case Manager, Social Worker, or Health Navigator to provide transitional care support throughout their hospitalization, and after they leave the hospital. Members are also assessed for ongoing care management needs provided through Complex Case Management, Enhanced Care Management, Disease Management, or other available resources.

The Lead Case Manager, whether Alliance-based or community-based, is responsible for the following services:

- Enrollment
- Ensuring completion of the discharge risk assessment
- Ensuring completion of the discharge document (containing lead case manager's name and contact information) and share with appropriate parties
- Evaluation of post-discharge needs in association with TOC bundle.
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon evaluation.
- Clear documentation of service(s) provided, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

H. Specialized Services

The Alliance maintains several programs to assist Members with specific or targeted program needs. Those programs include:

- California Children Services (CCS)
- Community Supports
- Continuity of Care (CoC) with Out-of-Network providers
- Major Organ Transplants
- Transportation

California Children Services

The Alliance participates in the identification and referral of eligible children to the California Children Service Program. California Children's Services (CCS) is a statewide program that assists children and youth:

- With a chronic, disabling, or life-threatening CCS eligible medical condition
- In need of specialty medical care
- Meeting income requirements (See Eligibility, below)
- Age birth to 21

Referred children are screened for eligibility criteria and referred to a specialized contracted CCS provider. As the program is limited to providing services to children under the age of 21 years, The Alliance has developed a program to identify and provide care coordination of services for children in CCS whose needs are not covered with the CCS

program, and who are nearing 21 years of age and aging out of pediatric health care services. As CCS children age out of the system, staff will assist with the transitions to appropriate adult specialists in a collaborative manner to protect the individual and ensure age-appropriate care is provided.

The CCS Program is coordinated through the UM department, including the Out of Plan RN, and the Case Managers provide coordination of care in collaboration with the UM department as needed to ensure that all needs are met.

Community Supports Services

Community Supports (CS) services include a variety of services not typically covered by managed care plans. These services are intended to provide additional cost-effective support to members in lieu of higher-level services. In 2024, the Alliance is providing twelve (12) CS services:

- Housing Navigation
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Recuperative Care (Medical Respite)
- Medically Tailored/Medically Supportive Food
- Asthma Remediation
- (Caregiver) Respite Services
- Personal Care & Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Sobering Centers

Each CS service has eligibility criteria following the DHCS requirements. The Alliance has contracted with Community Based Organizations (CBOs) to provide the CS services, including the Alameda Health Care Services Agency (HCSA,) for housing services and Asthma Start, medical respite providers (Lifelong, Cardea Health, and BACS,) and Project Open Hand for Medically Tailored/Supportive Meals. HCSA infrastructure includes a community health record, and the Alliance uses it as a tool for managing members through the continuum. The goal of the collaboration is to ensure targeted Members and providers can access intensive, community-based care management services from anywhere in the care continuum, providing the “right care-right place-right time”. The program outcomes focus of providing services that will:

- Improve physical and behavioral health outcomes.
- Improve Quality of Life
- Enhance PCP and Member experience with the Health Plan
- Enhance the efficiency and effectiveness of service delivery

The Alliance maintains regular communication and coordination with contracted CS providers to ensure optimal delivery of CS services, providing clinical consultative and liaison support to navigate the managed care plan.

Continuity of Care (CoC) with Out-of-Network Providers

When the Alliance's network is unable to provide necessary services covered under the Plan to a particular Member, The Alliance must adequately and timely cover these services with out-of-network providers, until services are completed, or the Member can be safely transitioned back into The Alliance network of providers. Continuity of Care may be provided to members in one of the following situations:

- Mandatorily enrolled from Medi-Cal FFS or another managed care plan
- Members with terminated providers
- Medical Exceptions Requests for Newly Enrolled Medi-Cal Enrollees
- Newly enrolled with active course of treatment

The Alliance's UM Department is responsible for the initial care determinations related to CoC situations. Once the CoC is approved, the Member is referred to Case Management for the identification of any care needs. The Case Management program engages in activity that monitors and assesses continuity and coordination of clinical care. Individual registered nurses work closely with the Member, the physicians and any other associated healthcare delivery organization involved in the case, to provide timely, quality-based care meeting the needs of the individual member. The CM staff ensure the coordination of services with the Primary Care Providers and Specialists. A full description of the CoC process can be found in the relevant UM Policies.

Major Organ Transplants

In 2022, the Major Organ Transplants (MOT) benefit was carved-in to the Alliance, from Medi-Cal Fee-for Service. This uniquely vulnerable member population is provided focused Case Management services throughout the care continuum, from pre-transplant to post-transplant. The CM program works closely with Centers of Excellence providing the transplants to ensure comprehensive, wraparound services to support members throughout their transplant care.

Transportation Services

Transportation services are covered benefits, including:

- Emergency
- Non-emergency medically necessary (NEMT)
- Non-medical transportation (NMT)

The Alliance contracts with a vendor, ModivCare (formerly called LogistiCare), to provide NEMT and NMT. The day-to-day operational monitoring of NEMT and NMT utilization is performed by Case Management staff, in collaboration with ModivCare. Specifically, CM staff obtaining completed Physician Certification Statement (PCS) forms prior to

coordinating Non-Emergency Medical Transportation (NEMT), collaborating with the vendor management department to ensure that Transportation processes align with the requirements of APL 22-008 for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT). A full description of the process is defined in the most recent policies on transportation services.

The Alliance is also responsible for the provision of NMT and NEMT to eligible children under the age of 21 to access Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, (now called Medi-Cal for Kids and Teens). The Alliance provides appointment scheduling assistance and necessary transportation, including NEMT and NMT, to and from medical appointments for the medically necessary covered services. The Alliance is not responsible for providing non-medical transportation to and from the services that are carved-out, including dental services. AAH follows DHCS All Plan Letter 19-010 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment of Services for Medi-Cal Members Under the Age of 21.

VII. Case Management Monitoring and Oversight

The Alliance utilizes several activities to monitor and oversight CM program activities and staff performance. Management staff and auditors monitor cases for timeliness of screening, triage, assessment, and care planning in compliance with CM/CCM policies and procedures. Triage nurses, Case Managers, and all internal IDT Members are provided with timely feedback (both positive and negative). Retraining and the disciplinary process are employed as indicated by monitoring.

Internal reports developed to monitor CM/CCM activities for case referrals by source, open active cases, cases open by number of days, timeliness of triage and assessments, timeliness of Member contacts, timeliness of care plan development, PCP contact for care planning purpose, and case closure activities.

Monitoring and oversight activities are the responsibility of CM management. Monitoring occurs monthly, with reporting to the UMC and QIHEC on a quarterly basis.

A. Program Effectiveness

The Alliance is committed to continuous program improvement. Care Management leadership seeks to improve the CCM program through several formal processes.

Complex Case Management Performance Measurement

The Alliance maintains performance measures (see Appendix E) for the complex case management program to maximize Member health, wellness, safety, satisfaction, and cost efficiency while ensuring quality care. The Alliance selects measures that have significant and demonstrable bearing on the entire complex case management population or a defined subpopulation. The Alliance CM leadership staff annually evaluates the measures of the effectiveness of its complex case management program

based on the following performance goals and corresponding measures (also see Appendix E):

1. Achieve and maintain high levels of satisfaction with CM services.
Measure One - Member Satisfaction Rates

2. Improve Member outcomes
Measure Two - All-Cause Admission Rate
Measure Three – Emergency Room Visit Rate
Measure Four – Percentage of Eligible Members enrolled in CCM
Measure Five – Care Management for High-Risk Members after Discharge
Measure Six – Percentage of members enrolled in ECM

3. Achieve optimal Member functioning.
Measure Seven – Health Status Rate

4. Use of Appropriate Health Care Services
Measure Eight – Use of Services (Primary Care)

For each of the performance measures, the Alliance completes the following procedures to produce annual performance measurement reports:

1. Identifies a relevant process or outcome.
2. Uses valid methods that provide quantitative results.
3. Sets a performance goal.
4. Clearly identifies measure specifications.
5. Analyzes results.
6. Identifies opportunities for improvement, if applicable
7. Develops a plan for intervention and re-measurement.

Performance measurement involves the use of quantitative information derived from a valid methodology that considers the numerator and denominator, sampling methodology, sample size calculation, and measurement period. The measure is relevant to the target population so appropriate interventions result in a significant improvement to the care or health of the population.

With data analytic support from the Healthcare Analytics, the CM Medical Director, Senior Director of Health Services, Director of Social Determinants of Health and Manager of Case and Disease Management, in collaboration with the Chief Medical Officer, establish a quantifiable measures and performance goal for each measure that reflects the desired level of achievement or progress. The team will identify measure specifications to ensure that reliable and valid measures can be produced with available analytic capabilities and data resources. Annually the data is compiled, and results reviewed against performance goals. The team completes the evaluation using qualitative and quantitative analysis to identify opportunities to improve performance on the measures and improve the overall effectiveness of the CM program. When opportunities to improve a measure are

identified, the CM leadership team will develop an intervention action plan to improve measurement performance and subsequently re-measure performance to assess effectiveness of the intervention.

Member Experience with Case Management

An annual assessment of Member experience with the CM program is conducted. Member satisfaction is evaluated using a Member survey upon discharge from the CCM program. Any Member complaints received regarding CCM are also used, whether the complaint was made during the case or submitted after case closure. Formal quantitative and qualitative analyses are conducted using trended data over time, identification of opportunities, barrier analysis, development of interventions for implementation, and plans for re-measurement. The Experience with CM Process report is presented to the UM Committee for review and approval.

Annual CM Program Evaluation

The Chief Medical Officer, the Senior Director, Health Care Services, and the Director or Manager of Case and Disease Management collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of Member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the UMC and QIHEC for review and feedback. The UMC and QIHEC make recommendations for actions and/or interventions to improve program performance, as appropriate.

Annual CM Workplan

Each year, the Alliance establishes objectives and priorities based on findings from the Annual Program Evaluation and outlines a strategic workplan for the coming year. The workplan incorporates goals, measures, anticipated completion timeframes, and responsible parties, and is maintained throughout the year to monitor progress towards goals and adjust goals, as necessary. The CM workplan is reviewed and approved by the UMC and QIHEC annually.

Delegation of Case Management Activities

The Compliance Department is responsible for monitoring and tracking the overall performance of delegates, including completion of annual audits. CM department staff review the CM components of the annual audit, which includes a review of delegates' policies and procedures and member case files. The CM team also reviews the delegated entities' annual work plans/evaluations, and semi-annual reporting. The Compliance Department is responsible for finalizing the audit findings. For entities that do not meet thresholds, a corrective action plan may be issued and tracked to ensure adequate resolution of the deficiency. All audit findings are reported to the Compliance Committee and the QIHEC.

In 2024, the Alliance delegates Care Coordination to the following entity:

Delegate	Provider Type	HRA	Care Coordination	CCM	DM
CHCN	Managed Care Organization	No	X	No	No

The Alliance is responsible for ensuring delegated entities deliver quality, cost-effective services. In all delegated arrangements, oversight and evaluation are maintained through the following activities:

1. Evaluation of the delegate's abilities to perform case management functions prior to delegation in accordance with all regulatory requirements and accreditation standards.
2. Review of required reports monthly, quarterly, semi-annually, and annually, or as defined by the delegate's contract.
3. Annual delegation review

When a Provider Group is identified as interested in performing a delegated function, the Alliance performs a pre-delegation review to ensure the entities can perform the functions in compliance with the regulatory and accreditation standards. When delegation occurs, the CM team works with the Contracting department to create an appropriate delegation agreement which requires the delegated entity to comply with all regulatory and accreditation requirements. The oversight of a delegated activity includes regular reporting of CM services provided to Alliance Members (e.g., monthly, quarterly, semi-annually, or annually).

B. Summary of Program Enhancements in 2024:

Operational Efficiency and Compliance

Basic Population Health Management (including Care Coordination for Medical and Behavioral Health Services and Disease Management):

- Increase engagement in care coordination for medical services by continuing efforts to find alternative contact information for members through Electronic Health Records (EHR), PCP clinics, and Community Health Record (CHR)
- Work with Healthcare Analytics department to further enhance population analysis and program interventions to evaluate program efficacy
- Work with IT department to identify additional opportunities to automate processes administrative CM processes
- Further solidification of case coordination processes for behavioral health services to increase efficiency and uniformity of practice
- Further collaboration with Alameda County Behavioral Health to ensure member's needs are met across systems of care

- Further collaboration Alameda County Office of Education to coordinate school-based services
- Initiate bi-directional coordination of care between physical health and mental health providers, including deployment of PCP referral to Mental Health Web Form, enabling PCPs to communicate more completely the needs of the members they refer for mental health services that can be passed on to the Mental Health Provider to enhance their evaluation
- Behavioral Health Treatment/Applied Behavioral Analysis Treatment plan deployed on the Alliance Provider Portal to enable Autism Service Providers to submit their assessments and treatment plans securely, that can then be shared with referring pediatricians and PCPs.
- Continued identification of data sharing pathways between PCPs and Behavioral Health Practitioners
- Increase member engagement into Alliance Disease Management programs through member mail and call campaigns and provider education

Complex Case Management:

- Continue to identify, implement, and evaluate different avenues to continue to increase member engagement.
- Continue SMART goal for:
  - Collaborative efforts with partnered hospitals
  - Productivity standard of Complex member outreach and engagement
  - Obtaining accurate member contact information.
  - Continue the use of the CHR and PCP for alternate phone numbers for member engagement

Enhanced Care Management:

- Continue to develop, train, and maintain the ECM Provider network, in preparation for further expansion to support all ECM populations of focus.
- Provide consistent/routine monthly in-person and virtual provider audits and respective in-services to ensure ECM compliance and optimal use of ECM benefits.
- Work closely with ECM providers in monthly IDT meetings to provide guidance with the ECM graduation process.

Transitional Care Services:

- Continued efforts to improve member engagement rate will continue in 2024 via finding alternate phone numbers through CHR, and PCP office.
- Increased partnerships with hospital systems.
- Increased partnerships with PCP offices in collaborating on TCS, particularly post discharge appointments.
- Increased focused on specific TCS populations such as OB and FFS Medicare Part A members.

Community Supports:

- Transition the operational oversight of Community Supports to LTSS Director
- Launch the last two CS services (Short-Term Post-Hospitalization Housing and Day Habilitation Programs) by January 1, 2025.
- Continue to broaden CS provider network, as appropriate.
- Increase staff where appropriate as department expands to better meet needs of members and providers.
- Continue to build relationships with billing to assist providers with receiving timely payments.
- Continue to work with Analytics to further enhance a dashboard for CS services
- Continue development of accurate and reliable closed loop referral process with Community Supports providers, in alignment with the DHCS requirement by January 1, 2025; establish mechanism for CS providers to confirm members are being serviced after authorizations have been issued
- Provide training to all CS providers to promote best practices while working with our members and to continue to build rapport with CS providers

Quality Improvement

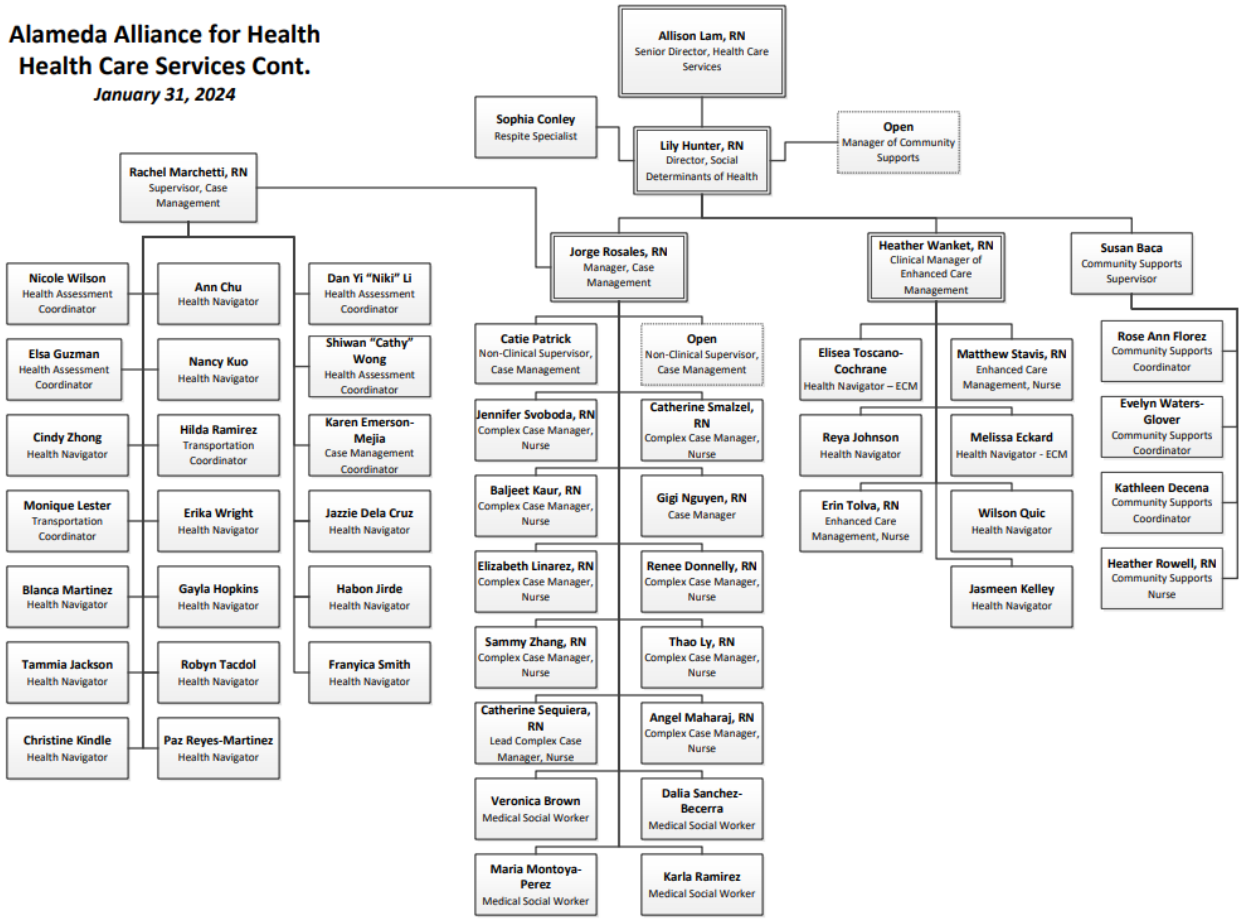
Member Satisfaction with CM:

- Increasing the return rate of satisfaction surveys. Satisfaction surveys are attached to case closure letters, which are sent to all members who complete their CM case. CM will work on ensuring members are educated that they will receive a survey upon case closure to increase return rate.
- Continue educating members on care management process, including establishing communication plan with member and establishing mutually-agreed upon scheduled calls
- Continue educating members on effective strategies for working with provider offices, including setting realistic expectations about provider treatment protocols

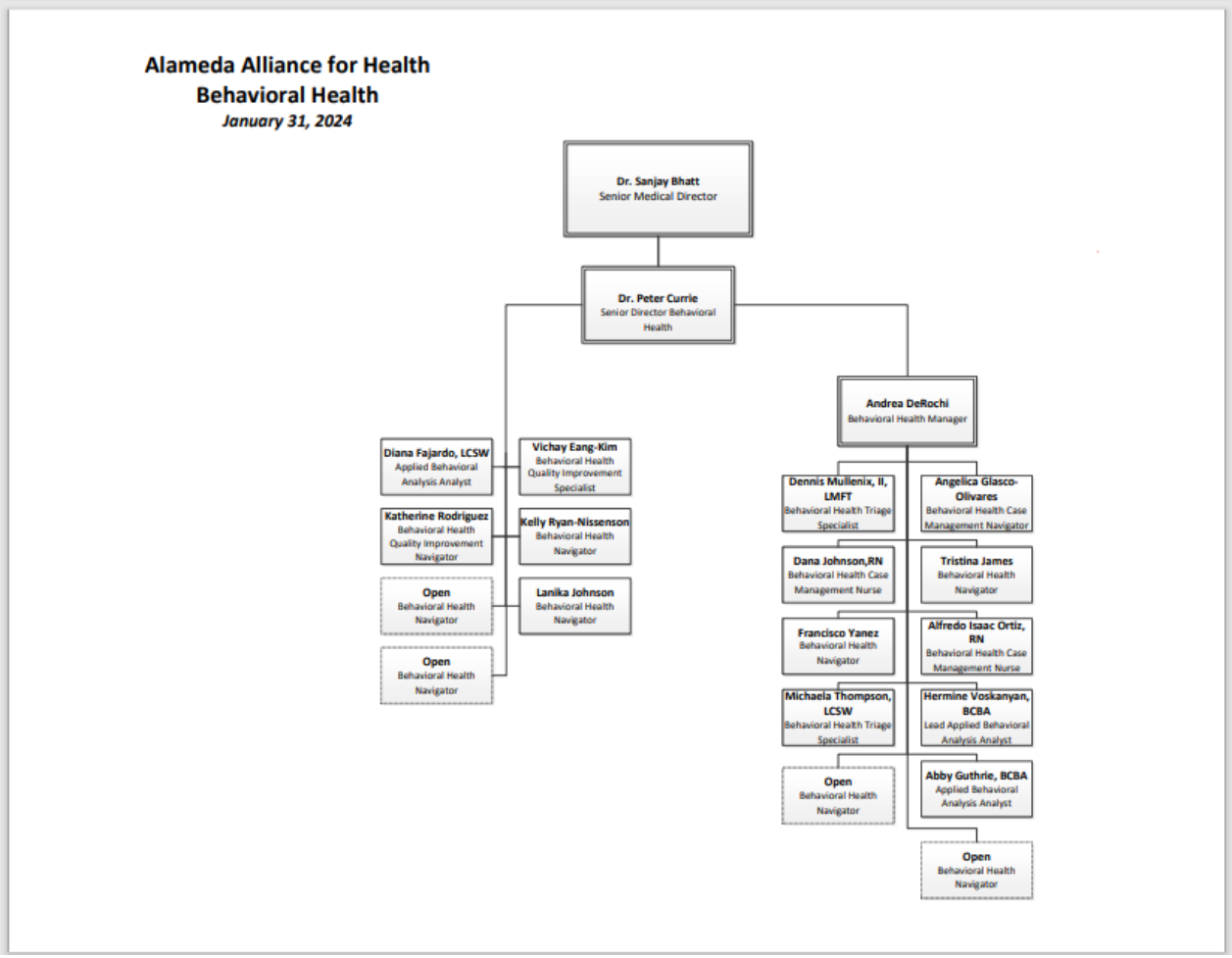
Delegated Case Management:

- Partner with the Compliance Department to evaluate audit tools and establish metrics that align with The Alliance's key performance indicators.
- Provider regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance's Population Health Management strategy

Appendix A – Case Management Department Organization Chart



Appendix B – Behavioral Health Department Organization Chart



Appendix C – Clinical Practice Guidelines

The Alliance recommends its provider network follow the most current versions of Clinical Practice Guidelines, as found on the Alliance Provider Website and detailed below:

Preventive Care Guidelines

Preventive Care

For Alliance members 21 years of age and under, the Alliance adheres to the most recent Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care. This is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. The full periodicity schedule is found here.

For asymptomatic healthy adults and pregnant women, the Alliance follows the current U.S. Preventive Services Task Force (USPSTF) A and B Recommendations for providing clinical preventive services. Current recommendations are found here.

Immunizations

The Alliance covers immunizations according to the immunization schedules recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC) and other medical associations. The child and adult immunization schedules are found here.

Perinatal Guidelines

The Alliance provides perinatal services for pregnant members according to the most current standards and guidelines of the American College of Obstetrics and Gynecology (ACOG). Current guidelines are found here.

Mental and Behavioral Health Services

The Alliance uses the following externally validated criteria for provision and effective management of Behavioral and Mental Health services:

1. Milliman Clinical Guidelines. Current guidelines found here.
2. Level of Care Utilization System (LOCUS). Current guidelines found at the American Association for Community Psychiatry (AACAP).
3. Child and Adolescent Level of Care Utilization System (CALOCUS). Current guidelines found at the American Academy of Child and Adolescent Psychiatry (AACAP).
4. Early Childhood Service Intensity Instrument (ECSII). Current guidelines found at the American Academy of Child and Adolescent Psychiatry (AACAP).
5. APA Board Guidelines for Autism Spectrum Disorders. Current guidelines found here APA-Approved Standards and Guidelines.

Tobacco Cessation Guidelines

1. Alameda Alliance for Health Tobacco Provider Guide
2. U.S. Department of Health and Human Services – Treating Tobacco Use and Dependence Guidelines: 2008 Update

Appendix D – Complex Case Management Criteria

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

Complex Case Management Criteria

(any 3 of ANY of the following)

High Utilization:

- ER visits: greater than 4 in the past 6 months
- Acute inpatient admissions: greater than 3 admissions in the past 6 months
- Readmissions: 2 or more readmissions in past 6 months

At Risk Diagnoses:

- Cancer
- CHF
- COPD
- CVA
- Diabetes
- End Stage Renal Disease (ESRD) with or without dialysis
- Hemophilia
- HIV/AIDS
- Multiple Sclerosis (MS)
- Transplant
- Neonates who are premature, have a congenital anomaly, or cancer (If selected, this will qualify member for Complex criteria alone)
- Schizophrenia
- schizoaffective
- anxiety
- depression
- bipolar
- PTSD
- Chemical dependency/substance use

Complex Medical/Psychosocial Needs:

- Three (3) or more dependencies for ADLs
- The member reports abuse, neglect, or threat of harm to self or others (Reminder, if select: file appropriate report with protective services)
- The member does not have permanent housing
- There is no caregiver present
- Per the member, the caregiver is unreliable
- Per the member, the caregiver is not enough

Appendix E – CCM Performance Measures (2024)

	Goal	Measure	Measurement	Performance Goal	2023 Outcome	Goal Met in 2023?
#1	Achieve and maintain high level of satisfaction with CM services	Member Satisfaction Rates	High level of satisfaction with CM services	90%	100%	Yes
#2	Improve member outcomes	All-Cause readmission Rate	Readmission rates for all causes for members in CCM with admission within 6 months of enrollment in CCM	90%	*N/A - Report in development*	
		Emergency Room Visit Rate	ER rates for members enrolled in CCM	90%	*N/A - Report in development*	
		Percentage of Eligible Members enrolled in CCM	The number and percentage of members eligible for Complex Care Management (CCM) who are successfully enrolled in the CCM program	Establishing baseline in 2024	N/A – new measure for 2024	
		Care Management for High-Risk Members after Discharge	The number and percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge	Establishing baseline in 2024	N/A – new measure for 2024	
		Percentage of members enrolled in ECM	The number of members who are enrolled in ECM out of the total number of enrolled members in the Alliance	Establishing baseline in 2024	N/A – new measure for 2024	
#3	**Achieve optimal member functioning**	Health Status	% of members in CCM responding that their health status improved because of CCM	90%	100%	Yes
#4	**Use of Appropriate Health Care Services**	Use of Services (Primary Care)	Percentage of members who had at least one primary care visit within a 12-month period	Establishing baseline in 2024	N/A – new measure for 2024	

Appendix F – Health Risk Assessment (HRA) Questionnaire

ALAMEDA Alliance FOR HEALTH

Health Survey

Member Name: _____ Alliance Member ID#: _____

Member Address: _____ Member Phone Number: ☐ Cell ☐ Home _____

1. What is your preferred language:
   ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese
   ☐ Other: _____

2. Where do you live:
   ☐ Own home ☐ Temporary housing
   ☐ Rent ☐ Homeless
   ☐ Staying with friends/family ☐ Group home
   ☐ Assisted living ☐ Other: _____

Please answer the questions on this form as best you can.

3. In general, how would you describe your health?
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Decline to answer

4. Do you know the name of your Primary Care Provider (PCP)? Your PCP is the main doctor you see for check-ups and when you have a medical problem. ☐ Yes ☐ No

5. Have you had a hard time trying to see your PCP or specialist? ☐ Yes ☐ No

6. Have you seen your PCP in the last three (3) months? ☐ Yes ☐ No

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7.	Do you need to see a doctor in the next 60 days?	☐ Yes	☐ No
8.	Are you under the care of any specialists?	☐ Yes	☐ No
9.	Are you pregnant?	☐ Yes	☐ No
	a. If you are pregnant, are you currently seeing a doctor for this pregnancy?	☐ Yes	☐ No
10.	Do you have a condition that limits your activities or what you can do?	☐ Yes	☐ No
11.	Do you have chronic pain?	☐ Yes	☐ No
12.	Have you been to the Emergency Room (ER) two (2) or more times in the last 12 months?	☐ Yes	☐ No
13	Have you been admitted to the hospital in the past 12 months?	☐ Yes	☐ No
14	Have you been in a Skilled Nursing Facility (SNF) in the past 12 months?	☐ Yes	☐ No
15.	Do you see a doctor regularly for a chronic condition?	☐ Yes	☐ No

If yes, check all that apply:

☐ Asthma	☐ Cancer	☐ Cystic Fibrosis
☐ Diabetes	☐ Heart Problems	☐ Hepatitis
☐ High Blood Pressure	☐ HIV or AIDS	☐ Kidney Disease
☐ Seizures	☐ Sickle Cell Anemia	☐ Tuberculosis

☐ Other: _____

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16. Do you take three (3) or more prescription medicines each day? ☐ Yes ☐ No

17. Please tell us the medications you are taking at this time (if any):

Name of Medication	Dose (How Much)	How Often Taken

18 Do you need help picking up your medication? ☐ Yes ☐ No

19. Do you need help taking your medicines? ☐ Yes ☐ No

20. Over the past month (30 days), how many days have you felt lonely?

- ☐ None – I never feel lonely
- ☐ Less than 5 days
- ☐ More than half the days (more than 15 days)
- ☐ Most days – I always feel lonely

21. Do you see a doctor regularly for a mental health condition such as depression, bipolar disorder, or schizophrenia? ☐ Yes ☐ No

22.

	Not at all	Several Days	More than half the days	Nearly everyday
a. Over the last two (2) weeks, how often have you had little interest or pleasure in doing things?				
b. Over the last two (2) weeks, how often have you felt down, depressed or hopeless?				

23. Have you had any changes in thinking, remembering, or making decisions? ☐ Yes ☐ No

24. Do you feel you have a problem with:
    a. Alcohol use ☐ Yes ☐ No
    b. Drug Use ☐ Yes ☐ No
    c. Tobacco use ☐ Yes ☐ No

25. If you use tobacco or smoke, are you ready to try quitting within the next month? ☐ Yes ☐ No

26. Are you using medical equipment or supplies, such as a hospital bed, wheelchair, walker, oxygen, or ostomy bags? ☐ Yes ☐ No
    Please list _____

27. Do you need assistive devices that you do not have? ☐ Yes ☐ No
    Please list _____

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28. Do you need help with any of these actions?

a. Taking a bath or shower	☐ Yes	☐ No
b. Going up stairs	☐ Yes	☐ No
c. Eating	☐ Yes	☐ No
d. Getting dressed	☐ Yes	☐ No
e. Brushing your teeth or hair, or shaving	☐ Yes	☐ No
f. Making meals or cooking	☐ Yes	☐ No
g. Getting out of a bed or a chair	☐ Yes	☐ No
h. Shopping and getting food	☐ Yes	☐ No
i. Using the toilet	☐ Yes	☐ No
j. Walking	☐ Yes	☐ No
k. Washing dishes or clothes	☐ Yes	☐ No
l. Writing checks or keeping track of money	☐ Yes	☐ No
m. Getting a ride to the doctor or to see your friends	☐ Yes	☐ No
n. Doing house or yard work	☐ Yes	☐ No
o. Going out to visit family or friends	☐ Yes	☐ No
p. Using the phone	☐ Yes	☐ No
q. Keeping track of your appointments	☐ Yes	☐ No

If yes, are you getting all the help you need with these actions? ☐ Yes ☐ No

If you get help with any of the tasks listed above, who is your helper? ☐ Yes ☐ No

Name of your helper: _____

What is your relationship to the helper: _____

May we contact your helper? ☐ Yes ☐ No

Phone number of helper: _____

29. Do you ever think your caregiver has a hard time giving you all the help you need? ☐ Yes ☐ No

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30. Is there a family member or friend who helps you make your health care decisions or who is involved in your plan of care? ☐ Yes ☐ No

If yes, please provide the name and relationship to you.

Name: _____

Relationship: _____

31. As of today, do you receive any of these services from an agency?

a. Home Health Nurse ☐ Yes ☐ No

b. Physical, Occupational, Speech Therapy at Home ☐ Yes ☐ No

c. Home Care Worker ☐ Yes ☐ No

d. Social Worker ☐ Yes ☐ No

e. Adult Day Care Center ☐ Yes ☐ No

f. Help with Transportation ☐ Yes ☐ No

Other (please list): _____

32. Do you have family members or others willing and able to help you when you need it? ☐ Yes ☐ No

33. Do you need help with food? ☐ Yes ☐ No

34. Do you need help with housing? ☐ Yes ☐ No

35. Do you need help with transportation? ☐ Yes ☐ No

36. Do you need help with your heating or water bill? ☐ Yes ☐ No

37. Have you completed an Advance Directive (a form that directs your health care wishes)? ☐ Yes ☐ No

38. Can you live safely and move around easily in your home? ☐ Yes ☐ No

39. If no, does the place where you live have:

a. Good lighting	☐ Yes	☐ No
b. Good heating	☐ Yes	☐ No
c. Good cooling	☐ Yes	☐ No
d. Rails for any stairs or ramps	☐ Yes	☐ No
e. Hot water	☐ Yes	☐ No
f. Indoor toilet	☐ Yes	☐ No
g. A door to the outside that locks	☐ Yes	☐ No
h. Stairs to get into your home or stairs inside your home	☐ Yes	☐ No
i. Elevator	☐ Yes	☐ No
j. Space to use a wheelchair	☐ Yes	☐ No
k. Clear ways to exit your home	☐ Yes	☐ No

40. Have you fallen in the last month?	☐ Yes	☐ No
41. Are you afraid of falling?	☐ Yes	☐ No
42. Do you need help filling out health forms?	☐ Yes	☐ No
43. Do you need help answering questions during a doctor's visit?	☐ Yes	☐ No
44. Are you afraid of anyone or is anyone hurting you?	☐ Yes	☐ No
45. Is anyone using your money without your okay?	☐ Yes	☐ No
46. Do you sometimes run out of money to pay for food, rent, bills, and medicine?	☐ Yes	☐ No

This Health Survey is complete. Thank you!

Please return to:

Alameda Alliance for Health
Case Management Department
1240 S. Loop Road
Alameda, CA 94501

If you have questions, please call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-free at **1.877.932.4567**
People with hearing and speaking impairments (CRS/TTY):
711/1.800.735.2929

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Appendix G – Long-Term Services and Supports Referral Questions

Background: In 2016, the Department of Health Care Services (DHCS) announced several strategies designed to improve referrals to Long Term Services and Supports (LTSS), including creating and releasing standardized LTSS referral questions for all Medi-Cal managed care plans (MCPs) to administer during the Health Risk Assessment (HRA) process. DHCS convened a workgroup to develop recommendations to increase the effectiveness of the questions.

The workgroup identified four different categories of risk factors: social determinants, functional capacity, medical conditions, and behavioral health conditions. These risk factors address the spectrum of challenges a beneficiary may face, reflecting a whole person approach to understanding the need for LTSS. The workgroup developed standardized LTSS referral questions to address the most directly connected risk factors. Each of the questions seeks to identify whether a beneficiary is experiencing risk factors that make them a candidate for LTSS services that will help keep them in their home and community. The questions are organized in the following two tiers and MCPs must take a holistic view of questions in both tiers to identify beneficiaries in need of follow-up assessments:

• Tier 1 contains questions directly related to LTSS eligibility criteria and should trigger a follow-up assessment to determine if the beneficiary is eligible for LTSS services.
• Tier 2 contains questions that identify contributory risk factors, which would put a beneficiary at higher risk for needing LTSS services when combined with risk factors identified in Tier 1.
The headings in italics are not part of the questions but provide the intent of the questions.

Long-Term Services and Supports Referral Questions *Reference: DHCS Population Health Management Policy Guide*
Tier 1 LTSS Questions
Activities of Daily Living Functional Limitations / Instrumental Activities of Daily Living Limitations / Functional Supports (Functional Capacity Risk Factor)
Question 1: Do you need help with any of these actions? (Yes/No to each individual action) a) Taking a bath or shower b) Going up stairs c) Eating d) Getting Dressed e) Brushing teeth, brushing hair, shaving f) Making meals or cooking g) Getting out of a bed or a chair h) Shopping and getting food i) Using the toilet j) Walking k) Washing dishes or clothes l) Writing checks or keeping track of money m) Getting a ride to the doctor or to see your friends n) Doing house or yard work o) Going out to visit family or friends p) Using the phone q) Keeping track of appointments If yes, are you getting all the help you need with these actions?
Housing Environment / Functional Supports (Social Determinants Risk Factor)
Question 2: Can you live safely and move easily around in your home? (Yes/No) If no, does the place where you live have: (Yes/No to each individual item) a) Good lighting b) Good heating c) Good cooling d) Rails for any stairs or ramps e) Hot water f) Indoor toilet g) A door to the outside that locks h) Stairs to get into your home or stairs inside your home i) Elevator j) Space to use a wheelchair k) Clear ways to exit your home

Long-Term Services and Supports Referral Questions *Reference: DHCS Population Health Management Policy Guide*
Low Health Literacy (Social Determinants Risk Factor)
Question 3: "I would like to ask you about how you think you are managing your health conditions" a) Do you need help taking your medicines? (Yes/No) b) Do you need help filling out health forms? (Yes/No) c) Do you need help answering questions during a doctor's visit? (Yes/No)
Caregiver Stress (Social Determinants Risk Factor)
Question 4: Do you have family Members or others willing and able to help you when you need it? (Yes/No) **Question 5:** Do you ever think your caregiver has a hard time giving you all the help you need? (Yes/No)
Abuse and Neglect (Social Determinants Risk Factor)
Question 6a: Are you afraid of anyone or is anyone hurting you? (Yes/No) **Question 6b:** Is anyone using your money without your ok? (Yes/No)
Cognitive Impairment (Functional Capacity, Medical Conditions, Behavioral Health Condition Risk Factor)
Question 7: Have you had any changes in thinking, remembering, or making decisions? (Yes/No)
Tier 2 LTSS Questions:
Fall Risk (Functional Capacity Risk Factor)
Question 8a: Have you fallen in the last month? (yes/No) **Question 8b:** Are you afraid of falling? (Yes/No)
Financial Insecurity or Poverty (Social Determinants Risk Factor)
Question 9: Do you sometimes run out of money to pay for food, rent, bills, and medicine? (Yes/No)
Isolation (Social Determinants Risk Factor)
Question 10: Over the past month (30 days), how many days have you felt lonely? (Check one) None – I never feel lonely Less than 5 days More than half the days (more than 15) Most days – I always feel lonely

Appendix H – ECM Providers

ECM Contracted Providers	ECM Sites
HCSA – Alameda County Behavioral Health	ACBH
Alameda Health Systems (AHS)	AHS Eastmont
AHS Highland	AHS Highland
AHS Hayward	AHS Hayward
Bay Area Community Services (BACS)	BACS
California Cardiovascular Consultants	California Cardiovascular Consultants
California Children's Services (CCS)	CCS
CHCN	Asian Health Services
	BACH - Liberty
	BACH - Mowry
CHCN Axis Community Center	La Clinica – San Antonio
CHCN La Clinica De La Raza	La Clinica - Transit Village
CHCN LifeLong Medical Care	LifeLong – Downtown Oakland
	Lifelong – East Oakland
	Lifelong – Howard Daniel
	Lifelong – Trust Center
	Lifelong – West Berkeley
CHCN Native America Health Center	Native America Health Services
CHCN Tiburcio Vasquez Health Center	Tiburcio Vasquez Health Center
CHCN West Oakland Health Council	West Oakland Health Council
East Bay Innovations (EBI)	EBI
Full Circle	A Better Way
	Alameda Family Services
	Alternative Family Services
	East Bay Agency for Children
	Fred Finch Youth and Family Services
	Lincoln Family Services
	Stars. Inc
	West Coast Children's Clinic
Institute on Aging (IOA)	IOA
La Familia	La Familia
MedZed	MedZed
Roots Community Health Center	Roots Community Health Center
Seneca Family Services	Seneca Family Services
Titanium Health Care	Titanium Health Care

2024 Case Management Work Plan

Performance Measures	2024 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
Program Scope and Structure					
Utilization Management Committee (UMC) schedule	UMC meets at least quarterly; 2025 UMC schedule/agenda prepared and distributed by November 2024	UMC Meeting Minutes	Sr. Director, HCS	meet at least Quarterly; 2025 UMC schedule completed by November 2024	N/A - operational
Review of Policies & Procedure	100% of P&Ps reviewed within annual timeframe, and as needed	P&Ps	Sr. Director, Health Care Services	As needed, and at least Annually	UMC - annually
2023 CM Program Evaluation	Complete 2023 CM Program Evaluation by Q1 2024	2023 CM Program Evaluation	Sr. Director, Health Care Services	Annually, by Q1 2024	UMC - annually
2024 CM Program Description	Complete 2024 CM Program Description by Q1 2024	2024 CM Program Description	Sr. Director, Health Care Services	Annually, by Q1 2024	UMC - annually
2024 CM Work Plan	Complete 2024 CM Work Plan by Q1 2024	2024 CM Workplan	Sr. Director, Health Care Services	Annually, by Q1 2024	UMC - annually
CM Program Effectiveness					
CM Measures					

Performance Measures	2024 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
Health Risk Assessment for SPDs (timely outreach & completion rate for newly enrolled and annual reviews)	≥ 90% timely outreach; ≥ 30% completion rate for newly enrolled; ≥ 30% completion rate for annual reviews	HRA Dashboard Report	Manager, CM	Quarterly	UMC - quarterly
HIF/MET (timely completion rate)	≥ 90% timely completion rate	HIF/MET Dashboard	Manager, CM	Quarterly	UMC - quarterly
Quality Audit Scores	≥ 90% audit score (CM, ECM, CS)	Internal File Review Audits (CM, ECM, CS)	Managers (CM, ECM, CS)	Monthly	UMC - quarterly
Percentage of Eligible Members enrolled in CCM	establish baseline	PHM KPI report	Manager, CM	Quarterly	UMC - quarterly
Percentage of Transitions for high-risk members that had at least 1 interaction with assigned CM within 7 days post-discharge	establish baseline	PHM KPI report	Manager, CM	Quarterly	UMC - quarterly
Percentage of members enrolled in ECM	establish baseline	PHM KPI report or IPP report	Manager, ECM	Quarterly	UMC - quarterly
Percentage of members who had at least one primary care visit within 12-month period	establish baseline	PHM KPI report	Quality Improvement / Manager, CM	Quarterly	UMC - quarterly
All-cause readmission rates (for members in CCM)	establish baseline	Analytics Report	Manager, CM	Quarterly	UMC - quarterly
Emergency Room Utilization (for members in CCM)	establish baseline	Analytics Report	Manager, CM	Quarterly	UMC - quarterly
BH - increase case closures with reason "complete"	5% increase in completed BH CM cases	BH Case Closure Report	Manager, BH CM	Quarterly	UMC - quarterly
ECM Oversight (includes Grandfathered ECM members, network capacity expansion)	100% grandfathered ECM members re-evaluated for eligibility, expand ECM capacity	ECM Project Report	Manager, ECM	Quarterly	UMC - quarterly
CS Oversight (includes expansion of CS services and network capacity expansion)	expand CS services and CS capacity	CS Project Report	Manager, CS	Quarterly	UMC - quarterly
Member Experience with CM					
Member Satisfaction Survey	≥ 90% overall satisfaction with the CM program	Member Survey Outcomes	Manager, CM	Annually	UMC - annually
Member compliants related to CCM program activities (NCQA)	< 3% will file G&A related to CM process	G&A Reports	Manager, CM / Director, G&A	Quarterly	UMC - quarterly
Community Advisory Committee Insights	Present Quarterly report of Community Advisory Committee Insights	Community Advisory Committee Report	Director, Population Health	Quarterly	UMC - quarterly
Evaluation of Delegated Case Management					
Delegation Oversight - Audit & Corrective Action monitoring	100% timely review, analysis, and attestation completion for Delegate audits & corrective action plans	Delegation Oversight Auditing Templates	Delegation Oversight / CM Director	Quarterly	UMC - quarterly
Delegation Oversight - Standard CM monitoring	100% timely review, analysis, and attestation completion for Delegate CM reports (monthly, quarterly, annually)	Delegation Oversight Reporting Templates	Delegation Oversight / CM Director	Monthly, Quarterly, Annually (depending on report)	N/A - operational
Regulatory, Compliance, Accredidation Findings					
DHCS - Corrective Action Plans for CM Activities	100% timely participation and response to DHCS CM Findings and/or Corrective Action Plans and associated activities	DHCS Findings / CAP Report	Sr. Director, Health Care Services	as needed	UMC - as needed

Performance Measures	2024 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
DMHC - Corrective Action Plans for CM Activities	100% timely participation and response to DMHC CM Findings and/or Corrective Action Plans and associated activities	DMHC Findings / CAP Report	Sr. Director, Health Care Services	as needed	UMC - as needed
NCQA - Corrective Action Plans for CM Activities	100% timely participation and response to NCQA CM Findings and/or Corrective Action Plans and associated activities	NCQA Findings / CAP Report	Sr. Director, Health Care Services	as needed	UMC - as needed
CM Processes					
TCM - Identification and Referrals made to TCM LGAs	Benchmark -≤ 1%	Internal Tracking Log	Manager, CM	Quarterly	N/A - operational
Out of Plan Services - Referrals made for Developmental Disabled/Regional Center	Benchmark -≤ 1%	Regional Center Tracking Log	Manager, CM	Quarterly	N/A - operational
Out of Plan Services - Referrals made for Early Intervention Services/Regional Center	Benchmark -≤ 1%	Regional Center Tracking Log	Manager, CM	Quarterly	N/A - operational
CM Activity Reporting (AAH CM only) - engagement and UTC rate	≥ 60% engagement rate; ≤ 30% UTC rate	Case and Disease Management Dashboard	Manager, CM	Quarterly	N/A - operational
CCM Activity Report - referrals & outreach rate, UTC rate, aged-cases rate (CCM case open >90days); ICT completion rate	≥ 80% outreach rate to CCM-eligible members; ≤ 40% UTC rate; ≤1% of CCM cases open >90 days; ≥ 90% ICT completion (for CCM members open for >90 days)	Case and Disease Management Dashboard, Daily Aging Report and Complex Case Log	Manager, CM	Quarterly	N/A - operational
CCM Assessment Timeliness (per NCQA)	100% of CCM cases with initial assessment started within 30 calendar days of identifying a member for CCM; 100% of CCM cases with assessment completed within 60 days of identifying a member for CCM	CM Aging Report	Manager, CM	Quarterly	N/A - operational
Collaborate with Analytics to enhance predictive modeling to improve identification of appropriate members for CCM	100% active participation in Population Health Management Workgroups and Risk Stratification discussions	Population Health Report	Director, SDOH	Semi-annual	N/A - operational
Major Organ Tranplant Reporting	100% timely review and submission of DHCS MOT Report	DHCS Quarterly MOT Reports	Manager, CM	Quarterly	N/A - operational
MCP Transition Post-Transitional Monitoring (PTM) Reporting	100% timely review and submission of DHCS MCP Transition PTM Reports	DHCS Quarterly MCP Transition Post-Transition Reports	Sr. Director, HCS	per DHCS schedule	N/A - operational
Continuity of Care (MER & OON requests) Reporting	100% timely review, analysis, and submission of COC and OON sections in DHCS Quarterly Monitoring Report	DHCS Quarterly Monitoring Reports	Sr. Director, HCS	Quarterly	N/A - operational
Accuracy of Published CM content	100% timely completion of platform audits	Member and Provider Portals (public and secure site), Platform Audit Results	Sr. Director, HCS	As needed, and at least Annually	N/A - operational
Accuracy of Member and Provider Communications related to CM, ECM, and CS Process	100% participation in creation or updates to member and/or provider-facing content for CM activities (including NOAs, EOC, Provider Manual, Website, Portals)	Member- and Provider-facing communications	Sr. Director, HCS	As needed, and at least Annually	N/A - operational
Administrative					

Performance Measures	2024 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
Annual Review of CM Staffing	Timely and accurate submission of staffing review, including applicable justifications	Staffing Worksheets	Sr. Director, HCS	Annually, by Q1 2024	N/A - operational
Clinical Information System Enhancements	100% participation in TruCare Steering Committee and System Optimization Efforts	Change Requests, Project Plans	Sr. Director, HCS	n/a	N/A - operational

Utilization Management Program Evaluation

2023

Utilization Management
2023 Program Evaluation

Signature Page

_____	_____
Date	Allison Lam, RN Senior Director, Health Care Services
_____	_____
Date	Rosalia Mendoza, M.D. Medical Director, Utilization Management
_____	_____
Date	Sanjay Bhatt, M.D., MS, MMM Senior Medical Director Vice Chair, Quality Improvement Health Equity Committee
_____	_____
Date	Donna Carey, M.D. – Interim Chief Medical Officer, Medical Management Chair, Quality Improvement Health Equity Committee
_____	_____
Date	Matthew Woodruff Chief Executive Officer
_____	_____
Date	Rebecca Gebhart Board Chair

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2023
Utilization Management Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors, senior management and the Quality Improvement Health Equity Committee (QIHEC), the Health Services 2023 Utilization Management Programs were successfully implemented. This report serves as the annual evaluation of the effectiveness of the Utilization Management (UM) program activities, which include appropriate medical necessity evaluation and evidence-based clinical decision making.

The processes and data reported covers activities conducted from January 1, 2023 through December 31, 2023.

Membership and Provider Network

The Alliance products include:

- Medi-Cal Managed Care: serving beneficiaries eligible through one of several Medi-Cal programs, including Temporary Assistance for Needy Families (TANF), Seniors and Persons with Disabilities (SPD), Medi-Cal Expansion and Dually Eligible Medi-Cal members who do not participate in California's Coordinated Care Initiative (CCI). For dually eligible beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.
- Alliance Group Care (commercial product): an employer-sponsored plan providing low-cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Covered services are provided to beneficiaries via Alliance's direct network or one of Alliance's contracted provider networks. In 2023, The Alliance's contracted provider networks included Alameda Health System (AHS), Children First Medical Group (CFMG), Community Health Center Network (CHCN), and Kaiser Permanente. The figures below represent the Alliance's membership trends in 2023.

Figure 1a. 2023 Membership - by Category of Aid

Category of Aid Trend							
Category of Aid	Dec 2023	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	52,174	15%	10,629	9,872	790	22,025	8,858
Child	101,634	29%	8,380	9,382	32,231	33,788	17,853
SPD	30,848	9%	10,020	4,407	1,148	13,052	2,221
ACA OE	119,669	35%	19,524	36,581	1,231	47,077	15,256
Duals	40,976	12%	24,440	2,463	1	9,784	4,288
LTC	135	0%	134	1	-	-	-
LTC-Dual	951	0%	950	-	-	-	1
Medi-Cal	346,387		74,077	62,706	35,401	125,726	48,477
Group Care	5,622		2,164	842	-	2,616	-
Total	**352,009**	**100%**	**76,241**	**63,548**	**35,401**	**128,342**	**48,477**
Medi-Cal %	98.4%		97.2%	98.7%	100.0%	98.0%	100.0%
Group Care %	1.6%		2.8%	1.3%	0.0%	2.0%	0.0%
	Network Distribution		*21.7%*	*18.1%*	*10.1%*	*36.5%*	*13.8%*
			% Direct:	**40%**		**% Delegated:**	**60%**

Figure 1b. 2023 Membership - by Age Group

Age Category Trend			
	Members		
Age Category	Jan 2022	Jan 2023	Dec 2023
Under 19	101,615	104,152	104,062
19 - 44	109,198	120,648	121,694
45 - 64	61,651	69,127	72,612
65+	30,709	35,887	53,641
Total	**303,173**	**329,814**	**352,009**

Figure 1c. 2023 Membership – by Provider Network

Network Trend						
	Members			% of Total (ie.Distribution)		
Network	Jan 2022	Jan 2023	Dec 2023	Jan 2022	Jan 2023	Dec 2023
Independent (Direct)	57,046	53,870	76,241	18.8%	16.3%	21.7%
AHS (Direct)	58,927	66,052	63,548	19.4%	20.0%	18.1%
CFMG	32,689	33,741	35,401	10.8%	10.2%	10.1%
CHCN	109,878	126,433	128,342	36.2%	38.3%	36.5%
Kaiser	44,633	49,718	48,477	14.7%	15.1%	13.8%
Total	**303,173**	**329,814**	**352,009**	**100.0%**	**100.0%**	**100.0%**

Figure 1d. 2023 Membership – by Provider Network (Delegated vs. Direct)

Delegation vs Direct Trend						
	Members			% of Total (ie.Distribution)		
Members	Jan 2022	Jan 2023	Dec 2023	Jan 2022	Jan 2023	Dec 2023
Delegated	187,200	209,892	212,220	61.7%	63.6%	60.3%
Direct	115,973	119,922	139,789	38.3%	36.4%	39.7%
Total	**303,173**	**329,814**	**352,009**	**100.0%**	**100.0%**	**100.0%**

In 2023, The Alliance membership increased by 22,195 members by year-end. The largest membership increase was seen in the population aged 65 and older. The Alliance direct network experienced the largest membership gains, with an increase of 19,867 members by the end of 2023. This trend aligns with increases in Medi-Cal Enrollment overall, including dual-eligible

members and Long-Term Care members receiving custodial level of care in Skilled Nursing Facilities in January 2023.

Utilization Management Program Scope and Structure

UM Program Scope

The UM Program serves Alliance members by ensuring that appropriate processes are used to review and approve the provision of medically necessary covered services. The UM Program also ensures timely and appropriate access to care, including the provision of continuity of care and coordination of medical and behavioral services to improve member health outcomes. Additionally, the UM Program encompasses delegated utilization management functions, whereby the Alliance provides oversight and monitoring of delegated entities for compliance with all utilization management activities.

The Alliance offers a comprehensive list of covered services, including but not limited to:

- Ambulatory Care
- Behavioral health (mental health and substance use disorder services)
- Care Coordination, including arrangements for linked and carved-out services, programs, and agencies
- Emergency services
- Hospital care
- Home Health care
- Hospice
- Palliative Care
- Managed Long Term Services and Support (MLTSS)
  - Community-based Adult Services
  - Long-term Care in skilled nursing facilities
- Pharmacy
- Rehabilitation services
- Skilled nursing services - Acute
- Transplant Services
- Transportation
- Pharmacy

A full list of covered services is available to members in the Evidence of Coverage, published online and available in print, upon request. Covered services are provided through a contracted network of providers that include hospitals, nursing facilities, ancillary providers, and contracted vendors. The UM program, in coordination with the Contracting and Quality teams, monitors the adequacy of the Alliance's contracted network to ensure members have access to care within time and distance standards. As needed, contracting arrangements are made with providers outside of the network if Alliance's contracted network is not available to service the need.

UM Program activities promote utilization of covered services at the right time and at the most appropriate site and level of care. Activities include the following, but are not limited to:

- Admission and concurrent review
- Discharge planning: pre-admission, concurrent, and post-discharge follow-up with member/provider
- Coordination with Claims, including review of Provider Disputes
- Coordination with Compliance, to support monitoring and auditing activities for internal and delegated entities

- Coordination with Grievance and Appeals, including review of overturned decisions
- Continuity and coordination of care for members when a provider is terminated from the network
- Continuity and coordination of care for members newly eligible with The Alliance, receiving active care and treatment from a non-Alliance provider
- County Behavioral Health Care Services (ACBHCS)
- Discharge planning: pre-admission, concurrent, and post-discharge follow-up with member/provider
- Evaluate and refer members needing care coordination/case management (including children/youth under Medi-Cal for Kids & Teens, California Children's Services, Enhanced Care Management, Complex Case Management, Community Supports, Dental Health, Behavioral Health, or Long-Term Care)
- Integration of medical and behavioral health, including collaboration with Alameda County Behavioral Health Services
- Peer-to-peer discussions to support providers regarding clinical decision-making
- Prior authorization of services (including pre-admission education)
- Quality improvement projects, based on analysis of utilization trends
- Retrospective review

UM Program Structure

The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of the Alliance health care delivery network. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect entities and multiple disciplines within the organization. The UM Program is evaluated on an on-going basis for efficacy and appropriateness of content by The Alliance staff and oversight committees.

Responsibility, Authority and Accountability / Governing Committee

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 19-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of the Alliance programs and is responsible for approving the Quality Improvement and Utilization Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to the Alliance Chief Medical Officer (CMO) and the Quality Improvement Health Equity Committee (QIHEC). The CMO and the QIHEC provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management Program. Utilization Management activities are the responsibility of the Alliance Health Care Services staff under the guidance of the Medical Director for Utilization Management and the Senior Director of Health Care Services, in collaboration with the Alliance CMO.

Committee Structure

The Board of Governors appoints and oversees the QIHEC, the Peer Review and Credentialing Committees, and the Pharmacy and Therapeutics Committee (P&TC) which,

in turn, provide the authority, direction, guidance, and resources to enable the Alliance staff to carry out the Quality Improvement, Utilization Management and Case Management Programs. Committee membership consists of provider representatives from the Alliance contracted networks and the community, including those who provide health care services to populations served by The Alliance (for example: Seniors and Persons with Disabilities, Dual-eligible members, and members with Chronic conditions).

The P&T Committee is responsible for oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization, and developing provider education programs on drug appropriateness. P&T Committee meeting minutes and pharmacy updates are shared with the BOG. The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or designee
- Alliance Director of Pharmacy Services (Co-Chair)
- Practicing physician(s) representing Internal Medicine
- Practicing physician(s) representing Family Practice
- Practicing physician(s) representing Pediatrics
- Practicing physician(s) representing common medical specialties
- Practicing community pharmacists contracted with Alliance (not to exceed 1/3 of the voting membership of the committee or three pharmacists, whichever is greater).

The QIHEC provides oversight, direction, makes recommendations, and has final approval of the UM Program. Committee meeting minutes are maintained to summarize committee activities and decisions with appropriate signatories and dates.

QIHEC charters a sub-committee called the Utilization Management Committee (UMC), which meets at least once every 2 months. In 2023, the UMC had 10 meetings. UMC serves as a forum for The Alliance to evaluate current UM activities, processes, and metrics. The UMC also evaluates the impact of UM programs on key stakeholders in other departments, including Compliance, Member Services, Quality, and Grievance and Appeals. Input from UMC members is included in continuous UM program monitoring, evaluation, and design of interventions.

The 2022 UM Program Evaluation and 2023 UM Program Description and Workplan were presented for review and approval at the March 31, 2023 UMC meeting, and subsequently presented at the March 31, 2023 QIHEC meeting for final Board of Governors approval (documented in meetings minutes). The committee was chaired by the Chief Medical Officer with support of the Senior Director of Quality Management, external physicians, and key organizational staff.

Integration of Medical and Behavioral Health

The Alliance’s utilization management activities for behavioral healthcare have been performed in partnership with Alameda County Behavioral Health Care Services

(ACBHCS). Beacon Health Options (Beacon) was delegated for behavioral health utilization management through March 2023. Effective April 1, 2023, Behavioral health was insourced by The Alliance. This has allowed for further integration of behavioral and medical health within The Alliance. The Alliance provides access to mental health services for the Medi-Cal and Commercial membership in several ways:

- Basic mental health care needs are provided by Primary Care Providers.
- Medi-Cal members with "mild to moderate" impairments in mental, emotional, or behavioral functioning were referred to the contracted behavioral health delegate, Beacon Health Options (Beacon) through 3/31/23. Effective 4/1/23, the Medi-Cal members were referred to The Alliance's network for behavioral health care.
- Medi-Cal members diagnosed with a severe persistent mental health disorder and Substance Use Disorders are carved-out and managed by Alameda County Behavioral Health Care Services Department (ACBHCS).
- Commercial members accessed mental health/ SUD benefits through the contracted BH delegate, Beacon Health Options (Beacon) through March 31, 2023. Effective April 1, 2023, commercial members were referred to The Alliance's network for behavioral health care.

Increasing access to care and increasing utilization was a primary driver of the Alliance's decision to insource the management of behavioral health services. The Behavioral Health Program includes a care coordination program staffed by licensed clinicians and behavioral health navigators.

- The mental health team consists of 4 licensed clinicians and the Applied Behavior Analysis (ABA) team consists of 3 licensed clinicians.
- The clinical teams are supported by 5 behavioral health navigators.
- A behavioral health manager was hired in Q4 2023 to further support the growth and visibility of the behavioral health program at the Alliance.
- The Alliance behavioral health program operates under the leadership of a Senior Director of Behavioral Health and Medical Director.

Involvement of senior-level physician and behavioral healthcare practitioners

The Board of Governors delegates oversight of Quality and Utilization Management functions to The Alliance Chief Medical Officer (CMO). The CMO provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management Program. The CMO delegates senior level physician involvement in appropriate committees to provide clinical expertise and guidance to program development. Dr. Peter Currie, Ph.D., Senior Director, Behavioral Health Services, provides leadership to behavioral health care at The Alliance, further supporting the integration of behavioral health care with medical care. Together, the senior-level physician and behavioral health practitioners are involved in the UM program by:

- Establishing UM policies (for medical and behavioral healthcare services)

- Reviewing UM cases for medical necessity determinations (for medical and behavioral healthcare services)
- Participating in various clinical and stakeholder committees (including UMC and QIHEC)
- Evaluating the overall effectiveness of the UM Program (for medical and behavioral healthcare services)

Utilization Management Resources

The Alliance UM Department is staffed with physicians, nurses, pharmacists, and non-clinical support staff including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2023 UM Program Description.

In 2023, the UM leadership structure was designed to meet the needs of the program and the staff, including the creation of distinct Utilization Management and Long-Term Services and Supports teams:

- 1.0 FTE Medical Director of Utilization Management
- 1.0 FTE Senior Director, Health Care Services
- 1.0 FTE Senior Director, Pharmacy
- 1.0 FTE Director, Utilization Management
- 1.0 FTE Senior Manager, Outpatient Utilization Management
- 1.0 FTE Non-Clinical Supervisor, Outpatient Utilization Management
- 1.0 FTE Clinical Supervisor, Outpatient Utilization Management
- 1.0 FTE Manager, Inpatient Utilization Management
- 1.0 FTE Clinical Supervisor, Utilization Management
- 1.0 FTE Director, Long Term Services and Supports
- 1.0 FTE Manager, Long-Term Care
- 1.0 FTE Lead Long-Term Care Nurse Specialist
- 1.0 FTE Pharmacy Supervisor
- 1.0 FTE Lead Clinical Pharmacist

With insourcing Behavioral Health in April 2023, additional leadership was added to support Behavioral Health utilization management:

- 1.0 FTE Senior Director, Behavioral Health Services
- 1.0 FTE Manager, Behavioral Health

The adequacy of utilization management resources is continuously evaluated to ensure appropriate staffing levels to manage programmatic changes and workload volumes, accounting for variations in members' health status, access and complexities of coordination of care needs. For example, in 2024, the Long-Term Services and Supports Director will assume oversight of the Community Supports team – this organizational shift will allow for continued expansion of Community Supports services, optimize utilization of Community Supports, and integrate supports for the highest risk members.

Delegated Utilization Management

The Alliance delegates UM activities to provider groups, networks and healthcare organizations that meet delegation standards. The contractual agreements between the Alliance and delegated groups specify the responsibilities of both parties, including:

- the functions or activities that are delegated;
- the frequency of reporting on those functions and responsibilities;
- how performance is evaluated; and
- corrective action plan expectations, if applicable.

The Alliance conducts a pre-contractual evaluation of delegated functions to ensure a delegates' ability to meet regulatory and accreditation standards and requirements. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with the UM Department, and other departments, to conduct the annual delegation oversight audits. When delegation occurs, the Alliance requires the delegated entity to comply with regulatory, contractual and NCQA standards, as well as submit regular utilization reports (i.e., quarterly, semi-annual, and annual) to assess the delegate's performance on services provided to Alliance members. The Alliance has adopted the Healthcare Industry Collaborative Efforts (HICE) UM Reporting Templates as an acceptable format of reporting results of the annual evaluation, and audit results are reviewed by the Compliance and Delegation Oversight Committee.

In 2023, Alliance delegated UM activities to the following entities:

Figure 2. Delegated Entities (UM activities only)

Delegate Name	**Provider Type**	**NCQA Accreditation or Certification**	**Delegated Activity-** Utilization Management	**Delegated Activity-** Grievance and Appeals
Kaiser	Health Maintenance Organization (HMO)	Yes	Yes	Yes
CHCN	Managed Care Organization (MCO)	No	Yes	No
CFMG	Managed Care Organization (MCO)	No	Yes	No
Beacon / College Health IPA* (through 3/31/23)	Managed Behavioral Healthcare Organization (MBHO)	Yes	Yes	No

**In April 2023, Mental Health/Behavioral Health services were insourced into The Alliance and Beacon/College Health IPA was a delegate only through March 31, 2023. Efforts in Q1 2023 were focused on transitioning the impacted members from Beacon to The Alliance.*

Utilization Management Information Systems

The Alliance maintains a core clinical information system, TruCare®, that is utilized by all Utilization Management, Long-Term Care, Case Management and Pharmacy teams. TruCare® is a member-centric application that aligns necessary clinical and administrative information related to members' care into a single chart record and allows seamless multidisciplinary collaboration within a case. In 2023, clinical staff, in collaboration with the Information Technology (IT) team, continued to identify opportunities to enhance the functionality of the system and optimize the systems' performance. Thorough vetting processes are established between clinical and IT teams to ensure any enhancements and upgrades to the platform are amenable to all system users. System optimization and upgrades are ongoing as standard practices, including staff training to ensure competence in using the platform and alignment on best practice workflows.

Clinical Decision Support Tools

Utilization Management Clinical Decision-Making

Clinical decision-making tools and screening criteria are designed to assist UM staff, and UM-delegated entities, in assessing the appropriateness of care for medical and behavioral health services. Application of the criteria is based on the specific and individualized health care needs of the member (including social determinant of health needs), medical risk factors, and in accordance with the member's plan benefits and capacity of the health care delivery systems. A full description of the criteria used for UM clinical decision-making is available in the 2023 UM Program Description. All decision-making criteria are available to members and providers upon request. In 2023, there were 5 requests from members, and no requests from providers for copies of the decision-making clinical criteria.

In 2023, the Alliance used Milliman's CareWebQI® interactive software tools, which integrate the MCG® criteria into the core clinical information system, TruCare®. The 27th Edition MCG® criteria was released in February 2023, staff were trained in August 2023, and TruCare® was updated in September 2023 to deploy the 27th Edition MCG® criteria for completing reviews. Prior to September 2023, reviews were completed using the 26th Edition MCG® criteria.

The Alliance also used evidence-based clinical decision support found in UpToDate®, a collection of well-referenced topics, guidelines, and updated research. UpToDate® makes updates three times a year, and new information goes through a multilevel peer-review process[1].

Upon review of member needs and the requirement to use alternative criteria as appropriate, there were no changes in 2023 to the clinical decision-making tools or hierarchy of applying the tools. Clinical criteria are applied in the following hierarchy:

1. Regulatory and contractual guidelines/regulations, including:
    - Department of Health Care Services (DHCS) Medi-Cal Provider Manuals and All-Plan Letters

[1] Fam Pract Manag. 2003;10(7):49-52

- Department of Managed Health Care (DMHC) All-Plan Letters
- WPATH Standards of Care (SOC) for Gender-Affirming Care
- LOCUS/CALOCUS, CASII/ECSII/ASAM for Mental Health and Substance Use Disorders
- Code of Federal Regulations
- California Health and Safety Code.
- California Code of Regulations Title 22.
- California Code of Regulations Title 28.
- California Welfare and Institution Code

2. Evidence based guidelines, primarily MCG®, US Preventive Services Task Force, National Comprehensive Cancer Network, and if needed, UpToDate®
3. Alliance guidelines, as approved through governing committees (including QIHEC and P&T)
4. National medical association guidelines (including American Commission of Obstetrics and Gynecology (ACOG), American Association of Pediatrics (AAP), American Diabetes Association (ADA)
5. Independent Medical Review for specialty consultation
6. Medical necessity/medical judgment

Consistency in Application of Criteria

The Alliance evaluates inter-rater reliability (IRR) to monitor consistency with which physicians, non-physicians, pharmacists, and behavioral health practitioners apply clinical decision-making criteria. A full description of the IRR testing methodology is referenced in Alliance policy and procedure QI-133. Testers complete 5 modules and up to 3 attempts per module, if needed to achieve a score of 90% or higher to pass the annual IRR evaluation. Remediation activities, based on IRR outcomes, are noted in the below figure. We continue to evaluate the effectiveness of the IRR evaluation and remediation processes, and will adjust remediation activities, as needed, to ensure all clinical reviewers are adequately trained to apply the clinical criteria.

Figure 3. 2023 Inter-Rater Reliability Scoring and Remediation Activities

IRR Score	Action/Remediation Activities
High – 90%-100%	No action required
Medium – 71%-89%	Additional training with Supervisor / Manager / Director / Clinical Designee to re-perform the IRR cases / scenarios
Low – Below 70%	Additional training provided. • If staff twice fails the IRR evaluation, a Corrective Action Plan is required with report to the Respective Department Director and CMO. • If staff three times fails to pass the IRR evaluation, the case will be escalated to Human Resources which may result in further disciplinary action.

In 2023, IRR testing was performed in Q4 2023. Results are shown in the below table:

Figure 4. 2023 IRR Scores

Clinical Reviewers	Number of Testers	2023 IRR Overall Score
Non-physician (RN) – Outpatient	9	96%
Non-physician (RN) – Inpatient	12	94%
Non-physician (RN) – Grievance & Appeals	2	98%
Non-physician (RN) – Long-Term Care	4	100%
Pharmacist	4	100%
Behavioral Health	9	100%
Physician	5	88.2%

Overall behavioral health, pharmacist, and non-physician reviewers IRR evaluations scored 90% or higher. Physician reviewers had an overall score of 88.2% - 2 physician reviewers did not meet the 90% passing rate for 1 of the 5 assigned modules, and remediation activities were completed with the Utilization Management Medical Director. Inpatient non-physician (RN) reviewers had an overall score of 94% - 2 RNs did not meet the 90% passing rate for 1 of the 5 assigned modules, and remediation activities were completed with the Utilization Management Manager.

Utilization Management Processes

Utilization Review Procedures

The Alliance follows all regulatory, contractual, and NCQA requirements to effectively administer utilization review procedures, including decision turn-around times and member and provider notification standards. For services that require prior authorization, the UM process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. Only physicians, pharmacists, or doctoral level behavioral health specialists can make determinations to deny or modify care based on medical necessity.

Services Exempt from Prior Authorization

For both Managed Medi-Cal and Group Care products, there are services exempt from prior authorization. Exemptions include, but are not limited to:

- Emergency Services
- Urgent Care
- Primary Care Visits
- Preventative Services including immunizations
- Mental Health Care and Substance Use treatment
- Women's health services – *a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/ OB-GYN and Certified Nurse Practitioners.*
- Basic *prenatal care*
- Family planning services, including counseling, pregnancy tests, medications, and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment,

and prevention
- HIV testing and counseling
- COVID-19 testing and therapies
- Second Opinions from In Network providers arranged by the assigned PCP
- Initial Mental Health Assessments
- Early and Periodic Screening, Diagnostic and Treatment
- Biomarker testing for members with advanced or metastatic cancer stage 3 or 4
- Annual Cognitive Assessment for Medi-Cal members over 65 without Medicare

Services Requiring Prior Authorization

The Alliance communicates to all contracted providers the procedures, treatments, and services that require prior authorization. Services that require prior authorization include, but are not limited to:

- Non-emergency/ elective out-of-area care
- Out-of-network care, for services not provided by contracted provider
- Inpatient Admissions if non-emergency/ elective
- Inpatient Admissions to Acute Skilled Nursing Facility or Nursing Home
- Outpatient hospital services/ surgery
- Outpatient facilities (non-hospital based), such as surgeries or sleep studies
- Outpatient diagnostic and radiology services, minimally invasive or invasive including CT Scans, MRIs, cardiac catheterization, PET
- Durable Medical Equipment, standard or customized; rental or purchased
- Infusion Services
- Medical Supplies
- Prosthetics and Orthotics
- Podiatry services
- Home Health Care, including skilled nursing, nursing aides, rehabilitation therapies, and social workers
- Transplant Services
- Tertiary/Quaternary office visits and consultations at academic centers
- Experimental or Investigational Services
- Cancer Clinical Trials
- LTSS, including Community Based Adult Services (CBAS) and LTC in SNFs
- Acupuncture, greater than 4 visits per month
- Chiropractic Services
- Second Opinions from out-of-Network providers
- Select behavioral health services

The Alliance routinely analyzes utilization patterns to determine whether it would be in members' best interests to add or remove any of the listed services from prior authorization requirements. All decisions to adjust prior authorization requirements are reviewed and approved by the appropriate committees (including UMC or P&TC, and QIHEC).

Review Types
Authorizations are processed based on the date the Alliance receives the request. Below are the types of utilization reviews:

- **Prospective (pre-service) Review** is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted prior to the delivery of a health care service or supply to a member. A prospective review decision is based on the collection of medical information available to the health care provider prior to the time the service or supply is provided.
- **Concurrent Review** is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted during a member's ongoing stay in a facility or course of outpatient treatment. The frequency of review is based on the member's medical condition with respect to applicable care guidelines.
- **Retrospective (post-service) Review** is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted after the health care service or supply is provided to a member. Retrospective requests received within 90 days from the date of service are reviewed for medical necessity. Retrospective received after 90 days from the date of service are denied for not obtaining prior authorization (with limited exceptions, including member eligibility issues, if the services were emergent/urgent, or inpatient services where the facility is unable to confirm enrollment with the Alliance).

Timeliness Standards
The Alliance processes authorizations within the following turn-around times, following the strictest regulatory standard:

Figure 5. UM Turnaround Times

Review Type	Managed Medi-Cal	Group Care
Pre-Service – Urgent	72 hours	72 hours
Pre-Service – Routine	5 business days	5 business days
Concurrent	24 hours	24 hours
Retrospective	30 calendar days	30 calendar days

For routine pre-service and retrospective decisions, notifications of the decision must be sent to members within 2 business days and to providers within 24 hours of the decision.

For urgent pre-service and concurrent decisions, notifications of the decision must be sent to members and providers within 72 hours of receiving all information needed to make a decision.

Notice of Action Requirements
For any adverse benefit determination (including denial, delay, modification, termination, suspension, reduction, or carve-out of a treatment or service), The Alliance provides

members with a written Notice of Action (NOA). The Notice of Action includes all DHCS-required templates to inform members of their rights, and the content of the notification includes all the following:

a. A statement of the action the Alliance intends to take.
b. A clear and concise explanation of the reasons for the decision.
c. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guideline.
d. The clinical reasons for the decision. The Alliance must explicitly state how the member's condition does not meet the criteria or guidelines.
e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions must be communicated to the member in writing. In addition, except for decisions rendered retrospectively, decisions must be communicated to the provider initially by telephone or facsimile, and also in writing.

Utilization Review Measures

The Alliance monitors, measures, and evaluates all aspects of the above utilization review procedures as follows:

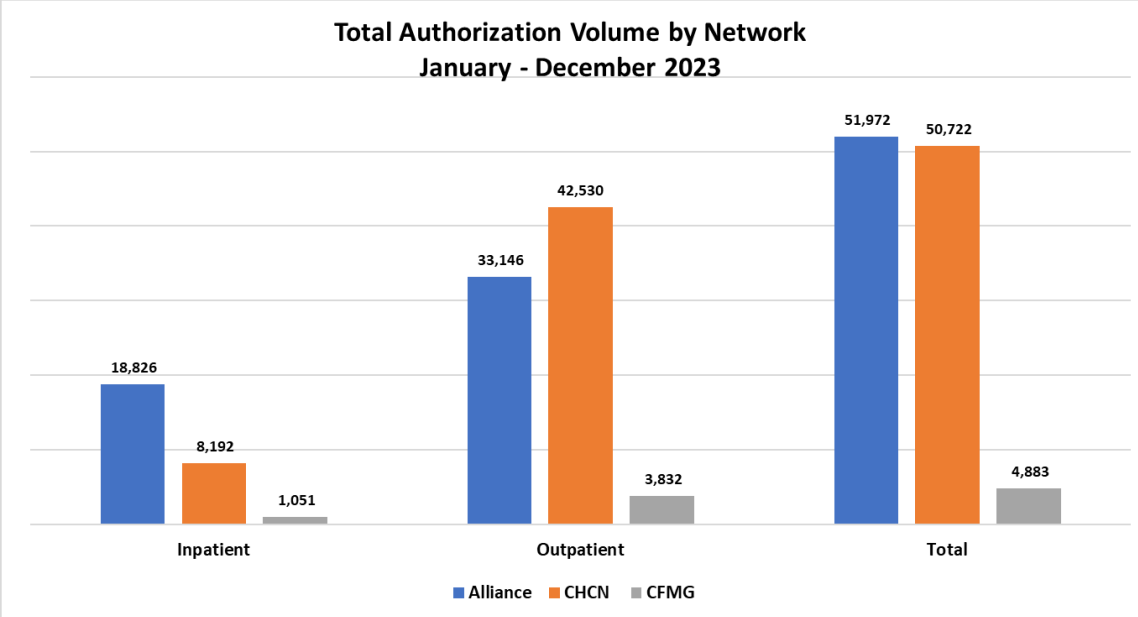
- Volume of authorization requests, reported by:
  - Total Number of requests
  - Total Number of requests approved, denied, and partially denied
- Denial Rate (the established threshold is 5% denial rate)
- Compliance with timeliness standards (the established threshold is 95% compliance)
- Compliance with NOA requirements, including appropriate content and enclosures

NOTE: The Group Care product represents 1.6% of the total Alliance membership, and 3% of the total volume of authorization activity. Therefore, the data for both product lines is aggregated for reporting. In key areas where the activities are specific to a network, the report will note the differences. Also, inpatient and outpatient data are represented for medical services only - LTSS, BH, and Pharmacy data is reported separately.

Authorization Volumes and Determinations

The below figure shows the total volume of inpatient and outpatient authorizations processed by the Alliance and its delegates in 2023. Total Authorization volume is measured by line items.

Figure 6. 2023 Total Authorization Volumes



The Alliance inpatient authorization volume accounted for 67% of all Inpatient authorizations in 2023. The primary reason for higher Alliance network volume was because CHCN and CFMG were not delegated to complete authorizations for the Long-Term Care services that were carved-in starting January 2023. The Alliance staff issued Long Term Care authorizations while members remained delegated to their assigned network. CHCN completed more Outpatient authorizations than the Alliance in 2023,

consistent with the historical delegated membership distribution and higher medical acuity.

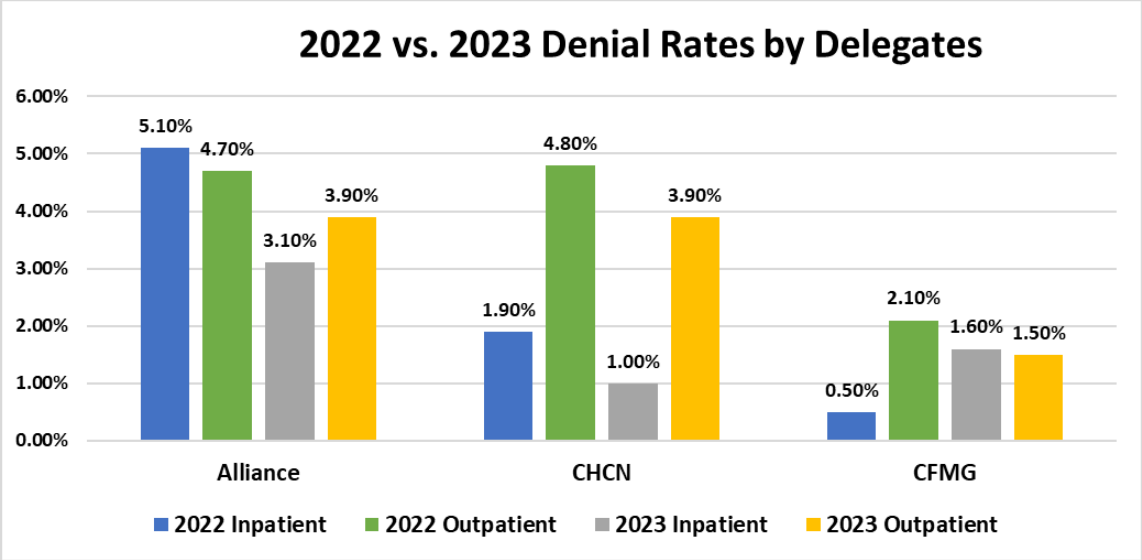
Outpatient service requests historically comprise the largest authorization volume for the health plan. Outpatient service requests experienced the largest authorization volume increases in the Alliance and CHCN networks. CFMG continues to have the lowest number of authorizations, related to the group's lower overall membership comprised of primarily children and adolescents and lower overall utilization rates in this population.

Of note, there was a significant increase in total authorization volume in 2023 (+99,578) compared to volumes reported in 2022 – this was attributable to membership growth and higher observed utilization with the new Long-Term Care membership, in particular. Additionally, enhancements to Alliance's system configuration to capture authorization volumes may have contributed to the increase – the system configuration will continue to be evaluated in 2024 to ensure accurate reporting of authorization volumes.

Denial Rates

Denial rates are evaluated to ensure appropriate service utilization, consistent evidence-based clinical decision-making, and to identify potential outlier trends that warrant further root cause analysis.

Figure 7. Denial Rates by Delegates from January – December 2023



Across all networks in 2023, the inpatient authorization denial rate was 1.9% and the outpatient denial rate was 3.1%. Combined all denial rates, across all networks was 2.5% in 2023, representing a -0.7% year-over-year decrease compared to the prior year.

By network, The Alliance saw a decreased inpatient denial rate (3.1%, -2.0) and an increased outpatient denial rate (3.9%, +0.8). Rises in outpatient denial rates are attributable to the introduction of medical necessity reviews for MRI and CT scans in 2023, the launch of the Tertiary Quaternary policy for academic care, and the continued

practice of redirected services to in-network care that meet timely access when unrelated to continuity of care.

The CHCN delegated network saw an inpatient denial rate decrease (1.0%, -0.9) of unclear reason, and an outpatient denial rate decrease (3.9%, -1.1). Annual delegate audit and DHCS Audit case reviews with the UM Delegate team and provider education were attributable to these reduced denial rates.

The CFMG delegated network saw an inpatient denial increase (1.6%, +1.1) due to ineligible members, and outpatient denials decreased (1.5%, -0.6%) in 2023. The overall decrease in outpatient denial rates across all networks, are attributable to education provided to UM reviewers on appropriate application of the Medi-Cal Provider Manual, evidenced based clinical guidelines, and UM policies, and improved standardization between reviewers, and with UM Delegate reviewers. Goals for 2024 are to integrate the CHCN Authorization denial and approvals reasons into The Alliance analytical reports to better monitor decision making and network adequacy.

Authorization Turnaround Time

The Alliance monitors authorization turnaround time (TAT) to ensure members receive appropriate and timely access to care. The below figures show TAT compliance throughout 2023.

Figure 8a. 2023 Inpatient Authorization TAT

2023 Inpatient Authorization TAT						
	Q1	**Q2**	**Q3**	**Q4**	**MY2023**	***Goal***
Medi-Cal	96%	96%	95%	95%	**97%**	***95%***
Group Care	99%	96%	96%	96%	**97%**	***95%***
Overall	98%	96%	95%	96%	**96%**	***95%***

Figure 8b. 2023 Outpatient Authorization TAT

2023 Outpatient Authorization TAT						
	Q1	**Q2**	**Q3**	**Q4**	**MY2023**	***Goal***
Medi-Cal	98%	98%	98%	99%	**98%**	***95%***
Group Care	100%	99%	100%	99%	**100%**	***95%***
Overall	99%	99%	99%	99%	**99%**	***95%***

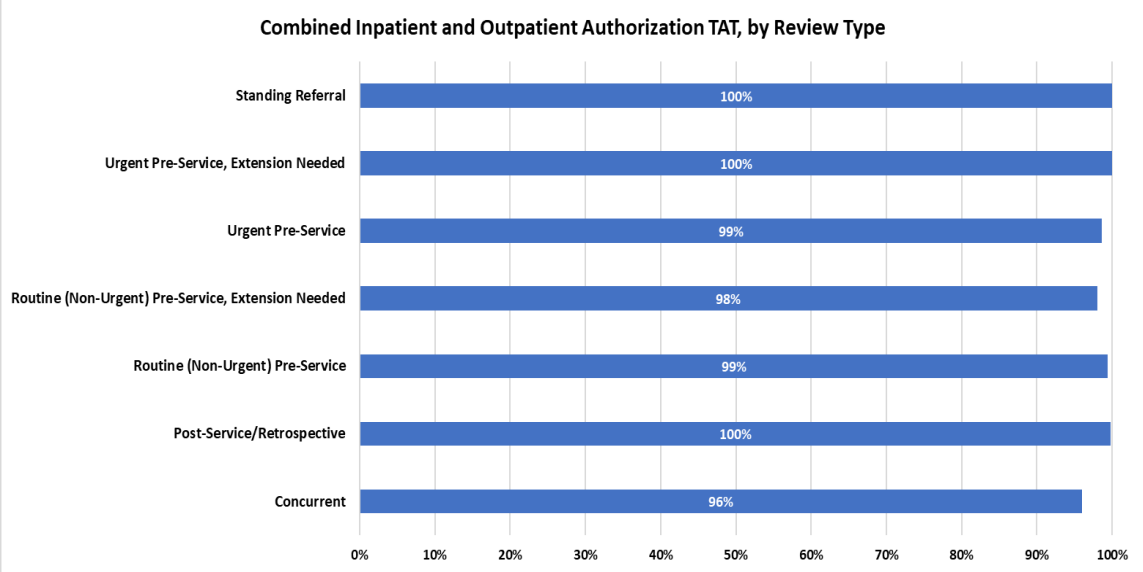
Figure 8c. 2023 Combine Inpatient & Outpatient Authorization TAT

2023 Combined Inpatient & Outpatient Authorization TAT						
	Q1	**Q2**	**Q3**	**Q4**	**MY2023**	***Goal***
Medi-Cal	97%	97%	97%	97%	**97%**	***95%***
Group Care	100%	98%	98%	98%	**99%**	***95%***
Overall	99%	98%	97%	98%	**98%**	***95%***

For 2023, both inpatient and outpatient TAT compliance were above threshold quarter-over-quarter, with an overall TAT compliance of 98% across both product lines. This represents a consistent year-over-year trend, given the overall TAT compliance in 2022 was 98.5% across both product lines.

Attention will be placed on individual staff fall outs if there is a trend to direct education, improve production line processes or staffing, and support alignment with department goals. Additionally, efforts are planned for aligning UM Analytical report configuration with Regulatory TAT for Inpatient authorizations. Continued monitoring of TAT compliance will continue in 2024.

Figure 9. 2023 Overall Authorization TAT, by Review Type



Looking at the data categorized by Review Types, the Routine (Non-Urgent) Pre-Service, Extension Needed and the Concurrent Reviews had lower TAT compliance than other review types. While both categories exceeded benchmarks, they will be focus areas in 2024.

Notice of Action (NOA) Compliance

In 2023, the Alliance continued to perform quality assurance monitoring to ensure compliance with NOA requirements for the Alliance UM team, and the UM-delegated entities. Annual NOA audits were performed to review for accurate application and reference of medical necessity guidelines, clear and concise letters, culturally and linguistically appropriate health literacy considerations, and TAT of provider/ member notifications. Continued monitoring is required for both the Alliance UM team and the UM-delegated entities to ensure all appropriate enclosures are sent with NOA letters, especially as DHCS and DMHC make periodic updates to their required templates.

Inpatient and Outpatient UM - Recommended Actions for 2024:

Upon evaluation of the above utilization review measures, potential program enhancements are:

- Continued monitoring and process improvements to meet NOA compliance

- End-to-end authorization system enhancements to streamline authorization processing and eliminate manual workarounds
- Continued evaluation of services that do not require prior authorization with goal to remove unnecessary reviews
- Continue the Tertiary Quaternary Policy
- Develop Authorization and claims stay level configuration for inpatient levels of care and facility types
- Validate different network contracting to ensure accurate out-of-network utilization is reflected in Plan analytical reports and aligned with Delegate utilization reporting.
- Increased alignment with case management, specifically related to transitional care services in alignment with DHCS population health management policy guide

Long-Term Services and Supports (LTSS)

The LTSS department was newly formed in 2023 as an extension of the Utilization Management team. The formation of the LTSS department was essential to accommodate the carve-in of the Long-Term Care (LTC) skilled nursing facility benefit in 1/1/2023. This dedicated team was also needed to prepare for the continued expansion of the LTC benefit effective 1/1/2024, to include members in adult and pediatric subacute facilities and intermediate care facilities for developmentally disabled. The LTSS department is responsible for the provision of Long-Term Services and Supports, defined in the DHCS contract as:

> *"Services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS) programs and includes carved-in and carved-out services"*

The DHCS contract defines LTC as specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, Intermediate Care Facility/ Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) homes.

The DHCS contract defines HCBS programs as programs that include but are not limited to HCBS programs authorized under the Social Security Act (SSA) at 42 USC section 1396n(c), the California Medicaid State Plan option authorized under 42 USC section 1396n(k), California Medicaid State Plan HCBS benefits authorized under 42 USC section 1396n(k), and other State and federally funded Medi-Cal HCBS programs.

The LTSS department consists of clinical and non-clinical staff who administer the program, providing oversight & monitoring to ensure adherence to all regulatory requirements and performance standards. Team members work collaboratively with other internal departments (including UM, Case Management, Pharmacy, and Behavioral Health), delegated entities, and safety net providers within the community to deliver timely, appropriate, cost-effective, and quality healthcare to members using LTSS benefits.

While the LTSS department is in its first year, evaluation measures were developed to establish baseline thresholds and to identify opportunities for further refining of measures. These measures included authorization turnaround times, acute admissions, bed holds, emergency room visits, and facility network status.

Authorization Turnaround Times

LTC authorization requests are monitored to ensure compliance with contractually required turnaround times (TAT). Timeliness standards are aligned with those listed in the section titled, Utilization Review Procedures. The established threshold is 95% compliance.

Figure 10. 2023 LTC Authorization TAT

	Q1	Q2	Q3	Q4	MY2023
Authorizations Meeting TAT	362	473	602	902	2339
Total Authorizations	476	674	865	1407	3422
% Compliant	76%	70%	70%	64%	68%
Goal	*95%*	*95%*	*95%*	*95%*	*95%*

For 2023, TAT compliance did not reach the goal for any quarter, with an overall TAT compliance of 68% for the year.

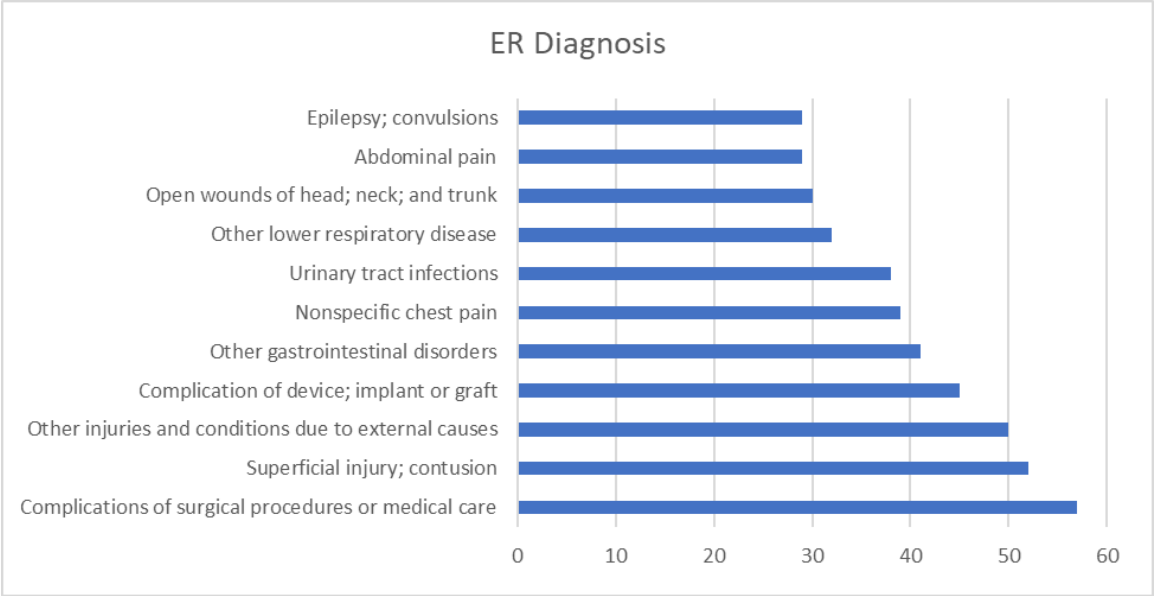
Root cause analysis was conducted to determine key drivers for noncompliance. The primary drivers for TAT noncompliance were related to authorization volume increase, staffing, internal process gaps, provider training needs, system configuration and data analytic issues. All primary drivers have been addressed with internal staff hiring and training, provider education, and system reconfiguration. Ongoing education and monitoring for TAT compliance will continue to be a high priority for the LTSS department in 2024.

Emergency Room Visits

Monitoring for avoidable emergency room (ER) visits can identify potential member education and provider training opportunities. It can also support the Quality Management team's review of potential LTC facility quality of care issues.

Figure 11a: 2023 ER Visits (LTC population)

Figure 11b: 2023 ER Visits by Diagnosis (LTC population)



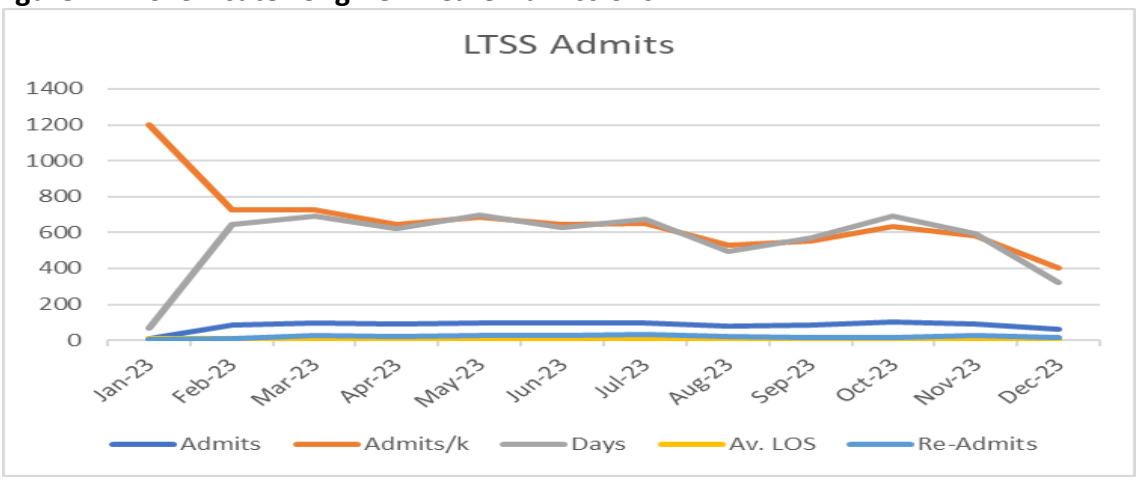
For 2023, there was a monthly average of 90 ER visits/month for the LTC population, with peaks in July, September, and October. The top 3 reasons for ER visits were surgical complications, contusions, and other conditions and injuries due to external causes.

In 2024, in collaboration with the Quality Management department, the LTSS department will develop quality performance measures for LTC facilities, with the goal of preventing unnecessary/avoidable ER visits.

Acute Admissions

Monitoring of acute admissions can provide insight on the disease burden of the LTC population and allow evaluation and identification of additional resources that might support their needs. The below figure shows the monthly trend of acute admissions, average length of stay (ALOS), and readmission rate for the LTC population in 2023.

Figure 12. 2023 Acute Long-Term Care Admissions

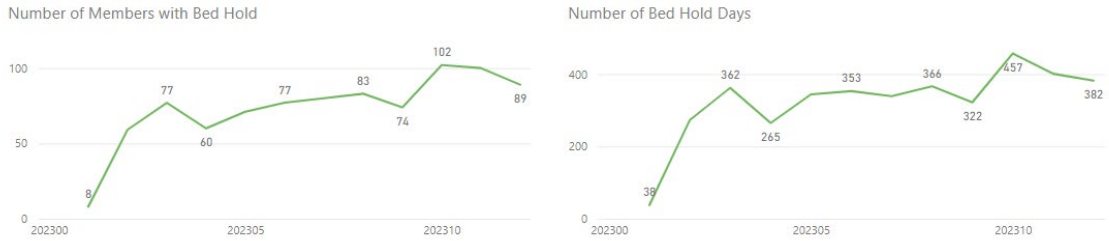


For 2023, the number of acute admissions for LTC members has been consistent, averaging 85 admits/month since the carve-in of the LTC benefit in January 2023. The average length of stay (ALOS) for 2023 was 6.25 days, and the readmission rate was 1.28% for 2023.

Bed holds

For members who get admitted to an acute care hospital from a nursing facility, the nursing facility is allowed to request a bed hold authorization, in which they hold the bed vacant for a maximum of seven days per hospitalization. Monitoring the utilization of bed holds can provide insight on the disease burden of the LTC population, as the bed hold is correlated with the acute admission. The below figure shows the monthly trend of LTC members with approved bed holds and the total number of bed hold days authorized.

Figure 13: 2023 Bed holds (LTC population)



For 2023, there was an average of 74 members/month with approved bed holds, and an average of 331 bed hold days authorized/month. In October 2023, there was a high number of admissions (103), correlating with the increase in bed hold requests. One trend identified in the second half of 2023, was the rising retrospective submission of bed holds

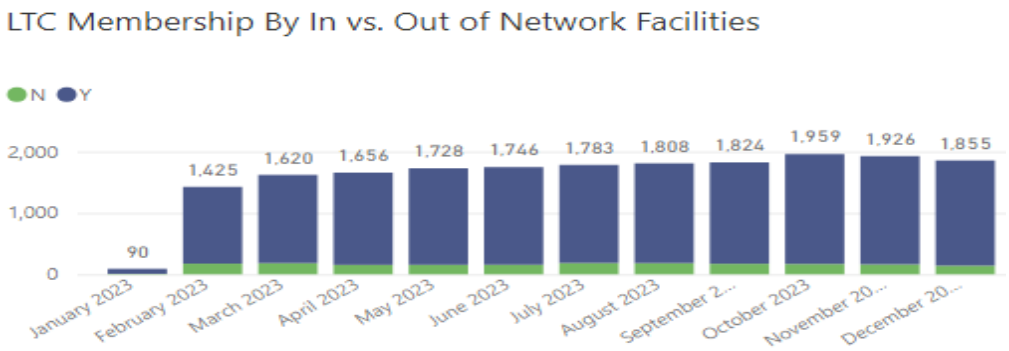
and some LTC nursing facility admissions which exceeded 90 days from the dates of service.

The LTSS department will be implementing an LTC care management program to support high-risk LTC members, including those with high numbers of acute admissions, high numbers of bed holds, or those who may be at high-risk for re-admissions. Continuous monitoring of acute admissions, preventable re-admissions, and bed hold utilization in 2024 will determine the efficacy of the care management interventions.

Facility Network Status

For Members residing in LTC facilities after the January 1, 2023 carve-in of the benefit, the Alliance ensured eligible Members had continued residency in the nursing facilities for 12 months, for continuity of care, with the coordinated contracting efforts by Provider Services.

Figure 14. In vs. Out of Network Facilities for LTC Memberships



In 2023, the majority of LTC members were in contracted facilities. In February 2023, the Alliance had 174 members residing at out-of-network facilities, while 1,425 were at in-network facilities, and in December 2023, there were 142 members at out-of-network facilities, while 1855 were at in-network facilities. The LTSS department continues to work with the Contracting team to identify network and access gaps to facilitate data-informed efforts to seek contracts with additional facilities.

LTSS - Recommended Actions for 2024:

Upon evaluation of the above LTC measures, potential program enhancements are:

- Hire LTSS Medical Director to provide dedicated LTSS clinical leadership support
- Continued monitoring and process improvements to meet TAT compliance goals
- Successful implementation of LTC care management program, including transitional care services in alignment with DHCS population health management policy guide
- Improve facility awareness to notify the Alliance about changes to LTC member Transition of Care status, and timely Bed Hold and Admission LTC authorizations.
- Continuing to collaborate with LTSS liaison and provider services to establish relationships with facility partners, including consistent onsite facility visits from LTSS social workers
- Ensure the Quality Management department develops quality performance measures for LTC facilities

Community-Based Adult Services (CBAS)

CBAS is a type of LTSS benefit, and CBAS centers offer services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. The Alliance is responsible for ensuring Members who are eligible to receive LTSS are identified and referred and dedicates an RN on the UM team to provide assessment, re-assessment, and re-authorization of CBAS services to members. The below figure shows the total number of members enrolled in CBAS in 2023.

Figure 15. 2023 CBAS Enrollment by Center, by Delegate

Number of Members					
Facility Name	**Alliance**	**IHSS**	**CHCN**	**Kaiser**	**Total**
Adult Day Services Of Napa Valley	0	0	0	0	0
Alzheimer Services of The East Bay	1	0	6	0	7
Family Bridges Inc.	52	0	172	0	224
Golden Castle Adult Day Health Care Center	0	0	0	0	0
Grace Adult Day Healthcare	7	0	0	0	7
Silicon Valley Adult Day Health Care	0	0	0	0	0
Total	**60**	**0**	**178**	**0**	**238**

In 2023, there were a total of 238 members receiving services through one of five contracted CBAS centers. The center with the highest volume of members is Family Bridges.

In 2023, CBAS Centers continued to provide remote services and remain in telephonic communication with their members through Temporary Alternative Services (TAS). In October 2023, DHCS released APL 22-020, replacing the TAS with CBAS Emergency Remote Services (ERS). This APL enacted requirements regarding circumstances in which remote services could be provided to members in CBAS, and The Alliance established processes to ensure that ERS requirements were met. The Alliance stayed in close contact with the centers to ensure that services were provided, to problem solve with the CBAS Centers, and to ensure the continuous support for these vulnerable members.

Behavioral Health Services

The Alliance provides access to behavioral health services for the Medi-Cal and Commercial membership in several ways:

- Basic mental health care needs are provided by Primary Care Providers
- Medi-Cal members with “mild to moderate” impairments in mental, emotional, or behavioral functioning were referred to are referred to the contracted behavioral health

delegate, Beacon Health Options (Beacon) through 3/31/23. Effective 4/1/23, the Medi-Cal members were referred to The Alliance's network for behavioral health care.

- Medi-Cal members diagnosed with a severe persistent mental health disorder and Substance Use Disorders are carved-out and managed by Alameda County Behavioral Health Care Services Department (ACBHCS).
- Commercial members access mental health/Substance Use Disorder benefits through the contracted BH delegate, Beacon Health Options (Beacon) through March 31, 2023. Effective April 1, 2023, commercial members were referred to the Alliance's network for behavioral health care.
- Behavioral Health Treatment (BHT) also known as applied behavioral analysis for people with autism and related disorders.

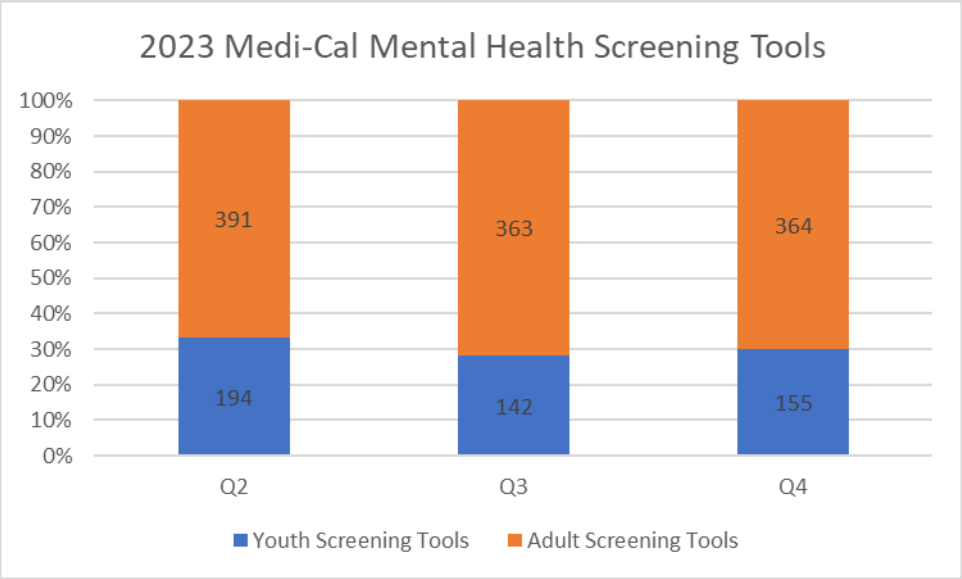
The Alliance worked closely with both ACBHCS and Beacon to identify members who may benefit from co-management of both medical and behavioral health services. The UM/Behavioral Health (BH) Departments are also responsible for maintaining the relationship with ACBHCS to ensure eligible Medi-Cal members receive services through the Linked and Carved Out mental health programs. The focus of the activities is to ensure contracted providers continue to identify and refer members with serious persistent mental health/SUD conditions to the appropriate ACBHCS programs, as well as to facilitate coordination activities for co-existing medical and behavioral health disorders to assist with their treatment access and follow-up care.

After the No Wrong Door policy was issued by DHCS in 2022, AAH and ACBHCS began monthly meetings to jointly implement the new requirements that focused on closer coordination of care to ensure members could access appropriate behavioral health services in both systems and ensure appropriate members could receive non-duplicative services from both systems simultaneously. AAH and ACBHCS worked to implement the new DHCS-required age-appropriate screening and care transitions tools that went into effect on January 1, 2023. AAH and Beacon participated in joint meetings with Beacon and ACBHCS through March 31, 2023, to ensure that implementation of the new screening and care transition tools would be implemented for bi-directional referrals that would occur prior to the insourcing transition scheduled for April 1, 2023. After insourcing, The Alliance continued regular meetings with ACBHCS to facilitate coordination of care and identify duplication of services.

Throughout 2022, the Alliance contracted with Beacon to administer the applicable Medi-Cal benefits for members with Mild/Moderate behavioral health needs and Commercial (IHSS) mental health benefits. AAH worked collaboratively with Beacon all through 2022 planning for insourcing of the behavioral health benefit management in April 2023. When they were delegated, Beacon and College Health IPA (CHIPA) worked collaboratively to perform all behavioral health plan management functions. College Health IPA (CHIPA) is the clinical arm of Beacon and performs contracting and any utilization management functions. CHIPA maintained the NCQA accreditation. The relationship and operations are coordinated on behalf of members and providers. Data for Q1 2023 is not available from Beacon as the organizational focus was on planning for insourcing.

The graph below represents the number of adult and child DHCS MH screening tools that were completed by the Alliance Q2-Q4 2023 for Medi-Cal.

Figure 16: AAH 2023 Q2 to Q4 Mental Health Screening and Referrals

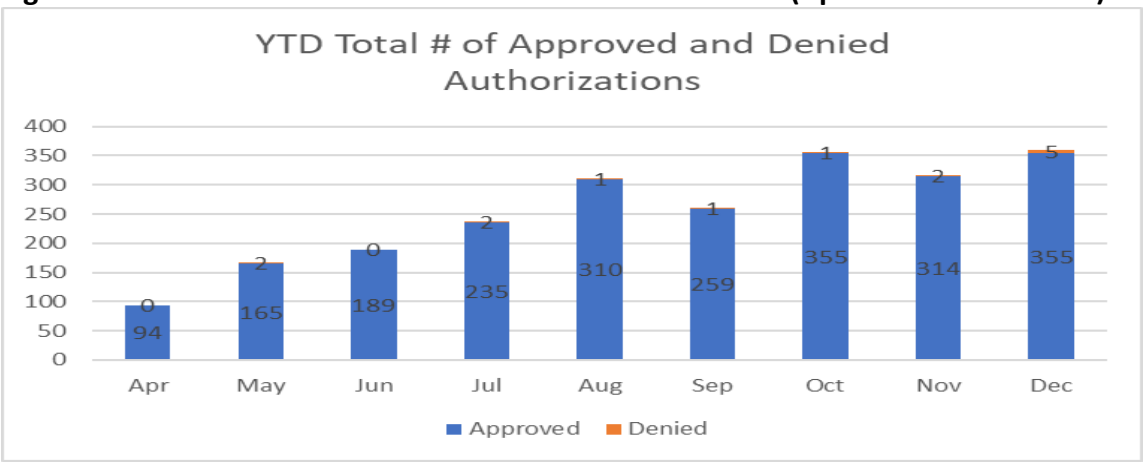


In April 2023, The Alliance Behavioral Health department insourced utilization review for all behavioral health services including behavioral health treatment also known as applied behavioral analysis indicated for autism and related disorders. The graph below represents the overall growth in authorization counts by line of business. The growth in the number of authorizations processed has been steady since the insourcing of these processes in April 2023. In response to this growth, the Alliance increased staffing to better meet operational demands.

Authorization Volumes, Determinations, and Denial Rates

The graph below represents the total number of authorizations processed after the insourcing of BH utilization review to The Alliance, and by approval and denial determinations.

Figure 17. Behavioral Health Authorization Determinations (April - December 2023)



There was a monthly average of 254 authorizations processed. Overall, the denial rate is low, which is representative of the commitment the Alliance has to members accessing appropriate mental health care.

Authorization Turnaround Times

The data below represents decisioning turnaround times for mental health and BHT/ABA authorizations.

Figure 18a. 2023 Combined Mental Health & BHT/ABA Decision TAT

BH Turnaround Time (Mental Health & BHT/ABA)				
	Q2	Q3	Q4	MY2023
Authorization Meeting TAT	349	724	777	1850
Total Authorizations	450	808	1011	2269
% Compliant	78%	90%	77%	82%
Goal	95%	95%	95%	95%

Figure 18b. 2023 Mental Health Decision TAT

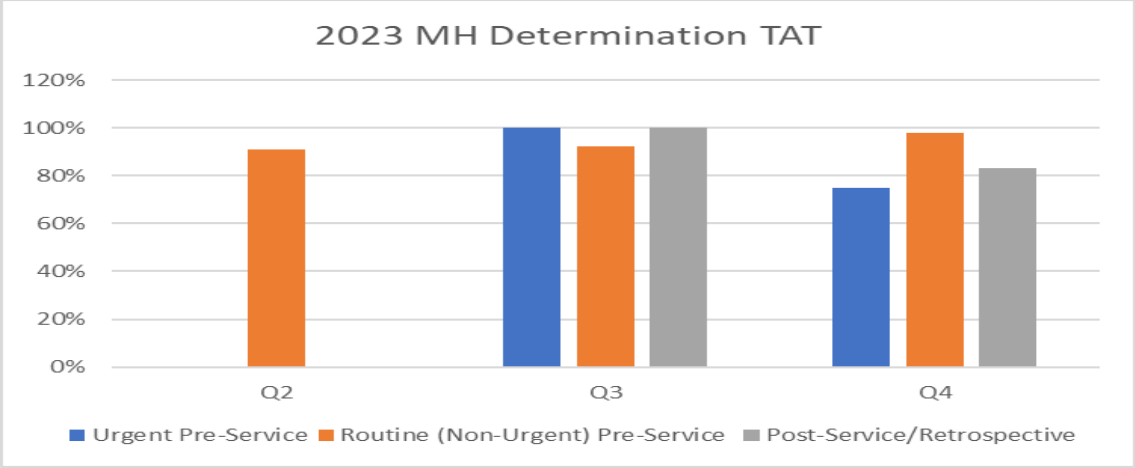
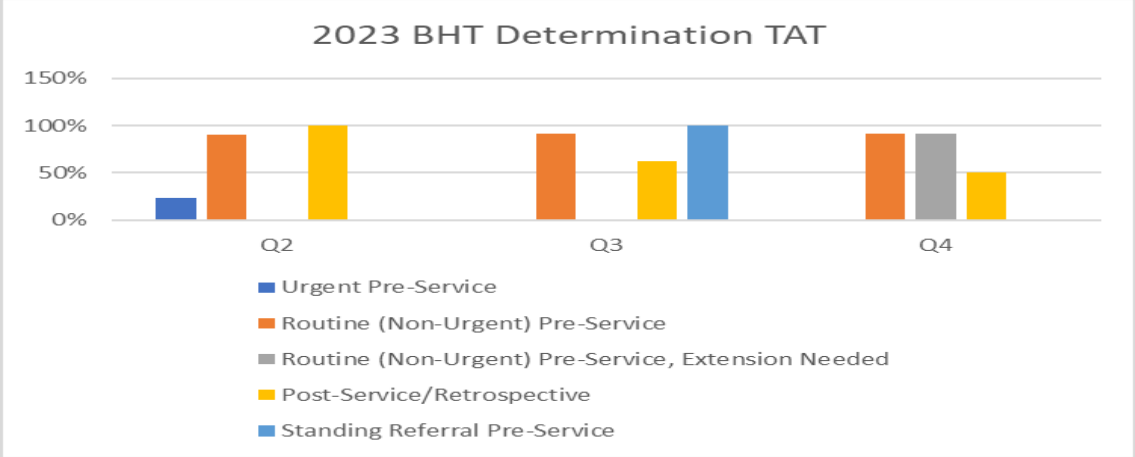


Figure 18c. 2023 BHT/ABA Decision TAT



Since the Alliance insourced behavioral health utilization review in April 2023, the team had an overall TAT compliance of 82%. The team has evaluated process defects that have contributed to missed TAT determinations and have identified process improvements to reach the overall goal of 95% or greater TAT met within regulatory guidelines.

The graphs below represent the decision notification turnaround times for the mental health and BHT/ABA programs. The goal for decision notification letters is < 95% meeting regulatory turnaround times.

Figure 19a. 2023 Behavioral Health Notification TAT

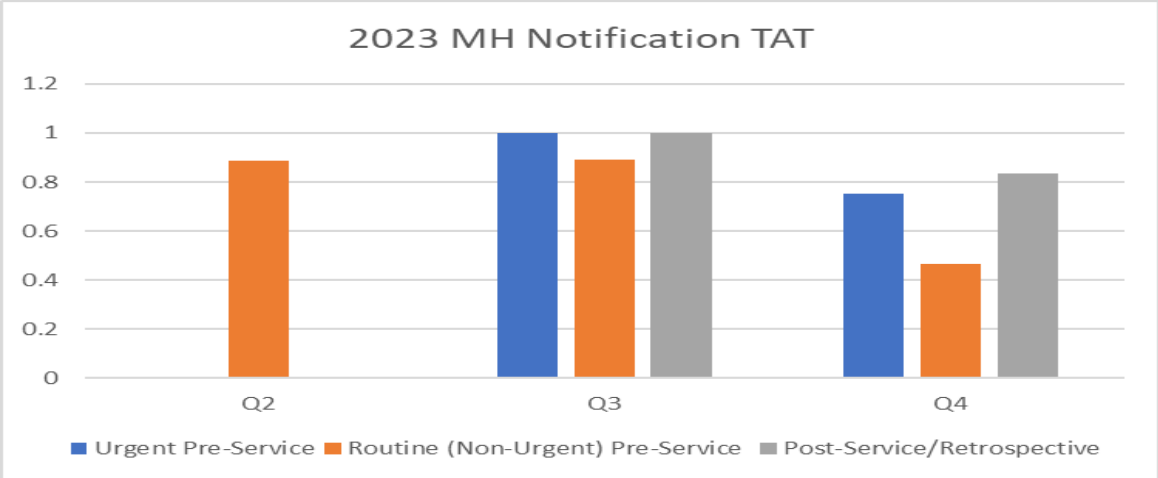
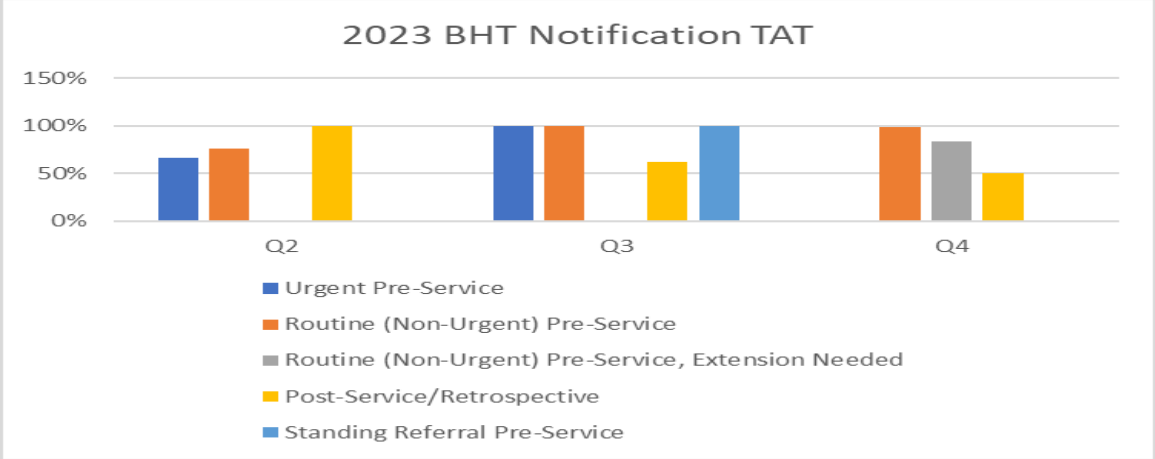


Figure 19b. 2023 BHT/ABA Notification TAT



The behavioral health program letter rules in our software platform were newly established with the program's inception in April 2023. The process requires manual due date tracking and letter generation. Opportunities for process improvement were identified in Q4 2023 for implementation in Q1 2024.

Behavioral Health Services - Recommended Actions for 2024:

Upon evaluation of the above BH measures, potential program enhancements are:

- Enhance process defects impacting TAT performance and implement interventions to meet

TAT goals in 2024.

- Increase access as measured by an increase in unique utilizers of mental health and BHT/ABA services.
- Ensure that Contracting continues to increase network capacity, particularly for ABA services.

Pharmacy

The management and monitoring of Pharmacy utilization activities is reported through the Pharmacy and Therapeutics Committee and QIHEC. A full review of Pharmacy Utilization activities can be found in the P&T Committee minutes; summary data is represented below.

The data below represents the total Outpatient Pharmacy prior authorization volumes and TAT for Group Care members.

Figure 20. Outpatient Pharmacy Authorization Volume & TAT

	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Number of Outpatient Pharmacy PAs Processed	203	469	462	414
TAT (%)	100%	100%	100%	100%

The data below represents the total Physician Administered Medications/Injections prior authorization volumes and TAT for both Medi-Cal and Group Care members.

Figure 21. Physician Administered Medications (PAD)/Injections Authorization Volume & TAT

		Q1 2023*	Q2 2023*	Q3 2023	Q4 2023
Number of Physician Administered Medications/Injections PAs Processed	Group Care	--	--	24	19
	Medi-Cal	--	--	638	672
Total Auth Volume		--	--	662	691
TAT (%)	Group Care	--	--	100%	100%
	Medi-Cal	--	--	99%	99%
TAT Average (%)		--	--	99%	99%

* Q1 and Q2 2023 data is included in the previously reviewed OP UM data. In collaboration with the UM department, the review of Physician or Physician Administered Medications/Injections in All Settings transitioned to the Pharmacy operations team on June 1, 2023.

Pharmacy - Recommended Actions for 2024:

Upon evaluation of the above Pharmacy measures, potential program enhancements are:

- Investigating utilization of unclassified drugs and unclassified biologics for drug utilization patterns and appropriate coding.
- Fully transition Advisor Reviews for Physician Administered Medications/Injections from Alliance Medical Directors to Pharmacists

Clinical Appeals

Clinical Appeals are investigated to determine if the initial UM determination was appropriate. The final appeal is resolved with determinations of upheld, overturn, or partially overturned. Overturn appeal determinations are considered an opportunity to assess the UM process, and all overturned cases are reviewed monthly with Medical Directors for educational feedback, adherence to DHCS regulation, and review of UM process opportunities. The Alliance established a threshold of 25% for overturn determinations.

The grievance and appeals department reports appeal & overturn trends in UMC and QIHEC, allowing committee members to provide insights on notable trends. As the Alliance only delegates the resolution of grievances and appeals to Knox-Keene licensed Health Plans, the data below is inclusive of determinations made by the Alliance and all delegated provider groups, except Kaiser.

The below figures show Appeal and Overturn trends for 2023.

Figure 22a. 2023 Medi-Cal Clinical Appeals

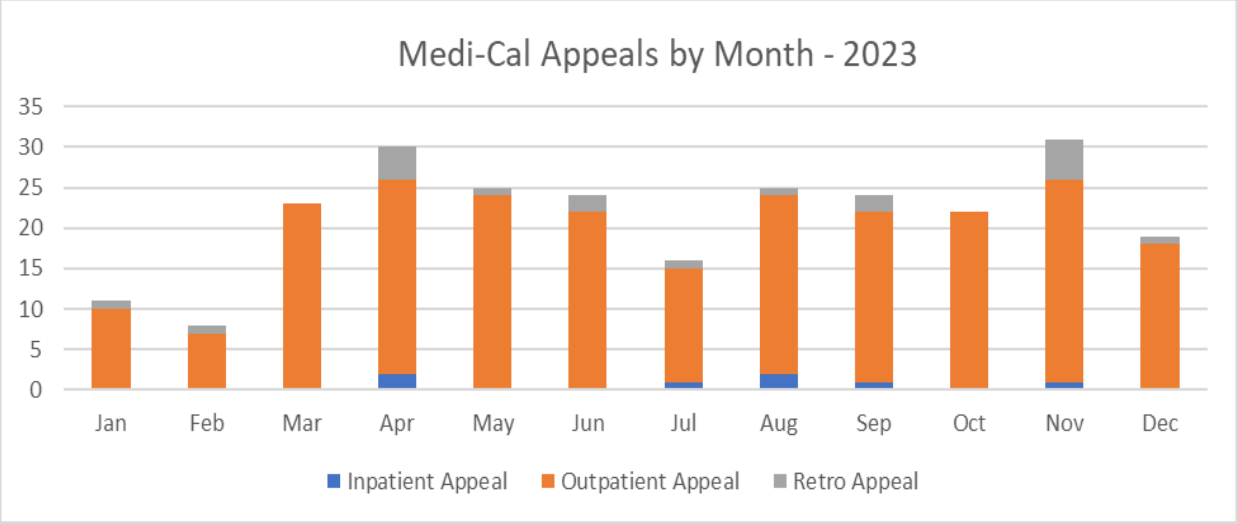
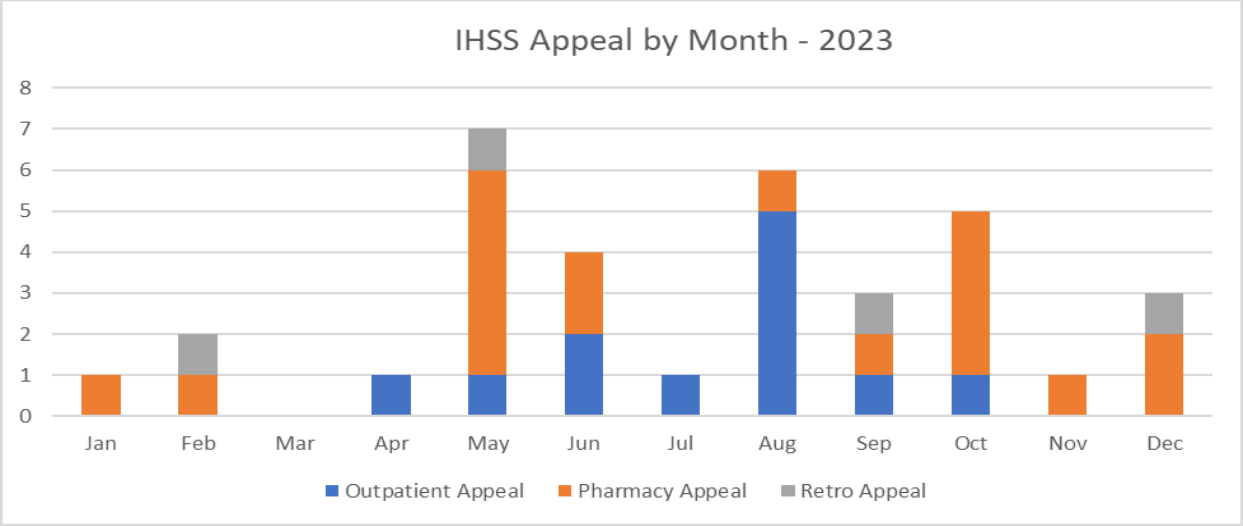


Figure 22b. 2023 IHSS Clinical Appeals



There was a steady increase in appeals from February to December with a slight dip in July for both Medi-Cal and IHSS. Appeal increase may be attributed to membership growth in Q1 and Behavioral Health transition to the Alliance.

Figure 23a. 2023 Medi-Cal Overturn Rate by Decision Maker

Medi-Cal Overturn Rate by Decision Maker Q1 2023 - Q4 2023				
Decision Maker	**Q1 2023**	**Q2 2023**	**Q3 2023**	**Q4 2023**
CFMG	0.0%	33.3%	0.0%	0.0%
CHCN	6.6%	13.7%	29.4%	9.10%
Plan - Outpatient	29.6%	12.8%	18.4%	23.4%
Plan - Retro/Inpatient	0.0%	37.5%	62.5%	0.0%

- **CFMG:** There is not enough data to identify any trends with CFMG.
- **CHCN:** CHCN experienced a significant decrease in the overturn rate in Q4 2023 compared to Q3 2023 and did meet our internal benchmark for Q4 2023. The Alliance continues to meet with CHCN decision makers monthly to review overturns, this could possibly attribute to the decrease of overturn rate.
- **The Plan – Outpatient**: appeals experienced an increase in overturn rate for Q4 2023; however, we did meet our internal benchmark. Overturns are reviewed by decision makers on a bi-weekly basis for training purposes.
- **The Plan - Retro/Inpatient:** For Q4 2023, there were no overturns for retro/inpatient appeals.
- There was a total of 13 overturned appeals in Q4 2023:
  - 3 - Additional information was obtained from the providers.
  - 3 - Appeals were inappropriately denied.
  - 2 - Members met medical necessity
  - 2 - The services were not available within network.
  - 3 - Other:

- 1 - Appeal overturned because the member was previously approved for home health services.
- 1 - Appeal overturned because the member was previously approved for wound care services.
- 1 - Appeal overturned because member would benefit from receiving a non-covered service.

Figure 23b. 2023 IHSS Overturn Rate by Decision Maker

IHSS Overturn Rate by Decision Maker Q1 2023- Q4 2023				
Decision Maker	**Q1 2023**	**Q2 2023**	**Q3 2023**	**Q4 2023**
CHCN	0.0%	0.0%	100.0%	0.0%
Plan – Pharmacy	0.0%	71.4%	0.0%	28.6%
Plan – Outpatient	0.0%	33.3%	0.0%	0.0%
Plan – Retro/Inpatient	0.0%	0.0%	0.0%	0.0%

- **CHCN:** No trends identified.
- **The Plan - Pharmacy:** In Q4 2023, we did not meet our overturn rate of 25% or below. There was a total of 2 appeals out of 7 that were overturned.
- **The Plan - Outpatient:** No trends identified.
- **The Plan - Retro/Inpatient:** No trends identified.
- There were 2 overturned appeals in Q4 2023. The appeals were overturned because they met medical necessity.

Figure 24a – 2023 Medi-Cal Clinical Appeals by Resolution/ Overturn – Threshold Compliance

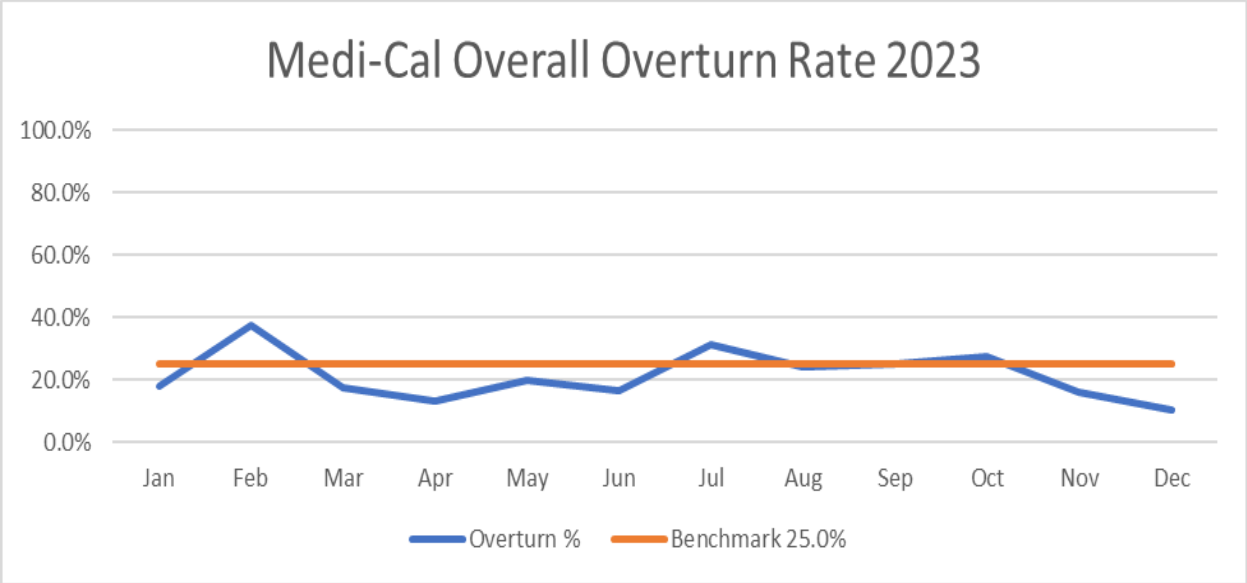
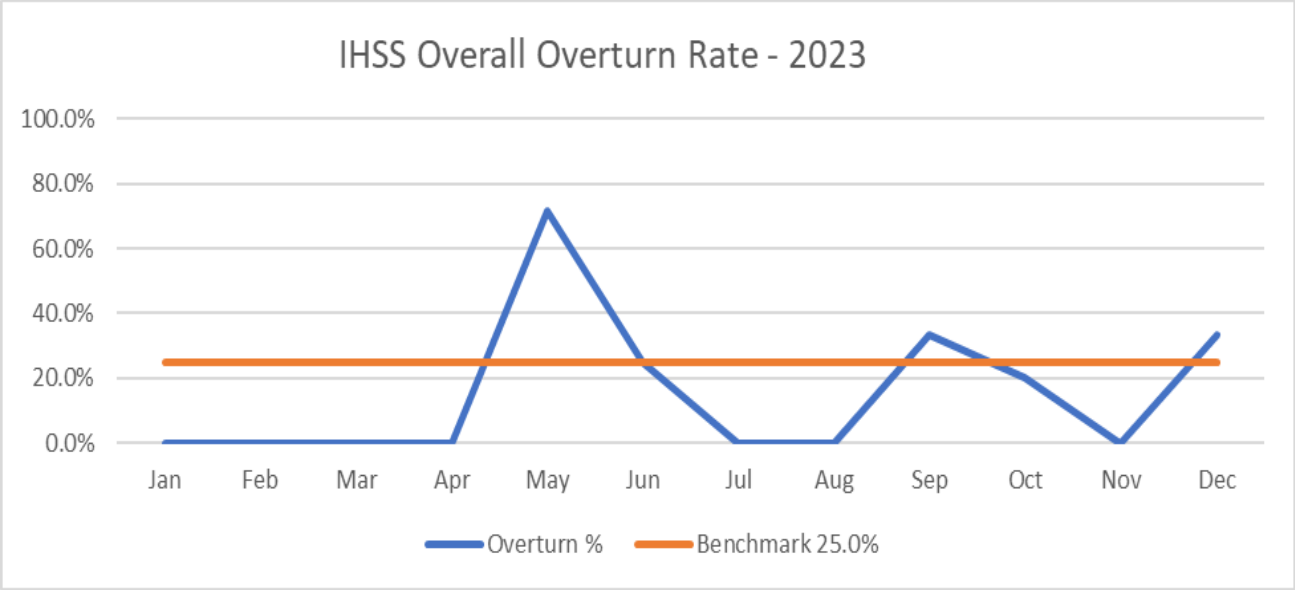


Figure 24b – 2023 IHSS Clinical Appeals by Resolution/ Overturn – Threshold Compliance



The Alliance had an average overturn rate of 13.4% for 2023, below our internal benchmark of 25%. Most months were consistent excluding a dip in December; however, with the annual overturn meeting our benchmark no interventions were identified. The IHSS numbers were so low that no significant trend was identified.

Clinical Appeals - Recommended Actions for 2024:

Upon evaluation of the above Appeal measures, potential program enhancements are:

- Continued monitoring appeals for Carpal Tunnel Surgery during Q1 2024 to see if the overturn trend continues and warrants continued education and ongoing monitoring.

Coordination with Compliance Department

The Alliance UM Department works closely with the Compliance Department to prepare for regulatory audits. In April 2023, the department participated in DHCS' annual audit. There was one finding related to delegated utilization management activities, in which The Alliance did not ensure a UM-delegated entity sent Notice of Action letters to providers and members to inform of adverse benefit determinations. The UM department, in coordination with the Delegation Oversight Department, implemented DHCS' recommendation to ensure policies and procedures for ensuring that UM-delegated entities send required Notice of Action letters.

To maintain the integrity of The Alliance's UM processes, including those of delegated entities, ongoing auditing and monitoring of key operational functions will continue, ensuring compliance with all federal, state, regulatory, contractual and accreditation standards.

Evaluation of Delegated Utilization Management Activities

The Alliance provides covered services to members through a delegated network. For UM-delegated entities, the Alliance has shared-risk arrangements, meaning the delegated entity is typically responsible for outpatient authorization reviews, while the Alliance UM Department is

typically responsible for certain outpatient and inpatient authorization reviews. UM-delegated entities perform utilization management activities based on their contract, which includes agreements on divisions of responsibility.

The Compliance Department is responsible for monitoring and tracking the overall performance of delegates, including completion of annual audits. UM department staff review the UM components of the annual audit, which includes a review of delegates' policies and procedures and member case files. The UM team also reviews the delegated entities annual work plans/evaluations, and other standing reporting activities, as required. The Compliance Department is responsible for finalizing the audit findings. For entities that do not meet thresholds, a corrective action plan may be issued and tracked to ensure adequate resolution of the deficiency. All audit findings are reported to the Compliance Committee and the QIHEC.

In 2023, the UM staff conducted annual audits on the three (3) delegates with delegated UM responsibilities. The threshold for UM audit compliance was 90%. In 2023, delegate audit results for UM activities included:

- Kaiser, CHCN, and CMFG did not pass the annual UM audit (≤ 90.0%), and corrective actions were required
- Beacon did not have audits due to contract termination effective 3/31/2023

Figure 25. 2023 Delegate Annual Audit Results (UM components only)

Delegate Name	Provider Type	2023 Audit Results	Corrective Action Required
Kaiser	Health Maintenance Organization (HMO)	5 findings File Review (86% score)	1. The Delegate should submit supporting documentation of late member notifications and evidence of member notification for impacted cases. 2. The Delegate should submit supporting documentation of late notification of UM decision, and evidence of member letter for impacted cases. 3. The Delegate should submit documentation of NOAs that state which criteria the member did not meet to support the denial. 4. The Delegate should include year of policy/handbook or page when citing guidelines in NOA letters.

Delegate Name	Provider Type	2023 Audit Results	Corrective Action Required
			5. The Delegate should update NOA letter's member rights to specifically identify how to file for an expedited appeal.
		5 findings P&P Review	1. Per our 2023 DHCS audit, only licensed health care professional can supervise medical necessity decisions including approvals. Please amend this to include approved requests as well. 2. Document for UM Denial of practitioner requested services does not list a turnaround time for practitioner notification for all request types of 24 hours. Please amend this document to state that the turnaround time for practitioner notification for all request types is 24 hours. 3. Send policy that states that contracted practitioners will obtain an Informed Consent for all Medi-Cal members for all contraceptive methods, including sterilization. 4. Send policy that states that minors ages 12 to 18 years old can receive the services listed below without parental consent: a. Sexual assault, including rape. b. Drug or alcohol abuse. c. Pregnancy. d. Family Planning. e. Sexually transmitted infections (STI).

Delegate Name	Provider Type	2023 Audit Results	Corrective Action Required
			f. Outpatient Mental Health Care. 5. Provide P&P that states that state providers must follow the latest California Lead Poisoning Prevention Branch (CLPPB) guidelines, including reporting results to the CLPPB.
CHCN	Managed Care Organization (MCO)	5 findings File Review (80% score) *These are preliminary findings*	1. Submit policy & procedure/process for monitoring compliance with notification turn-around times. 2. Review and participate in training opportunities related to UM decision-making, including appropriate application of guidelines. 3. Submit policy & procedure/process for monitoring accuracy of notification letters (to include verification of citing appropriate criteria, required content, and appropriate translations). 4. Submit policy & procedure/process for monitoring accuracy of notification letters (to include verification of citing appropriate criteria). 5. Submit policy & procedure/process for monitoring accuracy of notification letters (to include verification of appropriate dates).
		5 findings P&P Review (86% score)	1. Add explicit language that approved services provided

Delegate Name	Provider Type	2023 Audit Results	Corrective Action Required
		These are preliminary findings	by out-of-network providers are at no cost to Medi-Cal members. 2. Add language that emergency services are provided at no cost to Medi-Cal members. 3. Add language regarding assessing the member's level of mental function prior to discharge. 4. Provide or create policies and procedures that state providers must follow the latest California Lead Poisoning Prevention Branch (CLPPB) guidelines, including reporting results to the CLPPB. 5. Provide or create vaccine/immunization policies that include flu vaccine administration that includes: • The importance to enrollee health and the health care system stability of widespread flu vaccination and prompt provider reimbursement. • The UM/protocol flexibility for flu vaccination administration. *Note that the policy could address vaccine/immunizations more broadly and include the required language.

Delegate Name	Provider Type	2023 Audit Results	Corrective Action Required
CFMG	Managed Care Organization (MCO)	4 findings File Review (84% score) *These are preliminary findings*	1. Submit P&Ps/workflows that explain monitoring & oversight process to ensure compliant content in NOAs. a. Please complete staff retraining on NOA requirements (per APL 21-011) and send training content, training date, and list of staff who attend training. 2. Submit evidence of pend notification sent to provider to comply with Element B2 Factor 1; if not available, explain why. 3. Submit evidence of pend notification sent to provider to comply with Element B2 Factor 4; if not available, explain why. 4. Submit evidence of pend notification sent to provider to comply with Element B2 Factor 5; if not available, explain why.
		23 findings P&P Review (60% score) *These are preliminary findings*	1. Include a description of how CFMG manages the behavioral health needs of members in the Program Description for 2023 and on. 2. Include a description of how CFMG involves a behavioral health practitioner in the implementation of the behavioral health aspects of the program in the Program Description for 2023 and on. 3. Add language to the UM Program description that

Delegate Name	Provider Type	2023 Audit Results	Corrective Action Required
			indicates that CFMG provides services, free of charge, in the requested language through bilingual staff or an interpreter. This can note that it is provided through the health plan. 4. Specify the qualifications of staff able to approve services. 5. Provide job description or language additions to policies reflecting that Practitioners who review denials of care are required to have Education, training or professional experience in medical or clinical practice. 6. Separate timelines for decision making from the timeline for notification 7. Describe the audit process for Factors 1-6. 8. In policies, change language to reflect that the Final decision or decision to extend is made within 14 calendar days of receipt. For deferred requests in extension, final decision is made within 28 calendar days of receipt. 9. In Policies, change practice and/or add language to direct to alternative care if the case is denied 10. In policies, change language to reflect that pended cases are finalized (approved, modified, denied) within 28 days of the request.

Delegate Name	Provider Type	2023 Audit Results	Corrective Action Required
			11. Provide policies that describe the process for allowing women direct access to in-network women's health specialists for covered-routine and preventive health care services. 12. Change language to explicitly state that emergency services do not require prior authorization. 13. – 21. Create or submit policies describing the discharge planning process. 22. Add language specifying that contracted practitioners will obtain an Inform Consent for all Medi-Cal members for all contraceptive methods, including sterilization. 23. Add language to the policy to the importance to enrollee health and the health care system stability of widespread flu vaccination and prompt provider reimbursement. This language does not have to be specific to flu vaccine but can be used regarding all immunizations.
Beacon/College Health IPA (CHIPA) (Q1 2023)	Managed Behavioral Healthcare Organization (MBHO)	*N/A (contract termed 3/31/2023)*	*N/A (contract termed)*

For 2023, the current UM delegates continued to meet the program's required scope of activities. The individual issues of compliance regarding delegation requirements are addressed with the delegate through the Compliance Department. The UM team works collaboratively with the

Compliance Department on identifying potential process improvement activities and monitoring corrective action plans.

Delegated Utilization Management - Recommended Actions for 2024:

- Partner with the Compliance Department to evaluate audit tools and establish metrics that align with The Alliance's key performance indicators.
- Monitor and support Delegate CAP activities, in coordination with the Compliance Department
- Provider regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance's Population Health Management strategy

Over/Under Utilization

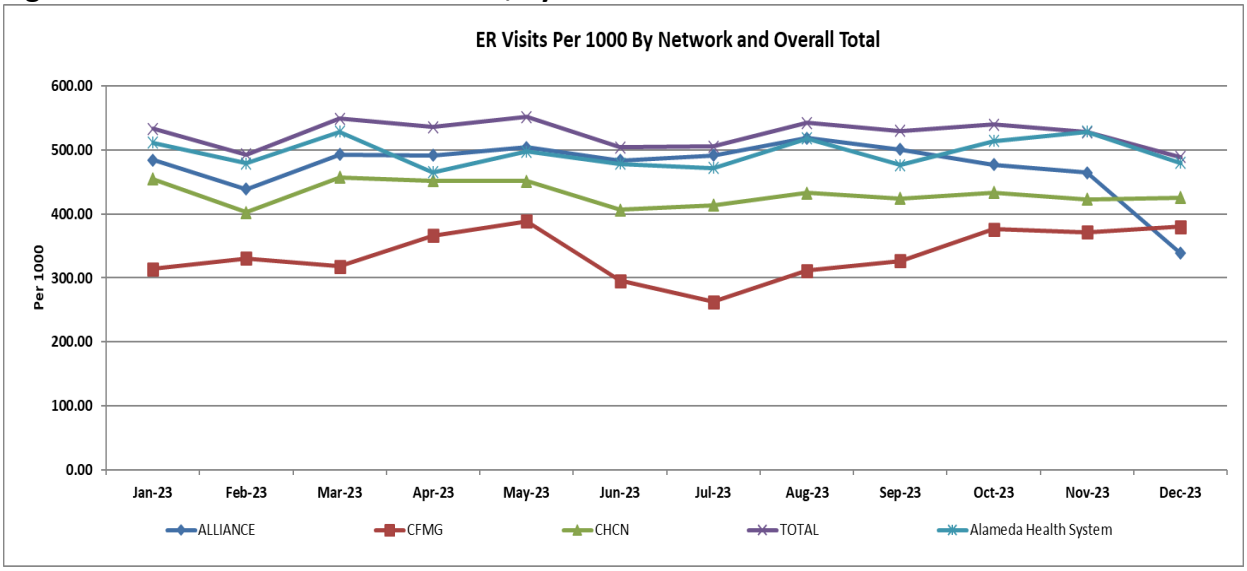
Assessment and monitoring of Over/Under Utilization is a collaborative effort between the Quality Management and UM Department. This evaluation will focus on those efforts specific to the UM department, in which over- and under-utilization is evaluated for selected services or treatments that may indicate barriers to accessibility for covered health care services. Over/Under Utilization reports are presented at UMC to elicit insights from committee members and identify opportunities for improvement, as necessary. The UM Department monitors over- and under-utilization for:

- Emergency Room Visits
- Acute Inpatient Hospitalizations
- Specialty and Ancillary visits (including out-of-network activities)
- Unused Authorizations

Emergency Room Utilization

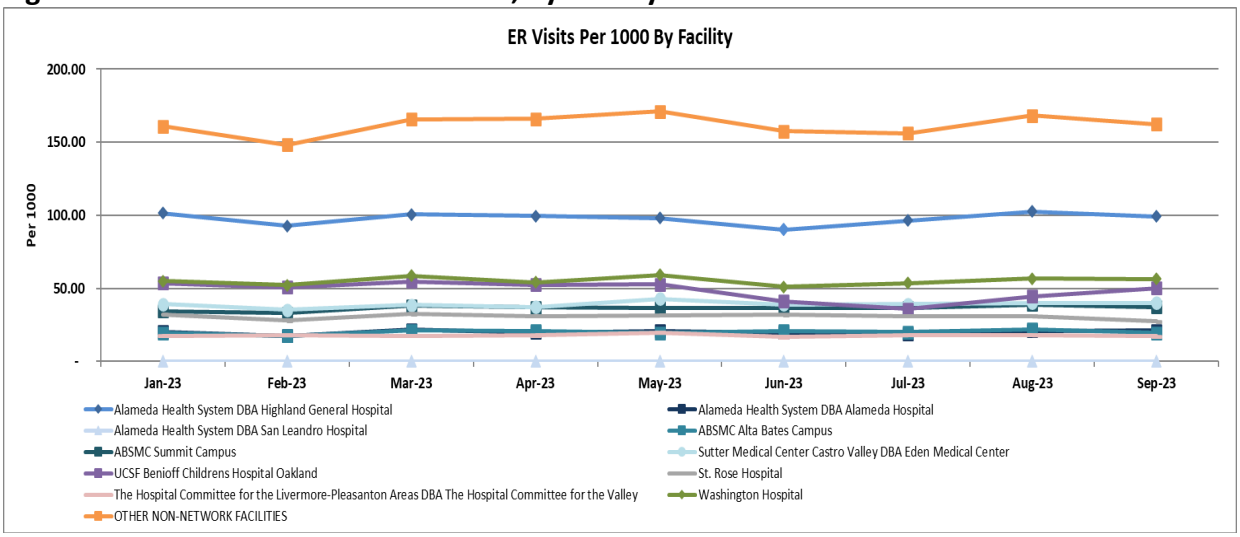
Monitoring for avoidable emergency room (ER) visits can identify potential member education, primary care access needs, and provider training opportunities.

Figure 26a. 2023 Overall ER utilization, by Network



In 2023, emergency utilization was 525.0 visits/1000 members across all networks, which was an increase in volume (+9.9) compared to 2022. Members in the CFMG network continue to have the lowest ER utilization rate (336.9 visits/1000), while members in the Alameda Health Systems network have the highest emergency room utilization rates (495.56 visits/1000) comprising the 3 county hospitals in West Oakland, Alameda and San Leandro.

Figure 26b. 2023 Overall ER Utilization, by Facility



In 2023, emergency room utilization is highest at out-of-network hospitals with 159.79 visits/1000 members, followed by Highland Hospital at 97.46 visits/1000 (+0.34) and Washington Hospital at 54.44 visits/1000 members (-1.4). Overall, out-of-network emergency room rates were 159.79 visits/ 1000 members (+4.4).

The Out-of-Network hospitals consist primarily of Kaiser facilities, including Kaiser Richmond, Kaiser San Leandro, and Kaiser Hayward. This is related to the geographic hospital desert in the northern part of Alameda County, following the closure of the Doctors Medical Center in Richmond (2015). Both Highland Hospital which is a Tier-1 trauma center for Alameda County and Washington Hospital which is the only major facility in the southern part of Alameda County, continue to be the two highest contracted hospitals for emergency room utilization.

Emergency Room Utilization - Recommended Actions for 2024:

- Continue collaboration with Quality Management and Population Health Management team to ensure access to post-discharge care, particularly with primary care providers.
- Monitor diagnosis drivers for emergency room visits, especially for repeat utilizers and for facilities with high emergency room rates.
- Monitor PCP primary care homes for facilities with high ER rates and for repeat utilizers and facilities with high emergency room rates: Identify Teledoc opportunities and those diagnoses that could be managed in primary care offices.
- Track ED utilization that is associated with members who readmit to the hospital, for case escalation to the Case Management department and supports.
- Increase collaboration with Behavioral Health team and Alameda County Behavioral Health Services to support access to necessary BH/SUD treatment

Acute Inpatient Hospitalizations – Utilization Management

Inpatient Admissions

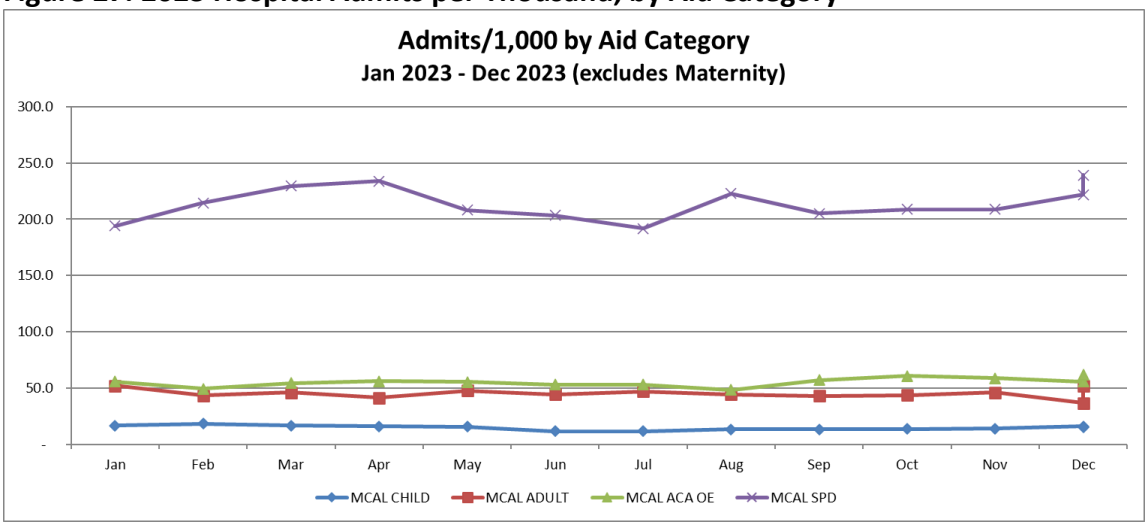
The Alliance UM department provides clinical oversight of the inpatient concurrent/continued stay review process when members are admitted to an acute care hospital. Reviews for acute admissions focus on:

- Facilitating timely provision of services through evidence-based medical necessity review processes, including appropriate and timely notification of review decisions
- Promoting adherence to established UM and Discharge Planning standards of care with Transition of Care service integration.
- Identifying any Quality-of-Care issues, including Hospital Acquired Infections, delayed services rendered while hospitalized, preventable readmissions, and other Potential Quality Indicators
- Coordinating safe and timely transfer to the most appropriate level of care and care settings
- Identifying and coordinating ongoing follow-up and/or case management needs after discharge, including but not limited to:
- Communicating to the attending physicians, specialists, and members regarding covered services needed post-discharge, or upon transfer to a lower level of care
- Assisting with locating appropriate placement for members with complex medical or psychosocial barriers to discharge.

- Referring to the Alliance Case Management (CM) department, or other appropriate care management programs, including Enhanced Care Management, Community Supports, and Targeted Case Management

To evaluate trends in acute hospitalizations, the Alliance measures admissions per thousand, average length of stay (ALOS), and bed days per thousand**.** Inpatient authorizations are measured in line items.

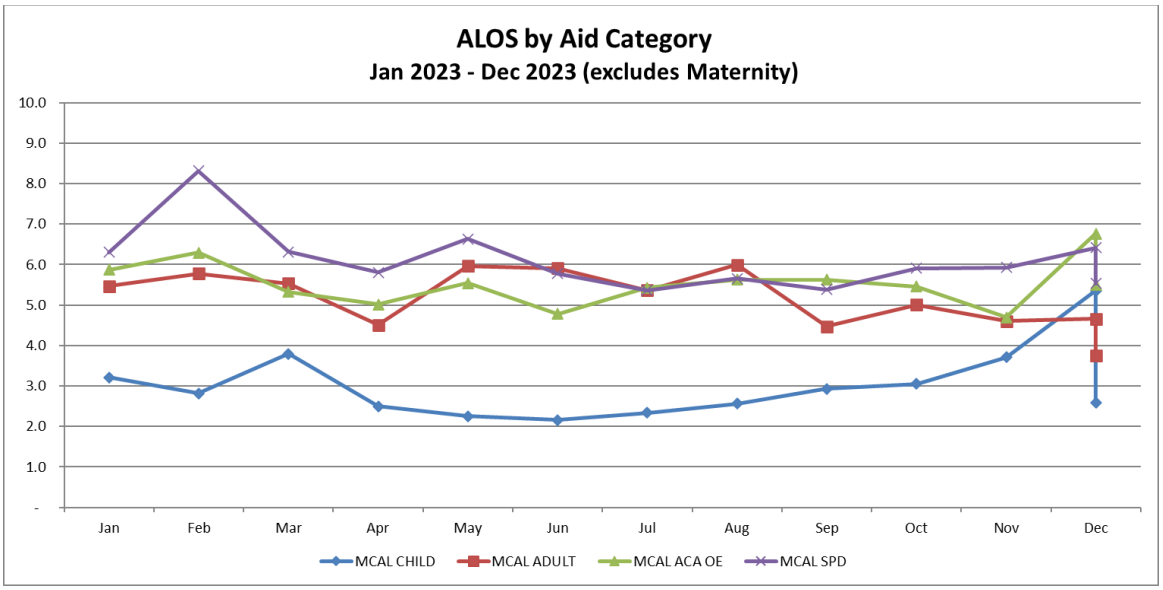
Figure 27. 2023 Hospital Admits per Thousand, by Aid Category



Claims data comprise the admits per thousand metric for all lines of business in inpatient utilization management. Medi-Cal SPDs continue to have the highest admits per 1000 members (195.9 on average) while all other member aid categories remain significantly less. In decreasing order, the other aid categories were the Affordable Care Act Open Enrollment (ACA OE) with 55.3, Medi-Cal Adult- 54.1, and the Medi-Cal Child 14.6 per 1000 members. The SPD population has more complex medical needs and more frequent utilization, and it is expected to have a higher than average admits per 1,000 as compared to the other aid category populations. When comparing these volumes to 2022, both Medi-Cal SPD (-23.4) and Medi-Cal Child (-1.8) decreased their Admits/1000, where as MCal Adult (+9.8) and MCal ACA OE (+1.6) both increased.

For this population, focus remains on supporting them with care transitions between settings, particularly during and after a hospitalization, and connecting increased supports as necessary. These members are also at risk of transitioning to Long-Term Care in the long term.

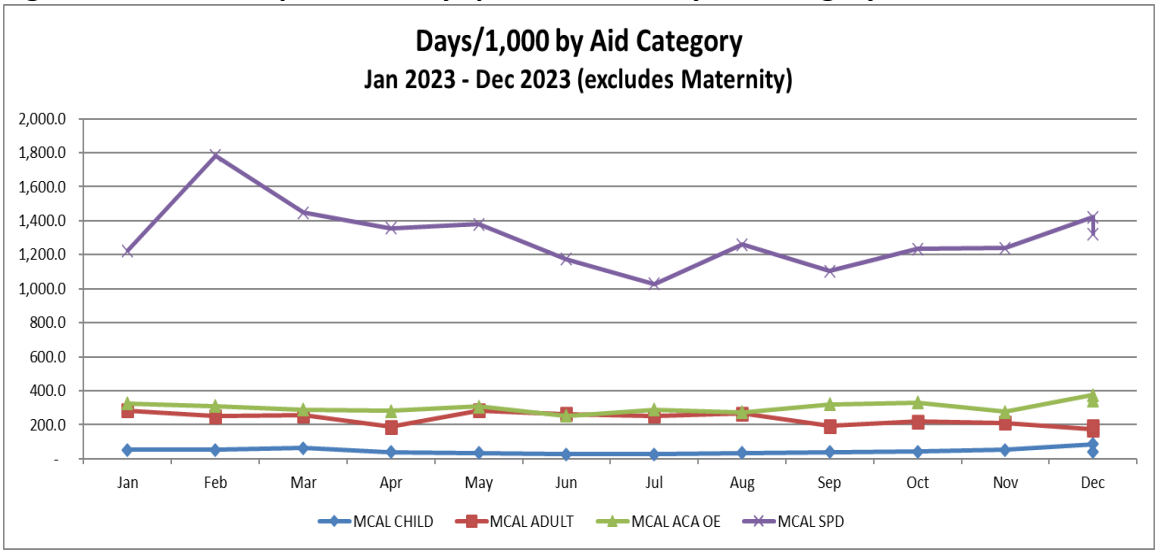
Figure 28. 2023 Hospital Average Length of Stay (ALOS) per Thousand, by Aid Category



In 2023, there was an increase in the number of members admitted to the hospital with complex social determination of health barriers that led to barriers with discharge and placement at lower levels of care. These barriers contributed to the ALOS in 2023 decreasing (-0.05%) in 2023 compared to 2022. Medi-Cal Child and Medi-Cal ACA OE populations both saw a slight increase in 2023, but the drops in our larger Medi-Cal Adult and SPD populations show that the efforts being made by the Inpatient teams in alignment with the DHCS Transitional Care Services requirements have been effective in reducing overall Long Length of Stays. The most common discharge barriers related to placement difficulties included higher member age, the presence of complex behavioral health diagnoses requiring placement, conservatorship and placement needs, ventilator/ tracheostomy with hemodialysis needs, and members with multidrug-resistant organisms (MDRO) status.

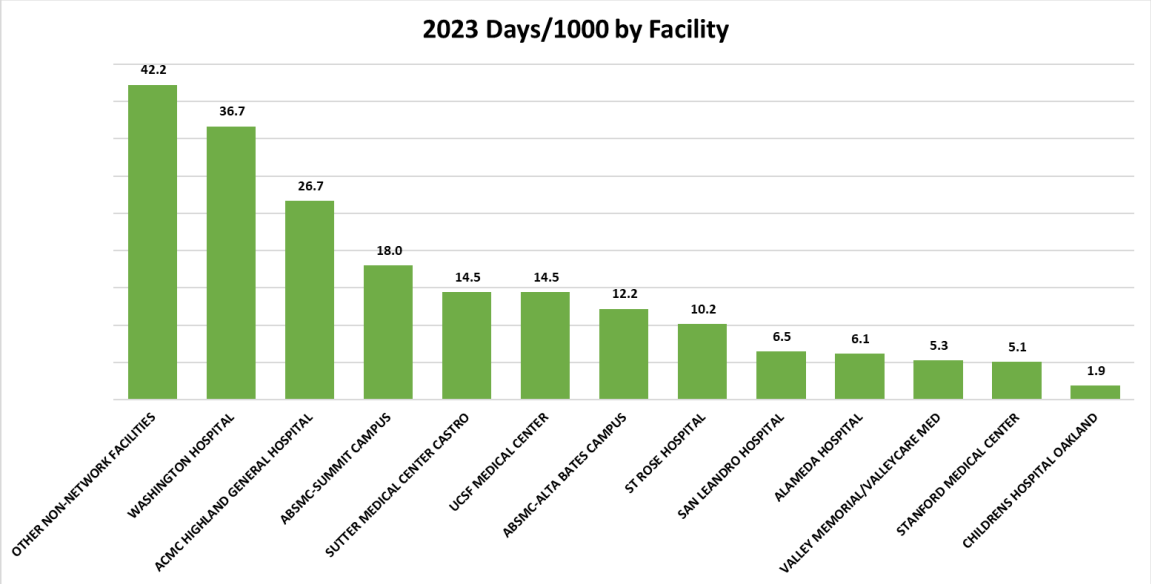
The UM team and TCS teams work collaboratively to reduce ALOS related to inappropriate discharge delays by proactively collaborating with hospitals in discharge planning from the point of admission notification, coordinating joint rounds with hospitals, expanding searches for skilled nursing facilities and/or other lower level-of-care settings, and linking providers to care management resources, including Enhanced Care Management and Community Supports.

Figure 29a. 2023 Hospital Bed Days per Thousand, by Aid category



For 2023, the Medi-Cal SPD population again had the highest bed days per 1000 members, while all other aid categories remain relatively flat, which is consistent with significantly higher SPD admits/1000 members and higher on average length of stay. However, the aid categories that experienced year-over-year increases in days/1000 members were Medi-Cal Adults (+19.5) and MediCal Expansion (+1.6). Aid categories that experienced year-over-year decreases in days/1000 members were Medi-Cal SPD (-3.6) and Medi-Cal Child (-18.6).

Figure 29b. 2023 Hospital Bed Days per Thousand, by facility



For 2023, the average days/1000 at out-of-network facilities saw the highest increases, with 46.2 days/1000 (+11.5) in 2023. Highland Hospital saw a decrease to 26.7 days/1000 (-34.3) in 2023, and Alta Bates Summit Medical Center decreased to 18 days/1000 (-23.3). After the top out-of-network hospital average of 42.2 days/1000 members, the top in-

network hospital with high bed days/1000 was Washington Hospital (36.7 days/1000) with a (-2.0) change from 2022.

The increase in out-of-network hospitalization days/1000 is related to continued trends of Kaiser hospitalizations at Hayward, San Leandro, and Richmond facilities and their respective ED utilization. Possible key driver for high out-of-network hospital authorization volume could be member choice and geographic location when seeking emergent care, because ultimately emergency room visits drive out-of-network inpatient admissions. Additional out-of-network utilization is explained by the new LTC carve-in benefit in January 2023, and The Alliance honored continuity of care for non-contracting LTC SNF facilities.

To support the appropriate management of acute hospitalizations, The Alliance continued joint rounds with contracted acute hospital partners in 2023. The joint discharge rounds have provided an opportunity to collectively share resources and brainstorm solutions to support members with complex medical and social health needs. The Alliance was in discussion with Alameda Hospital/ Highland Hospital to restart weekly rounds in early 2024, following partner staffing turnover that required a temporary suspension. The University of California San Francisco and Stanford Medical Center facilities were added to the joint weekly rounds to incorporate improved transplant, oncology care, and other complex tertiary quaternary care coordination and discharge planning. The inpatient discharge risk assessment form was updated to improve Transition of Care warm handoff to Case Management. Notable increases in LTC acute SNF authorizations volume following acute hospital discharge were noted in 2023 due to the LTC membership expansion. The Alliance also contracted with additional Long-term Acute Care Hospitals (LTACs), Subacute facilities, and Medical Respite Beds to address LTC placement needs to the next level of care and ensure transition to appropriate care settings.

Readmission Rate

All-Cause Readmission rates, defined as an unplanned readmission to an acute hospital within 30 days of discharge, are monitored and evaluated to identify preventable readmissions and member centric care plans and identify potential gaps in post-discharge care, such as high-risk social determinants of health, increased skilled or caregiving needs, and Transitions of Care support needs. *Note: December 2023 data is not available due to delay in claims activity.*

Figure 30a. 2023 Overall Inpatient Hospital Readmission Rate

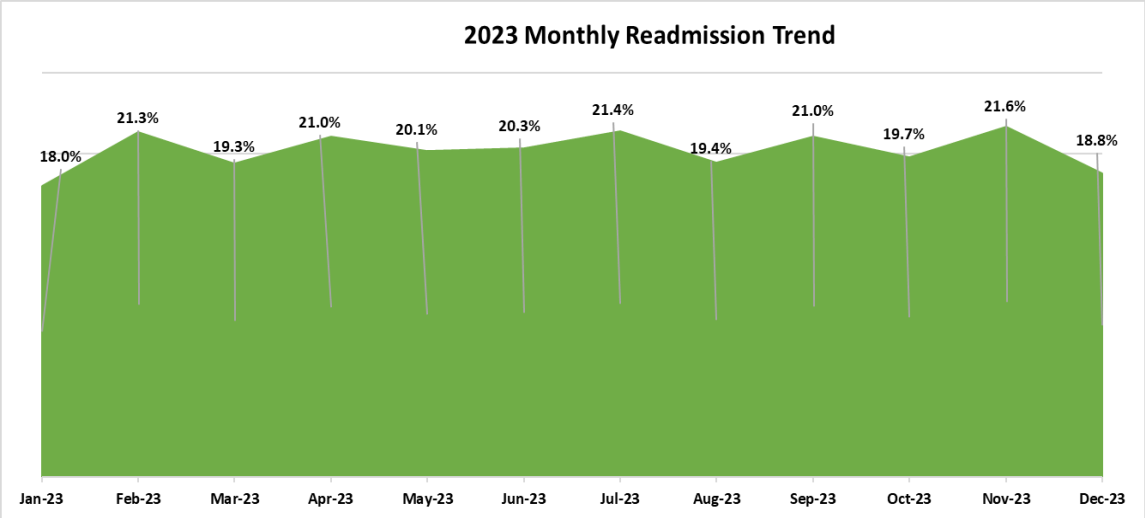
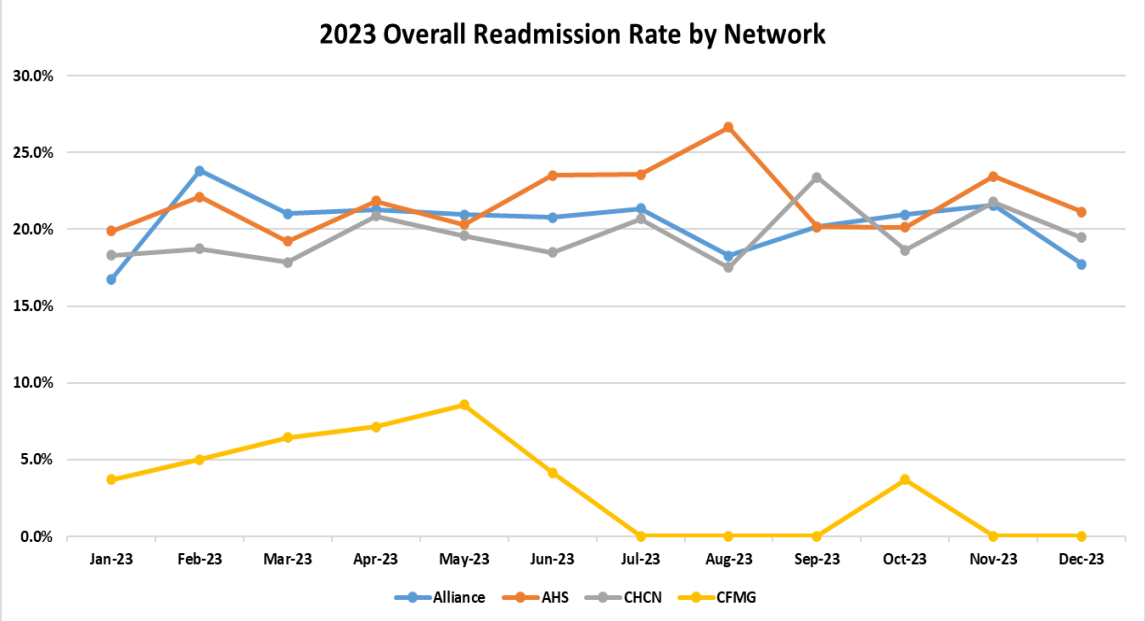


Figure 30b. 2023 Overall Inpatient Hospital Readmission Rate, by Network



The Alliance and CHCN networks saw relatively stable readmissions rates in 2023. The AHS network is known for medically complex members with higher social determinant of

health, which are served by the 3 county hospitals in Oakland, Alameda, and San Leandro. This network saw an upward readmission trend and a unique August spike.

The AHS readmissions workgroup is focused on reducing readmissions for Black members with substance use disorders and behavioral health needs and are developing a risk stratification tool rather than disease-based strategies for reducing readmissions. The Alliance is also aware of access issues to see new AHS primary care physicians and establish follow-up visits after hospital discharge in the AHS network, with current strategies focusing on replacing medical staff FTE to increase access capacity in 2024.

The CFMG network typically experiences few readmissions with low admissions and readmissions. In 2023, CFMG saw a few acute infection readmissions for dehydration, and a pediatric eating disorder readmissions case at UCSF that skewed the readmissions in Q1 and early Q4 in 2023.

Figure 30c. 2023 Overall Hospital Readmission Rate, by Aid Category

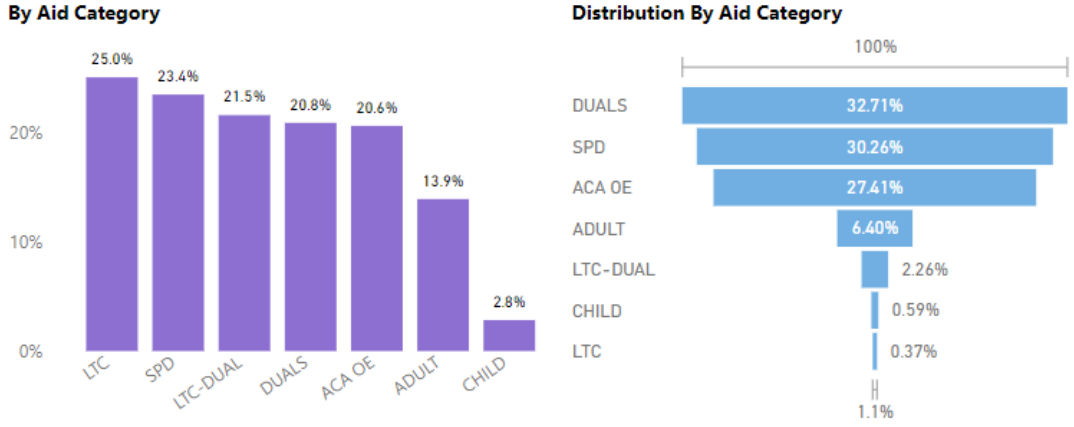


Figure 30d. 2023 Overall Hospital Readmission Rate, by Aid Category

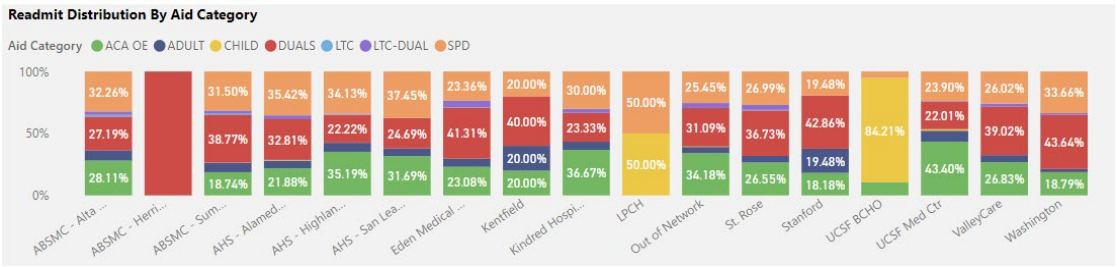
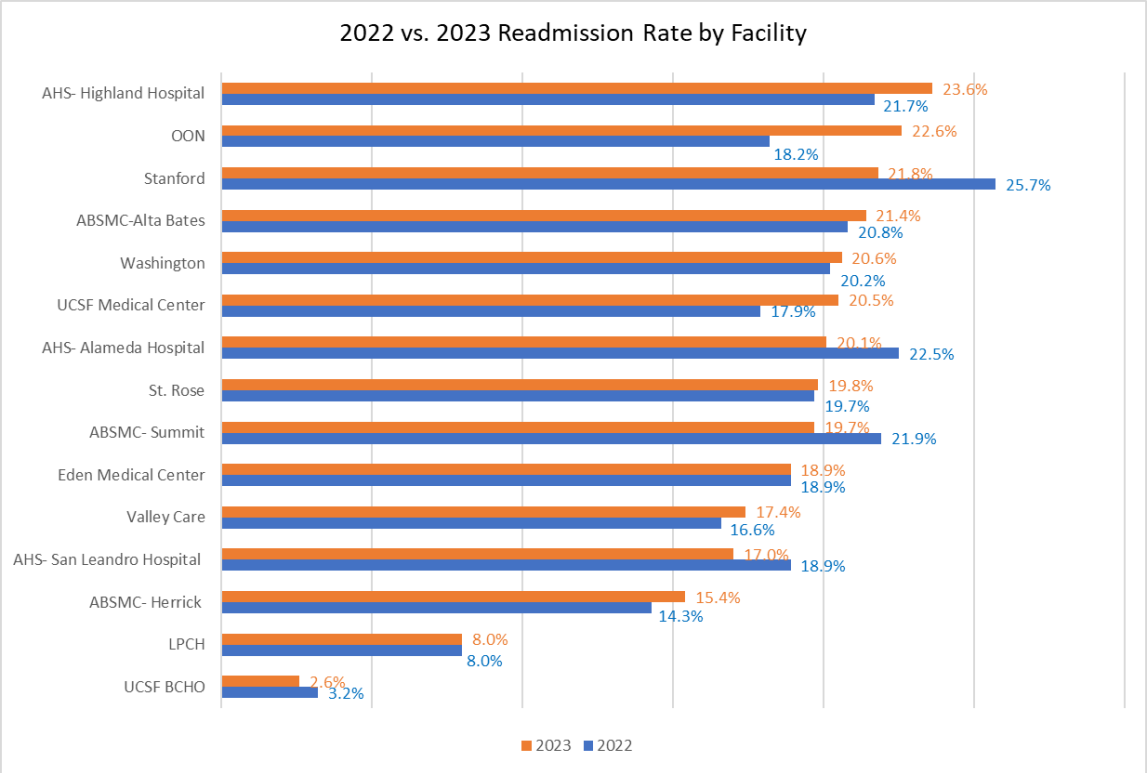


Figure 30e. 2022 vs. 2023 Overall Hospital Readmission Rate, by Facility



In 2023, the overall all-cause readmission rate across all networks increased to 20.1%, compared to 19.6% from 2022. Highland Hospital had the highest overall readmission rate (23.6%, +1.9) in 2023, replacing Stanford (21.8%, -3.9) as the highest readmitting facility in 2023. Highland readmissions were comprised of Affordable Care Act (35.2%), SPD (34.1%), and Duals (22.2%).

The biggest change in readmissions compared to 2022, occurred at out-of-network facilities (22.6%) with a +4.4 jump, comprised of Affordable Care Act (34.2%), Duals (31%), SPD (25.5%) aid categories. The fourth highest readmissions occurred at Alta Bates Medical Center (21.4%, +0.6) comprised of SPD (32.3%), Affordable Care Act (28%), and Duals (27%) aid categories. Dual members comprise a larger percentage of readmissions at Washington Hospital (43.7%), Stanford (42.9%), and Eden Hospital (41.3%). The LTC (25%) members replaced the SPD (23.4%) aid categories for the highest readmission rate across all networks, demonstrating the anticipated higher utilization for this membership due to their higher morbidity and mortality risk factors and intensity of of care needs.

In 2023, there was strengthened efforts to prevent inappropriate readmissions. The UM team, in alignment with DHCS' Transitional Care Services requirements, completed discharge risk assessments for high-risk members who admitted to a facility, proactively identifying potential barriers to discharge, identifying high risk readmissions diagnoses, identifying changes in prior functioning at discharge, and determining any follow-up care

needs while simultaneously referring admitted members to the appropriate Case Management programs like Community Supports or Enhanced Case Management team. Identifying follow-up care and discharge needs well before discharge allowed more adequate time for planning follow-up care when Care Managers became involved. As part of new regulatory Transitional Care Services guidance, case managers served as a single point of contact for members and providers to receive support throughout the hospital stay, and as members transitioned out of the hospital. Care Managers maintained contact with members after discharge, ensuring they received all necessary follow-up care and linking them to ongoing care management or community-based support, as needed.

Acute Hospitalizations - Recommended Actions for 2024:

- Expand ADT feeds and comparable data sharing sources for acute hospitals that are not yet established (Stanford, UCSF, Childrens Hospital).
- Build staffing capacity to manage new membership and inpatient volume for new Long-Term Care higher utilization and 2024 Managed Care Plan to Managed Care Plan and Fee-For-Service Medi-Cal Transitions
- Improve identification members who are at-risk for readmission or who re-admitted, including revision of risk-stratification methodology, and use of additional data sources as available to DHCS or community-based partners
- Implement Inpatient MCG medical necessity criteria trainings, particularly for extended stay evaluations and develop updated UM standard workflows for care optimization
- Provide training on referral criteria and referral process for Enhanced Care Management and Community Supports, with goal to link members to appropriate resources for next level of care
- Foster continued collaboration and relationship building with hospital and skilled nursing facility partners to support discharge management, and complex case rounds for members with long length of stay or complex discharge barriers.
- Coordinate collaboration between the Alliance and its delegates around identifying Potential Quality Issues, Avoidable days variance, Provider Preventable Conditions, and preventable readmissions
- Expand screening for appropriate Case Management referrals for palliative/hospice eligible members

Specialty Care Utilization

Certain specialty care utilization was monitored to detect patterns of over or under-utilization.

Figure 31. 2023 Specialty Care Utilization *(select specialties and ancillary services only)*

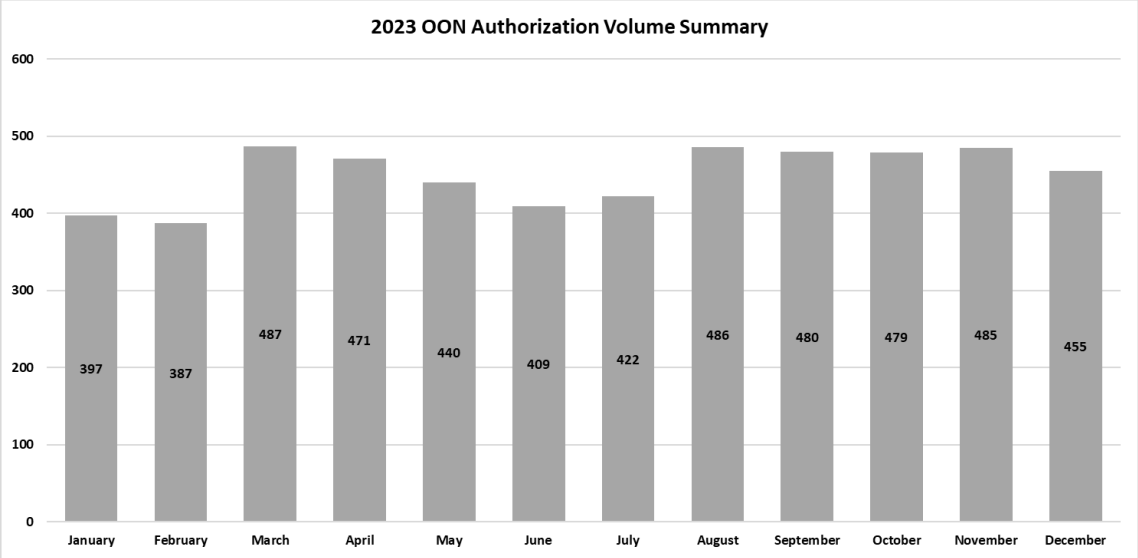
Podiatry is one of the few Specialty services that requires prior authorization for in-network and out-of-network care. In 2023, Podiatry observed a slight drop in utilization, an average 45/month, compared to 50-100 approved authorizations in 2022, however the reason is unclear. Acupuncture and chiropractic services saw relatively no change from 2022, and Transplant services increased by 30 cases per month. Palliative Care has risen by 4 cases per month. Since 2020, the Alliance has collaborated with Alameda Health Systems (AHS) to enhance and extend the use of this benefit by seriously ill members. In December 2022, the Alliance expanded the eligible conditions to receive Palliative Care to include members with advanced dementia and Alzheimer's disease, likely contributing to the increased utilization in 2023. Also, in 2023, efforts were focused on working with the Contracting team to expand the Palliative Care network.

Out-of-Network Services

In addition to monitoring the utilization of certain specialty types, the Alliance also monitors the utilization of out-of-network vs. in-network services to evaluate network adequacy. Out-of-network (OON) services are those provided by non-participating providers or facilities. Members may access OON services either through an emergency

room, or as a direct referral for specialty services that are not available in-network, or when they are available but do not meet timely access standards. OON services may also be accessed when new members meet continuity of care criteria, as outlined in DHCS APL 23-022.

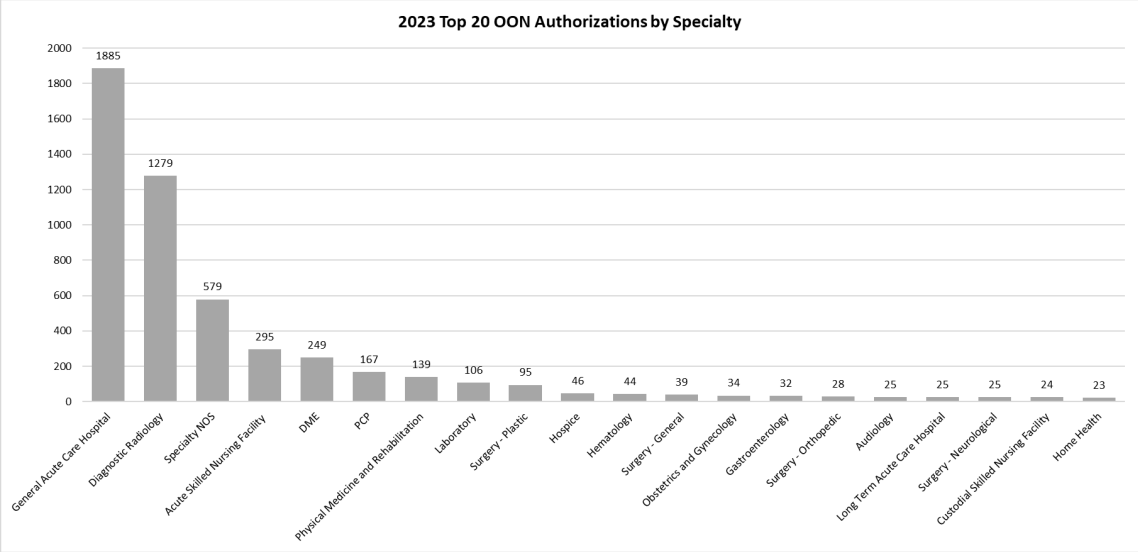
Figure 32a. 2023 Out-of-Network Authorization Volume



In 2023, a monthly average of 485 (+36) out-of-network authorizations were approved, representing an increase from 2022 despite member growth.

Continued work is being done to validate provider data from Delegates and the AAH direct network, capture Delegate out-of-network approval and denial reasons, ensure accurate reporting, and continue evaluating whether that the managed care plan network is adequate. Monitoring network adequacy and aligned provider contracting will be critical after transitioning all new Anthem and Adult Expansion members and LTC Subacute and ICF-FF members in 2024, supporting the single county plan model.

Figure 32b. 2023 Out-of-Network Authorization Volume, by Specialty

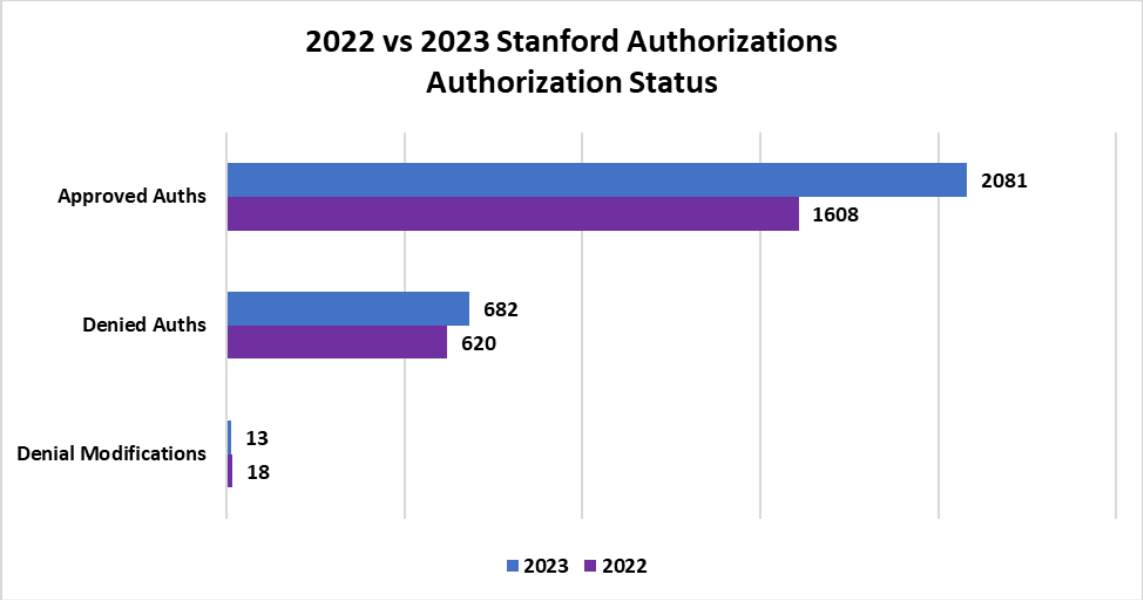


In 2023, the top 4 most accessed out-of-network services were General Acute Hospitalizations (1885), Diagnostic Radiology (1279), Specialty Care - not otherwise specified (579), Acute Skilled Nursing facilities (295). Of note, the data includes OON specialty types as reported by delegated entities (CHCN and CFMG), and the Alliance UM department is aware of potential differences in the outpatient network status between the AAH direct network and the Delegated networks. There is ongoing effort to enhance system configurations to appropriately validate potential network status discrepancies and ensure accurate reporting of OON specialties.

Stanford Utilization

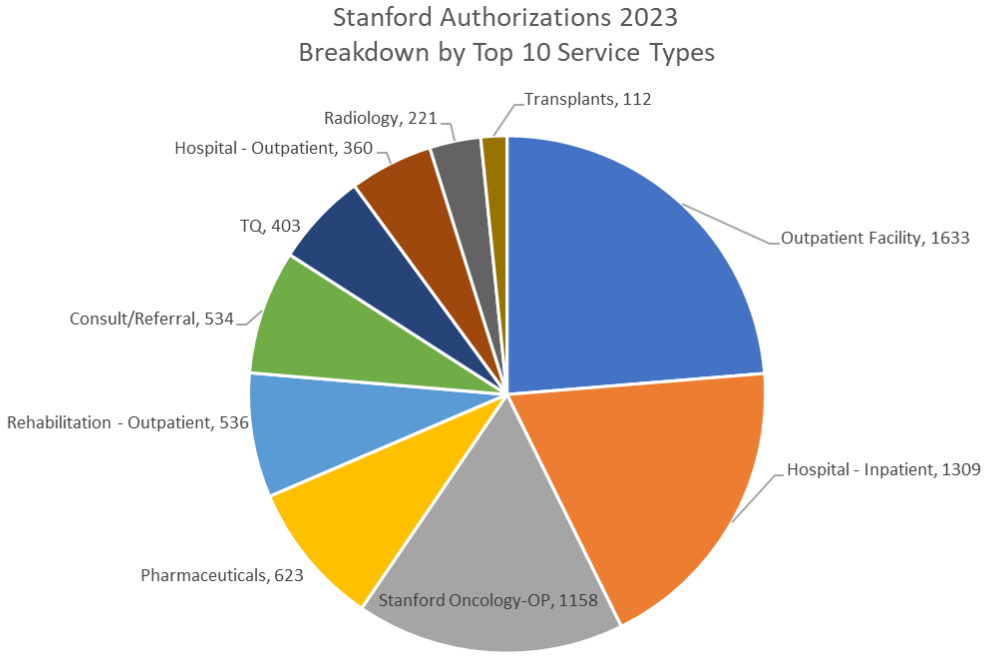
The Alliance contracts with Stanford for Transplant services, and both CHCN and AAH contract with Stanford for oncology care. For all other specialties, ancillary, and diagnostic testing at Stanford is considered out-of-network and requires close monitoring. AAH signed a Letter of Agreement for non-contracted Stanford services in Q4 2023 to ensure continuity of care for Dual and new members to the Plan, and additionally ensure academic Tertiary Quaternary access for Clinical trials and specialties not available in the in-network.

Figure 33a. 2023 Stanford Authorization Volume



Stanford continues to demonstrate a rise in total authorization volume in 2023 related to Oncology Program enrollment, Specialty referrals due to no timely access in-network, and related hospitalizations. Out-of-network Stanford approvals also are rising relative to Stanford denials due to continuity of care for Dual members increased in 2023, rising SHC Oncology program enrollment and related specialty services, and ED utilization.

Figure 34b. 2023 Stanford Authorization Volume, by Top 10 Service Types



In 2023, a total of 2,081 (+473) authorizations were approved at Stanford compared to 2022. The top 3 services accessed at Stanford were Outpatient Facility (1633), Hospital Inpatient admissions (1309), and Outpatient Oncology (1158). Inpatient admissions replaced Consults/ Referrals at Stanford in 2023,and reflects the growing contribution of elective hospitalizations and acute admissions for established patients under care at Stanford for Oncology and other Specialty Care.

Specialty Care Utilization - Recommended Actions for 2024:

- Monitoring elective hospitalizations, Inpatient hospitalizations through the emergency room, hospital transfers for higher level of care, and provider visits and ancillary services, related to established with the Oncology and Transplant Program enrollment.
- Continued partnership with Contracting team to provide insights on in-network needs, based on utilization patterns and identified access barriers, especially for tertiary and quaternary academic centers.

Unused Authorizations

The Alliance monitors the use and non-use of authorizations to ensure members are accessing approved services timely, and to identify potential barriers if findings indicate approved services aren't utilized. An "Unused Authorization Report" is generated to identify authorizations that have no evidence on claims activity; letters are sent to members to remind them to access the services they have been approved to use. Trends from these reports that were reviewed in UMC for committee input and further root cause analysis. In 2023, the most commonly unused authorized service types were Cardiology, Oncology, Urology and Gastroenterology. And members with diabetes represented about ~20% of the unused Podiatry authorizations. UCSF affiliated providers made up 87% of unused authorizations, compared to 7% for Stanford affiliated providers and 5% for Sutter affiliated providers. Timely access and waiting lists at academic centers emphasize the importance of network adequacy evaluation, care coordination for in-network care, and tertiary quaternary medical necessity. Continued monitoring and root cause analysis is required to determine the reasons for members not using approved services – some potential reasons may be loss of eligibility, change in member health condition, timely access at the authorized service, delay in claims activity, or other access barriers including lack of transportation.

Unused Authorizations - Recommended Actions for 2024:

- Continued partnership with Contracting team to provide insights on network needs, based on utilization patterns and identified access barriers
- Continued monitoring and root-cause analysis of unused authorizations

Integration with Quality Management

The UM department collaborates with Quality Management to ensure holistic analysis of utilization patterns that inform quality improvement activities, ultimately improving health outcomes of Alliance members. For examples, HEDIS reports are reviewed at UMC as part of the over/under-utilization trend monitoring. Also, the UM team identifies and reports Potential Quality Issues to the Quality Management department to ensure health and safety for Alliance members.

Member and Provider Satisfaction with UM Process

In addition to quantitative insight on the efficacy of the UM program, quality measures also include satisfaction surveys to assess the efficacy of the UM program from the perspective and experience of members and providers. Member and provider satisfaction surveys are administered annually by an external vendor.

Figure 35. Provider Satisfaction with Utilization Management

Question	MY2021	MY2022	MY2023	Benchmark
Access to UM Staff	44%	49.4%	48.5% *(83rd Percentile)*	35%
Obtaining Pre-Auth Info	48%	56.8%	49.0% *(78th Percentile)*	35%
Timeliness of Pre-Auth Info	47%	52.9%	49.0% *(76th Percentile)*	36%
Facilitation of Care	46%	51.8%	48.0% *(74th Percentile)*	37%
Coverage of Prevention	60%	54.9%	54.2% *(77th Percentile)*	42%

For 2023, all scores were well above the established benchmark of 35%, however, all scores were lower in comparison to 2022. The largest decrease in provider satisfaction score was related to procedures for obtaining prior authorization information (-7.8%), followed by the timeliness of obtaining prior authorization information (-3.9%).

The below figures show results from the Consumer Assessment of Healthcare Providers and Hospital Systems (CAHPS), used to assess patient satisfaction across health plans, providers, and health care facilities. The 3 selected questions are used to member satisfaction with UM. Survey results are currently available from measurement year 2022 (CAHPS data for measurement year 2023 will be available in August 2024).

Figure 36a. Member Satisfaction with Utilization Management – Medi-Cal (Adult)

CAHPS Question	MY2020	MY2021	MY2022
Getting Care Quickly	72%	76%	73%
Getting Needed Care	79%	76%	75%
Coordination of Care	83%	79%	92%

Figure 36b. Member Satisfaction with Utilization Management – Medi-Cal (Child)

CAHPS Question	MY2020	MY2021	MY2022
Getting Care Quickly	79%	78%	73%
Getting Needed Care	82%	78%	79.2%
Coordination of Care	73%	89%	83%

Figure 36c. Member Satisfaction with Utilization Management – Group Care (Adult)

CAHPS Question	MY2020	MY2021	MY2022
Getting Care Quickly	71%	62%	56%
Getting Needed Care	75%	66%	72%
Coordination of Care	77%	74%	80%

For measurement year 2022, there was an average 4.7% year-over-year decreases in satisfaction rates, across product lines, for Getting Care Quickly. The largest increase in satisfaction rates across product lines was for Coordination of Care for Adults at 9.5%.

Member and Provider Satisfaction with UM - Recommended Actions for 2024:

- Streamline and improve the accessibility of prior authorization information to providers, including increase visibility of authorization details on public portals and secure online platforms
- Ensure providers receive appropriate training to access the resources
- Participate in the review of satisfaction survey data for measurement year 2023, using those survey insights to further inform process improvement efforts

Conclusion

Overall, the 2023 UM Program was effective in maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The UM program activities have met most of the established targets, including a reduction in regulatory findings. The UM department successfully carved-in the Long-Term Care custodial nursing facility benefit in 2023, initiated the Tertiary Quaternary, changed the retro policy to allow for 90 days post service authorization submissions compared to 30 days, and was engaged in planning throughout the year to prepare for the carve-in of the Long-Term Care Intermediate Care Facility for the Developmentally Disabled (ICFDD) and the Subacute benefits in January 2024. The Alliance leadership has played an active role in the UM Program structure by participating in committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements. To ensure that the Alliance used a comprehensive approach to designing the UM program structure, practicing physicians provided input through QIHEC. The UM program continues to analyze internal benchmarks to further enhance progress and provide quality service to the Alliance membership.

UM Program Recommendations for 2024

As a result of the 2023 program evaluation, opportunities for improvement have been identified and will be incorporated into the 2024 UM Program and Work Plan. A summary of process improvement opportunities is noted below:

Operational Efficiency and Compliance:

Inpatient and Outpatient UM:

- Continued monitoring and process improvements to meet NOA compliance
- End-to-end authorization system enhancements to streamline authorization processing and eliminate manual workarounds
- Continued evaluation of services that do not require prior authorization with goal to remove unnecessary reviews
- Continue the Tertiary Quaternary Policy
- Develop Authorization and claims stay level configuration for inpatient levels of care and facility types
- Validate different network contracting to ensure accurate out-of-network utilization is reflected in Plan analytical reports and aligned with Delegate utilization reporting.
- Increased alignment with case management, specifically related to transitional care services in alignment with DHCS population health management policy guide

LTSS:

- Hire LTSS Medical Director to provide dedicated LTSS clinical leadership support
- Continued monitoring and process improvements to meet TAT compliance goals
- Successful implementation of LTC care management program, including transitional care services in alignment with DHCS population health management policy guide
- Improve facility awareness to notify the Alliance about changes to LTC member Transition of Care status, and timely Bed Hold and Admission LTC authorizations.
- Continuing to collaborate with LTSS liaison and provider services to establish relationships with facility partners, including consistent onsite facility visits from LTSS social workers
- Ensure the Quality Management department develops quality performance measures for LTC facilities

Pharmacy Services:

- Investigating utilization of unclassified drugs and unclassified biologics for drug utilization patterns and appropriate coding.
- Fully transition Advisor Reviews for Physician Administered Medications/Injections from Alliance Medical Directors to Pharmacists

Behavioral Health Services:

- Enhance process defects impacting TAT performance and implement interventions to meet TAT goals in 2024.
- Increase access as measured by an increase in unique utilizers of mental health and

BHT/ABA services.
- Ensure that Contracting continues to increase network capacity, particularly for ABA services.

G&A:
- Continued monitoring appeals for Carpal Tunnel Surgery during Q1 2024 to see if the overturn trend continues and warrants continued education and ongoing monitoring.

Delegated Utilization Management:
- Partner with the Compliance Department to evaluate audit tools and establish metrics that align with The Alliance's key performance indicators.
- Monitor and support Delegate CAP activities, in coordination with the Compliance Department
- Validate different network contracting to ensure accurate out-of-network utilization is reflected in the Plan's analytical reports and aligned with Delegate utilization reporting.
- Provider regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance's Population Health Management strategy

Quality Improvement

Management of Emergency Room Utilization:
- Continue collaboration with Quality Management and Population Health Management team to ensure access to post-discharge care, particularly with primary care providers.
- Monitor diagnosis drivers for emergency room visits, especially for repeat utilizers and for facilities with high emergency room rates.
- Monitor PCP primary care homes for facilities with high ER rates and for repeat utilizers and facilities with high emergency room rates: Identify Teledoc opportunities and those diagnoses that could be managed in primary care offices.
- Track ED utilization that is associated with members who readmit to the hospital, for case escalation to the Case Management department and supports.
- Increase collaboration with Behavioral Health team and Alameda County Behavioral Health Services to support access to necessary BH/SUD treatment

Management of Acute Hospitalizations:
- Expand ADT feeds and comparable data sharing sources for acute hospitals that are not yet established (Stanford, UCSF, Childrens Hospital).
- Build staffing capacity to manage new membership and inpatient volume for new Long-Term Care higher utilization and 2024 Managed Care Plan to Managed Care Plan and Fee-For-Service Medi-Cal Transitions

- Improve identification members who are at-risk for readmission or who re-admitted, including revision of risk-stratification methodology, and use of additional data sources as available to DHCS or community-based partners
- Implement Inpatient MCG medical necessity criteria trainings, particularly for extended stay evaluations and develop updated UM standard workflows for care optimization
- Provide training on referral criteria and referral process for Enhanced Care Management and Community Supports, with goal to link members to appropriate resources for next level of care
- Foster continued collaboration and relationship building with hospital and skilled nursing facility partners to support discharge management, and complex case rounds for members with long length of stay or complex discharge barriers.
- Coordinate collaboration between the Alliance and its delegates around identifying Potential Quality Issues, Avoidable days variance, Provider Preventable Conditions, and preventable readmissions
- Expand screening for appropriate Case Management referrals for palliative/hospice eligible members

Management of Specialty Care Utilization:

- Monitoring elective hospitalizations, Inpatient hospitalizations through the emergency room, Hospital transfers for higher level of care, and provider visits and ancillary services, related to established with the Oncology and Transplant Program enrollment.
- Continued partnership with Contracting team to provide insights on network needs, based on utilization patterns and identified access barriers, especially for tertiary and quaternary academic centers.

Management of Unused Authorizations:

- Continued partnership with Contracting team to provide insights on network needs, based on utilization patterns and identified access barriers
- Continued monitoring and root-cause analysis of unused authorizations

Member and Provider Satisfaction with UM*:*

- Streamline and improve the accessibility of prior authorization information to providers, including increase visibility of authorization details on public portals and secure online platforms
- Ensure providers receive appropriate training to access the resources
- Participate in the review of satisfaction survey data for measurement year 2023, using those survey insights to further inform process improvement efforts

Utilization Management
Program Description

2024

Utilization Management
2024 Program Description

Signature Page

_____	_____
Date	Allison Lam, RN Senior Director, Health Care Services
_____	_____
Date	Rosalia Mendoza, M.D. Medical Director, Utilization Management
_____	_____
Date	Sanjay Bhatt, M.D., MS, MMM Senior Medical Director Vice Chair, Quality Improvement Health Equity Committee
_____	_____
Date	Donna Carey, M.D. – Interim Chief Medical Officer, Medical Management Chair, Quality Improvement Health Equity Committee
_____	_____
Date	Matthew Woodruff Chief Executive Officer
_____	_____
Date	Rebecca Gebhart Board Chair

Table of Contents

I. Background

Alameda Alliance for Health (the Alliance) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to citizens most in need in Alameda County. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for Alameda County residents and reflects the cultural and linguistic diversity of the community. In addition, Alliance providers, employees, and Board of Governors live in areas that the health plan serves.

The Alliance provides health care coverage to over 300,000 children and adults in Alameda County through the Medi-Cal and Group Care programs. Through active partnerships with healthcare providers and community partnerships, the Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan Members.

The Alliance's Utilization Management (UM) Program was established to provide care management structures and key processes that enable the health plan to improve the health and health care of its members. The UM Program is a supportive and dynamic tool that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, and regulatory and accrediting organizations. The UM Program ensures parity between medical/surgical care and behavioral health care throughout all structures and functions. The UM Program is compliant with Health and Safety Code Sections 1363.5, 1367.01, 1368.1, 1374.16, 1374.72, 1374.76, and Title 28, CCR, Sections 1300.1300.67.2, 1300.70(b)(2)(H) & (c).

II. Program Purpose and Scope

The purpose of the Alliance's UM Program is to objectively monitor and evaluate the appropriateness of utilization management services delivered to members of the Alliance. The UM Program serves Alliance members through the following objectives:

- Ensure that appropriate processes are used to review and approve the provision of medically necessary covered services.
- Provide continuity of care and coordination of medical and behavioral services.
- Improve health, including behavioral health, outcomes; and
- Assure the effectiveness and efficiency of healthcare services.

The Alliance adheres to the following operating principles for the UM Program, for both the medical/surgical services and behavioral health services:

- Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria.
- UM decisions are made on appropriateness of care and service, as well as existence of benefit coverage.
- Appropriate processes are used to review and approve provision of medically necessary

covered services.

- Prior authorization requirements are not applied to emergency, family planning, preventive, or basic prenatal care, and sexually transmitted disease or HIV testing services.
- The Alliance does not financially reward clinicians or other individuals for issuing denials of coverage, care, or service.
- The Alliance does not encourage UM decisions that result in under-utilization of care to members.
- Members have the right to:
  - Participate with providers in making decisions about their individual health care, including the right to refuse treatment.
  - Discuss candidly with providers the appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
  - Receive written notification of a decision to deny, defer, or modify requests for prior authorization.
  - Request a second opinion from a qualified health professional at no cost to the member.
  - Voice grievances or appeals, either verbally or in writing, about the organization of the care received.
  - Request a Medi-Cal state hearing, including information on the circumstances under which an expedited fair hearing is possible.
  - Have access to, and where legally appropriate, receive copies of, amend or correct their medical record; and
  - Receive information about how to access State resources for investigation and resolution of member complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and its toll-free number, and the DMHC, Health Maintenance Organization (HMO) Consumer Service and its toll-free number

UM Program activities promote utilization of covered services at the right time and at the most appropriate site and level of care. Activities include, but are not limited to:

- Admission and concurrent review
- Discharge planning: pre-admission, concurrent, and post-discharge follow-up with member/provider
- Coordination with Claims, including review of Provider Disputes
- Coordination with Compliance, to support monitoring and auditing activities for internal and delegated entities
- Coordination with Grievance and Appeals, including review of overturned decisions
- Continuity and coordination of care for members when a provider is terminated from the network
- Continuity and coordination of care for members newly eligible with The Alliance, receiving active care and treatment from a non-Alliance provider
- County Behavioral Health Care Services (ACBHCS)
- Discharge planning: pre-admission, concurrent, and post-discharge follow-up with member/provider

- Evaluate and refer members needing care coordination/case management (including children/youth under Medi-Cal for Kids & Teens, California Children's Services, Enhanced Care Management, Complex Case Management, Community Supports, Dental Health, Behavioral Health, or Long-Term Care)
- Integration of medical and behavioral health, including collaboration with Alameda County Behavioral Health Services
- Peer-to-peer discussions to support providers regarding clinical decision-making
- Prior authorization of services (including pre-admission education)
- Quality improvement projects, based on analysis of utilization trends
- Retrospective review

III. Program Structure

The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of the Alliance health care delivery network. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect entities and multiple disciplines within the organization. The UM Program is evaluated on an on-going basis for efficacy and appropriateness of content by The Alliance staff and oversight committees.

A. Board of Governors

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 19-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of the Alliance programs and is responsible for approving the Quality Improvement and Utilization Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to the Alliance Chief Medical Officer (CMO) and the Quality Improvement Health Equity Committee (QIHEC). The CMO and the QIHEC provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management Program. Utilization Management activities are the responsibility of the Alliance Health Care Services staff under the guidance of the Medical Director for Utilization Management and the Senior Director of Health Care Services, in collaboration with the Alliance CMO.

The Board of Governors appoints and oversees the QIHEC, the Peer Review and Credentialing Committees, and the Pharmacy and Therapeutics Committee (P&TC) which, in turn, provide the authority, direction, guidance, and resources to enable the Alliance staff to carry out the Quality Improvement, Utilization Management and Case Management Programs. Committee membership consists of provider representatives from the Alliance contracted networks and the community, including those who provide health care services to populations served by The Alliance (for example: Seniors and Persons with Disabilities, Dual-eligible members, and members with Chronic conditions). Alliance committees meet on a regular basis and in accordance with Alliance Bylaws. Alliance Board meetings are open to the public, except for peer review activities, contracting issues, and other proprietary matters of business, which are held in closed session.

B. Quality Improvement Health Equity Committee (QIHEC)

The QIHEC provides oversight, direction, makes recommendations, and has final approval of the CM Program. Committee meeting minutes are maintained to summarize committee activities and decisions with appropriate signatories and dates. A full description of the QIHEC Committee responsibilities can be found in the most recent Quality Improvement Program Description.

The QIHEC provides the external physician involvement to oversee The Alliance QI and UM Programs. The QIHEC includes a minimum of four (4) practicing physician representatives with active, unrestricted licenses to practice in the State of California. The composition includes the Senior Director of Behavioral Health and/or a Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed.

The QIHEC functional responsibilities for the UM Program include:

- Annual review and approval of the UM Program Description
- Annual review and approval of UM Policies and Procedures
- Oversight and monitoring of the UM Program, including:
    - Recommend policy decisions
    - Review and approve clinical criteria for UM decision-making
    - Oversight of interventions to address over and under-utilization of health services.
    - Oversight of the integration of medical and behavioral health activities
    - Guide studies and improvement activities.
    - Review results of improvement activities, HEDIS measures, other studies and profiles and the results of audits
    - Recommend necessary actions

C. Pharmacy & Therapeutics Committee (P&TC)

The P&T Committee is responsible for oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization, and developing provider education programs on drug appropriateness. P&T Committee meeting minutes and pharmacy updates are shared with the BOG.

<u>The voting membership consists of:</u>

- Alliance Chief Medical Officer (Chair) or designee
- Alliance Director of Pharmacy Services (Co-Chair)
- Practicing physician(s) representing Internal Medicine
- Practicing physician(s) representing Family Practice
- Practicing physician(s) representing Pediatrics
- Practicing physician(s) representing common medical specialties
- Practicing community pharmacists contracted with Alliance (not to exceed 1/3 of the voting membership of the committee or three pharmacists, whichever is greater).

D. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a sub-committee of QIHEC. The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The sub-committee is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

UMC activities reporting through the QIHEC integrates UM activities into the Quality Improvement system. While the QIHEC is responsible for the overall direction and development of strategies to manage the UM program, including but not limited to reviewing all recommendations and actions taken by the UM Committee, the QIHEC has delegated authority of the following functions to the UMC:

- Annual review and approval of the effectiveness of the UM/BH Program
- Annual review and approval of the UM/BH Program
- UM/BH Policies/Procedures,
- UM/BH Criteria, and
- Other pertinent UM documents such as the UM Delegation Oversight Plan, UM Notice of Action Templates, and
- Case/ Care Management Program and Policies/ Procedures.

UM Committee Membership

The UMC is chaired by the Chief Medical Officer. Members of the UMC include:

- The Alliance Chief Analytics Officer
- The Alliance Medical Directors, UM
- The Alliance Medical Director, CM
- The Alliance Senior Medical Director, Quality Improvement
- The Alliance Senior Director, Quality Improvement
- The Alliance Senior Director, Pharmacy & Formulary
- The Alliance Senior Director, Health Care Services
- The Alliance Senior Director, Behavioral Health
- The Alliance Director, Compliance
- The Alliance Director, Member Services
- The Alliance Director of Provider Relations and Provider Contracting
- The Alliance Director, Quality Assurance
- The Alliance Director, Utilization Management
- The Alliance Director, Long Term Services and Supports
- The Alliance Director, Social Determinants of Health
- The Alliance Manager, Healthcare Analytics
- The Alliance Managers, Case Management
- The Alliance Managers, Utilization Management
- The Alliance Manager, Grievance & Appeals

UMC Voting Privileges
For the purposes of voting at the UM Committee, only physician and Director level members of the UM committee may vote.

UMC Quorum
A quorum is established when fifty one percent (51%) of voting members are present.

UMC Meetings
The UMC meets at least quarterly but as frequently as necessary. The meeting dates are established and published each year.

UMC Minutes
All meetings of the UM Committee are formally documented in transcribed minutes which include discussion of each agenda topic, follow-up requirements, and recommendations to the QIHEC. All minutes are considered confidential. Draft minutes of prior meetings are reviewed and approved by the UMC with noted corrections. These minutes are then submitted to the QIHEC for review and approval.

UMC Functions
The UM Committee is a forum for facilitating clinical oversight and direction. Its purpose is to:

- Improve quality of care for the Alliance members.
- Evaluate and trend utilization data for medical and behavioral health services provided to Alliance members and benchmark for over/under utilization. This includes in-network and out-of-network utilization data review to ensure services are accessible and available timely to members.
- Provide a feedback mechanism to drive quality improvement efforts in UM.
- Increase cross functional collaboration and provide accountability across all departments in Health Care Services
- Provide mechanism for oversight of delegated UM functions, including review and trend authorization and utilization reports for delegated entities to identify improvement opportunities.
- Maintain the annual review and approval of the UM/BH Program, UM/BH Policies/Procedures, UM/BH Criteria, and other pertinent UM documents such as the UM Delegation Oversight Plan, UM/BH Notice of Action Templates, and UM/BH and Case/Care Management Program and Policies/ Procedures.
- Identify behaviors, practices patterns and processes that may contribute to fraud, waste, and abuse with a goal to support the financial stability of our providers and network.
- Recommend actions to the Quality Improvement Health Equity Committee when opportunities for improvement are identified from review of utilization data including, but not limited to, Ambulatory Visits, Emergency Visits, Hospital Utilization Rates, Hospital Admission Rates, Average Length of Stay Rates, Behavioral Health usage and outcomes, and Discharge Rates.

- Receive updates about New Medical Technologies from the Pharmacy & Therapeutics Committee, including new applications of existing technologies that have been approved by P&T committee

Based on the decision of the UM Committee and recommendations through the appropriate Quality Committees, the approval of a new technology or new application of an existing technology by the QIHEC shall be deemed to be the Alliance policy on coverage, and where the Alliance does not have the authority to modify the benefit package, the Chief Medical Officer shall notify, in writing, each payer for whom the Alliance manages benefits of its recommendation.

The UM committee also evaluates the impact of UM/BH programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes.

E. Staff Resources

The Alliance Health Care Services Department is responsible for the operational management and oversight of clinical programs, including the UM Program. The UM, Behavioral Health (BH), and Pharmacy Departments administer the UM Program, and the primary staff roles and responsibilities are as follows:

Chief Medical Officer

The Chief Medical Officer is a designated board-certified physician with responsibility for development, oversight, and implementation of the UM Program. The CMO holds a current unrestricted license to practice medicine in California. The CMO serves as the chair of the QIHEC and UMC, and makes periodic reports of committee activities, UM Program activities and the annual program evaluation to the BOG. The CMO works collaboratively with Alliance network physicians to continuously improve the services that the UM Program provides to members and providers.

Any changes in the status of the CMO shall be reported to the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) within the required timeframe.

Medical Directors

The Medical Directors are licensed physicians with authority and responsibility for providing professional judgment and decision-making regarding matters of UM. The Medical Directors hold current unrestricted license to practice medicine in California. Medical Directors responsibilities include but are not limited to the following:

- Ensure that medical decisions are rendered by and are not influenced by fiscal or administrative management considerations
- The decision to deny services based on medical necessity is made only by Medical Directors
- Ensure that the medical care provided meets the standards for acceptable medical care

- Ensure that medical protocols and rules of conduct for plan medical personnel are followed
- The initial reviewer must not review any appeal cases in which they were the decision maker for the authorization
- Develop and implement medical policy

The Alliance may also use external specialized physicians to provide specific expertise in conducting utilization reviews. These physicians are currently licensed, and many have board certification in specific areas of medical expertise. The CMO is responsible for managing access and use of specialized physicians.

Senior Director, Health Care Services

The Senior Director, Health Care Services is a Licensed Registered Nurse and is responsible for overall UM Department operations, staff training, and coordination of services between departments. The Senior Director's responsibilities include:

- Develop and maintain the UM Program in collaboration with the CMO
- Coordinate UM activities with the Quality Department and other Alliance units
- Maintain compliance with regulatory and accreditation standards.
- Monitor utilization data for over and under-utilization, and coordinate interventions with the CMO to address under and over utilization concerns, as appropriate
- Monitor utilization data and activities for clinical and utilization studies;
- Maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Monitor documentation for adequacy
- Available for UM staff on site or by telephone

Senior Director, Behavioral Health Services

The Senior Director, Behavioral Health Services is a licensed Psychologist and is responsible for the overall Behavioral Health department operations, staff training, and coordination of services between departments. The Senior Director's responsibilities include:

- Develop and maintain the Behavioral Health (BH) Program in collaboration with the Senior Medical Director of Quality and the CMO.
- Coordinate BH activities with the Quality, UM, Case Management, Member Services Departments, as well as other Alliance units.
- Maintain compliance with the regulatory standards.
- Maintain professional collaboration with Alameda County Behavioral Health Care Services (ACBHCS) to coordinate care and care transitions across behavioral health care systems.
- Coordinate interventions with the Senior Medical Director and the CMO to address under and over utilization concerns when appropriate.

- Develop and monitor data and activities for clinical and utilization studies; and maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies.
- Monitor for consistent application of utilization criteria by BH staff, for each level and type of UM decision.

Senior Director, Pharmacy Services

The Senior Director, Pharmacy Services is a licensed pharmacist (Pharm.D.) responsible for coordinating daily operations and reviewing and managing pharmacy utilization reports to identify trends and patterns. The Director provides clinical expertise relative to the Pharmacy, Quality and UM components of Alliance plan management including Member and Provider Services and Claims operations. The scope of responsibilities of the Pharmacy Services Director includes:

- Function as the authoritative source of relevant and current information on all pharmaceuticals' efficacy, safety, comparative efficacy, cost, and cost impact.
- Oversee all levels of pharmaceutical information and/or education, in a proactive and timely manner to internal staff, members and providers.
- Oversee policies and procedures, systems, and processes to assure compliance with all federal and state regulatory requirements pertaining to Formulary and benefit management.
- Co-chair the Pharmacy & Therapeutics (P&T)
- Oversee the pharmacy prior authorization, physician administered drugs pass thru pharmacy, and pharmacy appeal process to meet the regulatory and contractual requirements with federal and state government agencies, including CMS, NCQA, DMHC and DHCS.
- Monitor, research, recommend and contract with vendors and implement programs related to pharmaceuticals include but not limited to PBM, Specialty pharmacy, Identify trends and patterns in pharmaceuticals utilization.
- Develop provider and member programs to improve medication prescribing patterns and to increase patient compliance and adherence for improving quality measures.

Lead Clinical Pharmacist, Medical Drug Management

The Lead Clinical Pharmacist, Medical Drug Management is a licensed pharmacist (Pharm.D.) responsible for leading the planning and implementation of new physician administered drugs (PAD) operational and/or clinical initiatives. This position works closely with Pharmacy Supervisor, Lead Pharmacy Technician, mentors clinical pharmacists and acts as a back up for pharmacy supervisor. The scope of responsibilities of the Lead Clinical Pharrmacist includes:

- Guide the tasks performed by the pharmacy technicians and clinical pharmacists related to PAD.
- Review and make determinations for outpatient pharmacy prior authorization

(PA) requests, coverage determinations, exceptions requests, complaints, and appeals and ensure criteria and decisions are properly communicated and applied.
- Create, update PAD policies & procedures and support pharmacy related audits related to PAD in accordance with DHCS, DMHC, NCQA and CMS requirements and other regulatory and contractual requirements.
- Create and update PAD related contents of the plan communications such as letters/fax blast and websites and portals and for member and provider bulletin in accordance with NCQA, MediCal and Medicare requirements.
- Develop and train educational services for internal staff, employers, providers, and other stakeholders related to PAD topics.
- Prepare and gather PAD related reporting for internal committees and/or external publication to assist the Senior Director of Pharmacy Services.

Clinical Pharmacists

The Clinical Pharmacists are licensed pharmacists and responsible for providing clinical expertise relative to the Alliance pharmacy drug benefit programs and participating in designing, developing, and implementing pharmacy clinical programs to promote a quality, cost-effective pharmacy benefit. This position reviews and makes determinations for outpatient pharmacy prior authorization (PA) requests and in office medical drug authorizations. The scope of responsibilities of the Clinical Pharmacists includes:

- Review pharmacy related coverage determinations, exceptions requests, complaints, and appeals and ensure criteria and decisions are properly communicated and applied.
- Make presentations to develop training, reports, and other communications for internal staff, employers, providers, and to other stakeholders related to clinical pharmacy issues.
- Provide pharmacotherapy expertise, review cases, and make formal recommendations at the request of Alameda Alliance clinical staff
- Analyze pharmacy and medical utilization data to identify trends and at-risk populations; recommend and develop appropriate interventions; monitor and act on results.

Pharmacy Supervisor

The Pharmacy Supervisor is a licensed pharmacist and responsible for ensuring efficient, compliant, and productive workflows in the operational and clinical areas of pharmacy services. The Pharmacy Supervisor leads the planning and implementation of new operational and/or clinical initiatives. The Pharmacy Supervisor is responsible for the direct supervision of lead technician, and pharmacy technicians while mentoring clinical pharmacists for guidance and/or decision making. This position also develops, reviews and updates policies and procedures, medication guidelines for pharmacy prior authorization (PA) and pharmacy appeal per DHCS, DMHC, NCQA and CMS requirements. The scope of responsibilities of the Clinical Pharmacists includes:

- Supervise and lead the provision of timely, efficient, equitable, and effective

pharmacy services.

- Hold staff accountable to the standards of the department and Alameda Alliance for Health.
- Serve as the liaison to coordinate compliance and regulatory issues for areas of responsibility.
- Support clinical pharmacy workflows and practice expectations through operational planning.
- Create, update pharmacy policies & procedures and support pharmacy related audits related to formulary and benefit management and pharmacy performance in accordance with to DHCS, DMHC, NCQA and CMS requirements and other regulatory and contractual requirements.
- Lead the Alliance's Pharmacy & Therapeutics (P & T) Committee presentation materials and implement the recommendations with a PBM and specialty pharmacy on formulary and PA guidelines including benefit coding and formulary updates on websites, PA guideline implementation, and follow up on other pharmacy related initiatives resulting from the Committee's decision(s).

Lead Pharmacy Technician

The Lead Pharmacy Technician is a licensed pharmacy technician. This position supports pharmacy prior authorization (PA), P & T, and DHCS, DMHC, CMS audits and NCQA survey preparation. The scope of responsibilities of the Lead Pharmacy Technician includes:

- Train and mentor pharmacy technicians.
- Train and mentor Pharmacy Technicians on how to draft the Pharmacy and Therapeutics (P & T) meeting materials included but not limited to the meeting minutes, the post P & T summary, and assist on other pharmacy related initiatives resulting from the P & T Committee's decision(s).
- Assist physician administered drugs prior authorization passing thru pharmacy and ensure criteria and decisions are properly communicated with PBM, specialty pharmacy (SP) and internal staff.
- Retrieve drug-specific technical data and information necessary for the completion of departmental and interdepartmental pharmacy-related functions and operations.
- Create and prepare ad hoc reports as well as recurring reports using pharmacy reporting tools for pharmacy clinical programs and quality initiatives, such as HEDIS, drug utilization review (DUR), medication reconciliation, medication therapy management (MTM), inter-rater reliability (IRR) reviews, audits, root-cause analyses, PDSA cycles, corrective action plans, and other related activities.
- Create, update desktop procedures, pharmacy policies & procedures and support pharmacy related audits related to Pharmacy Operations in accordance with DHCS, DMHC, NCQA and CMS requirements and other regulatory and contractual requirements.

Pharmacy Technicians

The Pharmacy Technicians are licensed pharmacy technicians. They utilize specialized pharmacy knowledge and expertise to assist participating pharmacies, members, and

providers to ensure the efficient, timely, and effective delivery of pharmaceutical products and services to Alliance members. This position is responsible for completing daily pharmacy service operations. This position also supports clinical staff through completion of the administrative and clinical coordinator functional components of Physician Administered (PAD) Disease medication management. The scope of responsibilities of the Pharmacy Technicians include:

- Process Pharmacy Authorizations (PA) and assist physician administered drugs prior authorization passing thru pharmacy and ensure criteria and decisions are effectively communicated with PBM, specialty pharmacy (SP) and internal staff in a timely manner according to the regulatory requirements.
- Support Pharmacy Transition of Care (TOC) and pharmacy referrals from CM (e.g., via email, outreach calls and TruCare).
- Coordinate employee RxNova via PerformRx and new internal DU access for FirstCI.
- Assist with drug recall, formulary change, channel management, population health, disease management, Alliance quarterly platform updates and/or product discontinuation support for impacted member and provider notifications (e.g., Cognito requests to C&O for mailing).
- Help coordinate with business ops/internal departments to ensure appropriate member eligibility/product overrides for access to medicinal treatment.
- Pharmacy Services phone queue and email triage/support.
- Perform ad-hoc audit of the pharmacy authorization letters and claims under the guidance of a pharmacist.
- Create and prepare ad hoc reports as well as recurring reports using pharmacy reporting tool.
- Retrieve drug-specific technical data and information necessary for the completion of departmental and interdepartmental pharmacy-related functions and operations.
- Process member reimbursement requests

Director, Utilization Management

The Director, Utilization Management has day to day responsibility for the operation of the UM Program under the direction of the Senior Director, HCS, and the Chief Medical Officer**.** The Director oversees health service compliance functions, internal and delegation oversight auditing and monitoring. The Director also serves on the QIHEC, UMC, and Healthcare Internal Compliance Committee (HICE).

Director, Long-Term Services and Supports

The Director, Long-Term Services and Supports, (LTSS) reports to the Senior Director, Health Care Services (HCS) and is responsible for the operational management and directional guidance of the LTSS Department and activities including institutional Long-Term Care (LTC), Community Supports (CS), and Community Based Adult Services (CBAS). The Director is knowledgeable of and responsible for compliance with regulatory requirements of Managed Medi-Cal and Medicare for LTSS, Nursing Facility (NF-B)/Sub-

Acute Facility (NF-A)/Distinct Part of Hospital (DP-H,) ICFs, IMDs, CBAS, CS/CalAIM, long term care settings, continued stay requirements, as well as transitions of care to community settings.

Managers, Utilization Management

The Managers, Utilization Management are Registered Nurses with current, active and unrestricted California nursing licenses. They supervise all Alliance UM activities, including:

- Provide supervision of assigned UM staff
- Participate in staff training
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Monitor documentation for adequacy
- Ensure staff are following policies, procedures, and all requirements
- Are available to UM staff on site or by telephone/computer
- Collaborate with other departments on interdepartmental initiatives that involve UM activities or functions
- Participate in delegate oversight activities, including annual and/or focused audits, meetings, and joint initiatives
- Participate in regulatory audits and enact regulatory changes or process changes as required

Manager, Long Term Care

Under the general direction of Director of Long-Term Services and Supports, the Manager, Long Term Care, is responsible for the oversight and operations of the Long-Term Care Department. The Manager is knowledgeable of and responsible for compliance with regulatory requirements of Nursing Facility (NF-B)/Sub-Acute Facility (NF-A)/Distinct Part of Hospital (DP-H) long term care admissions, ICF and ICF/DD admissions, continued stay requirements as well as transitions of care to community settings and case management activities for long term care. The Manager provides leadership and executes decision-making based on subject matter expertise and judgment. Additional responsibilities include:

- Monitor program performance to maintain compliance with federal and state regulatory agencies.
- Make decisions within department guidelines and policies, conduct staff training, and facilitate learning opportunities.
- Identify trends, patterns, and opportunities for improvement and communicate findings to appropriate Alliance committees; and
- Provide daily oversight of operations and staff.
- Develops and implements departmental policies and procedures.
- Develops, implements, and monitors performance standards.
- Facilitates inter-disciplinary meetings for LTC admissions.
- Lead any technological implementations for the unit.

- Provide training, development, and continuing education to staff.
- Conduct internal audits which include regular case audits
- Track turnaround time for decision-making and ensure cases are entered into the information system and updated in a timely manner.
- Serve as the primary liaison to resolve complex issues across departments.

Clinical and Nonclinical Supervisors, Utilization Management

Clinical Supervisors, Utilization Management are Registered Nurses and Nonclinical Supervisors are qualified staff with health care and utilization management experience. Supervisors are responsible for:

- Provide day to day oversight of the staff to ensure adherence to departmental processes, productivity, and departmental functions.
- Consult on or assume responsibility for challenging cases
- Provide staff training and coaching
- Assist in audit preparation

Lead Long Term Care, Nurse Specialist

Under general direction of the Manager of Long-Term Care and working in cooperation with other departments, such as Utilization Management, the Lead Long-Term Care (LTC) Nurse Specialist provides providing health plan administrative and clinical support to staff and to Members on the admissions and continued stay services in LTC Nursing Facilities/Intermediate Care Facilities/Distinct Part Hospitals. The lead role supports the day-to-day operations of the department by providing guidance and priority-setting for front line staff and communicating operational issues to the Manager of LTC. Additional Responsibilities include:

- Coordinate the identification, documentation, and resolution of LTC facility related issues in a timely manner.
- Identify opportunities for process improvements to facilitate department functions and ensure compliance within applicable governmental program guidelines.
- Audit staff documentation according to departmental standards.
- Work as part of a multidisciplinary care team to support members as well as meet Alameda Alliance, regulatory and accreditation requirements
- Participate in program development and quality improvement initiatives

Utilization Review Clinicians

Utilization Review Clinicians are Registered Nurses or Nurse Practitioners with current, active unrestricted California nursing licenses, Physician Assistants with active California Physician Assistant license, and/or licensed Behavioral Health clinicians responsible for the review and determinations of medical necessity coverage decisions. Clinicians may approve prospective, concurrent, and retrospective inpatient or outpatient medically necessary services using established guidelines and evidenced-based medical criteria, tools, and references within the scope of their clinical training and education. Licensed Vocational Nurses (LVNs) Nurse Reviewers are supervised by a Registered Nurse (RN) and

do not make clinical approval or denial decisions. Utilization Review Clinicians also work collaboratively with case managers and assist members with transitional care and discharge planning. For cases that do not satisfy medical necessity criteria, the UM Review Clinicians refer to a Medical Director/doctoral Behavioral Health Specialist for final determination. All clinical staff involved in the authorization review process must identify and refer any potential quality issues appropriately for further investigation.

Nurse Specialist, Long Term Care

Under general direction of the Manager of Long-Term Care and working in cooperation with other departments, such as Utilization Management, the Long-Term Care (LTC)) Nurse Specialist is responsible for providing health plan administrative support and clinical support to Members on the admissions and continued stay services in LTC Nursing Facilities/Intermediate Care Facilities/Distinct Part Hospitals. The Nurse Specialist collaborates with LTC facilities to ensure appropriate physical and behavioral healthcare and social services are provided timely and efficiently for Alliance members, including performing clinical review of Skilled Nursing Facilities (NF-A/B), Distinct Part Hospitals and Intermediate Care Facility admissions and recertifications to validate the appropriate level of care. The LTC Nurse Specialist has knowledge of current upcoming programs and services that intersect with LTC services, including Enhanced Case Management, Community Support, Population Health Management, Regional Services, HCBS (Home and Community Based Services). Performs clinical review of Skilled Nursing Facilities (NF-A/B), Distinct Part Hospitals and Intermediate Care Facility admissions and recertifications to validate the appropriate level of care.

Long Term Care, Social Worker

Under general direction of the Manager of Long-Term Care (LTC), and working in cooperation with other departments, the LTC Social Worker is part of a multidisciplinary care team that includes the Social Worker, a Health Navigator, a Nurse Case Manager, Medical Director and Long Term care/Skilled nursing facility partners. The LTC Social Worker serves as a resource for the care team on best practices for psychosocial assessment and mental health interventions. The Social Worker makes referrals to the community and manages internal and external relationships. The LTC Social worker also possesses knowledge of current upcoming programs and services that intersect with LTC services, including Enhanced Case Management, Community Support, Population Health Management, Regional Services, HCBS (Home and Community Based Services). Additional responsibilities include:

- Developing patient-centered plans based on clinical needs assessments and goals
- Organize and participate in clinical case conferences, multidisciplinary care team meetings and LTC/Skilled nursing ICT/IDT meetings consisting of other health professionals and collaborate to construct a treatment plan that addresses all the members' needs.
- Support complex, care coordination, continuity of care, end of life discussions, and transition of care throughout the continuum.

UM Coordinators

UM Coordinators are non-clinical staff responsible for performing basic administrative and operational UM functions. Clinical staff provides oversight to the non-clinical staff. Their roles and responsibilities include:

- Outpatient UM Coordinators
  - Ensure appropriate UM referral entries into the information system.
  - Process UM referrals approvals for selected requests identified as Auto Authorizations or Authorization in their Scope of Work that do not require clinical interpretation
  - Complete intake functions with the use of established scripted guidelines
  - Manage and complete UM Member and Provider communications.
  - Complete administrative denials for non-eligibility
- Inpatient UM Coordinators:
  - Monitor and collect facility admissions census data
  - Complete data entry of initial case.
  - Maintain member and provider communications
  - Assist in requesting additional information as needed
  - Review of hospital referral to ensure appropriate case closure
- Ensuring efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic UM nurse staff

Long Term Care, Coordinator

The Long-Term Care Coordinator supports clinical staff through completion of the administrative and nonclinical coordination functions. The Long-Term Care Coordinator is responsible for continuous processing and monitoring of the review and authorization process and ensuring that corresponding documentation is received timely. The Long-Term Care Coordinator is responsible in ensuring the quality and accuracy of any corresponding documentation. Additional responsibilities include:

- Processing and issuing member and provider notifications (mail, fax, electronic media, telephone)
- Establish, facilitate, and maintain effective ongoing relationships with network hospitals, SNFs, delegated groups, vendors and providers; facilitate communication and care coordination between network entities
- Respond to provider, member, and staff inquiries at any given time in a professional and timely manner.

Long-Term Services and Supports (LTSS) Liaison

The LTSS Liaison is trained on the rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies, prompt claims payment requirements, provider resolutions, policies and procedures, and care management, coordination and transition policies. They serve in both a provider representative and care coordination representative role, and support the facilitation of member care transitions, as needed, in collaboration with the LTC team.

Behavioral Health Navigators

The Behavioral Health Navigators are the non-clinical staff responsible for performing basic administrative and operational UM functions for behavioral health services. Behavioral Health Clinical staff provides oversight to the non-clinical staff. Their roles and responsibilities include:

- Ensure appropriate UM referral entries into the information system.
- Process UM referrals approvals for selected requests identified as Auto Authorizations or Authorization in their Scope of Work that do not require clinical interpretation.
- Complete intake functions with the use of established scripted guidelines
- Manage and complete UM Member and Provider communications.
- Complete administrative denials for non-eligibility
- Ensuring the efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic Behavioral Health Clinical staff

F. Delegated Utilization Management

The Alliance delegates utilization management activities to provider groups, vendor networks and healthcare organizations that meet delegation agreement standards. The contractual agreements between the Alliance and delegated groups specify: the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities to the Alliance; how performance is evaluated; and corrective action plan expectations, if applicable. The Alliance conducts a pre- contractual evaluation of delegated functions to assure capacity to meet standards and requirements. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department will work with other respective departments to conduct the annual delegation oversight audits. Delegate work plans, reports and evaluations are reviewed by the Alliance and the findings are summarized at QIHEC and Compliance Committee meetings, as appropriate. The Compliance Department in conjunction with each respective department monitors the delegated functions of each delegate through reports and annual oversight audits.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor a UM Program description that addresses all State, Federal, health plan and accreditation requirements.
- Provide encounter information and access to medical records pertainingto Alliance members.
- Submit at least quarterly reports, annual evaluations, and program descriptions and work plans; and
- Cooperate with annual audits and complete any corrective actions necessary by the Alliance.
- Participate in performance improvement activities.

IV. Benefits

Benefit coverage is verified by Utilization Management staff during the utilization review process. The Alliance administers health care benefits for members, as outlined by contracts established for each product line. Medi-Cal benefits are developed by the State of California, Department of Health Care Services (DHCS), and Group Care benefits are developed by the Public Authority of Alameda County. Covered services include but are not limited to:

- Ambulatory Care
- Behavioral health (mental health and substance use disorder services)
- Care Coordination, including for linked and carved-out services, programs, and agencies
- Emergency services
- Hospital care
- Home Health care
- Hospice
- Palliative Care
- Managed Long Term Services and Support (MLTSS)
    - Community-based Adult Services
    - Long-term Care in skilled nursing facilities
    - Intermediate care facility/developmentally disabled (ICF/DD)
    - Intermediate care facility/developmentally disabled-habilitative (ICF/DDH)
    - Intermediate care facility/developmentally disabled-nursing (ICF/DD-N)
- Pharmacy
- Rehabilitation services
- Skilled nursing services - Acute
- Transplant Services
- Transportation
- Pharmacy

A full list of covered services is available to members in the Evidence of Coverage, published online and available in print, upon request. Covered services are provided through a contracted network of providers that include hospitals, nursing facilities, ancillary providers, and contracted vendors. The UM program, in coordination with the Contracting and Quality teams, monitor the adequacy of the Alliance's contracted network to ensure members have access to care within time and distance standards. As needed, contracting arrangements are made with providers outside of the network if Alliance's contracted network is not available to service the need.

Benefit Exclusions

Based on the specific contract requirements and applicable laws, some services are explicitly excluded from coverage. Per contract requirements, specific services may not be covered benefits, unless clinical indicators support medical necessity, as determined by the Medical Directors, in which case the medically needed services will be provided. Every attempt is made by the UM staff to identify additional community programs to provide wrap-around services to enhance the Alliance benefit package.

Transition to Other Care when Benefits End
The Alliance assists with, and/or ensures that practitioners assist with, a member's transition to other care, if necessary, when benefits end.

V. Utilization Management Information System

The Alliance maintains a core clinical information system, TruCare®, that is utilized by all Utilization Management, Long-Term Care, Case Management and Pharmacy teams. TruCare® is a member-centric application that aligns necessary clinical and administrative information related to members' care into a single chart record and allows seamless multidisciplinary collaboration within a case. The clinical information system tracks all authorized, denied, deferred, and modified service requests and includes timeliness records. Clinical staff, in collaboration with the Information Technology (IT) team, identify opportunities to enhance the functionality of the system and optimize the systems' performance. Thorough vetting processes are established between clinical and IT teams to ensure any enhancements and upgrades to the platform are amenable to all system users. System optimization and upgrades are ongoing as standard practices, including staff training to ensure competence in using the platform and alignment on best practice workflows.

The core clinical information system is designed to ensure the accuracy, confidentiality and security of paper and electronic data and information. The Alliance has comprehensive security controls and established monitoring processes to ensure secure data management, and to prevent inappropriate modification of UM denials, including any inappropriate modification to receipt and denial notification dates.

VI. Clinical Decision Support Tools

A. Utilization Management Clinical Decision Making

Clinical decision-making tools and screening criteria are designed to assist UM staff, and UM-delegated entities, in assessing the appropriateness of care for medical and behavioral health services. Application of the criteria is based on the specific and individualized health care needs of the member (including social determinant of health needs), medical risk factors, and in accordance with the member's plan benefits and capacity of the health care delivery systems.

The appropriate use of criteria and guidelines require strong clinical assessment skills, sound professional medical judgment, and application of individual case information and local geographical practice patterns. Licensed UM, BH, and Pharmacy review staff apply professional judgment during all phases of decision-making regarding the Alliance members. Decision Support Tools are intended for use as references, resources, screening criteria, and guidelines with respect to the decisions regarding medical necessity of health care services, and not as a substitute for professional clinical judgment.

All utilization review staff document the clinical review criteria used to support authorization decisions. All decision-making criteria are available to members and providers upon request.

B. Clinical Review Criteria and Hierarchy

Review Criteria

The Alliance adopts the following definition of medical necessity from the DHCS contract:

> ***Medically Necessary*** *or* ***Medical Necessity*** *means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.*
>
> *For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.*

Medical necessity determinations are made based on a consistently applied, systematic evaluation of clinical criteria. The following clinical criteria and hierarchy are applied by UM staff and Medical Directors:

1. Regulatory and contractual guidelines/regulations, including:
    - Department of Health Care Services (DHCS) Medi-Cal Provider Manuals and All-Plan Letters
    - Department of Managed Health Care (DMHC) All-Plan Letters
    - WPATH Standards of Care (SOC) for Gender-Affirming Care
    - LOCUS/CALOCUS, CASII/ECSII/ASAM for Mental Health and Substance Use Disorders
    - Code of Federal Regulations
    - California Health and Safety Code.
    - California Code of Regulations Title 22.
    - California Code of Regulations Title 28.
    - California Welfare and Institution Code
2. Evidence based guidelines, primarily MCG®, US Preventive Services Task Force, National Comprehensive Cancer Network, and if needed, UpToDate®[1]
3. Alliance guidelines, as approved through governing committees (including QIHEC and P&T)

[1] a collection of well-referenced topics, guidelines, and updated research. UpToDate® makes updates three times a year, and new information goes through a multilevel peer-review process (Fam Pract Manag. 2003;10(7):49-52)

4. National medical association guidelines (including American Commission of Obstetrics and Gynecology (ACOG), American Association of Pediatrics (AAP), American Diabetes Association (ADA)
5. Independent Medical Review for specialty consultation
6. Medical necessity/medical judgment

The UMC and QIHEC review and approve clinical criteria and hierarchy for clinical decision-making at least annually, and more often as needed for changes and updates.

New Medical Technology Evaluation Assessment

The Alliance maintains a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in its coverage and review processes to keep pace with changes and to ensure that members have equitable access to safe and effective care. Evaluation of new technology is applied for medical and behavioral health procedures, pharmaceuticals, and devices. The UMC and Pharmacy and Therapeutics Committee are responsible for evaluating and recommending new technology to the QIHEC. Requests for evaluation of a new technology or a new application of an existing technology may come from a member, practitioner, organization, the Alliance's physician reviewers, or other staff. The following are evaluated when considering new technology:

- Organizational reviews from appropriate government regulatory bodies, such as FDA or CMS.
- Relevant scientific information from peer-review literature, professional societies, and/or specialists and professionals who have expertise in the technology.

After QIHEC approves utilization of a new technology or new application of an existing technology, the Alliance adopts the policy and follows all required processes to notify providers. When the Alliance does not have the authority to modify the benefit package, the Chief Medical Officer shall notify, in writing, each payer for whom the Alliance manages benefits of its recommendation.

C. Consistency in Application of Criteria

The Alliance evaluates inter-rater reliability (IRR) to monitor consistency with which physicians, non-physicians, pharmacists, and behavioral health practitioners apply clinical decision-making criteria. It provides a score of how much homogeneity or consensus there is when using clinical criteria to make a medical necessity determination. A full description of the IRR testing methodology is referenced in Alliance policy and procedure QI-133, and the methodology is evaluated at least annually to ensure effectiveness of the IRR evaluation and remediation processes. IRR test results are collated and reviewed by department management, and annually reviewed and approved by the UMC and QIHEC. The Alliance also reviews the IRR process and score reports for delegated entities engaged in utilization management activities.

VII. Utilization Management Processes

The UM Program consists of comprehensive and systematic functions, services, and processes that provide care management to members, including utilization review to determine the medical necessity of covered services. Utilization review procedures are further described below.

A. Communication to Members and Providers

Alliance members, providers, and the public can access information about the UM program in various ways.

Members and providers may contact the UM department to discuss any aspect of the UM program.

- Members may contact the Member Services Department and be warm-transferred to UM management.
- Providers may contact the UM Department directly at 510-747-4540.

UM staff are available at least 8 hours per normal business day (excludes weekends and holidays). During scheduled business hours, the Alliance provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. After-hour calls are answered by a contracted vendor and non-emergency calls are returned the following business day. After-hour calls requiring clinical decision-making are transferred to the Alliance on-call nurse or behavioral health crisis services for assistance. Staff identify themselves by name, title and as representatives of the Alliance when initiating or returning calls. HIPAA protocols are followed to ensure protection of privacy. Language assistance and TDD/TTY services are available as needed for members to communicate with the Alliance regarding the UM program.

The UM voicemail system is secured with password protections, accessible only by designated individuals in the UM department. The facsimile machines used for utilization review information are located within the Department to monitor and protect confidential health information.

The UM program description, and other core documents containing UM policies and procedures, can be found as follows:

- **Provider Manual**: available on the Alliance web site, and in print upon request, provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's UM Program, referral and tracking procedures, processes, and timeframes necessary to obtain prior authorization are included in the manual. In addition, the Provider Manual describes how providers may obtain a copy of the clinical guidelines used to make medical determinations.
- **Provider Bulletins:** periodic newsletter distributed to all contracted provider sites and delegated groups on topics relevant to the provider community, include new or updated UM policies, procedures, and activities.

- **Member Alert:** a periodic newsletter distributed to all Alliance members; each issue covers different topics of interest to members about their health, and may include information about UM policies and procedures
- **Evidence of Coverage (EOC):** distributed to members, based on their product line, provides details on benefits and authorization processes, including description of members' right to submit a complaint or grievance about any Plan action. The Evidence of Coverage document directs members to call the Member Service phone number to initiate complaints or grievances involving UM issues and actions. Member complaints or grievances are documented in the data system and forwarded to the UM unit for follow-up response. The Alliance Grievance and Appeal unit coordinates with the UM unit on appropriate responses to member complaints or grievances.

The Alliance arranges for triage, screening, and referral services, available by telephone to members 24 hours per day, 7 days per week. The Alliance ensures that telephone triage services are provided in a timely manner appropriate for the requesting member's condition, including medical/surgical and behavioral health conditions.

The Alliance's contracted provider network also provides triage services to its members. Primary care providers and mental health care providers provide triage and screening services 24 hours a day, 7 days a week for medical and behavioral health care services. For cases when the providers are unable to meet the time-elapsed standards, the Alliance provides members the Alliance's nurse advice line and/or a behavioral health crisis service call line, as an alternative triage and screening service arrangement. Providers who are unable to provide triage and screening services are required to inform members about the Alliance's nurse advice line information.

Emergency health care services are available and accessible within the service area 24 hours a day, 7 days per week. The Alliance provides access for members and providers to obtain timely authorization for medically necessary care, for circumstances where the member has received emergency services and care and is stabilized, but the treating provider believes that the member may not be discharged safely. Inpatient UM Staff are available for extended hours in the Evenings and on Weekends to assist with post-stabilization and/or discharge authorization needs. If an after-hours call is received, but not answered within 30 minutes, the Alliance allows for automatic approval until the member is stable, and UM staff is available to coordinate the transfer of stabilized Members in an emergency department, if necessary.

Emergency health care services, including behavioral health care services are covered without prior approval:

- to screen and stabilize the member where a prudent layperson*, acting reasonably, would have believed an emergency medical condition existed.
- when there is an imminent and serious threat to health including, but not limited to, the potential loss of life, limb, or other major bodily function.
- when a delay in decision making would be detrimental to the member's life or health or

could jeopardize the member's ability to regain maximum function.

- If an authorized representative, acting for the Alliance, has authorized the provision of emergency services.

*Prudent Layperson is defined as a person who is without medical training, and who draws on his/her practical experience when deciding whether emergency medical treatment is needed. A Prudent layperson is considered to have acted reasonably if other similarly situated laypersons would have believed that emergency medical treatment was necessary.

Other Alliance representatives who may direct members to emergency services include the Nurse Advice Line staff, and the Alliance nurse case manager or disease manager, an Alliance Member Services Representative or after-hours call answering service, or a contracted specialist. Additionally, the Alliance provides access to the Alameda County Crisis Services to respond to behavioral health calls after hours. The Alliance will honor health plan coverage for services when directed by any Alliance staff member or delegated representative.

B. Utilization Review Procedures

The Alliance follows all regulatory, contractual, and NCQA requirements to effectively administer utilization review procedures, including decision turn-around times and member and provider notification standards. For services that require prior authorization, the UM process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. Only physicians, pharmacists, or doctoral level behavioral health specialists can make determinations to deny or modify care based on medical necessity.

Services Exempt from Prior Authorization

For both Managed Medi-Cal and Group Care products, there are services exempt from prior authorization. Exemptions include, but are not limited to:

- Emergency Services
- Urgent Care
- Primary Care Visits
- Preventative Services including immunizations
- Mental Health Care and Substance Use treatment
- Women's health services – *a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/ OB-GYN and Certified Nurse Practitioners.*
- Basic *prenatal care*
- Family planning services, including counseling, pregnancy tests, medications, and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention
- HIV testing and counseling
- COVID-19 testing and therapies

- Second Opinions from In Network providers arranged by the assigned PCP
- Initial Mental Health Assessments
- Early and Periodic Screening, Diagnostic and Treatment
- Biomarker testing for members with advanced or metastatic cancer stage 3 or 4
- Annual Cognitive Assessment for Medi-Cal members over 65 without Medicare

Services Requiring Prior Authorization

The Alliance communicates to all contracted providers the procedures, treatments, and services that require prior authorization. Services that require prior authorization include, but are not limited to:

- Non-emergency/ elective out-of-area care
- Out-of-network care, for services not provided by contracted provider
- Inpatient Admissions if non-emergency/ elective
- Inpatient Admissions to Acute Skilled Nursing Facility or Nursing Home
- Outpatient hospital services/ surgery
- Outpatient facilities (non-hospital based), such as surgeries or sleep studies
- Outpatient diagnostic and radiology services, minimally invasive or invasive including CT Scans, MRIs, cardiac catheterization, PET
- Durable Medical Equipment, standard or customized; rental or purchased
- Infusion Services
- Medical Supplies
- Prosthetics and Orthotics
- Podiatry services
- Home Health Care, including skilled nursing, nursing aides, rehabilitation therapies, and social workers
- Transplant Services
- Tertiary/Quaternary office visits and consultations at academic centers
- Experimental or Investigational Services
- Cancer Clinical Trials
- LTSS, including Community Based Adult Services (CBAS), LTC in SNF and Subacute facilities, and ICF/DD
- Acupuncture, greater than 4 visits per month
- Chiropractic Services
- Second Opinions from out-of-Network providers
- Select behavioral health services

The Alliance also maintains an auto-authorization scope list that is reviewed and approved annually by the UMC and QIHEC, for services that do not require clinical review. The Alliance routinely analyzes utilization patterns to determine whether it would be in members' best interests to add or remove services from prior authorization requirements. All decisions to adjust prior authorization requirements are reviewed and approved by the appropriate committees (including UMC or P&TC, and QIHEC).

Review Types

Authorizations are processed based on the date the Alliance receives the request. Below are the types of utilization reviews:

- **Prospective (pre-service) Review** is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted prior to the delivery of a health care service or supply to a member. A prospective review decision is based on the collection of medical information available to the health care provider prior to the time the service or supply is provided.
- **Concurrent Review** is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted during a member's ongoing stay in a facility or course of outpatient treatment. The frequency of review is based on the member's medical condition with respect to applicable care guidelines.
- **Retrospective (post-service) Review** is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted after the health care service or supply is provided to a member. Retrospective requests received within 90 days from the date of service are reviewed for medical necessity. Retrospective received after 90 days from the date of service are denied for not obtaining prior authorization (with limited exceptions, including member eligibility issues, if the services were emergent/urgent, or inpatient services where the facility is unable to confirm enrollment with the Alliance).

Medical Necessity Review

Qualified health professionals supervise review decisions, including service reductions. UM decisions based on medical necessity to deny or authorize an amount, duration, or scope that is less than requested shall be made by qualified physicians/doctoral behavioral health specialists or appropriate health care professionals, who have appropriate clinical expertise in treating the condition and disease. Appropriate health care professionals at the Alliance are qualified physicians, qualified doctoral level behavioral health care professionals, and qualified pharmacists. Additionally, a qualified physician or pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan Medical Director in collaboration with the Plan Pharmacy and Therapeutics committee (P&T Committee) or its equivalent.

Board certified physician and doctoral level Behavioral Health Specialist advisors are available to the UM Program for consultation on clinical issues as well as consultation for potential denials. The UM Program maintains a list of board-certified physician specialists identified for consultation and documents their involvement in member authorization and appeal records when appropriate.

UM decisions are not based on the outcome of individual authorization decisions, or the number and type of non-authorization decisions rendered. UM staff involved in clinical and

health plan benefit coverage determination processes are compensated solely based on overall performance and contracted salary and are not financially incentivized by the Alliance based on the outcome of clinical determinations.

In addition to guidelines and criterion, patient records and conversations with appropriate practitioners are used in the decision-making process. UM staff collects relevant clinical information from health care providers to complete prospective, concurrent, and retrospective utilization review for medical necessity and health plan benefit coverage determinations. The Alliance collects only the minimum amount of information necessary to conduct reviews. Clinical information is provided to the appropriate clinical reviewers to support the determination review process. Examples of relevant sources of patient clinical data and information used by clinical reviewers to make medical necessity and health plan benefit coverage determinations include the following:

- History and physical examinations.
- Clinical examinations.
- Treatment plans and progress notes.
- Diagnostic and laboratory testing results.
- Consultations and evaluations from other practitioners or providers.
- Office and hospital records.
- Physical therapy notes.
- On-site, telephonic and fax concurrent reviews from inpatient facilities.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from responsible family members; and
- Independent, unbiased, and evidenced based analyses of new, emerging, and controversial healthcare technologies.

Prospective (pre-service) Authorization Management

Alliance network physicians are the primary care managers for member healthcare services. Based on the member's assignment, authorizations may be managed by the Alliance or a delegated Provider Group.

Network Primary Care Physicians (PCPs) may process in-network specialist and facility referrals directly to members as "direct referrals" without administrative pre-authorization from the UM Program or the Provider Group. These referrals are primarily for routine outpatient and diagnostic services and are tracked by the UM Program using claim and encounter data. Tertiary/Quaternary evaluations require prior authorization. For services identified as requiring prior authorization, practitioners and providers must submit and coordinate prior authorization for services that require prior authorization, such as DME, home health and certain radiology services. All elective inpatient surgeries and non-contracted provider referrals require prior authorization.

Practitioners and providers send requests for prior authorization to the UM Department via the Alliance provider portal, mail, fax and/or telephone, based on the urgency of the requested service. Requests must include the following information for the requested service:

- Member demographic information (name, date of birth, etc.)
- Provider demographic information (Referring and Referred to)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD-10 Code and description)
- Pertinent medical history and treatment
- Location where service(s) will be performed.
- Clinical indications necessitating service or referral

Authorization determinations related to Medi-Cal and GroupCare are defined, as follows:

- Approval – the determination to provide a service
- Modification – the determination to either approve less than what was requested, or to approve something else in place of what was requested
- Denial – a determination to not provide the request service.
- Delay – when a determination cannot be made, and additional time is required to obtain relevant clinical information.
- Termination – to not extend an extension of a previously authorized service (e.g., PT visits, SNF days, etc.); NOTE: must give 10 calendar days' notice of terminations

If non-physician UM reviewers have questions about the medical necessity of services, or the appropriateness of the level of care for service based on clinical criteria and guidelines, the case is referred to the Medical Director/doctoral Behavioral Health Specialist for review. The Medical Director/doctoral BH Specialist, or physician designee, may contact the attending physician to discuss the case, if necessary.

If a Medical Director or physician designee/doctoral Behavior Health specialist determine that requested services are not medically necessary or indicated, a denial determination may be made by the Medical Director/doctoral Behavioral Health specialist. Denial notification and communication to members and providers in accordance with current regulatory timeliness standards and denial notification requirements, as established by regulators, including the DHCS and Department of Managed Health Care (DMHC) and national accrediting organizations, such as NCQA.

Concurrent/Continued Stay Review (including Acute, Skilled, Rehabilitation, Long-Term Care/Custodial, Subacute and ICF/DD)

Concurrent/Continued Stay Review is performed during the course of a member's inpatient stay, which may include acute hospital, skilled nursing, acute rehabilitation and long-term care facilities, to assess the medical necessity and appropriateness of continuation of services at the requested level of care. Concurrent Review is performed

for both contracted and non-contracted facilities. Telephonic, facsimile, or electronic medical record reviews are completed daily, and/or on intervals based on a member's clinical status. If a scheduled review date falls on a weekend or holiday, UM staff coordinate a Concurrent Review on the workday prior to the scheduled review date, or not later than the first workday after the holiday or weekend.

Additional objectives of continued stay review are to:

- Ensure that services are provided in a timely and efficient manner.
- Ensure that established standards of quality care are met.
- Implement timely and efficient transfer to lower levels of care when clinically indicated and appropriate.
- Implement effective and safe discharge planning.
- Identify cases appropriate for Transitional Care Services and ongoing Case Management services.

Continued inpatient care that does not meet continued stay criteria are referred to the Medical Director/doctoral BH Specialist, or physician designee, to evaluate and consult with the attending physician, as appropriate. When the Medical Director decides that the case does not meet criteria for continued stay based on medical necessity or appropriateness, the attending physician will be contacted, and discharge planning discussed. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter may be issued immediately by fax or via overnight Certified Mail to the attending physician, hospital, and the member, if the member disagrees with the discharge plan.

Timeliness Standards

The timeliness of UM decisions shall be commensurate with the seriousness and urgency of the request, whether the request is routine or expedited, and made in a timely manner and not unduly delayed for medical conditions requiring time sensitive services. The Alliance maintains established timeliness standards for medical necessity determinations for routine and urgent Authorization Requests, in compliance with the strictest Regulatory Standards for each Product Line.

Review Type	Managed Medi-Cal	Group Care
Pre-Service – Urgent	72 hours	72 hours
Pre-Service – Routine	5 business days	5 business days
Concurrent	24 hours	24 hours
Retrospective	30 calendar days	30 calendar days

For routine pre-service and retrospective decisions, notifications of the decision must be sent to members within 2 business days and to providers within 24 hours of the decision.

For urgent pre-service and concurrent decisions, notifications of the decision must be sent to members and providers within 72 hours of receiving all information needed to make a decision.

Notice of Action Requirements

Decisions affecting care are communicated in writing to the provider and member in a timely manner, in accordance with regulatory guidelines for timeliness and translation, and are not unduly delayed for medical conditions that require time-sensitive services. Reasons for decisions are clearly documented in the member/provider correspondence in easily understandable language.

For any adverse benefit determination (including denial, delay, modification, termination, suspension, reduction, or carve-out of a treatment or service), the Alliance provides members and providers with a written Notice of Action (NOA). The Notice of Action includes all DHCS-required templates to inform members of their rights, and the content of the notification includes all the following:

a. A statement of the action the Alliance intends to take.
b. A clear and concise explanation of the reasons for the decision.
c. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guideline.
d. The clinical reasons for the decision. The Alliance must explicitly state how the member's condition does not meet the criteria or guidelines.
e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions must be communicated to the member in writing. In addition, with the exception of decisions rendered retrospectively, decisions must be communicated to the provider initially by telephone or facsimile and also in writing.

The NOA includes a statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, upon request. Providers are informed how to contact and speak with the Medical Director/doctoral Behavioral Health Specialist who made the decision.

The NOA also includes appeal rights and procedures. Member notifications comply with appropriate contractual and regulatory guidance for each member's line of business. Member correspondence about authorization decisions includes a statement in each Alliance threshold language instructing the member how to obtain correspondence in their preferred language. Notice of Action Letters are sent in the Members' preferred language for those members whose preferred language is an identified threshold language, following the requirements of APL-21-004. Records, including Notice of Action letters, meet contractual retention requirements. Members are informed that they may request copies of their medical records at no cost.

Peer-to-Peer Review (Discussing a Denial with a Peer Reviewer)

All NOAs for adverse benefit determinations include a name and phone number for contacting the Peer Reviewer, allowing the Requesting Practitioner the opportunity to discuss

issues or concerns regarding the decision. A practitioner can request a peer-to-peer by calling or writing, and the Peer Reviewer will make himself/herself available for discussion of the denial decision within one business day of the receipt of the provider's request. Upon completion of the peer-to-peer, the requesting practitioner can initiate an expedited or standard appeal, as appropriate.

Second Opinions

Alliance members may request a second opinion from any qualified primary care provider or specialist within the same medical group. If a qualified specialist is not available within the medical group, a referral is provided within the Alliance's network. If a qualified specialist is not available in the Alliance network, staff will assist the medical group to identify an out-of-network specialist. The second opinion from a qualified health professional will be provided at no cost to the member. The Alliance provides a second opinion from a qualified health care professional when a member or a practitioner requests it for reasons that include, but are not limited to, the following:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and requests consultation, or the member requests an additional diagnosis.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period given the diagnosis and plans of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the practitioner's advice or consulted with the initial practitioner concerning serious concerns about the diagnosis or plan of care.

The Alliance educates its members and practitioners of the availability of second opinions in annual member publications. Policies regarding second opinions are available to the public upon request. Member rights related to second opinions include:

- To be provided with the names of two physicians who are qualified to give a second opinion.
- To obtain a second opinion within 30 calendar days, or if the medical need is emergent or urgent, to obtain an opinion within a timeframe that is appropriate to the member's condition and that does not exceed 72 hours
- To see the second opinion report.

Standing Referrals

The Alliance maintains processes to provide members a standing referral to a specialist. The procedure shall provide for a standing referral if the PCP, in consultation with the specialist and the Alliance Medical Director (or designee), determines that the enrollee has a condition

or disease that requires continuing specialized medical care from the specialist or Specialty Care Center, (SCC) that has expertise in treating the condition or disease. For Members with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling, the Alliance has procedures to provide a standing referral to a specialist or SCC that has expertise in treating the condition or disease, for the purpose of having the specialist coordinate the Member's health care.

The Alliance may require the PCP to submit a treatment plan during care or prior to the referral, as determined by the Medical Director. If a treatment plan is necessary during care and is approved by the Alliance, in consultation with the PCP, specialist, and member, a standing referral shall be made in accordance with the treatment plan. A treatment plan may be deemed unnecessary if the Alliance approves a current standing referral to a specialist. The treatment plan may limit the number of visits to the specialist, limit the period during which visits are authorized, or require that the specialist provide the PCP with regular reports on the care and treatment provided to the enrollee.

Standing referrals to a specialist or SCC are provided within the Alliance's network to participating providers unless there is no specialist or SCC within the Alliance's network that is appropriate to provide treatment.

Transitional Care Services and Discharge Planning

Transitional Care Services and Discharge Planning management are components of the UM process that assess necessary services and resources available to facilitate member discharge and/or transition to the appropriate level of care. Discharge Planning refers to activities related to planning the discharge of a member out of an inpatient medical/psychiatric/SUD facility.

Transitional Care Services (TCS) refers to activities related to transferring a member from one setting or level of care to another, including but are not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings.

Depending on a member's risk level (high or low), TCS involves the identification of a single point of contact and/or entity to support members through the inpatient stay to the post-discharge period. In collaboration with the discharging facility, TCS also involves completing a discharge risk assessment, facilitating completion, and sharing of the discharge document with the member and appropriate providers, and post-discharge follow-up (including medication reconciliation and appointment scheduling). The discharge document includes the following information:

1. Pre-admission status, including living arrangements, physical and mental function, SUD needs, social support, DME uses, and other services received prior to admission;
2. Pre-discharge factors, including the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge;

3. The hospital, institution or facility to which the Member was admitted;
4. Specific agency or home recommended by the hospital, institution or facility after the Member's discharge based upon Member needs and preferences; specific services needed after the Member's discharge; specific description of the type of placement preferred by the Member, specific description of type of placement agreed to by the Member, specific description of agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling;
5. Summary of the nature and outcome of participation of Member, Member's parents, legal guardians, or ARs in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital, institution, or facility to be included in the Member's Medical Record; and
6. Information regarding available care, services, and support that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.

TCS begins at the point of admission to an inpatient facility, and is designed to identify and initiate cost effective, quality-driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physicians, hospital discharge planner, UM/BH staff, assigned TCS Care Manager, health care delivery organizations, and community resources to coordinate care and services.

Additionally, for nursing facility transitions, the Alliance ensures timely transitions that do not delay or interrupt any Medically Necessary services. UM staff coordinate with facility discharge planners and assist members and their authorized representatives by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other Home and Community Based Services (HCBS). Once discharged from the hospital, UM staff verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting, and follow-up with members, as appropriate, to ensure their needs are met.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of high-risk medical/psycho-social issues with potential need for post-hospital intervention, including a discharge risk assessment.
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member's care.
- Communication with the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital

UM/Discharge Planning staff, assigned TCS Care Manager, and UM staff.

- Referral to Transitional Care Services or Home Health Programs within or outside of AAH programs.

Continuity of Care

Continuity of Care (CoC) provisions ensure the lack of interruption in the care provided to members when circumstances dictate a change in the member's insurance coverage, geographic location, entity, or provider assignment. The Alliance provides Continuity of Care with an out-of-network provider according to all applicable laws, regulations, and state guidelines, if the below criteria are met:

- The Alliance can determine that the beneficiary has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider). An existing relationship means the member has seen an out-of-network primary care provider (PCP), behavioral health provider or specialist at least once during the 12 months prior to the date of his or her initial enrollment in the Alliance for a non-emergency visit, unless otherwise specified by regulation. CoC also extends to the following select ancillary providers: physical therapy, occupational therapy, speech therapy, respiratory therapy, and Behavioral Health Treatment (BHT) providers.
- The provider is willing to accept the higher of the Alliance's contract rates or Medi-Cal FFS rates.
- The provider meets the applicable professional standards and has no disqualifying quality of care issues (a quality-of -care issue means the Alliance can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other Medi-Cal beneficiaries)
- The provider is a California State Plan approved provider; and
- The provider supplies the Alliance with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, if it is allowable under federal and state privacy laws and regulations.

As outlined in DHCS APL 23-022, the Alliance also ensures CoC provisions for:

- Durable Medical Equipment (DME) Rentals and Medical Supplies
- Non-Emergency Medical Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Mandatorily enrolled members with active course of treatment
- Newly enrolled members with acute or serious chronic conditions
- Pregnant and post-partum members
- Newborns between Birth through age 36 months
- Members with Terminal Illness
- Members with denied Medical Exemption Requests (MER)
- Members needing to complete a course of treatment with a terminated provider

The Alliance is not required to provide CoC for services not covered by Medi-Cal or those services managed directly by DHCS. In addition, CoC protections do not extend to additional

ancillary services.

The UM staff work with the member's current treating physician and/or PCP to assist the member in continuity of care. For members who are assigned to a Provider Group, if the current treating physician is not affiliated with the existing Provider Group's network, the UM staff works with the Provider Group to make arrangements with the physician to continue care of the member until the treatment is completed or the member can be safely transitioned to a physician within the Provider Group. As needed, members are referred to Case Management for additional support with coordination of care with in-network and out-of-network providers.

Required Reporting

As applicable, UM staff are required to report the following activities during the course of utilization review activities:

- Potentially fraudulent or abusive practices identified to the Compliance Department
- Potential under and over utilization to the UM Manager
- Coordination of care for results or facilitation to the UM Manager
- Opportunities for improvement to the UM Manager
- Breaches of adherence to confidentiality and HIPAA policies to the Alliance's designated Compliance staff member
- Potential quality issues identified through UM activities to the Quality Improvement Department
- Barriers to accessibility and availability of UM services to the UM Manager

C. Long-Term Services and Supports (LTSS)

The LTSS Department is an extension of the Utilization Management program, adhering to utilization management procedures as described above. The LTSS department is responsible for the provision of Long-Term Services and Supports, defined in the DHCS contract as:

> *"Services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS) programs and includes carved-in and carved-out services"*

The LTSS department consists of clinical and non-clinical staff who administer the program, providing oversight & monitoring to ensure adherence to all regulatory requirements and performance standards. Team members work collaboratively with other internal departments (including UM, Case Management, Pharmacy, and Behavioral Health), delegated entities, and safety net providers within the community to deliver timely, appropriate, cost-effective, and quality healthcare to members using LTSS benefits.

Long Term Care (LTC)

DHCS defines LTC as specialized rehabilitative services and care provided in the following

settings:

- Skilled Nursing Facility (SNF)
- Adult subacute facility
- Pediatric subacute facility
- Intermediate Care Facility/Developmentally Disabled (ICF/DD)
- ICF/DD-Habilitative (ICF/DD-H)
- ICF/DD-Nursing (ICF/DD-N)

The LTC Program provides a comprehensive framework for oversight and monitoring of the delivery of healthcare services to members in LTC settings. Its purpose is to:

- Ensure that members in LTC settings are receiving the care and services to meet their needs in the least restrictive environment.
- Comply with State and Federal laws and requirements to assure governmental payors and other regulatory agency guidelines, standards, and criteria are adhered to, as applicable.
- Educate staff, delegates, contracted network providers and facilities on the policies and procedures to ensure compliance with the goals and objectives of the Program.
- Identify institutionalized Members who may benefit from transitioning back to the community with support.
- Optimize the member's health benefits by ensuring and supporting transitional care and coordination of services with the appropriate county/state sponsored programs.
- Monitor care delivery through internal and oversight auditing and monitoring activities.
- Provide Transitional Care Services
- Provide Basic and Intensive Care management, as needed

Community-Based Adult Services (CBAS)

DHCS defines HCBS programs as programs that include but are not limited to HCBS programs authorized under the Social Security Act (SSA) at 42 USC section 1396n(c), the California Medicaid State Plan option authorized under 42 USC section 1396n(k), California Medicaid State Plan HCBS benefits authorized under 42 USC section 1396n(k), and other State and federally funded Medi-Cal HCBS programs.

CBAS is a type of LTSS benefit under the HCBS umbrella of program. CBAS centers offer services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. The Alliance maintains procedures, processes, and mechanisms for administering assessments and re-assessments for CBAS services, including CBAS Emergency Remote Services (ERS), when appropriate.

The Alliance is responsible for ensuring Members who are eligible to receive LTSS, including CBAS, are identified and referred, and dedicates an RN on the UM team to

provide assessment, re-assessment, and re-authorization of CBAS services to members.

D. Behavioral Health Services

Behavioral Health Services are integrated with the Utilization Management program, adhering to utilization management procedures as described above and ensuring parity between medical and behavioral health services. The scope of the program covers behavioral health treatment that may be beyond the customary scope of practice of a primary care physician. Care settings include home and office-based services, free-standing and hospital-based programs, residential treatment programs and facility based acute care treatment units. Medical necessity is determined by applying level of care criteria, while the clinical appropriateness of services is evaluated using criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.

The provision of behavioral health and substance use services are applied to Alliance members according to their benefit. Group Care members receive a comprehensive benefit for all behavioral health services. For Medi-Cal beneficiaries, Alameda County Behavioral Health Care Services (ACBHCS) provides Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services. The Alliance provides mild-to-moderate behavioral health and substance abuse services not covered through ACBHCS. The Alliance also provides Behavioral Health Therapy (BHT) services for Medi-Cal members under the age of 21 for the treatment of Autism Spectrum Disorder and other conditions where excessive and/or deficits of behaviors significantly interfere with home and community activities. The Alliance provides behavioral health utilization management activities and maintains the provider network for behavioral health and substance abuse services.

Alameda County Behavioral Health Care Services (ACBHCS)

Specialty behavioral health services for Medi-Cal members excluded from the Alliance contract with DHCS are coordinated under a Memorandum of Understanding executed with ACBHCS. This is a carve-out arrangement for specialty behavioral health management with the State of California directly overseeing and reimbursing the behavioral health services provided to Medi-Cal members.

The referral procedure for Alliance members includes:

- Alliance Primary Care Providers (PCPs) render outpatient behavioral health and substance abuse services within their scope of practice.
- PCPs refer the members to ACBHCS for evaluation and coordination of medically necessary specialty behavioral health services by the Access Team, including inpatient psychiatric care.
- PCPs refer members to qualified Medi-Cal providers for the provision of services not covered by ACBHCS.

Behavioral Health Treatment Coverage

The Alliance is responsible for providing Early and Periodic Screening, Diagnosis, and Treatment (Medi-Cal for Kids and Teens,) services for beneficiaries ages 0 to 21. The

services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of children with any diagnosis including Autism Spectrum Disorder (ASD). In accordance with the requirements listed in the most recent DHCS All Plan Letter, the Alliance must provide continued access to out-of-network BHT providers (continuity of care) for up to 12 months.

Behavioral Health Integration

Members may contact the Alliance Behavioral Health Service department or be referred by the PCP and/or health care professional. The Alliance maintains procedures for providers to coordinate care and services for members in need of behavioral health services including, but not limited to, all medical necessary services across the behavioral health provider network.

The Alliance uses a variety of mechanisms that ensure behavioral health services and management processes are actively integrated into the UM Program and include:

- A behavioral healthcare practitioner, who is a behavioral healthcare physician or a doctoral-level behavioral health practitioner, is involved in quarterly QIHEC meetings to support, advise, and coordinate behavioral healthcare aspects into UM Program policies, procedures, and processes.
- The Senior Director of Behavioral Health Services directs all aspects of the BH program to ensure that the program meets all regulatory requirements and integrates with the UM Program, Case Management Program, Member Services, and other departments within the Alliance.
- There are regular care coordination rounds, in which the staff attending rounds evaluates topics such as access, availability, health management systems, practice guidelines, clinical and service quality improvement activities, member satisfaction, continuity and coordination of care and member's rights and responsibilities.
- The Alliance routinely generates clinical reports reflecting metrics and outcomes of the Behavioral Health Services program, which are reviewed and acted upon as needed at appropriate AAH Committees and QIHEC.
- The Alliance participates in periodic operational meetings with ACBHCS to review and coordinate administrative, clinical, and operational activities.

E. Pharmacy Management

The pharmacy benefit for Medi-Cal members is carved-out and administered by the DHCS Medi-Cal Rx program. Non-capitated carved-out drugs, such as HIV/AIDS/Hepatitis B treatment drugs, alcohol and heroin detoxification and dependency treatment drugs, Blood Factors: Clotting Factor Disorder Treatment and psychiatric drugs are covered by Medi-Cal Fee-For-Service Intermediary.

For those pharmacy benefits that are not carved-out to Medi-Cal Rx and for Group Care members, the Alliance ensures the provision of pharmacy management to a pharmacy benefit manager (PBM). The PBM possesses service level guarantees that manages pharmacy services under the delegated arrangement and maintains clinical policies and procedures that are revised at least annually. The Alliance delegates some of its pharmacy utilization management activities to the pharmacy benefit management company. The PBM supports full prior authorization review services, including confirmation of denials for weekends/holidays/emergency. The PBM provides support to the Alliance's Pharmacy and Therapeutic Committee activities including formulary management, guideline development and trend reviews related to pharmacy services. The Pharmacy and Therapeutics Committee meets quarterly and provides oversight for evidence-based, clinically appropriate pharmacy guideline criteria. Guidelines are developed in conjunction with review of peer-reviewed literature and with consideration for such factors as safety, efficacy, and cost effectiveness, with the input and evaluation of external clinical specialists appropriate to the subject matter.

The PBM receives and processes medication prior authorization (PA) requests for medications filled through network retail and specialty pharmacies. The PBM's Prior Authorization Department is comprised of certified technicians and clinical pharmacists who conduct reviews and approve requests that meet prior authorization criteria. All requests that the PBM cannot approve per their protocol are forwarded to Alliance for the final determination. All pharmacy PA requests must be processed, and a decision rendered within regulatory requirements. Pharmacy UM decision monitoring is reported through the UMC.

F. Linked and Carved Out Services

Linked and carved-out services are those that are not covered by the Alliance but are still available to Alliance members through other Medi-Cal programs. The Alliance provides linkages with such programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits. These linkages are established through specific program Memoranda of Understanding (MOU) with community agencies, such as the California Children's Services and the Regional Center of the East Bay (RCEB).

UM staff and delegated entity practitioners identify members who may be eligible for services, and coordinate referral to appropriate agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management Department to assist members transition to other care, if necessary, when benefits end. This includes informing members about other sources to continue care.

VIII. Special Programs

A. Transplant Programs

The Alliance provides an appropriate level of care and services within the member's benefits for transplants according to product line requirements All patients are monitored according to contractual requirements on an inpatient and outpatient basis, and the member, physician, and facilities are assisted to assure timely, efficient, and coordinated access.

Group Care Members are covered for all medically necessary organ transplants. This coverage is provided by Alliance-approved practitioners and facilities.

Medi-Cal Members are covered for medically necessary organ transplants, including related services such as organ procurement and living donor care. Coverage provisions are as follows:

a) The Alliance covers the following Major Organ Transplants: bone marrow transplant (BMT), heart, heart/lung, kidney/pancreas, liver, liver/small bowel, lung, pancreas, and small bowel. The Alliance also covers kidney and corneal transplants.
b) For members under 21 years of age, organ transplant coverage is provided by California Children Services (CCS). The Alliance refers members under 21 to CCS for evaluation of potential organ transplant. CCS will refer CCS-eligible members to the transplant Special Care Centers (SCC) for review and follow-up.
c) For member 21 years of age and older, Major Organ Transplant evaluations are referred to a Medi-Cal approved Center of Excellence (CoE) on the most recent DHCS CoE list of facilities. The Alliance authorizes the request for a transplant after the transplant program confirms the member is a suitable transplant candidate.
d) Kidney and corneal transplants are provided through Alliance-approved practitioners. Kidney transplants, along with related care such as dialysis, evaluation of potential donors, and nephrectomy from living or cadaver donors, continue to be covered benefits.

B. Palliative Care

Palliative Care Services are provided to members per the requirements of the latest All Plan Letter. Palliative care services may be delivered at the hospital, as part of the inpatient care treatment plan, or authorized and delivered in primary care, specialty care clinics, by home health teams, or by hospice entities. The Alliance offers a network of palliative care services to its members through various provider types.

The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care. The Alliance may also contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. The Alliance utilizes qualified providers for palliative care based on the setting and needs of the members if the provider complies with the existing Medi-Cal requirements.

The Alliance ensures that palliative care provided in a member's home complies with existing Medi-Cal requirements for in-home providers, services, and authorizations.

Palliative care services follow the utilization review procedures as described above. Through the authorization review and decision process, the type of palliative care (including the location where palliative care services can be delivered) will be determined based on medical necessity. Referral and care coordination for palliative services will be provided to the member within the timely access standard requirements. Alliance's network providers receive instructions of the referral and authorization process for palliative care through the Alliance's provider educational materials and via the Alliance's website.

IX. UM Program Monitoring and Oversight

A. Evaluating Program Effectiveness

The effective of the UM Program is monitored through quality assurance activities that support positive medical and behavioral health outcomes, and continuous quality improvement. The CMO guides these activities in collaboration with the Senior Director, Health Care Services, the Senior Director, Behavioral Health, the Senior Director, Quality, and the Director of Accreditation, with oversight by the QIHEC. Performance results are analyzed and reviewed, with opportunities for improvement identified for intervention and performance management. The following quality assurance activities are conducted:

- Monitoring Under and Over Utilization (used to inform activities related to network adequacy)
- Monitoring Utilization Review Measures
- Monitoring Internal Operational Quality Measures
- Monitoring Member Experience with the UM process
- Monitoring Grievances and Appeals (including Overturns)
- Monitoring Potential Quality Issue (PQIs), including Provider Preventable Condition identification and referral
- Operational Quality Audits
- Delegation oversight, including monitoring of Corrective Action Plans (as applicable)

Data sources used for quality assurance activities may include the following:

- Claims and encounter data.
- Medical records.
- Medical utilization data.
- Behavioral Health utilization data.
- Pharmacy utilization data.
- Appeal, denial, and grievance information.
- Internally developed data and reports.
- Audit findings; and
- Other clinical or administrative data.

Utilization Review Measures

The Alliance monitors, measures, and evaluates utilization review procedures as follows:

- Volume of authorization requests, including determination status
- Denial Rate (the established threshold is 5% denial rate)
- Compliance with timeliness standards (the established threshold is 95% compliance)
- Compliance with NOA requirements, including appropriate content and enclosures

Internal Operational Quality

The Alliance UM Department conducts ongoing auditing and monitoring of key operational functions to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. The monitoring process allows for early identification of compliance risks and opportunities for retraining of staff. Internal quality monitoring consists of monthly, and as-needed, audits as follows:

- **UM File Review**: Files are assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement. Elements of the review include, but are not limited to, ensuring the appropriate medical information is obtained, use of criteria, application of clinical decision-making criteria, and appropriate referral to physician reviewers, as applicable. For cases that are denied or modified, the file is also assessed for the NOA requirements for communication to the member and provider.

- **Authorization Turn-Around-Time (TAT):** An authorization aging report is used to monitor TATs for authorizations. Any open authorization without a final determination will appear in this report. The UM Manager or designee monitors the report daily to ensure all authorization determinations are compliant with UM TATs.

Monitoring Over and Under Utilization

The Alliance monitors potential over and under-utilization of covered services (including medical and behavioral health services), based on population and member-specific analysis of service utilization trends. Assessment and monitoring of Over and Under Utilization is a collaborative effort between the Quality Management and UM Department. The UM Department monitors over- and under-utilization for:

- Emergency Room Visits
- Acute Inpatient Hospitalizations
- Specialty and Ancillary visits (including out-of-network activities)
- Unused Authorizations

In the absence of national or regional benchmarks, the Alliance monitors monthly, quarterly, and annual utilization data (including claims, encounters, and authorizations) for significant trends. Root cause analysis is conducted to determine potential drivers

for trends, and recommendations are presented to the UMC and QIHEC, at least quarterly. Insights from committee members are used to identify opportunities for improvement, as necessary.

Grievances and Appeals

The Alliance maintains an effective member grievance and appeals (G&A) process that follows all regulatory, contractual and accreditation requirements. G&A is managed within Health Care Services, and complaints identified with clinical service needs are supported by UM staff and Medical Directors. Trending data for clinical appeals and fair hearings is reported to the UMC to identify opportunities to improve the UM experience for members and providers.

Potential Quality Issues

At any time during the utilization review process, staff may identify a condition or situation that appears to deviate from the professional standard of care. In such instances, a Potential Quality Issue (PQI), including Provider Preventable Conditions, is referred to the Quality Improvement Department to be evaluated per policy and procedure.

Member and Provider Experience with Utilization Management

Annually, Alliance members and providers are surveyed to assess their experience with the utilization management processes and services. Satisfaction surveys assess the efficacy of the UM program from the perspective and experience of members and providers.

- **Member Experience:** The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by mail to Alliance Medi-Cal members. UM program efficacy is evaluated using the below composite measures:
  1. Getting Needed Care – member experience when attempting to get care, tests, or treatments
  2. Getting Care Quickly – member experience when receiving care; and
  3. Rating the Health Plan

- **Provider Experience:** A vendor employed by the plan contacts a sample of network providers by mail and/or internet. Among the survey questions, six (6) questions ask providers to rate the plan on:
  1. Access to knowledgeable UM staff.
  2. Procedures for obtaining prior authorization information.
  3. Timeliness for obtaining prior authorization information.
  4. The Plan's facilitation/support of appropriate clinical care for patients.
  5. Degree to which the Plan covers and encourages preventive care and wellness.

  The Alliance conducts quantitative and qualitative analysis to identify areas for improvement. Survey outcomes, analysis, and recommendations are presented to the UMC and QIHEC to assist in identifying opportunities for improvement. The Alliance

UM Department actively participates in ideation to improve the member and provider experience with the UM process.

Delegation of Utilization Management Activities

The Alliance provides covered services to members through a delegated network. For UM-delegated entities, the Alliance has shared-risk arrangements, meaning the delegated entity is typically responsible for outpatient authorization reviews, while the Alliance UM Department is typically responsible for certain outpatient and inpatient authorization reviews. UM-delegated entities perform utilization management activities based on their contract, which includes agreements on divisions of responsibility.

The Compliance Department is responsible for monitoring and tracking the overall performance of delegates, including completion of annual audits. UM department staff review the UM components of the annual audit, which includes a review of delegates' policies and procedures and member case files. The UM team also reviews the delegated entities annual work plans/evaluations, and other standing reporting activities, as required. The Compliance Department is responsible for finalizing the audit findings. For entities that do not meet thresholds, a corrective action plan may be issued and tracked to ensure adequate resolution of the deficiency. All audit findings are reported to the Compliance Committee and the QIHEC.

Annual UM Evaluation

The Chief Medical Officer, the Senior Director, Health Care Services, and the Directors of UM and LTSS collaboratively conduct an annual evaluation of the Alliance UM program. The evaluation includes, at a minimum:

- Review of changes in staffing, reorganization, structure, or scope of the program
- Resources allocated to support the program
- Review of completed and ongoing UM work plan activities
- Assessment of performance indicators
- Review of delegated arrangement activities
- Recommendations for program enhancements

The results of the annual program evaluation are reported to the UMC and QIHEC for review and feedback. The UMC and QIHEC make recommendations for actions and/or interventions to improve program performance, as appropriate.

Annual UM Workplan

Each year, the Alliance establishes objectives and priorities based on findings from the Annual Program Evaluation and outlines a strategic workplan for the coming year. The workplan incorporates goals, measures, anticipated completion timeframes, and responsible parties, and is maintained throughout the year to monitor progress towards goals and adjust goals, as necessary. The CM workplan is reviewed and approved by the UMC and QIHEC annually.

B. Summary of Program Enhancements in 2024

Operational Efficiency and Compliance:

Inpatient and Outpatient UM:

- Continued monitoring and process improvements to meet NOA compliance
- End-to-end authorization system enhancements to streamline authorization processing and eliminate manual workarounds
- Continued evaluation of services that do not require prior authorization with goal to remove unnecessary reviews
- Continue the Tertiary Quaternary Policy
- Develop Authorization and claims stay level configuration for inpatient levels of care and facility types
- Validate different network contracting to ensure accurate out-of-network utilization is reflected in Plan analytical reports and aligned with Delegate utilization reporting.
- Increased alignment with case management, specifically related to transitional care services in alignment with DHCS population health management policy guide

LTSS:

- Hire LTSS Medical Director to provide dedicated LTSS clinical leadership support
- Continued monitoring and process improvements to meet TAT compliance goals
- Successful implementation of LTC care management program, including transitional care services in alignment with DHCS population health management policy guide
- Improve facility awareness to notify the Alliance about changes to LTC member Transition of Care status, and timely Bed Hold and Admission LTC authorizations.
- Continuing to collaborate with LTSS liaison and provider services to establish relationships with facility partners, including consistent onsite facility visits from LTSS social workers
- Ensure the Quality Management department develops quality performance measures for LTC facilities

Pharmacy Services:

- Investigating utilization of unclassified drugs and unclassified biologics for drug utilization patterns and appropriate coding.
- Fully transition Advisor Reviews for Physician Administered Medications/Injections from Alliance Medical Directors to Pharmacists

Behavioral Health Services:

- Enhance process defects impacting TAT performance and implement interventions to meet TAT goals in 2024.
- Increase access as measured by an increase in unique utilizers of mental health and BHT/ABA services.
- Ensure that Contracting continues to increase network capacity, particularly for ABA services.

G&A:

- Continued monitoring appeals for Carpal Tunnel Surgery during Q1 2024 to see if the overturn trend continues and warrants continued education and ongoing monitoring.

Delegated Utilization Management:

- Partner with the Compliance Department to evaluate audit tools and establish metrics that align with The Alliance's key performance indicators.
- Monitor and support Delegate CAP activities, in coordination with the Compliance Department
- Validate different network contracting to ensure accurate out-of-network utilization is reflected in the Plan's analytical reports and aligned with Delegate utilization reporting.
- Provider regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance's Population Health Management strategy

Quality Improvement

Management of Emergency Room Utilization:

- Continue collaboration with Quality Management and Population Health Management team to ensure access to post-discharge care, particularly with primary care providers.
- Monitor diagnosis drivers for emergency room visits, especially for repeat utilizers and for facilities with high emergency room rates.
- Monitor PCP primary care homes for facilities with high ER rates and for repeat utilizers and facilities with high emergency room rates: Identify Teledoc opportunities and those diagnoses that could be managed in primary care offices.
- Track ED utilization that is associated with members who readmit to the hospital, for case escalation to the Case Management department and supports.
- Increase collaboration with Behavioral Health team and Alameda County Behavioral Health Services to support access to necessary BH/SUD treatment

Management of Acute Hospitalizations:

- Expand ADT feeds and comparable data sharing sources for acute hospitals that are not yet established (Stanford, UCSF, Childrens Hospital).
- Build staffing capacity to manage new membership and inpatient volume for new Long-Term Care higher utilization and 2024 Managed Care Plan to Managed Care Plan and Fee-For-Service Medi-Cal Transitions
- Improve identification members who are at-risk for readmission or who re-admitted, including revision of risk-stratification methodology, and use of additional data sources as available to DHCS or community-based partners

- Implement Inpatient MCG medical necessity criteria trainings, particularly for extended stay evaluations and develop updated UM standard workflows for care optimization
- Provide training on referral criteria and referral process for Enhanced Care Management and Community Supports, with goal to link members to appropriate resources for next level of care
- Foster continued collaboration and relationship building with hospital and skilled nursing facility partners to support discharge management, and complex case rounds for members with long length of stay or complex discharge barriers.
- Coordinate collaboration between the Alliance and its delegates around identifying Potential Quality Issues, Avoidable days variance, Provider Preventable Conditions, and preventable readmissions
- Expand screening for appropriate Case Management referrals for palliative/hospice eligible members

Management of Specialty Care Utilization:

- Monitoring elective hospitalizations, Inpatient hospitalizations through the emergency room, Hospital transfers for higher level of care, and provider visits and ancillary services, related to established with the Oncology and Transplant Program enrollment.
- Continued partnership with Contracting team to provide insights on network needs, based on utilization patterns and identified access barriers, especially for tertiary and quaternary academic centers.

Management of Unused Authorizations:

- Continued partnership with Contracting team to provide insights on network needs, based on utilization patterns and identified access barriers
- Continued monitoring and root-cause analysis of unused authorizations

Member and Provider Satisfaction with UM*:*

- Streamline and improve the accessibility of prior authorization information to providers, including increase visibility of authorization details on public portals and secure online platforms
- Ensure providers receive appropriate training to access the resources
- Participate in the review of satisfaction survey data for measurement year 2023, using those survey insights to further inform process improvement efforts

2024 Utilization Management Work Plan

Performance Measure	2024 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
Program Scope and Structure					
Utilization Management Committee (UMC) schedule	UMC meets at least quarterly; 2025 UMC schedule/agenda prepared and distributed by November 2024	UMC Meeting Minutes	Sr. Director, HCS	meet at least Quarterly; 2025 UMC schedule completed by November 2024	N/A - operational
Review of Policies & Procedure	100% of P&Ps reviewed within annual timeframe, and as needed	P&Ps	Sr. Director, Health Care Services	As needed, and at least Annually	UMC - annually
2023 UM Program Evaluation	Complete 2023 UM Program Evaluation by Q1 2024	2023 UM Program Evaluation	Sr. Director, Health Care Services	Annually, by Q1 2024	UMC - annually
2024 UM Program Description	Complete 2024 UM Program Description by Q1 2024	2024 UM Program Description	Sr. Director, Health Care Services	Annually, by Q1 2024	UMC - annually
2024 UM Work Plan	Complete 2024 UM Work Plan by Q1 2024	2024 UM Workplan	Sr. Director, Health Care Services	Annually, by Q1 2024	UMC - annually
Clinical Decision Support Tools					
Review of Clinical Criteria & Hierarchy	Present Annual Review of Clinical Criteria and Hierarchy	Internal report: Clinical Criteria & Hierarchy	UM Medical Director / UM & LTSS Director	Annually	UMC - annually
Review of Code-Specific Prior Authorization Rules (including auto-authorization code list)	Present Annual Review & Recommendations for PA rules (including auto-authorization Code List)	PA grid, auto-authorization code list	UM Medical Director / UM Director	Annually	UMC - annually
Review of Board-Certified Consultants	Present Annual Review of Board-Certified Consultants	Internal report: Board-Certified Consultants; list of specialties from AMR	Sr. Director, HCS	Annually	UMC - annually
Inter-Rater Reliability	100% of eligible UM reviewers complete IRR by Q3 2024; ≥ 90% overall IRR score (UM, LTSS, Pharmacy, BH, Appeals, Physicians)	Internal IRR report	Quality Improvement / UM & LTSS Director	Annually	UMC - annually
Tracking Disclosures of UM Criteria/Policies	Present Annual Report on Volume of UM Criteria/Policies disclosed to members and providers	Member/Provider Request Log for UM criteria/policies	Managers (UM, LTSS, Pharmacy, BH)	Annually	UMC - annually
UM Program Effectiveness					
Utilization Review Measures					
Authorization Volume *MediCal & Group Care, separate data*	Present Quarterly Report of Authorization Volumes (UM, LTSS, Pharmacy, BH)	UM Reports (total auth volume and determination status)	Managers (UM, LTSS, Pharmacy, BH)	Quarterly	UMC - quarterly
UM Timeliness (Decision and Notification TAT) *MediCal & Group Care, separate data*	≥ 95% TAT compliance (UM, LTSS, Pharmacy, BH)	Analytics Report 02569_AuthTAT	Managers (UM, LTSS, Pharmacy, BH)	Quarterly	UMC - quarterly
Denial Rate *MediCal & Group Care, separate data*	≤ to 5% denial rate (UM, LTSS, Pharmacy, BH)	Analytics Report 01292_AllAuthDenialRates	UM Medical Director	Quarterly	UMC - quarterly
NOA Compliance *MediCal & Group Care, separate data*	≥ 95% audit score (UM, LTSS, Pharmacy, BH)	Internal Audits for NOA Content & Enclosures (UM, LTSS, Pharmacy, BH)	Managers (UM, LTSS, Pharmacy, BH)	Monthly	UMC - quarterly
Quality Audit Scores	≥ 95% audit score (UM, LTSS, Pharmacy, BH)	Internal File Review Audits (UM, LTSS, Pharmacy, BH)	Managers (UM, LTSS, Pharmacy, BH)	Monthly	UMC - quarterly
CBAS Measures	Present Quarterly Report of CBAS Measures	CBAS reports	Manager, UM	Quarterly	UMC - quarterly
California Children's Services (CCS) Measures	Present Quarterly Report of CCS Measures	CCS reports	Manager, UM	Quarterly	UMC - quarterly
UM System Controls					

Performance Measure	2024 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
UM System Controls Audit Scores	100% completion of quarterly system controls audits; present Quarterly Report of UM Denial System Control audit results (including analysis of inappropriate modifications within audit sample)	Analytics Report, Internal Audits	UM & LTSS Director	Quarterly	UMC - quarterly
Over/Under Utilization					
Emergency Room Utilization *MediCal & Group Care, separate data*	XX% decrease of avoidable ER visits	PBI Delegate Summary_UR_ALL ED Util tab	UM Medical Director / UM Director	Quarterly	UMC - quarterly
Acute Inpatient Hospitalizations (Admits/K, ALOS, Days/K) *MediCal & Group Care, separate data*	Present Quarterly Report of Acute Inpatient Hospitalizations	PBI 12412 Monthly Trend	UM Medical Director / UM Director	Quarterly	UMC - quarterly
Acute Inpatient Hospitalizations (Readmission Rate) *MediCal & Group Care separate reports*	XX% decrease of all-cause readmission rate	Hospital reports for readmissions	UM Medical Director / UM Director	Quarterly	UMC - quarterly
Specialty and Ancillary Visits (including Out-Of-Network utilization)	Present Quarterly Report of Specialty & Ancillary Utilization, including OON analysis	PBI 12378 Network Tab	UM Medical Director / UM Director	Quarterly	UMC - quarterly
Unused Authorizations	Present Quarterly Report of Unused Authorizations	PBI 13521 Util vs NonUtil % tab	UM Medical Director / UM Director	Quarterly	UMC - quarterly
Bedhold Utilization (SNF - skilled, custodial)	Present Quarterly Report of Bedhold Authorizations		UM & LTSS Director	Quarterly	UMC - quarterly
Behavioral Health Underutilization of Services	Present Quarterly Auth Volumes (BH and BHT/ABA)	Auth volumes report	UM BH Manager	Quarterly	UMC Quarterly
Grievance & Appeals					
Grievance & Appeals (volume and overturn rates)	Quarterly Report of Grievance & Appeals Analysis	Grievance and Appeal Report	Manager, G&A	Quarterly	UMC - quarterly
Potential Quality Issues (PQIs)					
Provider Preventable Condition Monitoring	100% of PPCs reported to QI team as PQIs	QI Report/Tracker (by referral sources) / Analytics report (with list of codes for PPCs crosswalked with logged PQI) - *in development*	Quality Improvement / UM & LTSS Director	Quarterly	Semi-annual
Member and Provider Experience with UM					
Member Satisfaction (CAHPS) *Medi-Cal Adult & Child, Group Care Adult)*	year-over-year improvement in the below categories: Getting Care Quickly Getting Needed Care Coordination of Care	CAHPS results (MY2023)	Sr. Director, HCS	Annually	UMC - annually
Provider Satisfaction (Provider Survey)	year-over-year improvement in the below categories: Access to UM Staff Obtaining Pre-Auth Info Timeliness of Pre-Auth Info Facilitation of Care Coverage of Prevention	Provider Satisfaction Survey (MY2024)	Sr. Director, HCS	Annually	UMC - annually
Community Advisory Committee Insights	Present Quarterly report of Community Advisory Committee Insights	Community Advisory Committee Report	Director, Population Health	Quarterly	UMC - quarterly
Evaluation of Delegated Utilization Management					
Delegation Oversight - Audit & Corrective Action monitoring	100% timely review, analysis, and attestation completion for Delegate audits & corrective action plans	Delegation Oversight Auditing Templates	Delegation Oversight / UM Director	Quarterly	UMC - quarterly

Performance Measure	2024 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
Delegation Oversight - Standard UM monitoring	100% timely review, analysis, and attestation completion for Delegate UM reports (monthly, quarterly, annually)	Delegation Oversight Reporting Templates	Delegation Oversight / UM Director	Monthly, Quarterly, Annually (depending on report)	N/A - operational
Regulatory, Compliance, Accredidation Findings					
DHCS - Corrective Action Plans for UM Activities	100% timely participation and response to DHCS UM Findings and/or Corrective Action Plans and associated activities	DHCS Findings / CAP Report	Sr. Director, Health Care Services	as needed	UMC - as needed
DMHC - Corrective Action Plans for UM Activities	100% timely participation and response to DMHC UM Findings and/or Corrective Action Plans and associated activities	DMHC Findings / CAP Report	Sr. Director, Health Care Services	as needed	UMC - as needed
NCQA - Corrective Action Plans for UM Activities	100% timely participation and response to NCQA UM Findings and/or Corrective Action Plans and associated activities	NCQA Findings / CAP Report	Sr. Director, Health Care Services	as needed	UMC - as needed
UM Processes					
Accuracy of Published UM content	100% timely completion of platform audits	Member and Provider Portals (public and secure site), Platform Audit Results	Sr. Director, HCS	As needed, and at least Annually	N/A - operational
Accuracy of Member and Provider Communications related to UM Process	100% participation in creation or updates to member and/or provider-facing content for UM activities (including NOAs, EOC, Provider Manual, Website, Portals)	Member- and Provider-facing communications	Sr. Director, HCS	As needed, and at least Annually	N/A - operational
Transitional Care Services - Completion of Discharge Risk Assessment for High-Risk Members *(defintion of high-risk per DHCS PHM Policy Guide)*	≥ 95% audit score	Internal File Review Audits (audit element: discharge risk assessment completed for "high-risk" member admitted to inpatient facility)	IP UM Manager	Monthly	N/A - operational
Continuity of Care (MER & OON requests) Reporting	100% timely review, analysis, and submission of COC and OON sections in DHCS Quarterly Monitoring Report	DHCS Quarterly Monitoring Reports	Sr. Director, HCS	Quarterly	N/A - operational
CBAS utilization (including ERS) Reporting	100% timely review and submission of DHCS CBAS Monitoring Report	DHCS Quarterly CBAS Reports	OP UM Manager	Quarterly	N/A - operational
Major Organ Tranplant Reporting	100% timely review and submission of DHCS MOT Report	DHCS Quarterly MOT Reports	OP UM Manager	Quarterly	N/A - operational
MCP Transition Post-Transitional Monitoring (PTM) Reporting	100% timely review and submission of DHCS MCP Transition PTM Reports	DHCS Quarterly MCP Transition Post-Transition Reports	Sr. Director, HCS	per DHCS schedule	N/A - operational
LTSS Post-Transitional Monitoring (PTM) Reporting	100% timely review and submission of DHCS LTSS PTM Reports	DHCS Quarterly LTSS Post-Transition Reports	LTSS Director/Manager	per DHCS schedule	N/A - operational
Administrative					
Annual Review of UM Staffing	Timely and accurate submission of staffing review, including applicable justifications	Staffing Worksheets	Sr. Director, HCS	Annually, by Q1 2024	N/A - operational
Clinical Information System Enhancements	100% participation in TruCare Steering Committee and Authorization Enhancement Project Deliverables	Authorization Enhancement Project Work Plan	Sr. Director, HCS	n/a	N/A - operational
MCG Auto-Authorization Implementation	100% participation in launching MCG Auto-Authorization, phase I	MCG Auto-Authorization SOW	Sr. Director, HCS	Quarterly	N/A - operational

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM EVALUATION 2023

ALAMEDA Alliance FOR HEALTH

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

2023 Quality Improvement Health Equity Program Evaluation Signature Page

_____ _____

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Senior Director, Quality
Quality Improvement Health Equity Committee

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Sanjay Bhatt, M.D., M.S., M.M.M. **Date**
Senior Medical Director
Vice Chair, Quality Improvement Health Equity Committee

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Donna Carey, MD **Date**
Interim Chief Medical Officer
Chair, Quality Improvement Health Equity Committee

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Matthew Woodruff **Date**
Chief Executive Officer
Chair, Quality Improvement Health Equity Committee

_____ _____

Rebecca Gebhart **Date**
Board Chair

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Introduction

Alameda Alliance for Health (Alliance) is a local, public, not-for-profit managed care health plan committed to making high-quality health care services accessible and affordable to County residents. The Alliance staff and provider network reflect the county's cultural and linguistic diversity. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for county residents. The Alliance currently provides health care coverage to over 354,822 children and adults through its programs.

Under the leadership and strategic direction established by the Board of Governors (BOG), senior management and the Quality Improvement Health Equity Committee (QIHE), the Health Care Services 2023 Quality Improvement Health Equity (QIHE) Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2023, through December 31, 2023.

Mission, Vision, and Values

Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of life.

Values

Teamwork: We actively participate, support each other, develop local talent, and interact as one team.

Respect: We put people first, embracing diversity and equity, striving to create a positive work environment, excellent customer service, and value all people's health and well-being.

Accountability: We work to create and maintain efficient processes and systems that minimize barriers, maximize access, and sustain high quality.

Commitment & Compassion: We are empathic and care for the communities we serve including our members, providers, community partners and staff.

Knowledge & Innovation: We collaborate to find better ways to address the needs of our members and providers by proactively focusing innovative resources on population health and clinical quality.

Scope of the 2023 Quality Improvement Health Equity Program Evaluation

The Alliance's Quality Department is designed to monitor the quality of clinical care and health care service delivery to all Alliance members. The structure provides ongoing reviews of activities and identifies opportunities to improve the quality of care provided, fosters financial stewardship to the health plan, and collaborates with internal and external stakeholders to deliver high quality and accessible health care. Further, the department fosters consistency in quality assessment and improvement to the health care system while:

- Adopting and integrating community health priorities, standards, and goals that impact the health of Alliance's members.
- Identify and target improvement to improve access, care, and service.
- Identify overuse, misuse, and underuse of health care services.
- Identify opportunities to improve patient safety and care.
- Address quality issues, both potential and tangible.
- Monitor data trends that display variations in services or disparities in care.

The Quality Department set goals designed to improve quality and the effectiveness of clinical care served to our members:

- Primary goal: to objectively monitor and evaluate the quality, appropriateness, health equity, and outcome of care and services delivered to members of the Alliance.
- Overall goal: to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs.

The Quality Department is structured to continuously pursue opportunities for improvement and problem resolution by:

- Monitoring services and care provided.
- Improving data and analytics to validate care outcomes.
- Peruse opportunities for improvement in areas that are important to Alliance members' care and health.
- Identify interventions when opportunities for improvement are identified.
- Improving member experience through provider access to care.

Quality Improvement Structure

QIHE Structure

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

Governing Committee

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

The QIHEC develops and implements the QIHE program and oversees the QIHE functions within the Alliance.

The QIHEC:

- Recommends policies or revisions to policies for the operational effectiveness of the QIHE Program and the achievement of QI program objectives.
- Oversees the analysis, evaluation, and monitoring of the QI, Utilization Management (UM) and Case Management (CM) programs and Work Plan activities and assesses the results.
- Ensures practitioner participation in the QIHE program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings.
- Identifies needed actions, and ensures follow-up to improve quality, prioritizing actions based on their significance and provides guidance on which to choose and pursue as appropriate.
- The QIHEC meets a minimum of four times per year or as often as needed, to follow-up on findings and required actions.
- Oversees the actions of the Internal Quality Sub-Committee, Utilization Management Sub-Committee, Access, and Availability Sub-Committee, and the Cultural and Linguistics Sub-Committee.

Committee Structure

The BOG appoints and oversees the QIHEC which, in turn, provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Programs. The BOG also oversees the Peer Review and Credentialing Committee (PRCC), which provides a peer review

platform and a platform to review provider credentialing and re-credentialing. Committee membership is made up of provider representatives from the Alliance contracted networks and the Alliance community including, those who provide health care services to members with Mental Health and Behavioral Health Treatment, Seniors, and Persons with Disabilities (SPD) and chronic conditions.

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

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

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

- Quality Improvement Health Equity Committee (QIHEC)
- Peer Review and Credentialing Committee (PRCC)
- Community Advisory Committee (CAC)
- Pharmacy and Therapeutics (P&T) Sub-committee
- Utilization Management (UM) Sub-committee
- Access and Availability Sub-committee
- Internal Quality Improvement Sub-committee (IQIC)
- Cultural and Linguistic Services Sub-committee
- Additionally, Joint Operations Meetings (JOMs) support the quality improvement work of the Alliance. Each committee meets at least quarterly, some monthly, and all committees / sub- committees, except the PRCC, CAC, and P&T committees, report directly to the QIHEC. The PRCC, CAC, and P&T report directly to the BOG. Each committee continues to meet the goals outlined in their charters, as applicable. The QIHEC membership includes practitioners representing a broad range of specialties, as well as Alliance leadership and staff.

Evaluation of Senior-Level Physician and Behavioral Health Practitioners

The BOG delegates oversight of QI, CM and UM functions to the QIHEC which is chaired by the Alliance CMO in collaboration with the CHEO, and vice-chaired by the Senior Medical Director. The CMO, CHEO, and Senior Medical Director provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Program. The CMO delegates senior level physician involvement in appropriate committees to provide clinical expertise and guidance to program development.

The committee is comprised of multiple physician representatives and includes CMOs of partner delegate groups. A psychiatrist and CMO of Alameda County Behavioral Health Care (ACBH),

actively participates in the QIHEC meetings and provides clinical input ensuring policies and reports considered behavioral health implications. The active involvement of senior-level physicians including the psychiatrist from Alameda County Behavioral Health (ACBH) has provided consistent input into the quality program. Their participation helped ensure that the Alliance is meeting accreditation and regulatory requirements. The Senior Director of Behavioral Health at Alameda Alliance for Health is also an active participant of the QIHE Program.

Program Structure and Operations

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

2023 QIHE Program activities included, but were not limited to the following:

- Evaluation of the effectiveness of the QIHE program structure and oversight.
- Implementation and completion of ongoing QIHE activities that addressed quality and safety or clinical care and quality of service.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis of QIHE initiatives and barriers to improvement.
- Monitoring, auditing, and evaluation of delegated entities QI activities for compliance with contractual requirements with the implementation of corrective action plans as appropriate.
- Internal monitoring and auditing of QIHE activities for regulatory compliance and assurance of quality and safety of clinical care and quality of service.
- Development and revision of department policies, procedures, and processes as applicable.
- Development and implementation of direct and delegate network corrective action plans because of non-compliance and identified opportunities for improvement, as applicable.

QI Resources

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

The QIHE program moved forward in providing quality improvement guidance enterprise-wide meeting regulatory and accreditation standards and promoting positive health outcomes for the Alliance membership. In Q1 2023, the Sr. Medical Director provided direction and oversight of the QI Department until the new Senior Director, Quality was hired. In 2023, to support growth with advancing skillset and succession planning, levels were incorporated as part of the Quality Improvement Project Specialist (QPS) position. Within the QPS position, the levels are QPS I, QPS II, and Lead QPS In addition, new positions were approved for fiscal year 2023/2024: 1) QI Engagement Coordinators to conduct outreach to members to complete all preventive

screenings and 2) QI Review Nurse to conduct facility site reviews and support Skilled Nursing Facility/Long Term Care quality monitoring. QI, Health Care Services, and the Alliance continue to evaluate staff turnover and strive to provide a positive work environment while creating a stable work force.

Throughout 2023, vendor partnerships were a part of the QI resource strategy. The QI department continued to augment QI resources via consultants and analytic expertise for the Healthcare Effectiveness Data and Information Set (HEDIS) program.

Additionally, the Alliance maintained its strong relationship with healthcare services support and survey vendor, Symphony Performance Health (SPH) Analytics. In 2023 SPH supported the QI Department work with implementation, analysis, and reporting on the following surveys:

- Afterhours and Emergency Instruction Survey
- Member Satisfaction Survey (CAHPS 5.1H, CG CAHPS)
- Provider Satisfaction Survey

Membership and Provider Network

Membership

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

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

Trended Enrollment by Network and Aid Category

Current Membership by Network by Category of Aid							
Category of Aid	**Nov-23**	**% of Medi- Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	52,215	15.00%	10,373	9,947	787	21,830	9,278
Child	101,660	29.20%	8,019	9,256	31,944	33,769	18,672
SPD	31,018	8.91%	10,205	4,453	1,141	12,899	2,320
ACA OE	120,761	34.69%	19,443	36,959	1,258	46,989	16,112
Duals	41,381	11.89%	24,689	2,518	1	9,778	4,395
LTC	139	0.04%	139				
LTC-Dual	986	0.28%	986				
Total Medi-Cal:	348,160	100%	73,854	63,133	35,131	125,265	50,777
Total: Group Care:	5,586		2,299	865	0	2,627	0
Total	**353,746**	**100%**	**76,153**	**63,998**	**35,131**	**127,892**	**50,777**
Medi-Cal %	98.42%		96.98%	98.65%	100.00%	97.95%	100.00%
Group Care %	1.58%		3.02%	1.35%	0.00%	2.05%	0.00%
			21.53%	*18.09%*	*9.93%*	*36.15%*	*14.35%*
			% Direct:	**40%**		**% Delegated:**	**60%**

2023 Trended Categories of Aid, Distibution and Growth/Loss

Category of Aid Trend											
	Members				% of Total (ie. Distribution)				% Growth (Loss)		
Category of Aid	Nov-2021	Nov-2022	Oct-2023	Nov-2023	Nov-2021	Nov-2022	Oct-2023	Nov-2023	Nov 2021 to Nov 2022	Nov 2022 to Nov 2023	Oct 2023 to Nov 2023
Adults	42,623	50,124	52,476	52,215	14.48%	15.37%	14.76%	14.76%	17.60%	4.17%	-0.50%
Child	97,935	101,680	101,670	101,660	33.27%	31.19%	28.59%	28.74%	3.82%	-0.02%	-0.01%
SPD	26,366	28,505	31,131	31,018	8.96%	8.74%	8.75%	8.77%	8.11%	8.82%	-0.36%
ACA OE	100,844	117,051	121,706	120,761	34.26%	35.90%	34.22%	34.14%	16.07%	3.17%	-0.78%
Duals	20,692	22,889	41,888	41,381	7.03%	7.02%	11.78%	11.70%	10.62%	80.79%	-1.21%
LTC	0	0	144	139	0.00%	0.00%	0.04%	0.04%	0.00%	100.00%	-3.47%
LTC-Dual	0	0	1,012	986	0.00%	0.00%	0.28%	0.28%	0.00%	100.00%	-2.57%
Medi-Cal Total:	288,460	320,249	350,027	348,160	98.00%	98.22%	98.42%	98.42%	11.02%	8.72%	-0.53%
Group Care Total:	5,880	5,791	5,607	5,586	2.00%	1.78%	1.58%	1.58%	-1.51%	-3.54%	-0.37%
Total Membership:	**294,340**	**326,040**	**355,634**	**353,746**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**10.77%**	**8.50%**	**-0.53%**

2023 Trend Enrollment by Age Category

	Members				% of Total (Distribution)				% Growth (Loss)		
Age Category	Nov-21	Nov-22	Oct-23	Nov-23	Nov-21	Nov-22	Oct-23	Nov-23	Nov-21 to Nov 2022	Nov-22 to Nov 2023	Oct-23 to Nov 2023
Under 19	100,206	103,974	104,125	104,107	33.95%	31.89%	29.28%	29.43%	3.76%	0.15%	-0.02%
19 - 44	104,239	119,089	123,815	122,783	35.32%	36.53%	34.82%	34.71%	14.25%	3.97%	-0.83%
45 - 64	60,571	68,279	73,486	72,981	20.52%	20.94%	20.66%	20.63%	12.73%	7.63%	-0.69%
65+	30,135	34,698	54,208	53,875	10.21%	10.64%	15.24%	15.23%	15.14%	56.23%	-0.61%
Total	**295,151**	**326,040**	**355,634**	**353,746**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	10.47%	9.08%	-0.53%

In November of 2023, the Alliance annual membership increased by 9.0% from November 2022. The Alliance experienced membership growth in all age categories from 2022 to 2023 with the exception for ages under 19, which was flat year-over-year, 4.0% growth in the 19-44 age category, 8.0% growth for 45-64 age category and 56.0% growth for the 65+ age category (largest growth category).

The percentage of total distribution for age category under the age of 64 decreased by –4.59% while age 65+ category increased by 4.59% from 2022 to 2023.

The increase in membership was due to the mandatory transition from Duals from FFS, increased SPD enrollment, and newly eligible Long-Term Care members. The delay in member disenrollments from health plans by the state are also contributed to the growth in membership.

Provider Network

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

2023 Provider Network by Type, Enrollment and Percentage

PROVIDER NETWORK	PROVIDER TYPE	MEMBERS (ENROLLMENT)	% OF ENROLLMENT IN NETWORK
Direct-Contracted Network	Independent	75,201	21.32%
Alameda Health System (AHS)	Managed Care Organization	63,617	18.04%
Children First Medical Group (CFMG)	Medical Group	35,444	10.05%

Community Health Clinic Network (CHCN)	Medical Group	128,483	36.43%
Kaiser Permanente	HMO	49,902	14.15%
TOTAL		**352,647**	**100%**

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

- Ambulatory care
- Hospital care
- Emergency Services
- Mental Health
- Home Health Care
- Hospice
- Palliative Care
- Rehabilitation Services
- Skilled Nursing Services
- Managed Long-Term Services and Support (MLTSS)
- Community Based Adult Services
- Enhanced Care Management and Community Support
- Long Term Care (custodial, Subacute care, and Intermediate Care Facility for the Developmentally Disabled (ICF/DD) facilities)
- Transportation
- Pharmacy

Care coordination along the continuum of care includes arrangements for linked and carved out services, programs, and agencies. These services are provided through a network of contracted providers inclusive of hospitals, nursing facilities, ancillary providers, and service vendors. The providers/vendors are responsible for specifically identified services through contractual arrangements and delegation agreements.

The Alliance provider network includes:

Alliance Ancillary Network

Ancillary Type	Count
Behavioral Health Network	Groups: 229 Individuals: 1,507
Durable Medical Equipment (DME) Vendor	1 Capitated, 12 Non-Capitated
Health Centers (FQHCs and non-FQHCs)	68
Hospitals	17
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200
Skilled Nursing Facilities (SNF)	103
Transportation Vendor	1 Individual Vendor with 380 Individual Transportation Providers

Alliance members may choose from a network of over 786 Primary Care Practitioners (PCPs), more than 9,000 specialists, 17 hospitals, 68 health centers, 103 skilled nursing facilities, and more than 200 pharmacies throughout Alameda County. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our priority.

The Alliance QIHE Program strives to ensure that members have access to quality health care services.

Health Plan Quality Performance

HEDIS Performance

The Alliance is committed to ensuring the level of care provided to all enrollees meets professionally recognized standards of care and is not withheld or delayed for any reason. The Alliance adopts, re-adopts, and evaluates recognized standards of care for preventive, chronic and behavioral health care conditions. The Alliance also approves the guidelines used by delegated entities. Guidelines are approved through the QIHEC. Adherence to practice guidelines and clinical performance is evaluated primarily using standard Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a set of national standardized performance measures used to report on health plan performance in preventive health, chronic condition care, access, and utilization measures. The California Department of Health Care Services (DHCS) requires all Medicaid plans to report a subset of the HEDIS measures. 2023 preliminary Medicaid administrative rates are noted below. Minimum Performance Level (MPL) and High-Performance Level are determined by the Medi-Cal Managed Care Division.

Note: 2023 rates are preliminary, final Administrative and Hybrid rates will be available July 2024

Medicaid Administrative HEDIS Rates

NCQA Acronym	Measure Description	2022 Admin Rates	2022 Hybrid Rates	2023 Admin Rates	MPL	Measure Type
Behavioral Health						
FUA1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day	29.82%		31.26%	36.34%	Administrative
FUM1	Follow-Up After Emergency Department Visit for Mental Illness - 30 Day	49.03%		33.65%	54.87%	Administrative
Children's Domain						
CIS10	Childhood Immunization Status - Combo 10	45.20%	52.80%	41.24%	30.90%	Administrative / Hybrid
IMA	Immunizations for Adolescents - Combo 2	49.36%	50.61%	49.27%	34.31%	Administrative / Hybrid
LSC	Lead Screening in Children	57.52%		60.67%	62.79%	Administrative / Hybrid
DEV	Developmental Screening in the First Three Years of Life	44.24%		54.37%	34.70%	Administrative /Hybrid
TFL	Topical fluoride for Children Rate 1 – dental or oral health services	12.18%		13.28%	19.30%	Administrative / Hybrid
W30	Well-Child Visits in the First 15 Months of Life - 6 or More Visits	46.56%		58.67%	58.38%	Administrative
W30	Well-Child Visits for Age 15 Months to 30 Months - Two or More Visits	69.01%		74.03%	66.76%	Administrative
WCV	Child and Adolescent Well-Care Visits	49.69%		56.26%	48.07%	Administrative
Women's Health						
BCS	Breast Cancer Screening	56.08%		59.58%	50.95%	Administrative
CCS	Cervical Cancer Screening	52.44%	53.83%	57.98%	57.11%	Administrative / Hybrid
CHL	Chlamydia Screening in Women	64.14%		66.91%	56.04%	Administrative
PPC1	Timeliness of Prenatal Care	85.36%	87.50%	85.60%	84.23%	Administrative / Hybrid
PPC2	Timeliness of Postpartum Care	81.72%	85.42%	85.93%	78.10%	Administrative / Hybrid

Chronic Disease						
AMR	Asthma Medication Ratio	74.71%		69.87%	65.61%	Administrative / Hybrid
HBD 2	HbA1c Control (>9.0%)	37.06%	29.20%	32.47%	37.96%	Administrative / Hybrid
CBP	Controlling High Blood Pressure	41.77%	54.74%	48.82%	61.31%	Administrative / Hybrid

Analysis of HEDIS Medicaid Managed Care Accountability Set (MCAS)

In Measurement Year (MY) 2023, the Alliance has observed improvements in HEDIS rates compared to MY2022 across multiple measures. The recovery from the COVID-19 pandemic and the stabilization of the workforce have contributed to more in-person office visits, thus leading to an increase in rates. Other factors contributing to the rise in rates include data mining, educating and training the provider network on HEDIS specifications, reviewing, and encouraging the use of real-time actionable care gap reports, member outreach, and incentive programs.

Preliminary rates for MY2023 indicate a few areas where the Alliance falls short of the Minimum Performance Level (MPL): Follow-up After Emergency Visit for Alcohol and Drug Dependence and for Mental Health (FUA/FUM), Lead Screening for Children (LSC), Topical Fluoride for Children (TFL), and Well Child Visits in the First 15 Months of Life (W30 6+). The most notable reason for the low rates in these measures is data integrity issues. FUA/FUM measures are impacted by Alameda County data, and due to system upgrades, the Department of Health Care Services (DHCS) has not provided the Alliance with complete data since July 2023. The Alliance is anticipating a rise in the rates for FUA/FUM with complete data from DHCS.

While the Alliance has made efforts to increase fluoride treatments through primary care provider (PCP) offices, including communication on the importance of fluoride treatments and offering training in partnership with Alameda County Dental, a significant portion of the population of children aged 5-20 years relies on dental office visits for appropriate financial reimbursements. Consequently, the Alliance does not have oversight of Dental Services.

MY 2023 rates for LSC and W30 6+ visits have substantially increased over MY 2022. We are confident that the Alliance will meet the MPL on these measures with complete administrative and hybrid data.

The Alliance will continue its efforts to further increase HEDIS rates to meet or exceed the MPL. Our comprehensive quality strategy includes new interventions to meet or exceed the required 2024 milestones, including internal and external collaboration. The Alliance will continue its efforts to improve HEDIS measures below MPL by focusing on access, provider engagement, member and community engagement, educational efforts, and dedicated multidisciplinary workgroups to enhance HEDIS rates.

Quality Improvement Health Equity Performance Initiatives and Projects

Overview

The Alliance's quality improvement efforts strive to impact the safety and quality of care and service provided to our members and providers. Review of the Alliance's 2023 QIHE activities as described herein demonstrates the Alliance's QI department ability (in collaboration with internal and external entities) to successfully assess, design, implement, and evaluate an effective QIHE Program including but not limited to, the following:

1. Improved focus on the importance of chronic condition management and accessing appropriate care through initiatives to educate and connect with members, direct and delegated providers, community-based organizations, state, and county entities and enhance our improvements in our internal operations.
2. Maintained a targeted focus on the analysis of key drivers, barriers, and best practices to improve access to care.
3. Expanded staff knowledge of health disparities and equity within the Alliance membership through population data collection, analysis, segmentation, and targeted quality improvement activities as part of the Population Health Management Program
4. Promoted the awareness and concepts of inter-departmental QI initiatives and activities, data-driven approaches, including Plan-Do-Study-Act (PDSA), and Inter-Rater Reliability (IRR), to:
    a. Identify, investigate, and resolve Potential Quality Issues (PQIs).
    b. Identify and address service over-and-underutilization.
    c. Promote patient safety.
    d. Remove barriers to access to timely care and services.
5. Invested in quality measurement analysis expertise.
6. Identified PQIs operations gaps and root cause analysis to identify and overcome barriers, as well as best practices resulting in internal workflow improvements and staff retraining.
7. Monitored and demonstrated improvement in HEDIS measures.
8. Ensured timely Facility Site Review (FSR/Medical Record Review (MRR) audits and Physical Accessibility Review Surveys (PARS) in person and virtually.
9. Targeted QIHE initiatives to improve direct and delegate provider engagement in access to care efforts to improve rates of preventive care and services, screenings, and referrals for members.
10. Targeted partnerships with community-based county agencies and delegate providers to improve referral and resources triage and management through technology collaboration and support.
11. Promoted healthcare access and safety education for members and providers through targeted pharmacy substance use programs.

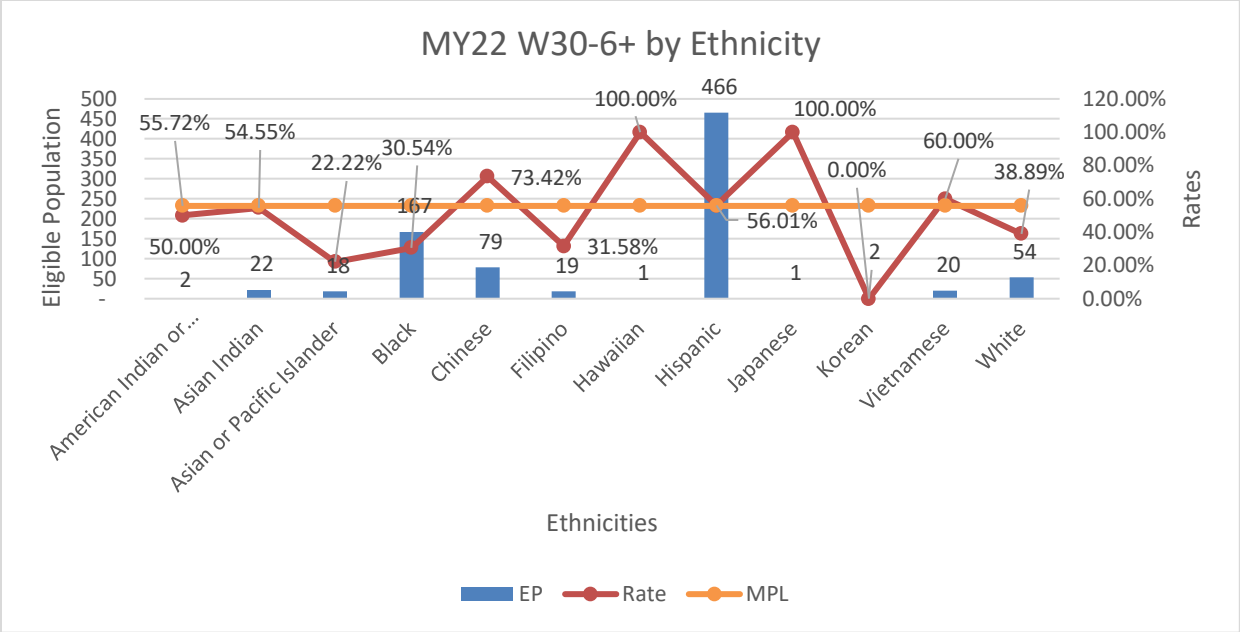
12. Improved engagement with interpreter services vendors and Alliance network providers to ensure quality interpreter services at all points of healthcare service contact.
13. Coordinated engagement with Behavioral Health, both when delegated and in-sourced in April 2023, for improved and timely access to care.
14. Collaborated with First 5 of Alameda County and delegate provider networks to improve well-child visits (WCV) and Early Periodic Screening and Diagnostic Treatment (EPSDT) service utilization for pediatric and adolescent members.
15. Provided webinars and technical assistance to providers to promote access, preventive care, chronic disease management, women's health, and behavioral health services.
16. Incorporated a health equity lens by analyzing health disparity data, member feedback on barriers and root causes, and alignment with the Population Health Strategy and Health Equity Department initiatives.

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

Equity Performance Improvement Project (PIP) (2023 – 2026) – Well Child Visit in the First 15 Months of Life - (W30 6+)

The Department of Health Care Services (DHCS) has reported a concerning trend of lower rates of well-child visits for African American children aged 0-15 months. As a result, the Equity Performance Improvement Project (PIP) topic for MY2023-MY2026 is focused on enhancing well-visit rates for African American children in this age group. In MY2023, the Alliance submitted population size and baseline data for African American children aged 0-15 months residing in Alameda County and a member of the Alliance to DHCS, and the PIP topic was accepted as an equity project through 2026.

The chart below indicates that the Well Child Visits in the First 30 Months of Life (W30-6+) score for Black/African American children ages 0-15 falls below the Minimum Performance Level (MPL). When comparing the Black population with other demographic groups in the Alliance population, the rates for Black children are significantly lower. The Alliance recognizes an opportunity to improve the current scores for Black children to reach or exceed the MPL of 55.72%. As the first step in the PIP process the Alliance is conducting barrier analysis through member surveys to help inform the Alliance and providers on barriers members encounter to completing well visits.



Nonclinical Performance Improvement Project (PIP) (2023-2026) – Improve the Percentage of Provider Notifications for Members with SUD/SMH Diagnoses Following or Within 7 Days of Emergency Department (ED) Visit

When a member seeks care in the Emergency Department (ED) for either substance use disorder (SUD) or mental health conditions, it is typically because they are in crisis or in need of assistance not currently provided by their regular providers. During such crises or urgent situations, there's an opportunity for intervention if the member can relate to the appropriate services and receive timely follow-up care. Without such follow-up, members are more likely to return to the ED, and their SUD or mental health conditions often worsen when consistent treatment is not initiated. Therefore, the Department of Health Care Services (DHCS) has identified Follow-up After Emergency Department Visit for Substance Use or Mental Health as the nonclinical Performance Improvement Project (PIP) for 2023 – 2026.

For the nonclinical PIP, DHCS has allowed managed care plans to choose from three topics:

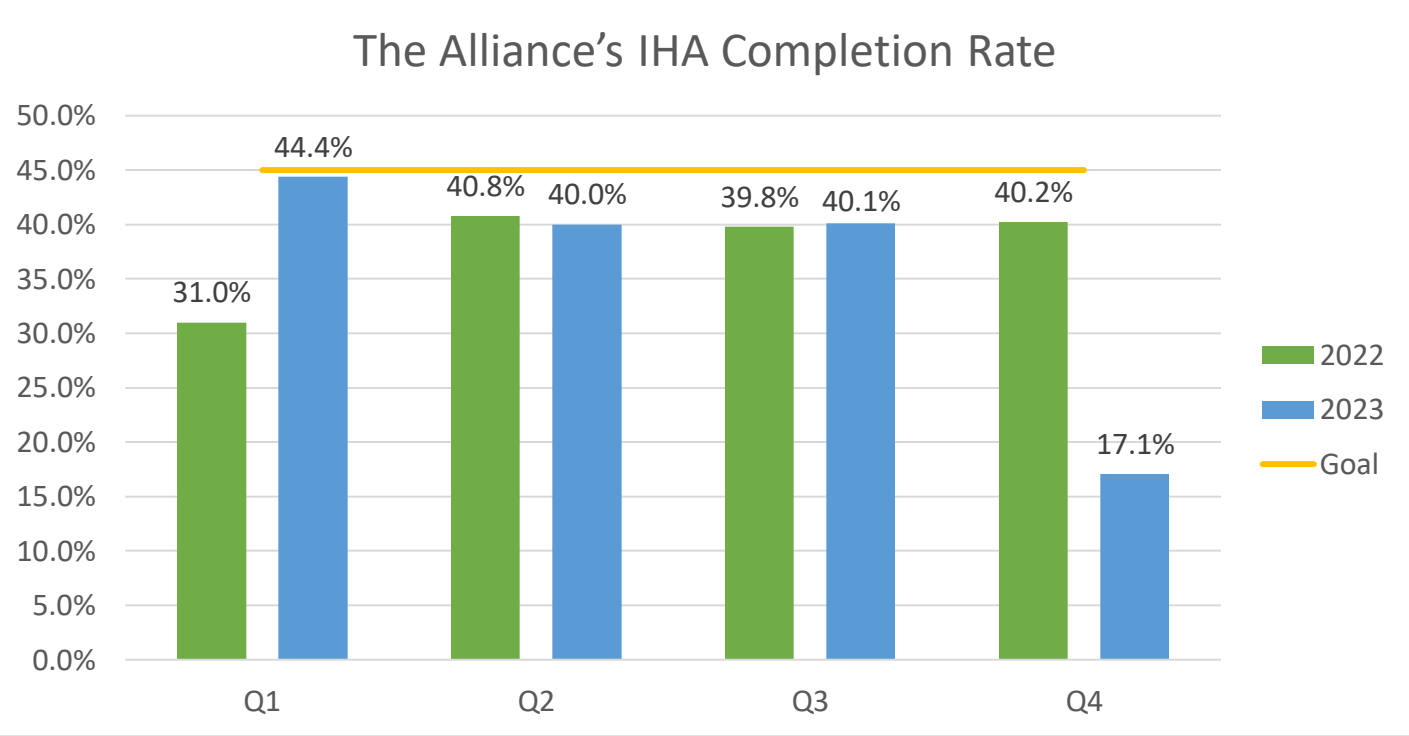
1. Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of an emergency department (ED) visit.
2. Enhance the percentage of referrals to Community Support programs (such as Sobering Centers, Day Habilitation programs) within 7 days of visiting the ED for members with a SUD/SMH diagnosis and seen in the ED for the same diagnoses.
3. Increase the percentage of members enrolled in care management, complex care management (CCM), or enhanced care management (ECM) within 14 days of a provider visit where the member was diagnosed with SMH/SUD.

The Alliance has selected topic number one: to improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of an ED visit. This choice was made because a notification system to ensure providers are aware that their patients had an ED visit is crucial and represents the first step in following up with patients.

In the chart below, MY2022 rates for Follow-up After ED Visit for Substance Use or Mental Health (FUA/FUM) within 7 days are low. Therefore, the Alliance believes that by increasing provider notifications, the rates for FUA/FUM within 7 days will also increase.

Measure	Number of Events	Notified Provider within 7 Days	Rate
Follow-Up After Emergency Department Visit for Substance Use (FUA)	1,700	37	2.18%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	1,591	44	2.77%

Initial Health Appointment (IHA) Rates & Audits



In 2023, the Alliance implemented IVR calls to members newly enrolled or re-enrolled, with a message to encourage them to schedule an appointment with their assigned PCP to establish care. Additionally, the Alliance provides an IHA report to help providers identify members who are newly enrolled or re-enrolled. Moreover, the Alliance communicates regularly with providers through provider meetings, newsletters, and fax blasts regarding the importance of Initial Health Appointments (IHAs).

The preliminary rates for 2023 indicate a substantial increase in quarter one; however, the rates for quarters two and three remain unchanged from MY2022. Due to claims lag and 120-day timeframe for completion, quarter 4 data is not finalized. The Alliance will continue to strategize opportunities for improving IHA rates.

Audit of Initial Health Appointments via FSR/MRR

IHAs include History and Physical (H&P). An IHA must be completed within 120 days of member

plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to plan enrollment/PCP effective date.

Alliance reviewed records of IHA for members enrolled before 2023 eligible for IHA criteria. IHA was also reviewed for newly enrolled members in 2023 who presented for well care visits at the provider's office. In 2023, medical records at 28 sites were reviewed for the presence of an IHA. During the MRR, there were at least 30% of records reviewed or members eligible for IHA. The Table below lists the results of these reviews. There was a total of 28 IHA charts audited and 50% (14) were compliant with the required elements. The 14 total non-compliant providers received CAPs and re-education/training on IHA compliance.

2023 MRR Results

TYPE	Q1	Q2	Q3	Q4	TOTAL
Total IHAs Audited via FSR	11	4	6	7	28
# of MRRs with Compliant* IHAs	9 (82%)	0 (0%)	3 (50%)	2 (29%)	14 (50%)
# of MRRs with Non-Compliant IHAs (CAPS)	2	4	3	5	14 (50%)

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

IHA Audit

The Alliance conducted an audit of the Initial Health Appointments (IHA). A random sample of member charts were selected, and medical records were requested to review the IHA elements, including:

- Comprehensive physical and mental exam
- Identification of risks
- Preventive care
- Health Education
- Diagnoses and plan of care

In 2023, 60 charts were requested, 40 received. The following were the results of the IHA audit:

- Adults – 20 charts reviewed, 68% of elements completed.
- Children – 17 charts reviewed, 76% of elements completed.
- Adolescents – 3 charts reviewed, 67% of elements completed.

To improve IHA compliance rates, the Alliance worked to:

- Ensure member education – through mailings, member orientation and outreach.
- Improve provider education – through provider manual and newsletter/packets, Joint Operational Meetings (JOMS), QIHEC meeting, provider site visits to educate providers on timely access standards, and provider educational webinars.
- Improve data sharing – by sharing gaps in care lists with delegates and providers.
- Developed an IHA Provider Guide with requirements, codes, and best practices which

was shared with providers through various communication methods.

- Monitor medical records – through IHA audits, FSR/MRR site review, and monitoring of IHA rates.

- Ensure accountability – through corrective action plans and follow up.

Well Child Domain

The Well-Child Workgroup focused on improving performance on childhood domain measures held to the Minimum Performance Level (MPL) on the California DHCS Managed Care Accountability Set (MCAS) for FY23/RY24. The aim of the workgroup was as follows:

Alameda Alliance for Health (AAH) will improve on well-child measures in the Managed Care Accountability Set (MCAS) that are under the Minimum Performance Level (MPL), by conducting improvement projects to increase the rates from below the MPL to above the MPL and to maintain current rates, by December 31, 2023, as follows:

- Child and Adolescent Well-Care Visits (WCV), from 49.24% to 59.34%, by December 31, 2023.
- Lead Screening in Children (LSC), from 57.47% to 67.47%, by December 31, 2023.
- Well-Child Visits in the First 0-15 Months of Life (W30-6+), from 46.56% to 56.57%, by December 31, 2023.

To support these improvements, the workgroup conducted various projects on member education, member outreach, provider education, provider collaboration, and addressing data gaps with the Analytics Department. Here are highlights of a few projects that helped drive improvements in the overall rates:

- HEDIS Crunch with Children First Medical Group (CFMG): The goal of this project was to meet or exceed CFMG's rates in W30-6+, W30-2+, and WCV measures by providing members, and their families, with a $25 Target Gift Card upon completion of their well-visits. For MY23, 19 CFMG clinics collectively distributed 2,983 gift cards from June-December of 2023. As a result, CFMG exceeded the MPL in the W30-2+ and WCV measures. W30-6+ did not meet or exceed the MPL; however, CFMG had a 24.35% improvement in this rate from MY22, which may be attributed to the HEDIS Crunch project contributed to.
- Measure Highlight Sheets: The Alliance's QI Team developed Measure Highlight Sheets to help providers, a reference guide on the various MCAS measure definitions, codes, best practices, and tips to meet the measures. Measure Highlight Sheet were developed for: Childhood Immunization Status – Combination 2 (CIS-2), Immunizations for Adolescents (IMA-2), Lead Screening in Children (LSC), Developmental Screening in the First Three Years of Life (DEV), Topical Fluoride Varnish for Children (TFL-CH), and Well-Child Visits for ages 0-21 years old (W30-6+, W30-2+, and WCV). The Measure Highlight Sheets were provided to all Pediatric provider offices.
- Supplemental Data for W30-6+: The QI Team partnered with the Analytics Team to bridge the gap in data for the W30-6+ visits. The Alliance learned that data gaps were significant in the first two visits, as typically the babies' Medi-CAL Client Index Numbers (CINs) are

tied to their Mother's Medi-Cal CIN. The challenges we learned through billing are that often claims do not delineate if the visit was for the mother or the baby. To improve this gap in data, the QI Team worked with CFMG clinics, who historically performed low in this measure, to collect medical records for review and determined if recorded encounters count towards our overall rate. As a result, the Analytics Department received 196 records from 11 CFMG clinics, of which 67 visits were found to be compliant. This contributed to CFMG's overall W30-6+ rate, which increased by 24.35% from MY22.

Disease Management Domain

The Chronic Disease Workgroup focused on improving performance on measures held to the MPL on the MCAS. The aim of the workgroup was as follows:

Alameda Alliance for Health (AAH) will improve or maintain performance on chronic disease management measures in the Managed Care Accountability Set (MCAS) to meet the Minimum Performance Level (MPL), by conducting PDSA (Plan, Do, Study, Act) projects by December 31, 2023, as follows:

Asthma Medication Ratio (AMR), maintain at least 10% performance above MPL, by December 31, 2023.

Controlling High Blood Pressure (CBP), increase from 38.2% to 60.0%, by December 31, 2023.

Hemoglobin A1c Control for Patients with Diabetes, decrease from 42.2% to 39%, by December 31, 2023

Two projects were initially discussed to undertake as a PDSA, including an informational campaign, and were eventually abandoned due to various administrative challenges. The Alliance previously partnered with the Alameda County Public Health Department to increase education and awareness of asthma prevalence and treatment, and there was a goal to continue the work by developing an educational video to display at provider office waiting rooms. After some investigation, it was determined that the amount of effort and cost to produce the video was too large for the potential impact due to low response from providers about their interest and ability to display the videos. The workgroup also pursued a project to increase A1c testing by mailing home test kits to members to obtain an A1c result and reconnect the member to care. The workgroup planned to partner with an in-network laboratory to provide and process the kits. After several months of discussion and reorganization of departments at the laboratory, it was again determined that the cost of the project outweighed the potential return.

One project focused on improving blood pressure control did demonstrate some success. The Community Health Center Network (CHCN) received funding from the Alliance to support community health centers' efforts to build or improve their remote self-monitored blood pressure (SMBP) program. Funds were used to purchase remote connected BP devices, to support EHR integration of BP measurements, and to improve patient engagement with the program and education on SMBP. Several measures were tracked: CBP measure rate overall and for the African American population, systolic BP change, number of patients with an SMBP order, percentage of enrolled patients with subsequent BP readings, and impact on staff capacity and workload. The program saw success in the overall CBP rate with an almost 20% increase in the administrative rate from MY2022 and narrowly missing the MPL with administrative data by 1%. The CBP rate among African American members also increased from MY2022. More than 3,700 members received SMBP orders; 81% of those members had a subsequent BP remote BP

reading and 65% improved their systolic BP after enrollment. Implementing a remote monitoring program and integrating with an EHR required a significant investment upfront, however less time was spent on data-related tasks as the program continued. Staff time spent on patient outreach increased throughout the year as more patients were enrolled yet staff capacity did not increase. Overall, the program was determined successful, and the Alliance will again provide support in MY2024.

Women's Health Domain

The Women's Health Workgroup focused on improving measures that were performing below the minimum performance level in the Managed Care Accountability Set (MCAS), aiming to increase rates to meet or exceed the minimum performance level (MPL) and coordinate efforts to address population health disparities. These measures included:

Cervical cancer screenings (CCS)

Breast cancer screenings (BCS)

Chlamydia screenings in women (CHL)

Timeliness of prenatal care (PPC 1)

Timeliness of postnatal care (PPC 2)

In 2023, the workgroup initiated several quality improvement projects to enhance measures in the women's health domain. These projects included mobile mammography, targeted member outreach to increase breast cancer screening rates among African American women, and outreach efforts through birthday card reminders and calls targeting women aged 24-30 who have significant care gaps.

Mobile Mammography: The Alliance aimed to improve access to BCS screenings for its members and streamline clinic workflows for breast cancer by offering mobile mammography services. In partnership with the provider network, the Alliance hosted six mobile mammography events, resulting in 109 completed screenings.

Breast Cancer Flyer: To enhance health education and awareness on breast cancer, a health education flyer was created and distributed to 780 eligible African American women. Following the distribution, 23 women completed a screening. Follow-up outreach calls were made to women who received the flyer but did not complete the screening, resulting in an additional six screenings.

CCS Birthday Card: Birthday cards targeting women aged 24-64 who were non-compliant with cervical cancer screenings were sent to encourage scheduling a screening with their primary care provider (PCP) and provide member education. Two versions of the birthday card were created: one with an incentive and one without. The incentive birthday card facilitated 95 screenings out of 4,021 eligible members from July to December 2023, while the non-incentive birthday card facilitated eight screenings from June to December among 418 eligible members.

CCS Outreach Calls: Data revealed low cervical cancer screening rates among women aged 24-30. From August 2nd to October 30th, 7,090 women in this age group received outreach calls providing timely instructions on scheduling and completing a cervical cancer screening. As a result, 354 women completed a screening.

Cervical Cancer Pap Drives: Multiple providers organized pap events to increase cervical cancer screenings for women aged 24-64. The Alliance supported these events by conducting

outreach calls to schedule appointments, remind members of their scheduled appointments, and providing incentives and giveaways. These efforts led to 262 completed cervical cancer screenings through these events.

As a result of the improvement projects all women's health measures held to MPL has met or exceed the benchmarks in MY2023. The preliminary administrative results are listed in the chart above under HEDIS results.

Behavioral Health

The Behavioral Health Workgroup focused on increasing performance rates of measures held to MPL on the MCAS: Follow-up after Emergency Department Visit for Mental Illness (FUM) and Follow-Up after Emergency Department Visit for Substance Use (FUA). The aim statement of the workgroup was as follows:

Alameda Alliance for Health will improve on Mental Health and Behavioral Health Treatment measures in the Managed Care Accountability Set that are held to the Minimum Performance Level (MPL), by conducting PDSA (Plan, Do, Study, Act) projects to increase the rates to meet or exceed the MPL by December 31st, 2023 as follows:

- FUM: Maintain 5% or greater performance above MPL (54.51%)
- FUA: Maintain 7% or greater performance above MPL (21.24%)

As the workgroup explored network performance on the measures, it became apparent that provider education on the measures was central to improving performance. Two webinars were held by the QI team in March and May to explain the measure definitions and requirements for meeting the measures, and to share best practices. 16 individuals attended the webinar session on March 15 and 8 individuals attended on May 24. Additionally, measure highlights with a similar focus on measure specifications and best practices were developed to share with providers in the network, and the webinars were recorded and made available to view on the Alliance website.

For the remainder of the year, the workgroup focused on supporting providers in their efforts to meet the measure requirements. Several providers experienced challenges developing workflows that were comprehensive and effective and not overly burdensome to clinic staff. It was also challenging for practices to understand which providers could conduct follow-up services and the appropriate coding for those services. The workgroup continued to focus on providing education on the measures and the use of ED visit notification reports to identify members who have been seen for visits that qualify for inclusion in the measures. The secondary focus of the workgroup shifted to exploring strategies for the Alliance to provide follow-up services directly, which included seeking vendors to provide services and developing a workflow to conduct services in-house. These strategies have not proven successful, and the focus of the workgroup in 2024 will shift to exploring opportunities to support positioning navigators in EDs who can provide follow-up assessments and care navigation and County collaboration.

First 5 Alameda Partnership

The Alliance continued to partner with First 5 Alameda in 2022-23. The goal of the initiative was to engage, assess, and connect Medi-Cal enrolled children, ages 0-5 and their families to appropriate clinical and community-based services and support to improve their health and well-being through an integrated community-based care management program. First 5 Alameda served as a key care management entity for Alliance pediatric members, ages 0 to 5 and worked

in partnership with the Alliance to:

- Conduct outreach and engagement to increase child access to well-child preventative care for select Alliance members, ages 0-5.
- Provide pediatric health education to families in a culturally appropriate and accessible manner.
- Bolster pediatric health provider capacity to deliver DHCS/Bright Futures mandated pediatric screenings, with an emphasis developmental screening, Adverse Childhood Experiences (ACEs) Screening, and social determinants of health.

Coordinate family-centered access to well-child visits, as well as needed developmental/behavioral services, mental health services, community-based services and supports, and social support needs, to enhance and supplement practice-based care coordination services and comply with EPSDT requirements.

Through our partnership with First 5, 480 members completed a well visit or had a scheduled well visit. First 5 facilitated provider improvement projects with 10 PCPs in the Alliance network. 884 Alliance members referred by First 5 to at least one community services or support.

Non-Utilization Outreach

The Alliance Board of Governors expressed concerns about the utilization of services by Alliance members. As a result, non-utilization was included as a strategic organization-wide goal. The goal was to reach out to at least 20% of non-utilizers over the age of fifty and connect 2% to primary care services, as well as to outreach to 20% of non-utilizers ages six and under and connect 2% to primary care services by June 30, 2023.

In partnership with Xaqt, a vendor for member outreach, the Alliance conducted outreach calls from April to June 2023. The outreach campaign aimed to facilitate scheduling an appointment for members who had not utilized primary care in the last 15 months, with a specific focus on adults 50 and older with ED visits and children 6 and younger. The primary goal of the outreach was to update the member's assigned PCP and facilitate scheduling an appointment with their assigned PCP. The secondary goal was to identify members with HEDIS measure completion gaps to tailor calls to complete needed preventive services. Three outreach attempts were completed, reaching a total of 4353 adults and 3334 children.

The results of the outreach campaign:

- 50% overall outreach success* rate – 47% of adults, 55% of children.
- 2.25% (102) adults and 1.26% (97) children had a PCP visit following a successful contact based on claims filed.
- 44% of calls resulted in a voicemail.
- 41% of members could not be reached due to incorrect/disconnected phone number, no option to leave voicemail or no phone number on file.

*Note – successful defined as, changed PCP, Left Voicemail, Shared General Information,

Spoke with Member, Parent or Guardian, Transferred to PCP.

Given that there will be new membership in January 2024 with Anthem and adult expansion members, a non-utilizer outreach will be repeated in 2024.

Opioid/SUD Continuation

In 2020, the Alliance partnered with the network providers and other local leaders to develop a Substance Use Disorder Program. This program has continued through 2023.

Alameda Alliance has continued to use multiple strategies involving *Member and Provider Educational Outreach and Pharmacy Safeguards*. The Alliance has accurate and comprehensive monthly reports that detail opioid overutilization, members grandfathered to high dose opioids, members excluded from the SUD Program (including those involved in hospice/palliative, cancer, and members with sickle cell disease), and monitoring the changes in Morphine Milligram Equivalence (MME).

The Alliance monitors a list of members who meet the definition of *chronic opioid users and potential chronic opioid users*. Chronic users are defined as members with prescriptions of greater than 120 MME consecutively for the last three months. Potential chronic opioid users are defined as members with prescriptions between 50 to 119 MME consecutively for the last three months.

The Alliance also has compiled a list of members who presented to the ED with opioid and benzodiazepine overdose and a separate list of members on concurrent use of opioids and benzodiazepines.

In 2023, the Alliance sent pertinent members and providers educational mailings. Mailing includes:

1. Provider Facing:
    a. Lists of identified members who are chronic users, high risk members on becoming chronic users, concurrent chronic opioid/benzodiazepine usage and members presenting to ED for opioid/benzodiazepine overdose.
    b. Provider Opioid and Benzodiazepine Tapering Tools.
    c. Treatment for opioid dependence.
2. Member Facing:
    a. Opioid Safety guide for members and caregivers.
3. Provider and Member Facing:
    a. Non-opioid formulary alternatives.
    b. Mailer Timeline

Day	Member	Provider
1	Original mailing gets sent out	Original mailing gets sent out.
45	Repeat mailing. Refer to case management if a member is on greater than 300 MME.	Repeat mailing.
90	Check if member transition to	Receive letters from medical

	buprenorphine or received appropriate pain treatment.	director. Submit a PQI.
120	N/A	Include operations and peer review committee to decide whether to keep in-network.

Note the above escalation process for members and providers with persistent chronic use of opioids. Cancer, hospice, and sickle cell anemia members are excluded from this. Pharmacy will work with QI to receive chart notes to check on this. Rising risk members will be tracked and looked at on a case-by-case basis. Handouts may include opioid safety, medication assisted therapy, non-opioid alternatives, opioid and benzodiazepines tapering tools and provider maps for non-opioid alternatives such as physical therapy, acupuncture, etc.

The table above outlines the actions to be taken after initially mailing to members and providers (day 1). Each respective row reflects a higher escalation process to be taken if members and providers continue to use opioid inappropriately or with no identified treatment plan.

This escalation process was implemented in the population health goals for 2023. This goal was as follows:" Between 1/1/22 and 12/31/22, ensure that 100% of members (>300MME) and providers (of members on >300MME) with ongoing use of opioids follow the SUD Escalation Process."

This goal was not met. We surveyed providers who provided feedback that mailing was not the most effective method of receiving education. The Alliance will discuss next steps for provider education and escalation process. Lastly, the creation of the tracking log and mailing process was delayed due to limited Communications & Outreach (C&O) and Analytic capacity and Alliance staffing transitions.

Opioids Stewardship Report

September2023: Mailings to 15 high-risk members with prescriptions of greater than 120MME consecutively for the last three months. These members received:

- High risk cover letter
- Health education: Safety guide for patients and caregivers
- Health education: Treating pain without opioids.
- Health education: Medicines for opioid dependence

September 2023: Mailings to 53rising risk members with prescriptions between 50 to 119 MME consecutively for the last three months. These members received:

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

September 2023: Mailings of a total of 39providers with members who were on any of the following lists:

- Opioid and Benzodiazepine Co-use list

- Rising risk list: 50-119 MME for 3 consecutive months
- High risk list: 120+ MME for 3 consecutive months
- Opioid and Benzodiazepine ER list
- Chronic use without Naloxone Mail list

The Alliance developed a Provider packet that included an Opioid and Benzodiazepine Tapering Tool, Shared Data for providers / delegates / committees, Health Education materials, Local Maps that identify providers who may meet the member's needs, and member facing materials.

Goals for 2023

- Continue educating members and providers who are chronic and rising risk opioid users.
- Continue sharing data for providers/delegates/committees.
- Organize materials on Alliance website to be accessible to members and providers.

Opioid and Benzodiazepine ER Reporting

- Reports are based on claims data and reflected on each unique claim with opioids/benzodiazepine related ICD code.
- Reports are shared with assigned PCPs of members on an annual basis.
- There were several peaks between 2022 and 2023 with opioid/benzodiazepine related ER visits. After August 2023, there was a steady decline in opioid/benzodiazepine overdose. The highest peak was in the beginning of 2023.

The Alliance will continue to improve our opioid stewardship program. Below are results of our interventions. As of January 1, 2022, DHCS has taken over the pharmacy benefit for outpatient drugs. The Alliance pharmacy has discontinued formulary safeguards for Medi-Cal but is continuing with formulary safeguards for IHSS members.

Table 1: 2022 – 2023 Benzodiazepines and Opioid ED visits

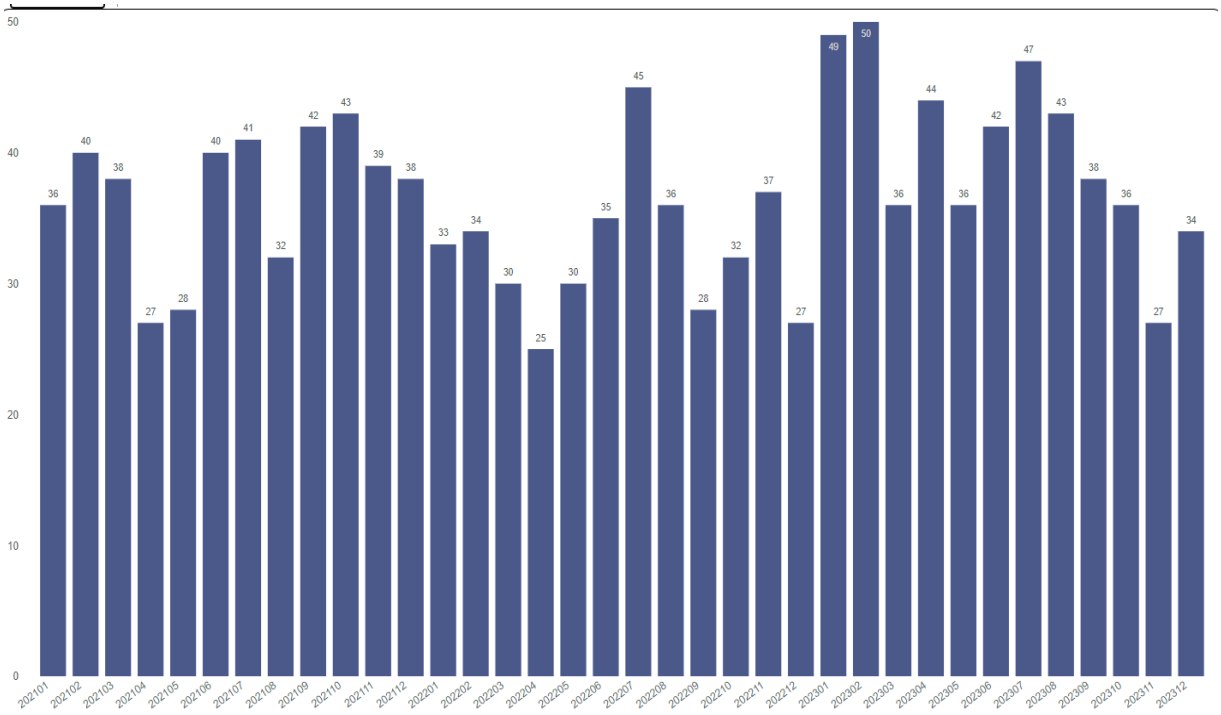
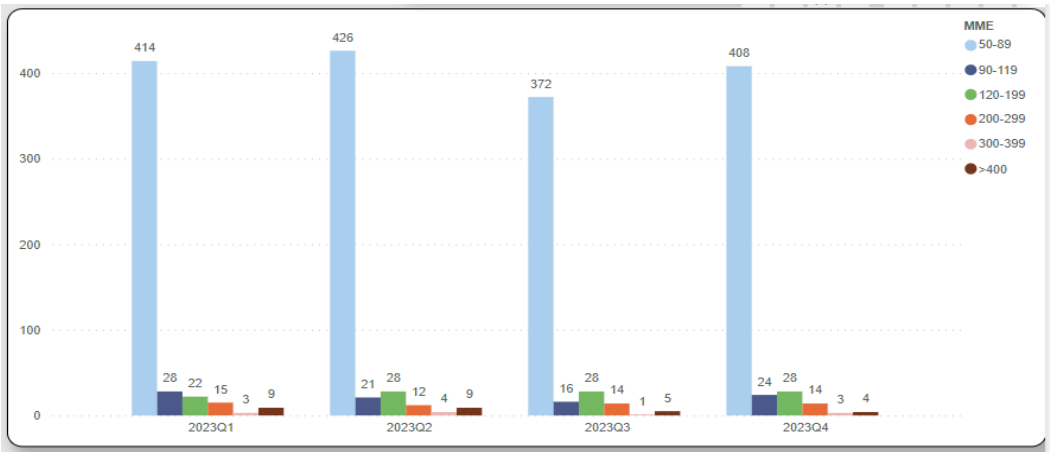


Figure 1: 3 Data for Members on Short Actin Opioids (SAO), Long-Acting Opioids (LAO), and Both SAO and LAO

Table 2: 3 Member per Quarter on >50MME

MME (MORPHINE MILLIGRAM EQUIVALENTS)				
MME	**Q1**	**Q2**	**Q3**	**Q4**
50-89	414	426	372	408
90-119	28	21	16	24
120-199	22	28	28	28
200-299	15	12	14	14
300-399	3	4	1	3
>400	9	9	5	4

Figure 2: 2023 Active Opioid Members by Quarter



2022 Active Members by Quarter

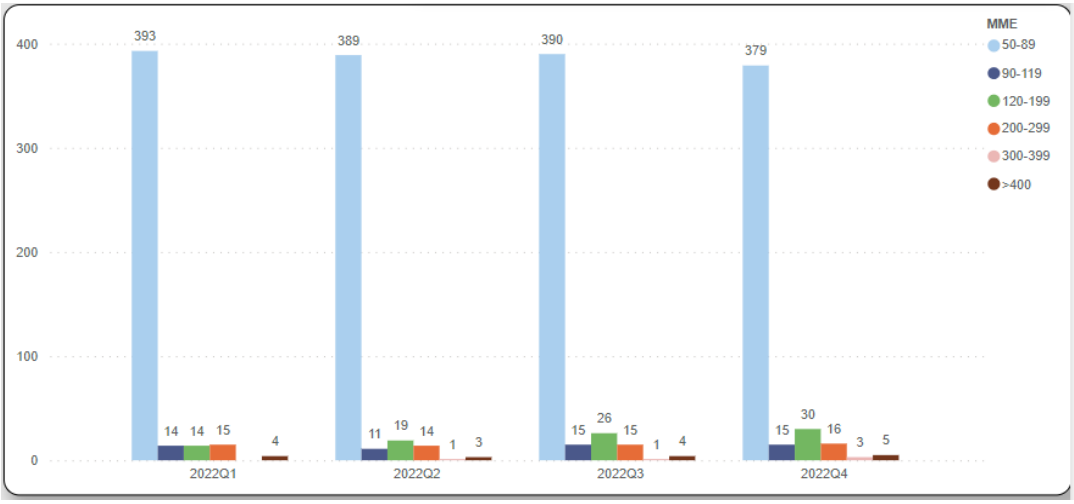
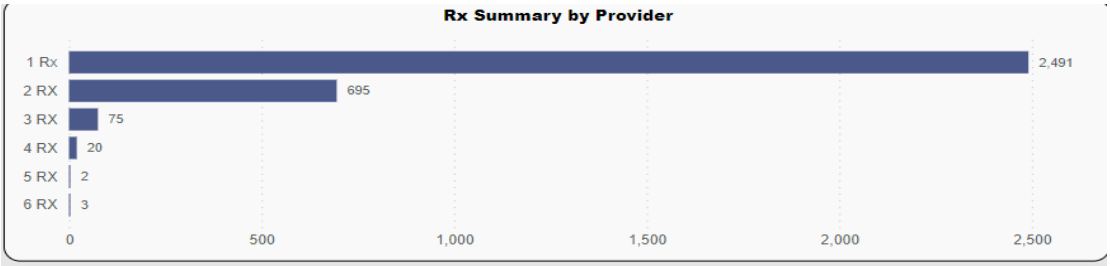


Figure 1 and Table 2 both show opioid utilization by type of opioids used and MME used. Table 2 shows short-acting utilization decreased in 2023. Similarly, Figure 3 shows 50-119 MME utilizers increased in 2023 while >120MME declined or had no change.

Below is a graph depicting how many unique providers prescribing opioids categorized by ascending MME. These graphs are looking at provider prescription claims. There is a general decrease in prescribing trend as the MME goes up. In 2023, 19 providers each wrote 1 prescription for 300-399 MME and 31 providers each wrote 1 prescription greater than 400 MME. In addition, 3 providers wrote at least 6 prescriptions. The top five providers who wrote more than 300 MME were oncology, internal medicine, and family practitioners. In comparison with 2022, there was a slight increase in utilization for all MME.

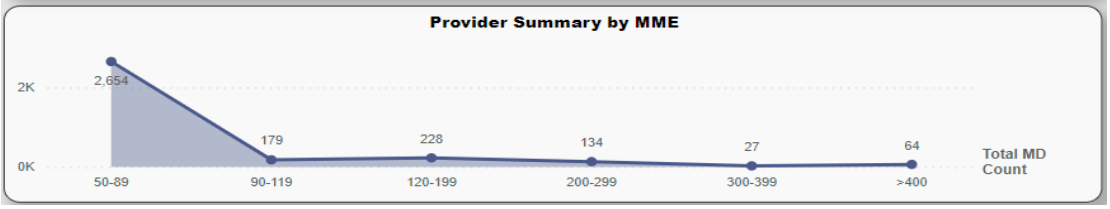
Figure 3: 2 Frequency of Provider Opioid Prescription Count by MME for 2021 and 2023

2023

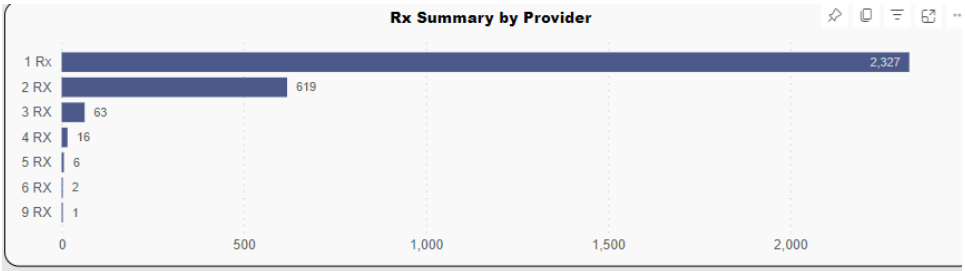


Rx by # Provider

MME	1 Rx	2 RX	3 RX	4 RX	5 RX	6 RX	Total
50-89	2,146	441	49	13	2	3	2,654
90-119	99	76	3	1			179
120-199	151	67	7	3			228
200-299	45	74	14	1			134
300-399	19	8					27
>400	31	29	2	2			64
Total	2,491	695	75	20	2	3	3,286

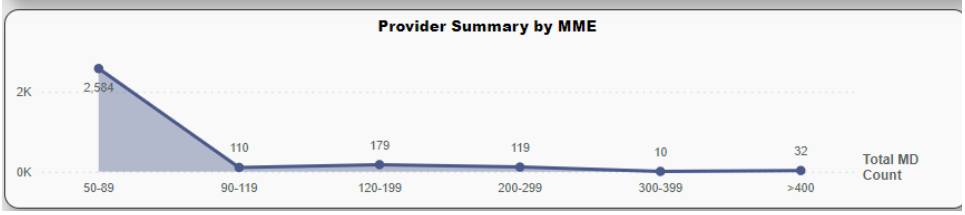


2022



Rx by # Provider

MME	1 Rx	2 RX	3 RX	4 RX	5 RX	6 RX	9 RX	Total
50-89	2,101	424	40	11	5	2	1	2,584
90-119	43	60	5	2				110
120-199	105	67	7					179
200-299	44	61	11	2	1			119
300-399	8	1		1				10
>400	26	6						32
Total	2,327	619	63	16	6	2	1	3,034



Drug Recalls

The Pharmacy Department monitors all drug recalls for IHSS. In 2023, there were 94 recalls. Recalls were monitored for adversely affected members. The number of notifications where the PBM completed a claims data review was 8.

2023 Pharmacy Recalls

RECALL TYPE	QUANTITY
Total number of safety notices/recalls	**94**
Total number of withdrawals	**0**
The number of notifications where PBM completed a claims data review	**8**

Pay-for-Performance Programs

Overview

The Alliance Pay-for-Performance (P4P) program offers performance-based incentive payments for delivered services. Through this program, primary care providers (PCPs) and PCP Groups are rewarded for superior performance and yearly improvement. The P4P program focuses on preventative care, pediatrics, access, and chronic disease and includes clinical quality (HEDIS) measures and other (non-HEDIS) measures. The evaluation of the P4P is for January 1, 2022, through December 31, 2022.

2022 Program Summary

The 2022 P4P program is tailored to each delegate and directly contracted PCP group category: AHS, CHCN, CFMG, and Directs. The measures for each are outlined below.

Category	Measure	AHS	CHCN	CFMG	Directs - Family Practice	Directs - Internal Medicine	Directs - Pediatrics
HEDIS	Childhood Immunizations: Combo 10 (CIS)			X			X
	Immunizations for Adolescents: Combo 2 (IMA)			X			X
	Well-Child Visits in the First 15 Months of Life: Six or More Visits (W30)	X	X	X			X
	Well-Child Visits 15- 30 Months of Life: Two or More Visits (W30)	X	X	X			X
	Child and Adolescent Well-Care Visits (WCV)	X	X	X	X		X
	Child and Adolescent - BMI percentile (WCC)	X	X	X			X
	Child and Adolescent - Nutrition (WCC)	X	X	X			X
	Child and Adolescent - Phys Activity (WCC)	X	X	X			X

	Breast Cancer Screening (BCS)	X	X		X	X	
	Cervical Cancer Screening (CCS)	X	X		X	X	
	HbA1c Testing for Diabetes (CDC) - Poor Control	X	X		X	X	
	Colorectal Cancer Screening (COL)					X	
Other	PCP Visits Per 1,000 Members	X	X	X	X	X	X
	ED Visits Per 1,000 Members	X	X	X	X	X	X
	Readmission Rate	X	X				
	Flue Vaccination Rate	X	X	X	X		X
	Member Satisfaction Survey: Non-Urgent Appt Availability	X	X	X	X	X	X
	Screening for Depression	Monitoring Measure	Monitoring Measure		Monitoring Measure	Monitoring Measure	

For delegates, points were earned based on performance compared to the overall Alliance population and/or improvement from the prior year. For directly contracted PCP groups, points were earned based on performance compared to the overall Alliance population excluding members assigned to delegates and/or improvement from the prior year. This applied to all measures except for “Member Satisfaction Survey: Non-Urgent Appointment Availability” and monitoring measures. Full points were earned for the “Member Satisfaction Survey: Non-Urgent Appointment Availability” if 80% of survey responses for a PCP group indicated that the member was able to schedule a non-urgent appointment within 10 business days. No points were assigned to monitoring measures.

Delegates and directly contracted PCP groups earned 39.58% of the available pool dollars for the 2022 P4P program. Directly contracted family practice providers performed the best, earning 61.57% of the pool dollars available to them. A breakout by delegate and directly contracted provider category is below.

Delegate/Directly Contracted Provider Category	% of Pool Dollars Earned
AHS	20.00%
CHCN	47.79%
CFMG	39.20%
Directs - Family Practice Providers	61.57%
Directs - Internal Medicine Providers	40.56%
Directs - Pediatric Providers	59.94%
TOTAL	**39.58%**

The measures, point values, and benchmarks vary from year-to-year, so it is difficult to make an apples-to-apples comparison against prior year results.

QI Training and Coaching

To establish a culture of quality across the organization and disseminate knowledge of quality

improvement methodologies, the Quality Team conducted a training program on the PDSA (Plan-Do-Study-Act) methodology. The training encompassed methods for enhancing quality, creating an aim statement, utilizing data for performance enhancement, tools for devising change ideas, and testing change ideas with the PDSA methodology. In June 2023, a webinar series comprising of three one-hour sessions was held, attended by 112 staff and management members from the Health Care Services departments. Out of the 15 respondents who completed the survey, 100% gave the course an excellent/very good rating. The QI team is planning to offer a third session of the training, accessible to all departments within the Alliance and all provider clinics in the Alliance network.

Annually, the Alliance conducts education sessions, to delegates and primary care direct providers, for the Pay-for-Performance (P4P) incentive program. The education session's objectives are for attendees to understand the P4P measures, goals, points, potential earnings, and review new or updated measure descriptions. Conducted in January 2023, the Alliance extended this opportunity to primary care direct providers for the first time, 50 provider staff attended.

Lastly, to support performance improvements on the DHCS Managed Care Accountability Set (MCAS), the QI Team offered a Measure Highlight Webinar Series which focused on the childhood domain measures, and two behavioral health domain measures: Follow-up After ED Visits for Mental Illness and Substance Use (FUM/FUA). The objectives for these webinars reviewed the measures specifications, share tips on what counts to complete the measures successfully, and allowed opportunity for high-performing providers to discuss and share bright spots on what made them successful in achieving the measures. This series spanned through March-May of 2023, with 55 attendees from various primary care clinics. Overall, 10 providers completed the survey, indicating they found this webinar beneficial particularly as it pertains to learning bright spots from their peers.

Patient Safety and Quality Compliance

Consistency in Application of Criteria

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

IRR Thresholds (UM)

SCORE	ACTION
High – 90%-100%	IRR Pass Rate - No action required.

Medium – 61%-89%	Increased training and focus by supervisors/managers.
Low – Below 60%	• Additional training provided on clinical decision-making. • If staff fails the IRR test for the second time, a Corrective Action Plan is required with reports to the Senior Director of Health Services and the Chief Medical Officer. • If staff fails to pass the IRR test a third time, the case will be escalated to Human Resources which may result in possible further disciplinary action.

The IRR process for PQIs involves reviewing actual PQI cases. Results will be tallied as they complete the process and corrective actions implemented as needed. When there are opportunities for improving consistency in applying criteria, QI staff address corrective actions through global, individualized training, or completing additional IRR case reviews.

For 2023, IRR testing was performed with QI clinical staff to evaluate consistency in classification, investigation and leveling of PQIs. All QI Review Nurses and Medical Director Reviewers passed the IRR testing with scores of 100%.

Facility Site Reviews

Facility Site Review (FSR) and Medical Record Review (MRR) audits are mandated for Medi-Cal Managed Care Plans to occur every three (3) years, per DHCS All Plan Letter 22-017. FSRs are another way the Alliance ensures member quality of care and safety within the provider office environment. Interim monitoring and focused reviews occur between each regularly scheduled full scope review. Corrective Action Plans (CAPs) for non-compliance are required depending on the site FSR and MRR scores and critical element failures.

The bi-annual DHCS report was submitted in July 2023 for FSRs conducted in January to June 2023). FSRs conducted in July to December 2023 have not been submitted due to DHCS' Managed Care Quality and Monitoring Division (MCQMD) Site Review Portal (MSRP). The bulk upload testing and production file submission was delayed until further notice.

In 2023, there were 131 site reviews including PCP sites, urgent care, and dialysis centers. The total number and types of audits are detailed in the table below.

2023 Facility Site Reviews

TYPE	Q1	Q2	Q3	Q4	TOTAL
FSR					

Initial FSR	2	0	0	4	**6**
Periodic FSR	8	0	2	3	**13**
Annual FSR	0	0	0	1	**1**
Urgent Care FSR	0	0	2	0	**2**
Dialysis	0	0	4	0	**4**
MRR					
Initial MRR	1	0	0	0	**1**
Periodic MRR	6	3	1	2	**12**
Annual MRR	0	0	0	1	**1**
Focused MRR	4	6	8	4	**22**
Interim Monitoring	11	27	20	11	**69**
Total Reviews	**32**	**36**	**37**	**26**	**131**

DHCS regulation requires that Critical Element (CE) CAPs be received by the Alliance within 10 business days and FSR/MRR CAPs within 30-days of the FSR and/or MRR Report. A CE CAP is issued for deficiencies in any of the 14 critical elements in the FSR that identify the potential for adverse effects on patient health or safety. In 2023, there were 43 CAPs issued and all CAPs are closed.

Per DHCS regulation, failed periodic reviews are reported bi-annually. In 2023, the Alliance had three providers with non-passing scores of 79% and below for the full scope MRR. Provider 1 is a shared provider with Contra Costa Health Plan (CCHP). CCHP is the assigned plan to conduct the review and share their findings with the Alliance. CCHP is responsible for the oversight of the site review completion and monitoring. Per APL 22-017 and CCHP MOU, if a provider receives a failed score from a collaborative plan, the Alliance must consider the PCP site as having a failing score. For provider 2, this is an initial MRR for a new PCP site. Alliance will continue to educate the provider on standards and conduct an annual full scope review. Provider 3 had provider changes in 2023. The nurse reviewer met with one of the doctors at the site and provided education. Alliance will conduct an annual full scope review.

In July 2022, DHCS implemented the use of the revised FSR/MRR tools. Many providers were adjusting to the new standards. Alliance anticipated the drop in scores. We conducted provider education and training leading to the changes. A corrective action plan was provided to DHCS. Failed reviews are escalated to the Medical Director to follow up with the provider. In addition, a new process implemented to facilitate CAP closure was placing new member assignments on hold for PCP sites that receive failing scores on FSR/MRR and/or providers who do not correct FSR/MRR deficiencies within established CAP timelines until the CAP is closed. In 2023, there were 12 providers with new member assignment holds.

PCP FSR/MRR CAPs Issued in 2023

TYPE	Q1	Q2	Q3	Q4	TOTAL
Total CAPs Issued	**14**	**9**	**8**	**12**	**43**
Open	0	0	0	1	1
Open >120 days	*0*	*0*	*0*	*1*	*1*
Closed	14	19	8	11	42

2023 Audits with Non-Passing Scores

QUARTER	Audit Date	FSR Score	MRR Score
Q1	Provider 1: 2/23/23 (conducted by CCHP) Provider 2: 3/6/23	86% N/A	Provider 1: 63% Provider 2: 75.20%
Q2	Provider 3: 4/28/23	91.20%	79.18%
Q3	N/A	N/A	N/A
Q4	N/A	N/A	N/A

Long Term Care Quality Monitoring

With the transition of the Long Term Care (LTC) benefit and members to Medi-Cal Managed Care Plans, the Alliance is in the process of building out the LTC quality monitoring program. For Skilled Nursing Facilities (SNF), to comply with APL 23-004, a tracker was developed to collect quality assurance and improvement findings from California Department of Public Health (CDPH) survey deficiency findings, Medicare Stars, and PQIs. An attestation was developed for SNF providers to attest to compliance with the five key elements identified by the Centers for Medicare and Medicaid (CMS) Quality Assurance Performance Improvement (QAPI) program. In addition, Analytics is in the process of programming a report for the LTC measures within the MCAS of performance measures for each SNF, including emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions. For Subacute facilities, these facilities will emulate the SNF quality monitoring process. For Intermediate care facilities for individuals with developmental disabilities (ICF/DD), in addition to monitoring CDPH findings, quality monitoring includes service delivery findings from the Regional Centers. The Subacute and ICF/DD facilities quality monitoring processes will continue to be further developed in 2024. Efforts include adding a QI Review Nurse (in recruitment) to conduct site visits as needed, interdisciplinary meetings with LTC facilities, and performance measures monitoring once reports are available. The QI team are working on the LTC quality monitoring processes in collaboration with the LTC teams at the Alliance to ensure appropriate coordination and oversight of these facilities.

Peer Review and Credentialing Committee

In 2023, 48 practitioners were reviewed for lack of board certification. If there were complaints about a practitioner's office, facility site reviews were conducted, and the outcome was reviewed by the PRCC. There were no site reviews conducted based on complaints in 2023. All grievances, complaints, and PQIs that required investigation were forwarded to this committee

for review. In 2023, 114 practitioner grievances, complaints, or PQIs were investigated by the committee. There were no practitioners that required reporting to the National Practitioner Data Bank (NPDB) by the Alliance.

In 2023, the PRCC granted a one-year reappointment for one (1) practitioner for grievances filed regarding quality of care and accessibility. The table below shows evidence of practitioners reviewed by the PRCC for credentialing and re-credentialing decisions.

Count of Practitioners Reviewed for Quality Issues at PRCC in 2023

Count of Practitioners Reviewed for Quality Issues At Credentialing Committee in 2023												
PRCC Date	PRC	NPDB	Attestation	Malpractice	Felony/Misdemeanor/Fraud	Facility Site Review	Grievance, Complaints, PQI	License Action	Board Certification	CAP	GAP	Total
January		2			1		7	1	1	2	7	21
February		3		1	1		14		12	4	12	47
March		5		4			21		3	3	14	50
April		2		1			12		1	3	9	28
May		2		2	2		9		4	2	20	41
June	1	2			2		6		2	3		16
July				2			9	1		1	4	17
August No Committee Meeting												
September		1		1			5		7	0	7	21
October		2		1	2		8		4	1	12	30
November		1		2			12		10	1	16	42
December		1					11		4	5	4	25
Total	**1**	**21**	**0**	**14**	**8**	**0**	**114**	**2**	**48**	**25**	**105**	**338**

Potential Quality Issues

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

Quality Review Nurses investigate PQIs and summarize their findings. QOA cases are referred to the A&A Team for review and tracking while QOS cases that do not contain a clinical component are investigated and closed by the review nurse. QOL cases are reviewed and investigated by the Cultural and Linguistic Team. The Senior Director and/or the QI RN Supervisor oversees and audits a random sample of all PQI case types. The QI Medical Director reviews all QOC cases, in addition to any QOA, QOL, or QOS cases where the Quality Review Nurse and RN manager/director requests Medical Director case review. The QI Medical Director will refer cases to the Peer Review and Credentialing Committee (PRC) for resolution, on clinical discretion or if a case is found to be a significant quality of care issue (Clinical Severity 3, 4).

Quality of Care (QOC) Issue Severity Level

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

The Alliance's QI Department received 9276 PQIs during MY2023, which is a 44% increase from 2022. The total volume of PQIs increased by 2,818 which is largely reflected in the number of QOS and QOA issues identified during the measurement year. Of the 9,276 PQIs received in 2023, 7%, or 644 of the PQIs were classified as a QOC. PQI monthly and quarterly totals are listed below:

2023 All PQI Type Monthly Totals

PQI Type	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	TOTAL	%
All Types of PQIs	650	643	875	707	764	846	857	945	858	930	716	465	**9276**	
QOA	198	183	254	216	229	240	265	314	273	250	223	140	**2785**	**30%**
QOC	56	62	90	39	45	61	53	52	46	56	42	42	**644**	**7%**
QOS	371	371	488	417	456	514	500	554	492	585	427	281	**5456**	**59%**
QOL*	12	14	32	27	27	25	32	19	35	31	17	16	**287**	**3%**
Other ***	13	13	11	8	7	6	7	6	12	8	7	6	**104**	**1%**

***Referred to Beacon or Kaiser*

QI clinical management investigated, reviewed, and triaged all referrals both internal and external to the organization to ensure that access, clinical, language, service related PQIs were addressed through RN investigation and oversight support from Compliance and Vendor Management as applicable.

2023 QOC PQI Quarterly Totals

INDICATOR	Q1	Q2	Q3	Q4
Indicator 1: QOC PQIs	Denominator: **2168** Numerator: **208** Rate: **1 0 %**	Denominator: **2317** Numerator: 145 Rate: **6 %**	Denominator: **2660** Numerator: **151** Rate: **6%**	Denominator: **2131** Numerator: 140 Rate: **7%**
Indicator 2: QOC PQIs leveled at severity C2-4	Denominator: **208** Numerator: **38** Rate **18.3%**	Denominator: **145** Numerator: **34** Rate: **23%**	Denominator: **151** Numerator: **18** Rate: **12%** **2 cases still open**	Denominator: **140** Numerator: **3** Rate: **2%** **67 cases still open**

QI RN management continued to conduct Exempt Grievances case audits via random sampling, to ensure that clinical PQIs are not missed and forwarded to the Quality Department. QI Department clinical management provides oversight of exempt grievances via review of randomly selected exempt grievances. In 2023, 100 exempt grievance cases per quarter were reviewed by QI clinical management, with an overall performance rate of 99.5% which exceeds the established performance metric of 90%.

	Q4 2021	Q1 2023	Q2 2023	Q3 2023*
Numerator	98	100	100	100
Denominator	100	100	100	100
Performance Rate	98	100	100	100
Gap to Goal	N/A	N/A	N/A	N/A
Universe	3126	5096	5352	5604

*Q4 2023 data available at the end of April 2024 due to 120-day TAT for closure

The Alliance IT department continues to provide support with workflow enhancements to the PQI application. An enhancement was made in Quality Suite with the ability to identify long term care (LTC) facilities when PQIs are opened. This will allow the QI clinical safety team to track and trend PQI cases in LTC facilities. The PQI application remains a robust and responsive system allowing for timely and accurate reporting, documentation, tracking, and adjudication of PQIs.

Quality in Member Experience

Overview

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

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

Standards and Provider Education

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

Appointments Wait Times

APPOINTMENTS WAIT TIMES	
Appointment Type:	**Appointment Within:**
Urgent Appointment that *does not* requires PA	48 Hours of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Non-Urgent **Primary Care** Appointments	10 Business Days of the Request
First Prenatal Visit	2 Weeks of the Request
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of the Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of the Request
Non-Urgent Appointment for **Ancillary Services** for the diagnosis or treatment of injury, illness, or other health conditions	15 Business Days of the Request

All Provider Wait Time/Telephone/Language Practices

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

Language Services – Provide interpreter services 24 hours a day, 7 days a week.

**Per DMHC and DHCS Regulations, and NCQA HP Standards and Guidelines PA = Prior Authorization*

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

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

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

Shortening or Extending Appointment Timeframes: The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.

Each of these standards are monitored as described in the table below. In 2023, the Alliance made changes to the CG-CAHPS instrument to ensure that the collected data was consistent with the Alliance standards which remained in place sinceMY2020.

Access Monitoring Surveys

Primary Care Physician (PCP) Appointment

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Measured By:**
Urgent Appointment that *requires* PA	PAAS, CG-CAHPS, Confirmatory Survey
Urgent Appointment that *does not* require PA	PAAS, CG-CAHPS, Confirmatory Survey
Non-Urgent **Primary Care** Appointment	PAAS, CG-CAHPS, Confirmatory Survey
First Prenatal Appointment	Non-PAAS, Confirmatory Survey
Non-Urgent Appointment with a **Specialis**t Physician	PAAS, Confirmatory Survey
Non-Urgent Appointment with a **Behavioral Health** Provider	PAAS, Confirmatory Survey
Non-Urgent Appointment for **Ancillary Services** for the diagnosis or treatment of injury, illness, or other health conditions	PAAS, Confirmatory Survey

All Provider Wait Time/Telephone/Language Practices

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES

Standard:	Measured By:
In-Office Wait Time	CG-CAHPS, Confirmatory Survey
Call Return Time	CG-CAHPS, Confirmatory Survey
Time to Answer Call	CG-CAHPS, Confirmatory
Telephone Access – Provide coverage 24 hours a day, 7 days a week	After Hours: Emergency Instruction Survey, Confirmatory Survey
Telephone Triage and Screening – Wait time not to exceed 30 minutes	After Hours: Emergency Instruction Survey, Confirmatory Survey
Emergency Instructions – Ensure proper emergency instructions	After Hours: Emergency Instructions Survey, Confirmatory Survey
Language Services-Provide interpreter services 24 hours a day, 7 days a week	CG-CAHPS

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

Plan: The standards were discussed and adopted, and surveys have been aligned with our adopted standards.

Do: The surveys were administered, per our policies and procedures (P&Ps); survey methodologies, vendors, and processes are outlined in P&Ps.

Study: Survey results along with QI recommendations were brought forward to the A&A Committee; the Committee formalizes recommendations which are forwarded to the QIHEC and Board of Governors

Act: Dependent on non-compliant providers and study / decision of the A&A Committee, actions may include, but are not limited to, provider education/re- education and outreach, focused discussions with providers and delegates, resurveying providers to assess/reassess provider compliance with timely access standard(s), issuing of corrective action plans (CAPs), and referral to the Peer Review and Credentialing Committee.

Provider Capacity

The Alliance reviews network capacity reports monthly to determine whether primary care providers are reaching network capacity standards of 1:2000. The Alliance Provider Services Department continues to monitor the threshold at 80% and above to ensure member assignment does not reach the 2,000-capacity standard. If a provider is close to the threshold, the plan will outreach to the provider to make them aware and see if they intend to recruit other providers. If not, the panel is closed to new assignment if they reach 2,000 capacity standards. During this

time, the plan and the provider were in communication of such changes. In 2023, there were three (3) providers who reached 80% of the threshold and received outreach and were monitored throughout the year. No providers exceeded the 2,000-capacity standard.

Geo Access

The geographic access reports were reviewed quarterly to ensure that the plan meets the geographic access standards for provided services in Alameda County. For PCPs, the Alliance has adopted standards of one provider within 30 minutes / 10 miles. For specialists, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. During 2023, the Alliance continued its cross functional quarterly meetings to review access issues and concerns.

In 2023, the Alliance continued to face geographic access issues for certain pediatric specialists in various parts of Alameda County. In those instances, the Plan requested approval of alternative access standards from DHCS. When reviewing the geographic access maps and data, there were a few members who resided in remote areas or unincorporated parts of Alameda County or where Pediatric Specialties may not be available (Livermore, Dublin, and Pleasanton), resulting in deficiencies. Even though the provider and member were in the same zip code, the time and distance standards were still compromised. The Plan requested alternative access standards in these instances.

Member Satisfaction Survey (CAHPS 5.1H)

The Medi-Cal and Commercial Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by the National Committee for Quality Assurance (NCQA), a certified Health Effectives Data and Information Set (HEDIS) survey vendor. Press Ganney Analytics was selected by the Alliance to conduct the 2023 CAHPS 5.1H survey. NCQA used a new 5.1H version of the CAHPS survey starting in 2021. The HEDIS CAHPS survey included minor changes to some of the instructions and survey items to indicate the different ways in which patients may be receiving care: in person or via telehealth.

The survey method includes mail and phone responses. Members in each Alliance line of business (LOB) was surveyed separately. The table below shows the survey response rates. As of April 2023, the Alliance had a total of 358,725 members.

The breakdown of member enrollment by network are as follows:

- AHS: 18.60%
- Directs: 20.85%
- CHCN: 36.45%
- CFMG: 9.69%
- Kaiser: 14.41%

Survey Response Rates by Line of Business

	Medi-Cal Adult	Medi-Cal Child	Commercial Adult
2023	11.7%	12.3%	20.0%
2022	12.4%	12.3%	21.5%

2021	15.9%	18.2%	23.7%

The Medi-Cal Child, Adult Medi-Cal, and Adult Commercial Trended Survey Results in the tables below, contains trended survey results for the Medi-Cal Child, Medi-Cal Adult, and Commercial Adult populations across composites. Quality Compass All Plans (QCAP) benchmark noted within the tables is a collection of CAHPS 5.1H mean summary ratings for the Medicaid and Commercial samples that were submitted to NCQA in 2022.

In respect to benchmark scores, Red signifies that the current year 2023 score is significantly lower than the 2022 score. For overall Medi-Cal trends, there were no composite rates significantly lower (red) than the 2022 score. Green indicates that the current year 2023 score is significantly higher than the 2022 score.

Medi-Cal Child Trended Survey Results

Summary Rate Scores: Medi-Cal Child				
Composite	**2023**	**Previous Year Comparison**	**2022**	**2021**
Getting Needed Care	79.2%	↑	78.4%	82.2%
Getting Care Quickly	73.0%	↓	77.8%	78.8%
How Well Doctors Communicate	92.8%	↑	91.3%	93.2%
Customer Service	92.1%	↑	85.5%	90.2%
Rating of Health Care (8-10)	81.7%	↓	89.5%	89.1%
Rating of Personal Doctor (8-10)	90.7%	↑	90.6%	91.0%
Rating of Specialist (8-10)	95.2%	↑	85.3%	87.2%
Rating of Health Plan (8-10)	86.6%	↑	86.0%	88.1%
Coordination of Care	83.0%	↓	89.1%	73.8%

Medi-Cal Adult Trended Survey Results

Summary Rate Scores: Medi-Cal Adult				
Composite	**2023**	**Previous Year Comparison**	**2022**	**2021**
Getting Needed Care	75.2%	↓	75.9%	79.0%

Getting Care Quickly	72.9%	↓	75.9%	72.4%
How Well Doctors Communicate	87.5%	↓	92.3%	83.5%
Customer Service	88.7%	↓	89.4%	84.1%
Rating of Health Care (8-10)	61.1%	↓	66.3%	73.1%
Rating of Personal Doctor (8-10)	80.0%	↓	82.9%	81.3%
Rating of Specialist (8-10)	80.3%	↑	78.6%	78.9%
Rating of Health Plan (8-10)	70.9%	↓	74.4%	74.9%
Coordination of Care	91.7%	↑	79.0%	83.0%

Commercial Adult Trended Survey Results

Summary Rate Scores: Commercial Adult				
Composite	**2023**	**Previous Year Comparison**	**2022**	**2021**
Getting Needed Care	72.0%	↑	65.8%	75.2%
Getting Care Quickly	56.0%	↓	62.0%	71.1%
How Well Doctors Communicate	87.5%	↑	83.2%	87.7%
Customer Service	82.9%	↑	78.5%	77.3%
Rating of Health Care (8-10)	76.7%	↑	61.0%	70.1%
Rating of Personal Doctor (8-10)	82.4%	↑	74.9%	77.4%
Rating of Specialist (8-10)	80.6%	↑	72.6%	82.9%
Rating of Health Plan (8-10)	67.1%	↑	65.9%	67.1%
Coordination of Care	80.0%	↑	74.4%	76.8%

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

Medi-Cal Child Trended Survey Results - Delegates

MY2023 CAHPS 5.1H Child MediCal	2023 Plan Total	CHCN			CFMG			Kaiser			AHS			Alliance		
		2023	2022	YoYT	2023	2022	YoYT	2023	2022	YoYT	2023	2022	YoYT	2023	2022	YoYT
Total Respondents		115	98		65	54		43	57		21	27		7	14	
Rating of Health Care (8-10)	81.7%	78.6%	88.2%	↓	82.9%	87.5%	↓	82.6%	93.9%	↓	92.9%	88.9%	↑	66.7%	87.5%	↓
Rating of Personal Doctor (8-10)	90.7%	87.5%	88.2%	↓	96.3%	95.2%	↑	89.7%	90.2%	↓	87.5%	94.7%	↓	100.0%	81.8%	↑
Rating of Specialist (8-10)	95.2%	100.0%	83.3%	↑	91.7%	91.7%	↔	85.7%	71.4%	↑	100.0%	100.0%	↔	100.0%	100.0%	↔
Rating of Health Plan (8-10)	86.6%	84.8%	87.9%	↓	90.2%	85.2%	↓	85.4%	87.3%	↓	90.0%	78.3%	↑	80.0%	84.6%	↓
Getting Needed Care	79.2%	71.9%	84.8%	↓	87.1%	75.8%	↑	86.0%	78.8%	↑	76.2%	63.9%	↑	83.3%	58.3%	↑
Getting Care Quickly	73.0%	70.9%	80.8%	↓	81.2%	71.1%	↑	65.8%	83.1%	↓	77.8%	88.9%	↓	55.0%	61.4%	↓
How Well Doctors Communicate	92.8%	90.5%	93.6%	↓	98.5%	92.3%	↑	90.6%	93.9%	↓	90.7%	80.0%	↑	93.8%	77.8%	↑
Customer Service	92.1%	88.8%	87.1%	↑	97.2%	83.2%	↑	87.5%	85.6%	↑	100.0%	83.3%	↑	100.0%	98.5%	↑
Coordination of Care	83.0%	92.0%	87.5%	↑	90.0%	88.9%	↑	50.0%	100.0%	↓	60.0%	66.7%	↓	100.0%	50.0%	↑

YoYT = Year-Over-Year Trend

Medi-Cal Adult Trended Survey Results - Delegates

MY2023 CAHPS 5.1H Adult MediCal	2023 Plan Total	CHCN			AHS			Alliance			Kaiser		
		2023	2022	YoYT	2023	2022	YoYT	2023	2022	YoYT	2023	2022	YoYT
Total Respondents	155	70	64		32	30		28	39		24	28	
Rating of Health Care (8-10)	61.1%	58.5%	52.5%	↑	70.6%	50.0%	↑	57.1%	77.3%	↓	62.5%	90.9%	↓
Rating of Personal Doctor (8-10)	80.0%	71.4%	87.2%	↓	92.0%	63.6%	↑	83.3%	81.3%	↑	78.3%	92.6%	↓
Rating of Specialist (8-10)	80.3%	70.8%	71.0%	↓	81.8%	70.0%	↑	94.1%	88.2%	↑	77.8%	91.7%	↓
Rating of Health Plan (8-10)	70.9%	67.1%	70.0%	↓	80.6%	62.1%	↑	69.2%	81.1%	↓	73.9%	89.3%	↓
Getting Needed Care	75.2%	71.8%	70.9%	↑	78.7%	76.3%	↑	90.6%	72.5%	↑	56.6%	90.6%	↓
Getting Care Quickly	72.9%	62.4%	74.3%	↓	80.3%	69.1%	↑	80.0%	66.4%	↑	80.8%	93.7%	↓
How Well Doctors Communicate	87.5%	81.8%	91.4%	↓	90.9%	94.6%	↓	92.1%	87.5%	↑	93.2%	97.7%	↓
Customer Service	88.7%	82.3%	87.2%	↓	95.5%	75.0%	↑	93.3%	95.8%	↓	100.0%	95.8%	↑
Coordination of Care	91.7%	93.3%	73.7%	↑	90.9%	80.0%	↑	85.7%	72.2%	↑	100.0%	92.9%	↑

YoYT = Year-Over-Year Trend

Commercial Adult Trended Survey Results – Delegated Network

MY2023 CAHPS 5.1H Adult Commerical	2023 Plan Total	CHCN			Alliance			AHS		
		2023	2022	YoYT	2023	2022	YoYT	2023	2022	YoYT
Total Respondents	215	91	98		90	103		34	30	
Rating of Health Care (8-10)	76.7%	73.7%	64.1%	↑	78.8%	58.6%	↑	80.0%	57.1%	↑
Rating of Personal Doctor (8-10)	82.4%	82.9%	76.8%	↑	79.2%	73.6%	↑	89.3%	73.9%	↑
Rating of Specialist (8-10)	80.6%	80.6%	83.9%	↓	78.0%	65.9%	↑	87.5%	66.7%	↑
Rating of Health Plan (8-10)	67.1%	68.2%	67.4%	↑	64.0%	68.3%	↓	72.7%	53.3%	↑
Getting Needed Care	72.0%	67.4%	66.4%	↑	72.0%	62.5%	↑	83.7%	77.4%	↑
Getting Care Quickly	56.0%	47.7%	62.4%	↓	60.6%	59.9%	↑	67.0%	68.8%	↓
How Well Doctors Communicate	87.5%	86.4%	84.5%	↑	87.6%	82.6%	↑	90.0%	81.9%	↑
Customer Service	82.9%	79.4%	74.2%	↑	83.9%	81.9%	↑	88.9%	83.3%	↑
Coordination of Care	80.0%	82.1%	70.6%	↑	75.8%	77.1%	↓	84.6%	76.9%	↑

YoYT = Year-Over-Year Trend

The 2023 CAHPS survey results year-over-year trends show variation within the **Alliance** business lines. Across LOBs, the Medi-Cal Child population had the highest measure summary rate scores in 2023.

MY2023 – 2022 Alliance and Delegate Comparative Findings

Medi-Cal Child

- AHS: Five (5) of nine (9) scores increased based on the above table. A significant increase in percentage scores were seen for 'Rating of Health Plan,' 'Getting Needed Care,' 'How Well Doctors Communicate' and 'Customer Service.' Significant decreases in percentage scores were seen for 'Getting Care Quickly.'
- Direct: Five (5) of nine (9) scores increased based on the above table. With significant increase in percentage scores for 'Rating Personal Doctor,' 'Getting Needed Care,' 'How Well Doctors Communicate' and 'Coordination of Care.' Significant decreases in percentage scores were seen for 'Rating of Health Care' and 'Getting Care Quickly.'
- CFMG: Six (6) of the nine (9) scores increased based on the above table. A significant increase in percentage scores was seen for 'Getting Needed Care,' 'Getting Care Quickly' and 'Customer Service.'
- CHCN: Three (3) of nine (9) scores increased based on the above table. A significant increase in percentage scores was seen for 'Rating of Specialist.' Significant decreases in percentage scores were seen for 'Rating of Health Care' and 'Getting Care Quickly.'
- Kaiser: Three (3) of nine (9) scores increased based on the above table. A significant increase in percentage scores was seen for 'Rating of Specialist. Significant decreases in percentage scores were seen for 'Rating of Health Care,' 'Getting Care Quickly' and Coordination of Care.'

Quantitative Trends:

- Overall, a consistent increase in percentage scores was seen throughout all delegate groups. A significant decrease in percentage score was seen mostly for 'Getting Care Quickly'.

Medi-Cal Adult

- AHS: Eight (8) of nine (9) scores increased based on the above table. A significant increase was seen for 'Getting Care Quickly,' 'Customer Service' and 'Coordination of Care'.
- Direct: Six (6) of nine (9) scores increased based on the above table. With significant increase in percentage scores for 'Getting Needed Care,' 'Getting Care Quickly' and 'Coordination of Care'. Significant decreases in percentage scores were seen for 'Rating of Health Care' and 'Rating of Health Plan.'
- CHCN: Three (3) of nine (9) scores increased based on the above table. With a significant increase for 'Coordination of Care.' Significant decrease in percentage score was seen for 'How Well Doctors Communicate.'
- Kaiser: Two (2) of nine (9) scores increased based on the above table. Significant decreases in percentage scores were seen for 'Rating of Health Care,' 'Rating of Personal Doctor,' Rating of Specialist,' 'Rating of Health Plan,' 'Getting Needed Care' and 'Getting Care Quickly.'

Quantitative Trends:

- All delegates increased percentage scores in 'Coordination of Care.'

Commercial Adult

- AHS: Eight (8) of nine (9) scores increased based on the above table. A significant increase was seen for 'Rating of Health Care,' 'Rating of Personal Doctor,' 'Rating of Specialist,' 'Rating of Health Plan' and 'How Well Doctors Communicate.'
- Direct: Seven (7) of nine (9) scores increased based on the above table. A significant increase was seen for 'Rating of Health Care,' 'Rating of Specialist' and 'Getting Needed Care.'
- CHCN: Seven (7) of nine (9) scores increase based on the above table. A significant increase was seen for 'Rating of Health Care' and 'Coordination of Care.' Significant decrease in percentage score was seen for 'Getting Care Quickly.'

Quantitative Trends:

- All delegates showed an overall increase in most of the measures. 'Rating of Health Care' received significant increase in percentage score for all delegate groups.

Top and Bottom 3 Measures

Population	Top 3 Measures	Bottom 3 Measures
Medi-Cal Child	Rating of Specialist (9-10)	How Well Doctors Communicate
	Customer Service	Getting Needed Care
	Rating of Personal Doctor (9-10)	Getting Care Quickly
Medi-Cal Adult	Coordination of Care	Getting Care Quickly
	Rating of Specialist (9-10)	How Well Doctors Communicate
	Customer Service	Rating of Health Care (9-10)
Commercial Adult	Rating of Health Plan (9-10)	Rating of Specialist (9-10)
	Rating of Health Care (9-10)	Getting Care Quickly
	Coordination of Care	How Well Doctors Communicate

'Getting Care Quickly' and 'How Well Doctors Communicate' are identified in 2023 as the common bottom measure for all three Lines of Business. The low scoring measures provide opportunities for improvement via root cause analysis as part of the QIHE Work Plan for 2024.

Key Drivers of Rating of Health Plan

Population	Key Drivers
Medi-Cal Child	Rating of Health Care
	Rating of Personal Doctor
	Getting Urgent Care
Medi-Cal Adult	Rating of Specialist
	Rating of Health Care
	Rating of Personal Doctor
Commercial Adult	Rating of Specialist
	Rating of Personal Doctor
	Dr. Spent enough time

The above table shows the top 3 Key Drivers for Rating of Health Plan for all three Lines of Business. 'Rating of Personal Doctor' was found to be the common Key Driver in all three Lines of Business. With 'Rating of Health Care' and 'Rating of Specialist' being the second most common Key Drivers in at least two Lines of Business.

Next Steps

The Alliance will continue to collaborate interdepartmentally, focusing on maintaining power in top rating measures and improving member perception of care and services ranked at the bottom of composite scores. Additionally, the Alliance will continue to partner with providers on initiatives designed to improve the member experience and survey scores in 2024 using PDSA cycle to improve or maintain Member Satisfaction scores.

Review improvement strategies recommendations by Press Ganey (PG) for targeted improvement focus that include:

- Assess CAHPS data by direct and delegate provider/networks. Beginning Q2 2024 share results at Joint Operations Meetings (JOM) with delegates. Correlate with grievance data and access PQI complaint data to share with providers.
- Continue best practices for LOBs with increasing survey results.
- Educate providers and staff about Plan and regulatory appointment wait time requirements or standards (i.e., CAHPS, CMS, States, etc.). Identify opportunities for improvement.
- Virtual/onsite visits to providers not meeting Timely Access year over year.
- Encourage/support provider in approaches toward open access scheduling. Allow portion of each day to open the schedules urgent care and/or follow-up care.
- Support members and collaborate with providers to enhance routine and urgent access to care through proactive approaches with Member Services, Provider Relations, Utilization Management, and Case and Care Management.
-

Provider Satisfaction Survey Overview

The Alliance contracted with its NCQA certified vendor, Press Ganey (PG), to conduct a Provider

Satisfaction Survey for MY2023. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Alliance provided PG with a database of Primary Care Physicians (PCPs), Specialists (SPCs) and Behavioral Health (BH) providers who were part of the Alliance network. Duplicate provider names or NPIs were removed from the database prior to submitting to survey vendor. From the database of unique providers, a sample of 915 records was sampled. A total of 131 surveys were completed between September - November 2023 (76 mail, 16 internet, 39 phone).

The table below contains the survey response rates, survey respondents, and role of survey respondents for 2023 compared to 2022.

Survey Response Rates for Mail/Internet and Phone: 2023 vs. 2022

	Mail/Internet	Phone
2023	12.6%	1.7%
2022	10.4%	2.5%

Survey Respondents for PCPs, BH Providers, SPCs: 2023 vs. 2021

	PCPs	BH Providers	SPCs
2023	9.7%	24.0%	14.6%
2022	8.7%	28.4%	14.5%

Year to Year Trend Comparisons

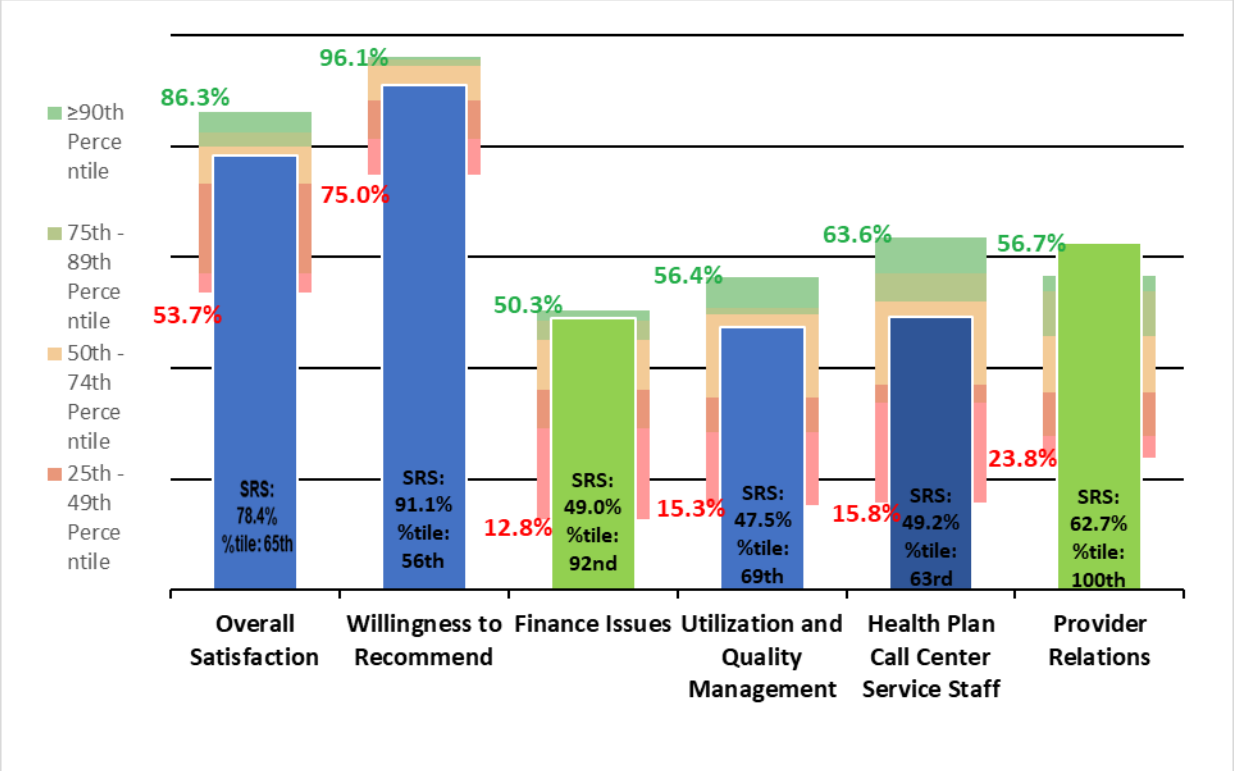
The table below contains the trended survey results across composites.

Trended Survey Results Across Composites

Summary Rate Scores					
Composite / Attribute	**MY 2023**	**Variance Compared to Previous Year**	**Variance Compared to PG Commercial Benchmark BoB**	**2022**	**2021**
Overall Satisfaction with the Alliance	**78.4%**	**Lower**	**Significantly Higher**	**86.3 %**	**77.3%**
All Other Plans (Comparative Rating)	**55.3%**	Higher	Significantly Higher	53.5%	50.0%%
Finance Issues	**49.0%**	Higher	Significantly Higher	44.3%	44.5%
Utilization and	**47.5%**	Lower	Significantly Higher	50.6%	45.3%

Quality Management					
Network Coordination of Care	**41.7%**	Significantly Higher	N/A	31.2%	37.6%
Pharmacy	**38.1%**	Higher	N/A	31.6%	35.1%
Health Plan Call Center Service Staff	**49.2%**	Lower	Significantly Higher	51.3%	54.0%
Provider Relations	**62.7%**	Higher	Significantly Higher	56.7%	63.5%

The Alliance identified higher composite scores in 5 of 8 measures compared to 2022 scores. One (1) of the 8 composites scored significantly higher compared to 2022. Six (6) of the 8 composites scores are significantly higher than the vendor commercial BoB benchmark.



Green bar = AA performing at or above the 75th percentile

Red bar = AA performing below the 25th percentile

Survey results indicated that the Alameda Alliance is performing above the 75th percentile in 2 of 6 composites compared to the distribution of scores in the 2022 PG Commercial Book of Business and performing above the median for the other measures.

PG Alliance POWER List:

Promote and Leverage Strengths (Top 5 Listed):

1. Procedures for obtaining pre-certification/referral/authorization information.
2. Timeliness of plan decisions on routine prior authorization requests.
3. Timeliness of obtaining pre-certification/referral/authorization information.
4. Timeliness of plan decisions on urgent prior authorization requests.
5. The health plan's facilitation/support of appropriate clinical care for patients.

Best Practice

Below are the performance results for the past three years, for Overall Satisfaction with the Alliance, which has exceeded the 2022 PG Aggregate BoB value in all three years.

Overall Satisfaction with Alameda Alliance for Health	Numerator: % Completely of Somewhat Satisfied	Denominator: No. of question respondents	Rate	2022 PG Aggregate Book of Business	Met 2022 PG Aggregate BoB? (Y/N)
Measurement Y1 2021	85	110	77.3	70.8%	Y
Measurement Y2 2022	88	102	86.3%	70.2%	Y
Measurement Y3 2023	98	125	78.4%	70.1%	Y

Next Steps

- Survey results will be shared at the Access and Availability Sub-Committee and Quality Improvement Health Equity Committee.
- A cross functional workgroup will study opportunities with PG POWER listing to promote and leverage identified strengths for ongoing improvement.

CG-CAHPS Survey

The Alliance contracted with Press Ganey (PG) Analytics to conduct its quarterly Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey within 2023, which measures member perception of and experience with three timely access standards: In-Office Wait Time; Call Return Time; and Time to Answer Call. The CG-CAHPS survey was fielded in Q1, Q2, Q3, Q4 of 2023. PG followed a mixed methodology of mail and phone to administer the survey to a randomized selection of eligible members who had accessed care with their PCP within the previous six months.

The table below presents the compliance rates across the three metrics for the CG-CAHPS surveys conducted in 2023 within each quarter.

CG-CAHPS Survey Results 2023

Metric	Compliance Goal	Q1 2023	Q2 2023	Q3 2023	Q4 2023
In-Office Wait Time (Within 60 minutes)	80%	92.0%	91.1%	94.0%	92%
Call Return Time (Within 1 Business Day)	70%	74.3%	74.5%	75.8%	75.2%
Time To Answer Call (Within 10 minutes)	70%	70.0%	71.4%	75.3%	72.2%

Since the pandemic, many providers and delegates have noted they continue to face staffing and provider shortages in their offices.

Possible Barriers	• 6-month delay in survey fielding from date of encounter. Results are based on *a member's perception* of encounter experience. • Survey conducted on member encounter experience during the COVID-19 PHE provider office operations restructuring.
Next Action Steps	• Track and Trend compliance rates. • Continue to follow escalation process for providers non-compliant with CG-CAHPS: o 1Q: Track & trend o 2Qs: Letter/JOM discussion o 3Qs: CAP/Discussion with COO/CFO • Share results with Provider Services department, FSR staff, to incorporate as part of Member & Provider Satisfaction work group discussions and PDSA/Intervention planning as applicable. • Share results with delegate groups and discuss improvement strategies. • Schedule onsite or virtual meetings with providers who have trends for non-compliance

After Hours Care

The Alliance contracted with Press Ganey (PG) Analytics to conduct the annual Provider After-Hours Survey for MY2023, which measures providers' compliance with the after-hours emergency instructions standard. The MY2023 After-Hours Survey was conducted in September of 2023. PG followed a phone-only protocol to administer the survey to the eligible provider population during closed office hours. A total of 493 Alliance providers and/or their staff were surveyed, which consisted of 104 primary care physicians (PCPs), 262 specialists, and 127

behavioral health (BH) providers. Of the 493 providers 325 providers were eligible with 168 providers ineligible and have been excluded from the survey results. The survey assesses the presence of instructions for a caller in an emergency, either via a recording or auto-attendant, or a live person.

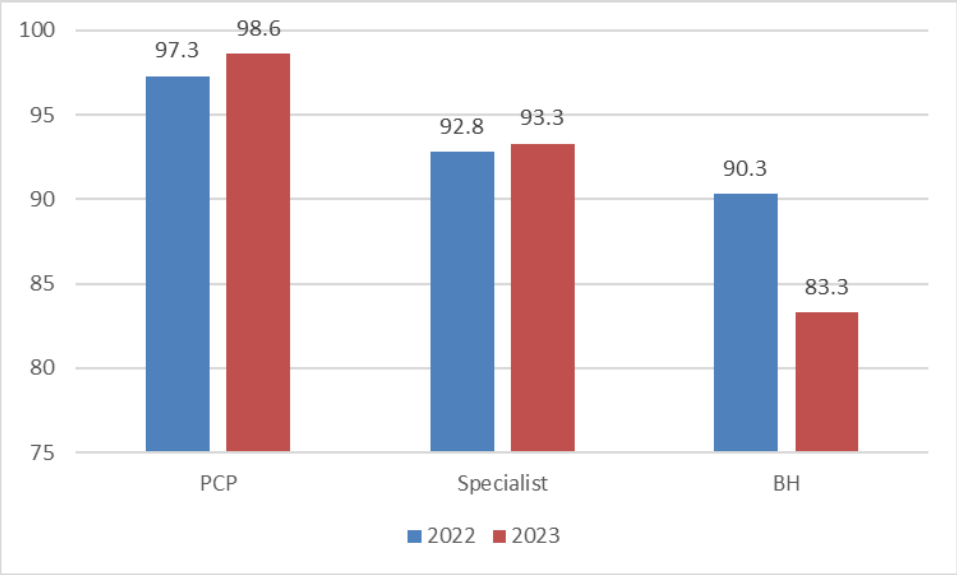
The table below presents the compliance rates for the providers surveyed in the After-Hours Survey:

Compliance Rates for After Hours Survey

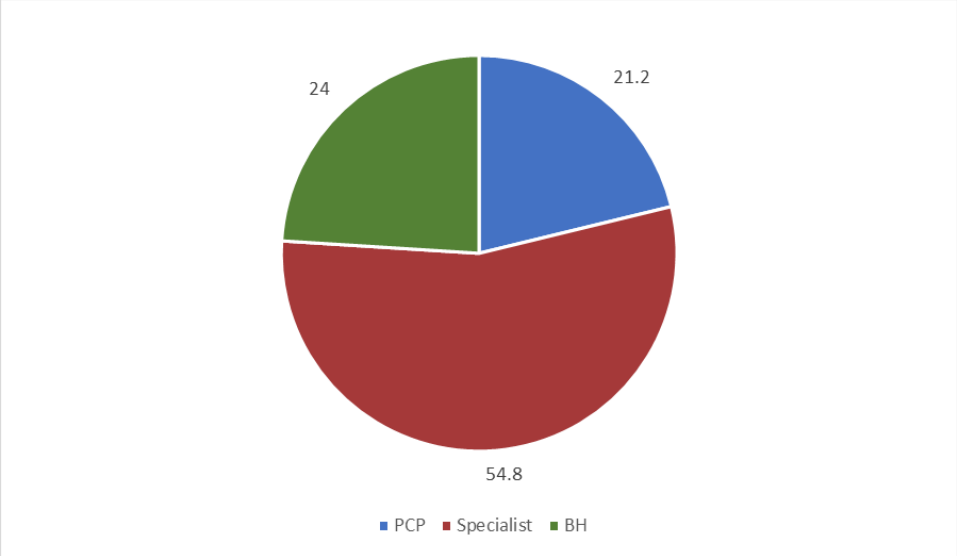
	Emergency Instructions		
Provider Type	**Total Compliant**	**Total non-compliant**	**Compliance Rate**
PCP	68	1	98.6%
Specialist	166	12	93.3%
BH	65	13	83.3%
Total	**299**	**26**	

A total of 26 providers (1 PCPs, 12 Specialists, 13 BH) were found to be non-compliant with the emergency instructions standard for the After-Hours Survey. Behavioral Health providers had the highest non-compliance rate in 2023.

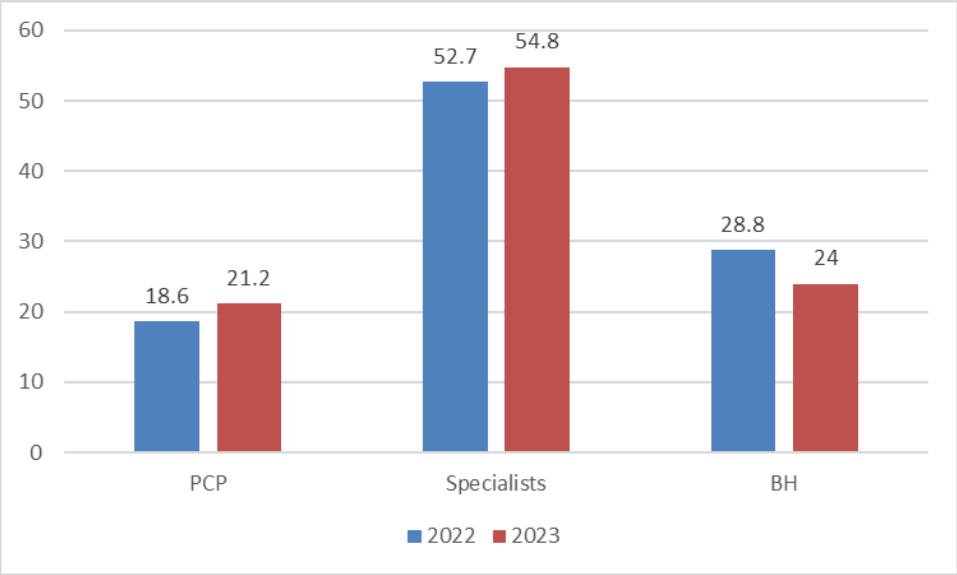
After Hours Emergency Instruction and Access to Physician Compliance Rate Comparison (2022 v 2023)



MY2023 Response Rate by Provider Type



After Hours Emergency Instruction and Access to Provider Survey Response Rate Comparison (2022 v 2023)



- Number of survey respondents in 2022 = 393
- Number of survey respondents in 2023 = 325.
- Year-over-year Specialist providers have had the highest response rate to the survey.
- BH providers response rate decreased in 2023 from 2022 by 4.8%.
- Specialist providers response rate increased in 2023 from 2022 by 2.1%.

In 2023, all the Alliance provider groups continue to perform above the 80% compliance rate, and met the 80% compliance rate threshold. Results of survey were presented at Q1 2024 Access and Availability Committee with the following next steps for improvement:

- Share results with Delegate and Direct entities.
- Share results with Provider Services and FSR staff to incorporate as part of provider and office staff education for identification of barriers and improvement opportunities.
- CAPs to be sent to non-compliant providers.
- CAPs are issued at the delegate level.
- CAPs are issued at the direct provider level.

Initial Pre-Natal Visits

The Alliance conducted the annual First Prenatal Visit Survey for MY2023, which measures providers' compliance with the first prenatal visit standard. The survey was conducted in September – November of 2023 and was administered to a random sample of eligible Alliance Obstetrics and Gynecology (OB/GYN) providers. The table below shows the results of the survey.

First Prenatal Visit Survey

Appointment within 2 weeks of request	75% Target Goal Met	Percent of Ineligibles	Precent of Non- Responsive
75.9%	Yes	28.5%	8%

The 2023 First Prenatal Visit survey met the compliance threshold goal of 75%. Corrective Action Plans (CAPs) will be issued to all non-responding and non-compliant providers within Q4 2023.

The Alliance's QI Department will continue:

1. Survey monitoring of First Prenatal Visit compliance via Quality of Access PQIs
2. Ongoing provider education and discussions at delegate JOMs regarding timely access standards.
3. CAPs for non-compliant and non-responsive providers.
4. Virtual/Onsite office visits to providers not meeting Timely Access year over year.
5. Collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.

Provider Appointment Availability Survey

The Alliance's annual Provider Appointment Availability Survey (PAAS) for MY2023 was used to review appointment wait times for the following provider types:

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

The Alliance reviewed the results of its annual PAAS for MY2023 to identify areas of deficiency and areas for potential improvement. The Alliance defines deficiency as a provider group scoring less than a seventy-five percent (75%) compliance rate on any survey question related to appointment wait times.

The Alliance analyzed results for Alameda County, as most members live and receive care in Alameda County, the Alliance's service area. Additionally, per the MY2023 Department of Managed Health Care (DMHC) PAAS Methodology, the Alliance reported compliance rates for all counties in which its contracted providers were located, regardless of whether the providers were located outside the Alliance's service area. This included provider groups in the following counties – Contra Costa, San Joaquin, Sacramento, San Francisco, Santa Clara, San Jose, Solano, Marin, Madera, Monterey, San Mateo, Santa Cruz, San Luis Obispo, Santa Barbara, and Sonoma.

MY2023 Compliance Rates by Appointment/Type across All Provider Types

Ancillary			
LOB	**Urgent Appt**	**Routine Appt**	
IHSS	Not applicable	100%	
MCL	Not applicable	100%	
PCPs			
LOB	**Urgent Appt**	**Routine Appt**	
IHSS	64.1%	73.1%	
MCL	68.6%	76.1%	
NPMH			
LOB	**Urgent Appt**	**Routine Appt**	**Follow-up Appt**
IHSS	86.7%	84.2%	87.3%
MCL	86.7%	84.2%	87.3%
Psychiatrists			
LOB	**Urgent Appt**	**Routine Appt**	
IHSS	76.9%	92.3%	
MCL	76.9%	92.3%	
Specialists			
LOB	**Urgent Appt**	**Routine Appt**	
IHSS	55.4%	56.7%	
MCL	55.6%	56.7%	

Across all provider types, there was greater compliance with the routine appointment standards than with the urgent appointment standard, and this was evidenced for both LOBs – MCL and IHSS for 2022, and 2023. The Alliance will continue engaging in provider/delegate re-education around the timely access standards, to increase its efforts around compliance for urgent and non-urgent appointment standard through the following ways:

- Biweekly fax blast 2 months prior up to the survey period
- Onsite office visits to providers not meeting Timely Access year over year

- Ongoing provider education and delegate JOM discussions regarding Timely Access Standards
- CAP and Timely Access Standard sent out to non-compliant and non-responsive providers,
- Access and Availability collaborate with Analytics and Provider Services to reconsolidate provider data, and thus to decrease the number of ineligible providers
- Provide incentives to extend office hours, focusing on improving access to care

Percentage of Ineligible Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2023	14.0%	23.0%	21.3%	10.0%	7.6%
2022	27.6%	21.4%	29.9%	19.0%	24.9%

In MY2023, across all provider types, PCPs had the highest percentage of ineligible providers, followed by Specialist providers, Psychiatrist, Ancillary and NPMH. Psychiatrists, Specialist, NPMH and Ancillary providers showed a decrease in percentage of ineligible providers from MY2022 to MY2023. While PCP providers show a slight increase in ineligible providers. The Alliance will ensure continued collaboration with its Analytics and Provider Services Teams, as well as with its delegate networks, to enhance accuracy of provider contact information, provider specialty, provider network status, and/or provider appointment availability, with the goal of decreasing the overall percentage of ineligible providers.

Percentage of Non-Responsive Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2023	17.5%	19.9%	51.9%	10.0%	36.2%
2022	27.0%	19.0%	33.4%	23.8%	28.0%

Across all provider types, Specialists had the highest percentage of non-responsive providers, followed by NPMH, PCPs and Psychiatrists providers, with Ancillary having the lowest percentages of non-responsive providers in MY2023 (see table above). The Alliance will increase its level of provider/delegate education around survey completion and purpose, including a focus on the development of provider/delegate improvement plans, with the overall goal of lessening and/or removing barriers for non-responsiveness. These efforts will include a focus on Specialists, given they had the highest level of survey non-responsiveness across provider types year-on-year.

Year-Over-Year Analysis

For eligible providers who completed the survey in MY2023, all provider categories showed an

increase in percentage score in at least one of the appointment standards. Ancillary providers were the only providers who scored a 100% compliance rate in MY2023 for non-urgent appointment standard. PCPs and Psychiatrists showed percentage increases for both urgent and non-urgent appointment standards for both LOBs. Both provider types showed a significant increase of at least +14% in compliance rate for the urgent appointment standard bringing the Psychiatrists score above the 75% compliance rate goal. NPMH providers also had an increase in percentage score for urgent appointment but a slight decrease in percentage score for the non-urgent appointment. However, even with the slight decrease in percentage score, NPMH continues to meet the compliance rate goal in MY2023. Specialist providers had percentage increases in both appointment standards for both LOBs but continued to score below the compliance rate goal.

Alameda Health Systems (AHS)

For the PCP provider type, AHS fell short of the compliance threshold goal for both appointment standards for both LOBs. For the Specialists provider type, AHS scored a 100% compliance rate for Gastroenterology, Oncology, and Urology for both appointment standards and LOBs. For Ophthalmology, AHS also scored a 100% compliance rate for the non-urgent appointment standard for both LOBs. However, AHS did not meet the threshold goal for both LOBs appointment standards for Pulmonology.

Children's First Medical Group (CFMG)

For the PCP provider type, CFMG providers maintained a stable rate of compliance with both appointment standards. For the Specialist provider type, CFMG providers showed a 100% compliance rate for both appointment standards in Cardiology, for urgent appointment standard in Ophthalmology, and non-urgent appointment standard in Pulmonology. Non-urgent appointments were not met for Ophthalmology and urgent appointment was not met for Pulmonology. The threshold goal was not met for both appointment standards for Dermatology and ENT.

Community Health Center Network (CHCN)

For Ancillary providers, CHCN scored a 100% compliance rate for non-urgent appointment standards for both LOBs. For PCP providers, the Medi-Cal LOB scored a 100% compliance rate for both standards. While for the Commercial LOB, non-urgent appointment standard met the 75% threshold goal and the urgent appointment fell short in meeting the threshold goal. For Specialists, CHCN scored a 100% compliance rate for Gastroenterology and Oncology for both appointment standard and LOBs. Aside from the urgent appointment standard for the Commercial LOBs, the compliance goal was met for all other appointment standards for the Cardiology specialty. Endocrinology, Dermatology, Neurology, ENT and Urology did not meet the threshold goal for either appointment standards and LOBs.

Individual Contracted Providers (ICP)

For the PCP provider type, ICPs did not meet the threshold goal of 75% for both appointment standards and LOBs. ICPs met the compliance threshold goal for Cardiology for both appointment standards and LOBs. Dermatology, Ophthalmology, ENT and Pulmonology all met the threshold goal of 75% percent in at least 2 of the 4 appointment standards. Gastroenterology, Neurology and Urology all did not meet the appointment standard threshold goal for MY2023.

For the Adult NPMH provider type, ICPs continues to meet the compliance rates for both appointment standards and LOBs.

Provider-Focused Improvement Activities

As part of the QI strategy for 2024, the Alliance will continue its ongoing re-education of providers/delegates regarding timely access standards via various methods (e.g., quarterly provider packets, fax blasts, postings on the Alliance website, targeted outreach to providers/delegates, and in-office provider visits as appropriate), with the goal of increasing individual response and compliance rates to ≥ 75%. Additionally, the Alliance A&A unit will conduct focused scheduled and confirmatory surveys/audits that assess provider compliance with timely access standards. Time-sensitive corrective action plans (CAPs) will be issued to all non-responsive and non-compliant providers. Results and corrective actions needed for improvement will be discussed with delegate leadership staff during Joint Operations Meetings between the Alliance and its delegate. The Alliance will review other survey result indicators of access and availability to identify both best practice and opportunities for improvement throughout the year for performance improvement activities.

For PAAS MY2023 all non-compliant PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their survey results and the timely access standards in which they were deficient, along with time-sensitive CAPs. All non-responsive PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their non-responsiveness reminding them of the requirement to respond to timely access surveys, along with the timely access standards and time-sensitive CAPs.

The Alliance will share findings from the MY2023 PAAS at the Q2 2024 Access and Availability Sub-Committee for feedback and recommendations, as well as, in the May 2024 QIHEC, which is comprised of Chief Medical Officer leadership from delegated networks, offering additional opportunities for discussion of best practice and improvement opportunities.

Provider Outreach and Engagement

During 2023, the Provider Services department continued outreach to all PCP, Specialists and Ancillary provider offices. Outreach and engagement with providers were done in various ways including virtual meetings, email, telephone, fax blasts, and mail.

Topics covered in the outreach, engagement, and fax blasts included but, were not limited to: Member Satisfaction update and reminders, Provider Satisfaction updates, Provider Appointment Availability Survey (PAAS) updates, utilization management updates and reminders, Immunizations, provider network updates, Annual Healthcare Effectiveness Data and Information Set® (HEDIS) medical record data retrieval notice, Fraud, Waste and Abuse information, Timely Access Standards Reminders, Pay-for-Performance program, Long-Term Care updates, behavioral health updates, Provider webinars, and Member Rights.

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

- Plan review and summary of Alliance programs,
- Review of network and contract information,

- How to verify eligibility,
- Referrals and how to submit prior authorizations,
- Timely Access Standards,
- Member benefits and services that require PCP referral,
- Filing of complaints and the appeal process,
- Interpreter Services process,
- Transportation benefit information,
- Initial Health Appointment,
- Coordination of Care, California Children's Services, Regional Center, WIC program,
- Claims and billing information,
- Child Health and Disability Program,
- Members' Rights and Responsibilities,
- Member Grievances,
- PQIs,
- Provider Portal, and
- Health Education.

Overall, there were over 500 quarterly packets mailed to providers with updates as mentioned above. Additionally, over 2,400 outreach occurrences were conducted during the 2023 calendar year. The Provider Services department plans to continue our robust provider outreach and engagement strategies in 2024.

Member Outreach and Member Services

The Alliance Member Services (MS) Department continues to have a strong focus on providing high-quality service. The Alliance mission is to help our members live a healthy life providing access to high-quality care and services that they need. Providing excellent customer service is just one of the many ways that we serve our members, providers, and community.

The Alliance monitors access to its Member Services Department quarterly. The following internal standards and goals are used to evaluate access to the Member Services Department by telephone.

Member Services Department Telephone Access Standards	
Standards	Goal
% of calls answered by a live agent within 30 seconds	80%
Calls Abandoned before a live voice is reached	≤ 5 %

The Alliance also offers a member orientation to help members better understand their benefits, the importance of the initial health assessment and who to call when they need help. The member orientation is available to all Alliance members.

Population Health and Equity

Population Health Management (PHM) Overview

In accordance with NCQA 2023 Population Health Program Standards and Guidelines and in alignment with the California Department of Health Care Services (DHCS) *CalAIM: Population Health Management Policy Guide*, the Alliance has developed a PHM Strategy for identifying and addressing member needs across the continuum of care with the aim of improving the health outcomes of the Alliance membership and supporting enhanced quality of life. This continuum includes members with the highest levels of needs, those with emerging risks, and wellness and prevention activities for all members. The Alliance conducts an annual analysis of the impact of its PHM strategy that includes quantitative and qualitative analysis for evidence of program effectiveness and opportunities for improvement.

PHM Strategy

Goal

Maintain and update a cohesive plan of action that addresses the Alliance member/population needs across the continuum of care.

Results

This goal was achieved. The Alliance created the *2023 Alliance Population Health Management Strategy* and approved the strategy at the May 19, 2023, Health Care Quality Committee (QIHEC) meeting and updated the strategy goals in October 2023 for submission to DHCS. The 2023 PHM Strategy is described in a separate document. The following table highlights objectives in key focus areas included in the 2023 Alliance PHM Strategy.

Note: Line of Business (LOB) is noted by Medi-Cal (MC) or Group Care (GC).

Alameda Alliance for Health 2023 NCQA PHM Strategy Goals

2023 PHM Strategy Goals			
Domain	**LOB**	**Program Name**	**Goal**
Managing Multiple Chronic Illnesses			
Hypertension & Diabetes	MC & GC	Living Your Best Life Diabetes and Hypertension Disease Management	By the end of March 2024, at least 2% of members receiving disease management outreach will engage in at least one disease management or case management conversation.
			At least 90% of members with diabetes and hypertension who complete the post-participation assessment by March 2024 will report increased confidence in disease self-management knowledge and behaviors.

Homelessness	MC	Enhanced Care Management	Increase ECM enrollment for eligible members experiencing homelessness with chronic conditions by at least 1 percentage point from 17.5% in 2022 to 18.5% in 2023.
Managing Members with Emerging Risk			
Children with Disabilities	MC	California Children's Services (CCS) Referrals	Increase enrollment in case management programs including CCS for children identified as potentially eligible but not enrolled in CCS from 29.96% in 2022 (July to December) to 30.96% in 2023.
Maternal and Adolescent Depression	MC & GC	Maternal Mental Health Program	Improve HEDIS prenatal (PND-E) and postpartum (PDS-E) depression screening rates by 2 percentage points from MY2022 (as of April 2023) to MY2024 (as of April 2024).
Keeping Members Healthy			
Well-Child Visits (Equity Focus)	MC	Black (African American) Well Child Visit QI Project	HEDIS well-child visit (W30) and immunization (CIS-10) rates will increase for Black (African American) members by 3 percentage points from MY2022 (as of April 2023) to MY2023.
Breast Cancer Screening (Equity Focus)	MC & GC	Black (African American) Breast Cancer Screening QI Project	Increase Breast Cancer Screening (BCS) rates for Black (African American) women ages 52-74 by 3 percentage points from MY2022 (as of April 2023) to MY2023.
Primary Care Utilization	MC & GC	Non-utilizer Outreach QI Project	Outreach to at least 20% of non-utilizers in 2022 ages 50 years and above by June 2023 and connect 2% to primary care services.
Primary Care Utilization	MC & GC	Non-utilizer Outreach QI Project	Outreach to at least 20% of non-utilizers in 2022 ages six and under by June 2023 and connect 2% to primary care services.
Patient Safety of Outcomes Across Settings			
ED Utilization for People with Mental Illness	MC	Follow-up after ED Visit for Mental Illness and Substance Use QI Project	Follow-up After ED Visits for Mental Illness (FUM) - 30 days HEDIS rate for Medi-Cal members will increase from 49.03% in MY2022 to 54.51% in MY2023 (pending DHCS approval of Performance Improvement Project).

Readmissions	MC & GC	Transitional Care Services	Increase the percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post-discharge from 22.6% in August 2023 to 23.6% in March 2024.
Catastrophic Cases	MC & GC	Catastrophic Case Management	Identify catastrophic cases and refer 95% of the cases into case management programs between April 2023 to March 2024.

Population Health Assessment

Goal

Conduct annual population health assessment according to NCQA (Group Care and Medi-Cal) and DHCS (Medi-Cal) guidelines including a gap analysis.

Results

This goal was achieved. The NCQA Population Health Assessment is part of the *2023 Alliance Population Health Management Strategy* that was presented at the May 19, 2023, QIHEC meeting and submitted in October to DHCS.

PHM Strategy Evaluation

Goal

Conduct yearly impact analysis of the PHM Strategy according to NCQA (Group Care and Medi-Cal) and DHCS (Medi-Cal) guidelines and implement activities to address findings.

Results

This goal was achieved. The Alliance conducted the 2023 comprehensive analysis of the impact of its Population Health Management (PHM) Strategy. The PHM Evaluation includes quantitative results for relevant clinical, utilization, and experience measures. Quantitative and qualitative analysis is conducted on the results for evidence of program effectiveness and continuous improvement. This analysis is conducted by the Health Care Services Department to support Alliance members and promote an effective PHM Strategy. The complete *2023 PHM Strategy Evaluation* is documented in a separate document.

Health Education Overview

Alliance promotes the appropriate use of plan health care services, risk reduction, healthy lifestyles, and self-management of health conditions through a Health Education Program available to all members. The Alliance Health Education Program develops culturally appropriate materials and programs that meet the diverse needs of the Alliance membership and participates in community collaborations to promote health and wellness in Alameda County. The 2023 Health Education objectives and results are as follows:

Member Wellness Handouts and Programs

Objective 1

Maintain a 95% fulfillment rate for health education material requests within 10 business days through the end of 2023. Sustain member wellness materials by updating and adhering to a five-year review cycle.

Results 1

The fulfillment goal for health education requests was met in quarters one and two (97.73% and 98.33%, respectively), but it was not met in quarters three and four (82% and 82.98%, respectively). An ongoing challenge is the necessity to have staff on-site to fulfill requests. An increase in requests for non-threshold materials in the last half of the year also presented a barrier to meeting the goal. Moving forward, a backup resource will be identified and trained to process on-site material fulfillment requests, and the goal will be refined next year to include a distinct service level agreement for non-threshold languages.

Members request health education materials and program information through the Wellness Request Form, referrals from Alliance staff, and provider referrals. The Wellness Request form is included in the Alliance biannual member newsletter (mailed out to all Alliance households) and Health Risk Assessment, Case Management and Health Education mailings. The Health Education materials update goal was met. All materials were reviewed and updated according to the five-year update schedule.

Top 6 Requested Health Topics

Topic	Member Requests
Nutrition	107
Weight Control	96
Physical Activity	88
Diabetes	81
Heart Health	64
Safety	63

Objective 2

Develop and implement health education programs and evaluations to drive program improvements by the end of 2023.

Results 2

This goal was achieved. Health education staff completed program evaluations for Family Paths parenting classes, Lactation Consultations, and Solera Diabetes Prevention Program (DPP), and Prenatal Hospital Classes by the end of June. The program that did not meet its goals was our DPP program through Solera. In response to the low performance and other contractual considerations, the Alliance will move its DPP offering to a different provider to address low engagement and low satisfaction with the program. The Alliance will also implement an incentive for returning post program surveys to increase member feedback. Below is a summary of Health Education program objectives and results.

Program	Objectives	Results
Family Paths Parenting Class Evaluation	Objective 1: 90% or more members returning Parenting class surveys will find the program helpful or very helpful.	Five of five (100%) members returning surveys found the program to be helpful or very helpful in achieving their health goals. **This objective was met.**
	Objective 2: 90% of Family Paths participants (members and non-members) agree or strongly agree that the teacher or facilitator treated them with respect.	Nearly all (96.37%) agreed or strongly agreed that the teacher or facilitator treated them with respect. **This objective was met.**
	Objective 3: 85% or more of Family Paths participants (members and non-members) agree or strongly agree that they feel more confident about their parenting or co-parenting skills.	Most participants (95.46%) agreed or strongly agreed that they feel more confident about their parenting or co-parenting skills. **This objective was met.**
Lactation Consultations	Objective: 90% of participating members returning surveys found the program helpful or very helpful	100% members returning surveys found the program to be helpful or very helpful in achieving their health goals. **This objective was met.**
Solera DPP	Objective 1: 90% or more of members returning surveys who attended 4 core sessions find the program helpful or very helpful.	71% members returning surveys found the program helpful or very helpful. **This objective was not met.**
	Objective 2: 25% of members who commit attend 4 core sessions	Of the 3 members who committed in 2022, 2 (67%) of them attended 4 core sessions. **This objective was met with a small number of participants.**
	Objective 3: 30% of members who have continued tracking their weight through 26 weeks have reached or maintained at least 5% weight loss.	At week 26, four participants had reached a 5% weight loss (25% of those tracking weight at week 26). **This objective was almost met**.
Prenatal Classes Alliance Hospitals	Objective 1: 11% or more of members who request prenatal class information participated.	In 2021, there were 20 members who requested and were mailed prenatal class information. Five of the members (25%) participated. **This objective was met.**
	Objective 2: 90% or more of participating members returning surveys will find the program helpful or very helpful.	There were no surveys returned, so this objective could not be measured.

Objective 3

Launch Maternal Mental Health Program by July 2023.

Result 1

This goal was not met. The Alliance launched bi-weekly workgroups to develop and implement the Maternal Mental Health program. Provider informing materials are near completion and internal processes are being refined to improve screening rates among perinatal members. Member informing materials have been developed and their distribution is targeted for early

2024. Competing priorities like the in-sourcing of the Alliance Behavioral Health provider network in April of 2023 presented barriers to achieving this goal. This goal will continue as a priority in 2024.

Objective 4

Submit Health Education Program descriptions to DHCS for approval by the end of September 2023.

Result 2

This goal was met, but the timeline was extended to the end of January 2024. The additional time was needed for health education, compliance, and communications and outreach staff to meet and understand the filing and compliance requirements for health education programs and services, including community-based and internal programs. All programs are currently compliant with filing requirements.

Disease Management Overview

Alliance Health Education and Case Management teams collaborate to launch programs and interventions that support members in disease self-management. In 2023, the Alliance focused on launching its full suite of disease management interventions in Asthma, Cardiovascular Disease, Diabetes, and Depression.

Objective 1

Implement the launch of expanded Asthma Disease Management health education and coaching campaigns in June of 2023. Implement the launch of Diabetes, Cardiovascular Disease, and Depression Disease Management health education interventions by the end of 2023.

Results 1

These goals were partially met. The Alliance offered disease management programs including a) diabetes health coaching and b) pediatric asthma education and remediation services throughout 2023. Disease management program descriptions, internal workflows, health education materials and provider communications were developed for asthma, cardiovascular disease, diabetes, and perinatal depression. Member outreach mailings were created for all programs and the first batch of monthly mailings to members were sent in December of 2023. The Depression member education and outreach mailing will launch in March of 2024. Excellent cross departmental collaboration facilitated progress in program development. Barriers to timely implementation included competing priorities in launching CalAIM initiatives and lengthy member-facing material approval processes requiring DHCS review and approval. Mid-way through the year, we engaged our project management team to support interdepartmental coordination and accelerate launch of our outreach efforts.

Behavioral Health Quality

The Alliance maintains procedures for monitoring the coordination and quality of behavioral healthcare provided to all members, including, but not limited to:

- Appropriate service utilization across Mental Health (MH) services and Behavioral Health Treatment (BHT)

- Monitoring of applicable performance measures
- Case Coordination
- Member engagement
- Collaboration with Alameda County Behavioral Health
- Interdepartmental collaboration for related behavioral health quality measures
- BH Work Plan and QI initiatives.
- Review and investigation of Potential Quality Issues (PQIs)
- Medically necessary services across the healthcare network

Prior to April 1, 2023, mental health (MH) and behavioral health treatment (BHT) services were delegated to Beacon Health Strategies, an NCQA Accredited MBHO, except for specialty behavioral health for Medi-Cal members, which were excluded from the Alliance contract with DHCS. The Specialty Behavioral Health Services are coordinated under a Memorandum of Understanding between The Alliance and Alameda County Behavioral Health (ACBH). The Alliance has reviewed Beacon's QIHE Program Description and Work Plan to ensure a complete transition and developed trilogy documents that include the health plan's responsibility of the QI/CM/UM function of behavioral health.

As part of the Alliance's insourcing, the Behavioral Health Department has expanded to new positions, including a behavioral health manager, licensed social workers, registered nurses, board-certified behavioral analysts, and BH navigators. The BH Department ensures all clients and families receive the highest mental health (MH) services and behavioral health treatment (BHT). In addition, BH collaborated with the QI team, such as the FUA/FUM HEDIS measures, and participates in the Behavioral Health workgroup.

The 2024 BH Workplan will be made available to the quality committees for reporting once the development and monitoring of the specific metrics are completed in the anticipated 2nd quarter of 2024.

Please see the UM & CM Program Description for additional information.

Delegation Oversight

As a part of its compliance program and strategy, the Alliance deploys an array of auditing and monitoring exercises throughout the year. Annually, First-tier subcontracted entities, called delegates, undergo an annual delegation oversight audit. The audits are conducted in accordance with DHCS, DMHC, and the NCQA regulations.

Audit results are reported to the Delegation Oversight Committee, which is a committee that reports to the Compliance Committee.

In 2023, the Alliance conducted annual delegation oversight audits for the entities included in the 2023 Alameda Alliance Delegated Entities noted in the table below.

To supplement its approach to Compliance, the Alliance holds quarterly JOMs with delegates, as necessary. JOMs cover a variety of topics, to include individual Access and Timeliness of Care survey results; HEDIS rate performance and opportunities for improvement; strategies for score improvement, and HEDIS timelines for reporting in the current year. In addition to JOMs,

the Alliance holds regular Executive Team meetings with its strategic partners CHCN and AHS.

ALAMEDA ALLIANCE DELEGATED ENTITIES - 2023

	Delegate's Name	Quality Improvement		Utilization Management		Credentialing X = NCQA Accredited		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
		Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
1	Community Health Center Network (CHCN)			X	X					X	X			X	X			X	X
2	March Vision Care Group, Inc.					X				X									
3	Children's First Medical Group (CFMG)			X		X				X									
4	PerformRx			X	X						X					X	X		
5	Kaiser	X		X		X		X		X		X		X		X		X	
6	UCSF (Credentialing)					X	X												
7	Physical Therapy PN (Credentialing)					X	X												
8	Lucille Packard (Credentialing)					X	X												
9	Teladoc (Credentialing)					X	X												
	Beacon Health Strategies LLC (Contract Termed Effective 03/31/2023)	X	X	X	X	X	X			X	X	X	X	X		X	X	X	

Analysis of 2023 Quality Program Evaluation and Effectiveness

The Alliance has identified successes, challenges/barriers, and improvements throughout the 2023 QIHE Evaluation. Many of the QIHE Program goals were met or exceeded. The evaluation included recommended activities and interventions to inform the 2024 QIHE Work Plan

Major accomplishments in which objectives were met for 2023 include but are not limited to:

- Adequate QI program resources to carry out roles, functions, and responsibilities.
- Coordinated transition of Health Care Quality Committee to the Quality Improvement Health Equity Committee in collaboration with the Chief Health Equity Officer
- Support of QI investments to improve HEDIS/MCAS performance through the following strategies: provider engagement, member engagement, data collection/sharing, innovative funding/projects, and organizational alignment.
- Enhanced Pay-for-Performance program with a focus on quality measures below the minimum performance level and promotion of primary care visits
- Launched a new Health Equity incentive for providers.
- Developed a Population Health Management Program, including publication of a Population Health Strategy with on-going goals/objectives, and in collaboration with multiple departments, utilized a health equity lens to address health disparities.
- Successful administration of all timely access surveys within the expected timeframes, allowing for timely analysis and implementation of next steps with providers and within the Alliance.
- Maintenance of favorable Provider Satisfaction Survey scores.
- QIHEC meetings in 2023 remain active in ensuring requirements of the QIHE Program were met.
- Stable and consistent Senior Level Physician involvement
- Improved HEDIS performance rates for measures; above the MPL for most reported HEDIS metrics.
- Ongoing Pediatric Care Management Program to promote access to care and EPSDT

service utilization in partnerships with direct, delegate, and CBOs.

- Improved turn-around times and root cause analysis of PQIs.
- Robust Health Education and Cultural and Linguistic Programs adding Quality of Language (QOL) PQIs segmentation for tracking and trending.
- Ongoing Community Advisory Committee and member input via virtual formats to ensure continued member input into programs and services.
- Updated grievance tracking system for capturing exempt grievances and accurate reporting and PQI referral submission to Quality department.
- Comprehensive monitoring of all practitioners during credentialing / re-credentialing to ensure high quality network.

Challenges and barriers to achieving objectives encountered within the 2023 program year included but are not limited to:

- Despite the COVID Public Health Emergency ending, timely access to care was strained as there continued to be provider workforce shortages compounded by pent up demand for preventive care services.
- QI leadership vacancy in Quarter 1, 2023 though a QI Medical Director performed the required functions until a Senior Director, Quality was hired.
- Increase in membership volume for members > 50 years old resulted in increases in PQIs and interpreter services.
- With the new Medi-Cal contract effective January 1, 2024, and several All Plan Letters issued by DHCS, significant modifications were made in policies and procedures, new processes, and program updates
- Financial impacts were imposed for quality sanctions and withholds based on HEDIS/MCAS performance.

Conclusion

Overall, the Alliance's QIHE Program was effective in reviewing data, assessing trends, identifying issues, and developing improvement activities within the Health Plan related to access to care, member and provider experience, health equity, and quality of care.

During 2023, Alameda Alliance focused on meeting the QIHE Program goals and completing all initiatives as outlined in the 2023 QIHE Work Plan. Health equity was integrated into the quality program and continues to be a main driver for the work. Throughout 2023, multiple PDSA activities and innovative projects resulted in improvements in the Alliance's quality performance. These PDSA activities have created a culture focused on the Alliance's mission, member-centric care, and provider satisfaction. In addition, there was significant program development to meet the DHCS requirements for Population Health Management, including alignment with the DHCS Bold Goals and collaborative efforts with both internal and external partners. In the latter part of the year, the Alliance committed to QI investments and support of strategies in member engagement, provider engagement, data collection/sharing, project funding, and organizational

alignment; all of which will continue in 2024. The Alliance is dedicated to improving the quality of healthcare delivered to its members through proactive analysis of shared processes and integration of health initiatives that align with the industry and government quality standards; including a preventive health model of whole person care and preemptive interventions related to health outcomes.

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM DESCRIPTION 2024

ALAMEDA Alliance FOR HEALTH

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

2024 Quality Improvement Health Equity Program Description Signature Page

_____ _____

Michelle N. Stott, R.N., M.S.N. Date
Senior Director of Quality

_____ _____

Sanjay Bhatt, M.D., M.S., M.M.M. Date
Senior Medical Director
Vice Chair, Quality Improvement Health Equity Committee

_____ _____

Lao Paul Vang Date
Chief Health Equity Officer

_____ _____

Donna Carey, MD Date
Interim Chief Medical Officer
Chair, Quality Improvement Health Equity Committee

_____ _____

Matthew Woodruff Date
Chief Executive Officer
Chair, Quality Improvement Health Equity Committee

_____ _____

Rebecca Gebhart Date
Board Chair

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OVERVIEW

Alameda Alliance for Health is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to lower-income people of Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents. The Alliance currently provides health care coverage to approximately 351,850 children and adults through its programs.

Alameda Alliance for Health is licensed by the State of California and product lines include Medi-Cal managed care and Group Care commercial insurance. Medi-Cal managed care beneficiaries, eligible through one of several Medi-Cal programs, e.g., TANF, SPD, Medi-Cal Expansion. For dually eligible Medi-Cal and Medicare beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

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

Alameda Alliance for Health's (Alliance) Quality Improvement Health Equity (QIHE) Program applies to all product lines and strives to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs. The QIHE program includes systematic and continuous activities to monitor, evaluate, and improve upon the health equity and health care delivered to Members in accordance with the standards set forth in applicable State and Federal regulations.

The QIHE Program Description is a comprehensive document with a set of interconnected documents that describes our quality program governance, structure and responsibilities, operations, scope, goals, and measurable objectives. Participation of all Alliance departments and staff in quality improvement activities is essential to the organization achieving our QIHE goals and objectives.

The Alliance complies with applicable State and Federal civil rights laws and does not discriminate based on race, color, religion, ancestry, national origin, ethnic group, age, mental or physical disability, sex, gender, gender identity, or sexual orientation, medical condition, genetic condition, or marital status. The Alliance QIHE Program is committed to serving the healthcare needs of our culturally and linguistically diverse membership. The Alliance staff and provider network reflect the county’s cultural and linguistic diversity.

MISSION AND VISION

Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of their life.

QIHE PROGRAM SCOPE AND GOALS

The purpose of the Alliance QIHE Program is to objectively monitor and evaluate the quality, safety, appropriateness, health equity, and outcome of care and services delivered to members of the Alliance. The overall goal of the QIHE Program is to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs. The QIHE Program is structured to continuously pursue opportunities for improvement and problem resolution. The QIHE Program is organized to meet overall program objectives as described below and as directed each year by the QIHE and UM Work Plans. Improvement priorities are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

Although not limited to, the goals of the QIHE Program are to:

1. Maintain the delivery of high quality, safe, and appropriate medical and behavioral health care that meets professionally recognized standards of practice that is delivered to all enrollees.
2. Utilize objective and systematic measurement, monitoring, and evaluation through qualitative and quantitative analysis of health care services and to implement QIHE activities based on the findings.
3. Conduct performance improvement activities that are designed, implemented, evaluated, and reassessed using industry recognized quality improvement models such as Plan-Do-Study-Act (PDSA).
4. Ensure physicians and other appropriate licensed professionals, including behavioral health, are an integral and consistent part of the QIHE Program.
5. Ensure medical and behavioral health care delivery is consistent with professionally recognized standards of practice.
6. Track and trend the delivery of healthcare services to ensure care and services are not withheld or delayed for any reason, such as potential financial gain or incentive to plan providers.
7. Design and maintain an ongoing organizational culture of quality to ensure continual HEDIS improvement and accreditation readiness.

The scope of the QIHE Program is comprehensive and encompasses the following:

1. Timely access and availability to quality and safe medical, behavioral, and specialty health care and services.
2. Care and Disease management services.
3. Cultural and linguistic services
4. Patient safety.
5. Member and provider experience
6. Continuity and coordination of care across settings, with the goal of establishing consistent provider-patient relationships.
7. Tracking of service utilization trends, including over-and under-utilization Clinical practice guideline development, adoption, distribution, and monitoring.
8. Targeted focus on acute, chronic, and preventive care services for children and adults Member

and provider education.

9. Prenatal, primary, specialty, emergency, inpatient, and ancillary care.
10. Case review, investigation, and corrective actions of potential quality issues Credentialing and re-credentialing activities.
11. Delegation oversight and monitoring.
12. Delegate performance improvement project collaborations.
13. Targeted support of special needs populations including Seniors and Persons with Disabilities and persons with chronic conditions.
14. Population Health Management Integration.
15. Health care diversity and equity.

ORGANIZATIONAL STRUCTURE AND SUPPORT COMMITTEES' RESPONSIBILITY

Overview

The Alliance Board of Governors (BOG) appoints and oversees the Quality Improvement Health Equity Committee (QIHEC), Pharmacy & Therapeutics (P&T) Committee, Peer Review/Credentialing Committee (PRCC), Community Advisory Committee, and Compliance Committee which in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Program.

The organizational chart in **Appendix A** displays the reporting relationships for key staff responsible for QIHE activities at the Alliance. **Appendix B** displays the committee reporting relationship and organizational bodies.

Board of Governors

The Alliance BOG is appointed by the Alameda County Board of Supervisors and consists of up to 15 members who represent members, provider, and community partner stakeholders. The BOG is the final decision-making authority for the Alliance QIHE Program. Its duties include:

- Reviewing annually, updating, and approving the QIHE Program description, defining the scope, objectives, activities, and structure of the program.
- Reviewing and approval of the annual QIHE report and evaluation of QIHE studies, activities, and data on utilization and quality of services.
- Assessing QIHE Program's effectiveness and direct modification of operations as indicated.
- Defining the roles and responsibilities of QIHEC.
- Designating a physician member of senior management with the authority and responsibility for the overall operation of the QIHE program, who serves on QIHEC.
- Appointing and approving the roles of the Chief Medical Officer (CMO), including the support of the Chief Health Equity Officer, and other management staff in the QIHE Program.
- Receiving a report from the CMO on the agenda and actions of QIHEC.

Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is a standing committee of the BOG and meets a minimum of four times per year, and as often as needed, to follow-up on findings and required actions. The QIHEC is responsible for the implementation, oversight, and monitoring of the QIHE Program and Utilization Management (UM) Program. The QIHEC recommends policy decisions, analyzes and evaluates the QIHE work plan activities, and assesses the overall effectiveness of the QIHE Program. The QIHEC reviews results and outcomes for all QIHE activities to ensure performance meets standards and makes recommendations to resolve barriers to quality improvement activities. Any quality issues related to the health plan that are identified through the CAHPS and Provider Satisfaction surveys and health plan service reports are also discussed and addressed at QIHEC meetings. The QIHEC oversees and reviews all QI delegation summary reports and evaluates delegate quality program descriptions, program evaluations, and work plan activities. The QIHEC presents to the Board the annual QIHE Program description, work plan and prior year evaluation. Signed and dated minutes that summarize committee activities and decisions are maintained. The Annual QIHE Program, Work Plan, Evaluation, and minutes from the QIHEC are submitted to the California Department of Health Care Services (DHCS).

Responsibilities include but are not limited to:

- Analyze and evaluate the results of QIHE activities including annual review of the results of performance measures, utilization data, satisfaction surveys, and findings and activities of the quality committees, such as the Community Advisory Committee.
- Approve, select, design, and schedule studies and improvement activities.
- Review CAHPS and other survey results and related improvement initiatives.
- On-going reporting to the BOG.
- Meeting at least quarterly and maintaining approved minutes of all committee meetings.
- Approve definitions of outliers and develop corrective action plans.
- Recommend and approve of Medical Necessity Criteria, Clinical Practice Guidelines, as well as pediatric and adult Preventive Care Guidelines and review compliance monitoring.
- Review member grievance and appeals data.
- Oversee the Plan's process for monitoring delegated providers.
- Oversee the Plan's UM Program.
- Review advances in health care technology and recommend incorporation of new technology into delivery of services as appropriate.
- Institute actions to address performance deficiencies, including policy recommendations, and ensure follow-up of identified findings.
- Provide guidance to staff on quality improvement activities.
- Monitor progress in meeting QIHE goals.
- Evaluate annually the effectiveness of the QIHE and Population Health Management program.
- Oversee the Plan's complex case management and disease management programs.
- Ensure that its fully delegated subcontractors and downstream fully delegated subcontractors

maintain a QIHEC that meets the QIHE program requirements.

- Review and approve annual QIHE and UM Program Descriptions, Work Plans, and Evaluations.
- Recommends and approves resource allocation for the QI Department Program. The QIHEC is chaired by the CMO and vice-chaired by the Sr. QI Medical Director. The members are representatives of the Alliance contracted provider network including those who provide health care services to members affected by health disparities, Limited English Proficiency (LEP) members, Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPD) and persons with chronic conditions. The QIHEC Members are appointed for two-year terms. The voting membership includes:
    - Alliance CMO (Chair)
    - Medical Director of Quality (Vice-Chair)
    - Chief Executive Officer (ex officio)
    - Chief Health Equity Officer
    - Medical Director or designee from each delegated medical group (i.e., Community Health Center Network, Children First Medical Group)
    - Physician representative of Alameda County Medical Center
    - Physician representative of Alameda County Ambulatory Clinics
    - Alliance contracted physicians (3 positions)
    - Representative of County Public Health Department
    - A Behavioral Health practitioner
    - Alliance Medical Directors
    - Alliance Senior Director, Quality

A quorum is established when the majority of voting membership is present at the meeting. The Chief Executive Officer does not count in the determination of a quorum.

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee assists the QIHEC in oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization, and developing provider education programs on drug appropriateness. P&T Committee meeting minutes are reported directly to the Board of Governors. Pharmacy updates are shared at the QIHEC meetings.

The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or designee
- Alliance Director of Pharmacy Services (Co-Chair)
- Practicing physician(s) representing Internal Medicine
- Practicing physician(s) representing Family Practice
- Practicing physician(s) representing Pediatrics
- Practicing physician(s) representing common medical specialties

- Practicing community pharmacists contracted with Alliance (not to exceed 1/3 of the voting membership of the committee or three pharmacists, whichever is greater).

Peer Review and Credentialing Committee (PRC)

The PRC is a standing committee of the BOG that meets a minimum of ten times per year. The chair of the Peer Review Committee is the Medical Director of QI. The chair of the Credentialing Committee is the CMO.

Responsibilities include:

- Recommending provider credentialing and re-credentialing actions.
- Performing provider-specific clinical quality peer review.
- Reviewing and approving PRC Program Description.
- Monitoring delegated entity credentialing and re-credentialing.

The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or Designee
- Alliance Case Management and Quality Improvement Medical Directors
- Medical Director/physician designee from Children First Medical Group
- Medical Director/physician designee from Community Health Center Network
- Physician representative for Alameda County Medical Center
- Two physicians from the South County area contracted with the Alliance.
- Physician representative from the Alliance BOG

Internal Quality Improvement Committee (IQIC)

The IQIC assists the QIHEC in oversight and assurance of the quality of clinical care, patient safety, and customer service provided throughout the AAH organization. Its primary roles are to maintain and improve clinical operational quality, review organization-wide performance against the Alliance quality goals, and report results to the QIHEC. All members shall complete a confidentiality and conflict-of-interest form, as required. A quorum, defined as a simple majority of voting members, must be present to conduct a meeting. The IQIC shall meet quarterly, at least four times per year. If urgent matters (as determined by the Alliance CMO) arise between meetings, additional meetings will be scheduled. Meetings may be conducted via conference call or webinar. All relevant matters discussed in between meetings will be presented formally at the next meeting. An agenda and supplementary materials, including minutes of the previous meeting, shall be prepared, and submitted to the IQIC members prior to the meeting to ensure proper review of the material. IQIC members may request additions, deletions, and modifications to the standard agenda. Minutes of the IQIC proceedings shall be prepared and maintained in the permanent records of the Alliance. Minutes, relevant documents, and reports will be forwarded to QIHEC for review.

Committee Responsibilities include but are not limited to:

- Develop, approve, and monitor a dashboard of key performance and QIHE indicators compared to organizational goals and industry benchmarks.

- Oversee and evaluate the effectiveness of AAH's performance improvement and quality activities.
- Review reports from other sub-committees and, if acceptable, forward them for review at the next scheduled QIHEC.
- Review plan and delegate corrective plans regarding negative variances and serious errors.
- Oversee compliance with NCQA accreditation standards.
- Make recommendations to the QIHEC on all matters related to:
    - Quality of Care, Patient Safety, and Member/Provider Experience.
    - Performance Measurement.
    - Preventive services including:
        - Seniors and Persons with Disability (SPD)
        - Members with chronic conditions
        - Medi-Cal Expansion (MCE) members.

The Committee shall be comprised of the following members:

- Alliance Chief Medical Officer (CMO)
- Alliance Medical Director(s)
- Sr. Director, Quality
- Quality Improvement Manager
- Access to Care Manager
- Population Health and Equity Director
- Members from Provider Relations, Member Services, Business Analytics, Health Education, Compliance, and Grievance and Appeals.

Utilization Management Committee (UMC)

The UMC is a forum for facilitating clinical oversight and direction. Its responsibilities are to:

- Maintain the annual review and approval of the:
    - UM and CM Program Descriptions, UM and CM Policies/Procedures, and UM Criteria
    - Other pertinent UM documents such as the UM and CM Program Evaluations, UM and CM Workplan, and any trends or updates pertaining to the workplans.
    - Enhanced Care Management (ECM) and Community Supports Policies/Procedures
    - Health Risk Assessment (HRA) and Health Information Form/Member Evaluation Tool (HIF/MET) Policies and Procedures
- Participate in the utilization management/continuing care programs aligned with the Program’s quality agenda.
- Assist in monitoring for potential areas of over and under-utilization and recommend appropriate actions when indicated.

- Review and analyze utilization data for the identification of trends, including trends related to health disparities, social determinants of health, and behavioral health.
- Recommend actions to the QIHEC when opportunities for improvement are identified from review of utilization data including, but not limited to Ambulatory Visits, Emergency Visits, Hospital Utilization Rates, Hospital Admission Rates, Average Length of Stay Rates, and Discharge Rates.
- Review information about New Medical Technologies from the Pharmacy & Therapeutics Committee including new applications of existing technologies for potential addition as a new medical benefit for Members.

Access and Availability Subcommittee (AASC)

The AASC reviews the Alliance's access and availability data to evaluate whether the Alliance is meeting regulatory standards and provides corrective actions and recommendations for improvement when needed. The committee identifies opportunities for improvement and provides recommendations to maintain compliance with access and availability regulatory requirements.

Membership is comprised of Alliance staff within departments that are involved with access and availability which include the following representation:

- Chief Medical Officer
- Senior Medical Directors
- Senior Director, Quality
- Access to Care Manager
- Quality Improvement Manager
- Health Education (Cultural & Linguistics) Manager
- Quality Assurance
- Grievance and Appeals Management
- Compliance
- Healthcare Analytics
- Utilization Management
- Member Services
- Provider Services

The following are the monitoring activities the subcommittee reviews to ensure compliance with access and availability and network adequacy requirements including but not limited to:

- Provider network capacity levels
- Facility Site Reviews
- Geographic accessibility
- Appointment availability surveys
- High volume and high impact specialists

- Access-related grievances and appeals. Access-related potential quality issues. Provider language capacity. Wait time and telephone practices related to access. Member and provider satisfaction survey
- After hours care

Cultural and Linguistic Services Subcommittee (CLSS)

The Cultural and Linguistic Services Subcommittee's role is to ensure members receive culturally and linguistically appropriate health care services and to monitor the Alliance's Cultural and Linguistic Services Program. The CLSS reviews demographic changes in the Alliance membership, language services, grievances and potential quality issues related to language access and discrimination, alternative formats and translation services, and overall execution of the Alliance's Cultural and Linguistic Services Program. The CLSS makes recommendations for program improvements and corrective actions as needed. The CLSS reports results to the QIHEC.

Responsibilities include but are not limited to:

- Monitor the cultural and linguistic needs of members.
- Review reports related to provision of cultural and linguistic services.
- Ensure that language assistance services are provided at all points of contact.
- Maintain and update cultural and linguistic services policies and procedures to be compliant with ongoing regulatory and contractual requirements.
- Annually review and update Cultural and Linguistic Services (CLS)'s program description and workplan. Quarterly monitor the CLS Workplan.
- Review input from the Community Advisory Committee (CAC) on cultural and linguistic services and consider how it may inform Alliance's CLS programs, policies, and procedures.
- Identify issues related to access and provision of culturally and linguistically appropriate services and develop corrective actions to correct deficiencies found.
- Review plan and delegate corrective action plans related to CLS.

The CLSS is composed of the following members:

- Chief Medical Officer
- Chief Health Equity Officer
- Senior Director of Quality
- Director, Population Health, and Equity
- Manager, Cultural and Linguistic Services
- Manager, Population Health, and Equity
- 1 Representative from Compliance
- 1 Representative from Communications and Outreach
- 1 Representative from Grievance and Appeals

- 1 Representative from Population Health and Equity
- 1 Representative from Health Care Services
- 1 Representative from Member Services
- 1 Representative from Provider Services
- 1 Representative from Quality Improvement

Community Advisory Committee (CAC)

The CAC provides a link between Alameda Alliance for Health and the community. The CAC reflects the Alliance's member population, and advised the Alliance on the development and implementation of policies and procedures that affect cultural and linguistic access, quality, and health equity. All CAC findings and/or activities are reported to the QIHEC.

The CAC carries out, but is not limited to, the following duties:

- Identify and advocate for preventive care practices to be used by the Alliance.
- Develop and update cultural and linguistic policy and procedures related to cultural competency issues, educational and operational issues affecting seniors, people who speak a primary language other than English, and people who have a disability.
- Advise on Alliance member and provider-targeted services, programs, and trainings.
- Provide and make recommendations about the cultural appropriateness of communications, partnerships, and services.
- Review findings from the Population Needs Assessment (PNA) and discuss improvement opportunities on Health Equity and Social Drivers of Health and provide input on selecting targeted health education, cultural and linguistic, and Quality Improvement (QI) strategies.
- Provide input and advice, including, but not limited to, the following:
    - Culturally appropriate service or program design
    - Priorities for health education and outreach program
    - Member satisfaction survey results
    - PNA findings
    - Marketing materials and campaigns
    - Communication of needs for network development and assessment
    - Community resources and information
    - Population Health Management
    - Quality
    - Health delivery systems to improve health outcomes.
    - Carved out services.
    - Coordination of care
    - Health Equity

- Accessibility of services
- Development of the provider manual and clarification of new and revised policies and procedures in the manual.

The CAC membership and representation reflects the Medi-Cal and Group Care populations in Alameda County, and representation includes the following:

- General population of the Alliance members (including, adolescents and/or parents and/or caregivers of children, including foster youth)
- Diverse and hard-to-reach populations (including populations that experience health disparities, such as those with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities)
- At least 51% of the committee shall be Alliance members (and/or the parents/guardians of Alliance members who are minors or dependents).

Joint Operations Committee/Delegation

The contractual agreements between the Alliance and delegated entities specify:

- The responsibilities of both parties.
- The functions or activities that are delegated.
- The frequency of reporting on those functions and responsibilities to the Alliance and how performance is evaluated.
- Corrective action plan expectations, if applicable.

The Alliance may delegate QI, Credentialing, UM, Case Management, Disease Management, Claims, Grievance and Appeals activities to Health Plans, County entities, and/or vendors that meet the requirements as defined in a written delegation agreement, delegation policies, accreditation standards, and regulatory standards.

To ensure delegated entities meet required performance standards, the Alliance:

- Provides oversight to ensure compliance with federal and state regulatory standards, and accreditation standards.
- Reviews and approves program documents, evaluations, and policies and procedures relevant to the delegated activities.
- Conducts required pre-delegation activities.
- Conducts annual oversight audits.
- Reviews reports from delegated entities.
- Collaborates with delegated entities to continuously improve health service quality.

As part of delegation responsibilities, delegated entities must:

- Develop, enact, and monitor quality plans that meet contractual requirements and Alliance standards.
- Provide encounter information and access to medical records pertaining to Alliance members as

required for HEDIS and regulatory agencies.

- Provide a representative to the Joint Operations Committee.
- Submit at least semi-annual reports or more frequently if required on delegated functions.
- Cooperate with state/federal regulatory audits as well as annual oversight audits.
- Complete any corrective action deemed necessary by the Alliance.

The Alliance collaborates with delegated entities to formulate and coordinate QIHE activities and includes these activities in the QIHE work plan and program evaluation. Delegated activities are a shared function. Delegate program descriptions, work plans, reports, policies and procedures, evaluations and audit results are reviewed by the Delegation Oversight Committee and Joint Operations Committee and findings are summarized at QIHEC meetings, as appropriate.

The Alliance currently delegates the following functions:

Table 1: Alameda Alliance Delegated Entities

ALAMEDA ALLIANCE DELEGATED ENTITIES - 2024																				
Delegate's Name	Quality Improvement		Utilization Management X = NCQA Accredited		Credentialing X = NCQA Accredited		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
Community Health Center Network (CHCN)			X	X					X	X			X	X			X	X
March Vision Care Group, Inc.					X				X									
Children's First Medical Group (CFMG)			X		X				X									
PerformRx (PBM)				X		X				X						X		
UCSF (Credentialing)					X	X												
Physical Therapy PN (Credentialing)					X	X												
Lucille Packard (Credentialing)					X	X												
Teladoc (Credentialing)					X	X												

QUALITY IMPROVEMENT PROGRAM RESOURCES

Responsibilities for QIHE Program activities are an integral part of all Alliance departments. Each department is responsible for setting and monitoring quality goals and activities.

The Alliance QI Department is part of the Health Care Services Department, and responsible for implementing QIHE activities and monitoring the QIHE Program. The QI Department participates in the accreditation process, manages the HEDIS and CAHPS data collection and improvement process, conducts facility site reviews (FSRs), processes Potential Quality Issues (PQIs), and oversees the quality activities in other departments and those performed by delegated groups.

Resource allocation for the QI Department is determined by recommendations from the QIHEC, CMO, CEO and BOG. The Alliance recruits, hires, and trains staff, and provides resources to support activities required to meet the goals and objectives of the QIHE Program.

The Alliance's commitment to the QIHE Program extends throughout the organization and focuses on QIHE activities linked to service, access, continuity and coordination of care, and member and provider experience. The Senior Director of Quality, with direction from the Medical Director of Quality and CMO, coordinates the QIHE Program. Titles, education and/or training for key positions within the Quality Department include:

Chief Medical Officer

The Alliance Chief Medical Officer (CMO) is responsible for and oversees the QIHE Program. The CMO has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The CMO provides leadership to the QIHE Program through oversight of QI study design, development, and implementation, and chairs the QIHEC, PRCC, and P&T committees. The CMO makes periodic reports of committee activities, QI study and activity results, and the annual program evaluation to the BOG. The CMO reports to the Alliance CEO.

Chief Health Equity Officer

The Chief Health Equity Officer (CHEO) reports directly to the Chief Executive Officer (CEO) and is matrixed to the Chief of Human Resources (CHR). The position partners with leaders across the organization to develop and drive forward the key strategies of the organization as they relate to Diversity, Equity, and Inclusion (DEI) for members, providers, and employees. The executive position implements policies that ensure health equity is prioritized and addressed and is responsible for setting and implementing an overarching vision of DEI for the organization, including programmatic and administrative outcomes. The position is responsible for the promotion of internal and external DEI for members, providers, and employees. With supervision by the Chief Medical Officer (or designee) of the QIHE program, the CHEO participates in QIHEC and collaborates on QIHE program activities.

Senior Medical Director

The Senior Medical Director has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The Senior Medical Director is part of the medical team and is responsible for strategic direction of the Quality Improvement Health Equity programs. The Medical Director also forms a dyad partner with the Sr. Director of Quality and serves as an internal expert, consultant, and resource in QI. They are responsible for clinical appropriateness, quality of care, pay for performance, access and availability, provider experience, member experience and cost-effective utilization of services delivered to Alliance members. The Senior

Medical Director has executive oversight over the Behavioral Health Program responsibilities include participating in the grievance and external medical review procedure process, resolving medically related and potential quality related grievances, and issuing authorizations, appeals, decisions, and denials. The Senior Medical Director reports to the CMO.

Senior Director of Quality

The Senior (Sr.) Director of Quality is responsible for the strategic direction of the Quality Improvement Health Equity Program. This position has direct oversight for the development, implementation, and evaluation of the QIHE Program. This position is responsible for all performance improvement activities, including improving access and availability of network services, developing and managing quality programs as identified by DHCS, DMHC, and NCQA (PIPs, Improvement Programs i.e., HEDIS/MCAS measures, QI Standards) as well as managing, tracking, analyzing, and reporting member experience/satisfaction (i.e. Consumer Assessment Health Plan Surveys (CAHPS) as requested. The Sr. Director is also responsible for the oversight of FSR and potential quality issues (PQIs) and will direct performance improvement, FSR, access and availability. The Sr. Director is also the senior nurse to the organization to augment clinical oversight. This position, along with the Director of Population Health, assists with setting the priorities of the Population Health Management program, and ensures Health Education and Cultural and Linguistic Services are incorporated into the QIHE program. The Sr. Director of Quality is a dyad partner with the QI Medical Director and reports to the CMO.

Senior Director of Behavioral Health

The Senior Director of Behavioral Health has relevant experience and current knowledge in clinical program administration, including behavioral health and autism spectrum disorder management. Alongside the Sr. Medical Director, the Sr. BH Director is responsible for and oversees the BH program. Responsibilities include participating in the QI, UM, and CM processes as they pertain to behavioral health and autism spectrum disorder programs. The Senior Director of BH reports to the Senior Medical Director.

Director of Population Health and Equity

The Director of Population Health and Equity (PHE) provides operational oversight and leadership for the Alliance's population health assessments, strategy and evaluation. The PHE Director is also responsible for state and federal regulatory and accreditation requirements concerning Population Health, Cultural and Linguistic Services and member Health Education. This position reports to the Senior Director of Quality Improvement and works closely with the Chief of Health Equity.

Manager of Population Health and Equity

The Population Health and Equity (PHE) Manager is responsible for the implementation of the Alliance's population health assessments, strategy and evaluation. In addition, the PHE Manager oversees the execution of the Alliance's population health, health education and health equity program, supervises PHE staff, and ensures compliance with state and federal regulatory and accreditation requirements concerning population health, health education, and health equity.

Manager of Cultural and Linguistic Services

The Cultural and Linguistic Services (CLS) Manager is responsible for direct oversight of the Alliance Cultural and Linguistic Services Program. This includes activities such as, ensuring members have access to language assistance services for interpreting services, implementation of cultural sensitivity

trainings for both staff and providers, review of provider capacity to meet the cultural and linguistic needs of members, and overall assessment of the cultural and linguistic needs of members. The CLS Manager is also responsible for compliance with state and federal regulatory and accreditation requirements related to CLS. Furthermore, the CLS Manager leads the planning and implementation of internal and external committees, such as the Cultural and Linguistics Services Subcommittee and the Community Advisory Committee. The CLS manager reports directly to the Population Health and Equity Director.

Quality Improvement Manager

The Quality Improvement (QI) Manager is responsible for the day-to-day management of the Performance Improvement Team, including but not limited to HEDIS project improvement development and submission oversight, Physician Profiling (practice profiling) activities, and Quality and Performance Improvement Project oversight. The QI Manager also acts as liaison between the Alliance's physician leadership and community practitioners/providers of care across all specialties and delegates. The QI Manager works collaboratively throughout the organization to lead and establish appropriate performance management/quality improvement systems including PDSA (Plan-Do-Study-Act).

Access to Care Manager

The Access to Care Manager is responsible for day-to-day management of access to care activities throughout the organization and includes leading and establishing appropriate access to care systems. The Access to Care Manager ensures the access program complies with timely access standards as regulated by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA). The Access to Care Manager ensures planning and oversight of access to care surveys, ensures appropriate follow up when compliance monitoring identifies deficiencies The Access to Care Manager reports to the Sr. Director of Quality.

Quality Improvement Nurse Supervisor

The Quality Improvement Nurse Supervisor works collaboratively throughout the organization to ensure appropriate oversight of performance management and clinical quality improvement assignments. The Quality Improvement Supervisor is responsible for day-to-day supervision of the work assigned to the clinical staff in the Quality Department. The Supervisor also acts as liaison between the health plan's physician leadership and community practitioners/providers of care across all specialties and delegates. The Quality Improvement Supervisor is responsible for oversight of timely and accurate investigation and completion of Potential Quality Issues (PQI), Provider Preventable Conditions (PPC), and quality of care corrective action plans, and participation in HEDIS activities. The QI Nurse Supervisor reports to the Sr. Director of Quality.

Quality Improvement Review Nurse (3)

The QI Review Nurse is a registered nurse responsible for timely and accurate investigation and completion of Potential Quality of Care Issues (PQIs), collecting quality related data and reviewing medical records for HEDIS abstraction and over reads, regulatory compliance, quality improvement (QI) activities development, data tracking and trending, and outcomes reporting. The Quality Review Nurse keeps accurate records, manages, and analyzes data, as well as responds appropriately and timely, both verbally and in writing to internal and external clinical issues of staff and regulatory agencies. The Quality Review Nurse identifies, investigates, and reports on Potential Quality Issues

(PQIs) and Provider Preventable Conditions (PPCs) as appropriate. s. Cases on quality-of-care issues are presented to the Medical for review and determination.

Senior Quality Improvement Nurse Specialist (1)

The QI Review Nurse is responsible for the training, certification and recertification of all Alliance Network Management and Delegated Provider Oversight staff in conducting FSR audits. The Sr. QI Nurse Specialist is also responsible for the oversight and monitoring of the qualitative and quantitative content of the medical record process and maintaining compliance with state and regulatory quality of care standards. The QI Nurse Specialist develops provider training and education materials to assist providers with meeting quality standards.

Lead Quality Improvement Project Specialist

The Lead Quality Improvement Project Specialist (LQIPS) conducts and manages complex analytical projects, plans and executes strategies, plans initiatives and methods that provide a comprehensive approach to promoting a strong quality culture. The LQIPS mentors and trains Quality Improvement Project Specialist I and II in improvement methodology and project management concepts and tools.

Quality Improvement Project Specialist II (4)

The Quality Improvement Project Specialist II (QIPS II) is responsible for developing and implementing quality assessment and performance improvement activities that include quality monitoring, evaluation and facilitation of performance improvement projects. The QI Project Specialist II conducts assessment activities and facilitates compliance with Medicare/Medicaid regulations, state licensure laws, and applicable regulatory/accrediting body.

Quality Improvement Project Specialist I (5)

The Quality Improvement Project Specialist I (QIPS I) is responsible for developing and implementing quality assessment and performance improvement activities that include quality monitoring, evaluation, and facilitation of performance improvement projects. The QI Project Specialist I conducts assessment activities and facilitates compliance with Medicare/Medicaid regulations, state licensure laws, and applicable regulatory/accrediting body.

Facility Site Review QI Coordinator (1)

The Facility Site Review Coordinator (FSRC) is responsible for performing facility site review audits and quality improvement activities in conjunction with the Sr. QI Nurse Specialists. The position assists with access and availability reports, provider training, HEDIS data collection, disease specific outreach, and preparation for accreditation and compliance surveys by external agencies such as DHCS, DMHC and NCQA.

Quality Program Coordinator (2)

The Quality Program Coordinator (QPC) is responsible for helping to plan, organize, and implement Alliance quality programs. Responsibilities include coordination of quality projects including PQI case tracking, assistance in patient safety audits, and coordination of internal and external meetings. Supports the successful implementation of projects within timelines for associated department assignments.

Quality Improvement Engagement Coordinator (2)

The Quality Improvement Engagement Coordinator (QIEC) responsibilities include coordinating quality improvement projects, member outreach by phone and mail, provider and community collaboration, and data tracking and reporting. The goal of this role is to increase access to care for Alliance members by helping connect them to services available directly related to QI measures.

ANCILLARY SUPPORT SERVICES FOR THE QIHE PROGRAM

Population Health and Equity

The Population Health and Equity team consists of a Population Health and Equity Director, a Population and Health Equity Manager, a Cultural and Linguistics Services Manager and supporting staff. The Population Health and Equity team is a component of the QI Department. The Population Health and Equity staff ensure integration of QIHE initiatives into the Alliance Population Health Strategy and support the QI team in the development and implementation of member and provider educational interventions and community collaborations to address health care quality, health equity and access to care. The Population Health and Equity team also manages and monitors the Population Health Management, Health Education, and Cultural and Linguistic programs for the Alliance. The Health Education and Cultural and Linguistic Programs and the Population Health Management Strategy are outlined in separate documents.

Analytics

The Analytics Department is comprised of two departments: 1) Healthcare Analytics and 2) Quality Analytics. The department works in collaboration with the Quality department on improvement activities and initiatives.

The Healthcare Analytics Department performs reporting and analyses across the organization on clinical, claims, provider, and member data. Quality activities include management and production of the HEDIS NCQA certified software, HEDIS data validation/collection and HEDIS rate reporting and trending. In addition, the department collaborates on Population Health Management (PHM) strategies and initiatives such as Risk Stratification and Segmentation (RSS) and supporting access and availability regulatory requirements.

The Quality Analytics Department is responsible for management of HEDIS operational activities, the pay for performance program and access and availability survey administration. HEDIS operational activities include Roadmap and rate submissions, oversight of the annual HEDIS audits, medical record retrieval and training, monitoring, and performing overreads, and oversight of the abstraction vendor.

Quality Assurance

The Director, Quality Assurance is responsible for the operations management of the Grievance and Appeals Department, NCQA Standard Accreditation, and internal monitoring of regulatory requirements for Health Care Services under the direction of the Chief Medical Officer. The Director is responsible for ensuring the Health Care Service's overall regulatory compliance with the Department of Managed Health Care and the Department of Health Care Services (DHCS) contractual responsibilities for Health Care Service Departments. The role is also responsible for overseeing ongoing audit readiness activities for DHCS, DMHC and NCQA. The Director is also responsible in coordinating processes,

activities, and regulatory compliance involving grievances and appeals for all lines of business. The position identifies, analyzes, and coordinates resolution of grievances and appeals.

Utilization Management (UM) Services

The UM and QI Departments are part of the Alliance Health Care Services Department. These departments work collaboratively to ensure that appropriate quality and safe health care is delivered to members in a timely and organized manner. QI ensures that QIHEC can identify improvement opportunities regarding concurrent reviews, tracking key utilization data, and the annual evaluation of UM activities.

The Alliance's Utilization Management (UM) activities are outlined in the UM Program Description which describes the UM program structure, and how UM decisions are made based on evidence-based guidelines, applied in a consistent manner. The Alliance's Case Management (CM) Program works in an integrated manner with the UM Program, in which care coordination and complex case management programs are designed to address the needs of members with complex physical, mental, or social determinant of health needs. Some high-risk populations include seniors and persons with disabilities (SPDs), members with multiple chronic conditions, or members with unmet social determinant of health needs (i.e.: housing or food insecurity). Core Case Management program interventions include outreach, assessment, and care coordination with members and their trusted supports, to ensure the improvement of member outcomes and overall member satisfaction. Care management staff also assist the QI department in QIHE activities through conducting member outreach calls and mailings, as appropriate.

There are identified staff persons dedicated to working with "linked and carved out services" such as East Bay Regional Center, California Children Services (children with complex health care needs), and the Alameda County Behavioral Health Care Department. The UM and CM Program Descriptions are approved by the UMC and QIHEC. For additional information, refer to the UM and CM Program Descriptions.

Pharmacy Services

The Pharmacy Department and QI Department work collaboratively on various QIHE projects. The Pharmacy Department supports patient safety initiatives including working with the Pharmacy Benefit Manager (PerformRx) to inform members, providers, and network pharmacies of medication safety alerts. Responsibilities also include review and update of the formulary through P&T, oversight of the Pharmacy Benefit Manager, and collaboration with QIHEC.

Network Management/Provider Services

The Network Management/Provider Services Department is the primary point of contact for network providers. They assist the QI Department on various QIHE activities with network providers as appropriate as well as disseminating QI information to practitioners. The Department monitors provider capacity and collaborates with Access and Availability in assessing provider satisfaction with Alliance processes and educates providers on monitoring availability and accessibility standards at physician offices, including after-hours coverage. Provider Services staff also assist the QI Department with practitioners who do not comply with requests from QI.

Credentialing Services

The Credentialing staff support the credentialing and re-credentialing processes for practitioners and network providers. The Credentialing staff conducts ongoing monitoring and evaluation of network

practitioners to ensure the safety and quality of services to members. The QI Department provides the Credentialing Department with Facility Site Review and Medical Record audit scores. The Credentialing staff is responsible for coordinating the PRCC meetings.

Member Services and Member Outreach

The Member Services staff fields all member inquiries regarding eligibility, benefits, claims, programs, and access to care. The Communication and Outreach conducts New Member orientations to educate new members about the health plan benefits. Member Services staff also work with the QI Department on member complaints via the PQI referral process and appeals in accordance with established policies and procedures. To assist in improving HEDIS scores, the QI Department may conduct member outreach activities to get HEDIS services completed. Hold messages are used to remind members of plan benefits and services offered while waiting to speak to an agent.

Grievance and Appeals

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into two processes, complaints, and appeals. In both instances, the details of the member's complaints are collected, processed, and reviewed and actions are taken to resolve the issue and Potential Quality Issues are forwarded to QI for review and investigation as needed. QI will continue to collaborate with G&A for assurance of accurate reporting exempt grievance data in 2024.

Methods and Processes for Quality Improvement

The QIHE Program employs a systematic method for identifying opportunities for improvement and evaluating the results of interventions. All program activities are documented in writing and all quality studies are performed on any product line for which it seems relevant. The Alliance QIHE Program follows the recommended performance improvement framework used by the Department of Health Care Services (DHCS). The Alliance Quality department has adopted the DHCS framework based on a modification of the Institute for Health Care Improvement (IHI) Quality Improvement (QI) as a Model of Quality Improvement. Key concepts for DHCS performance improvement projects (PIP) utilize the following framework:

- PIP Initiation
- SMART Aim Data Collection
- Intervention Determination
- Plan-Do-Study-Act
- PIP Conclusion

Identification of Important Aspects of Care

The Alliance uses several methods to identify aspects of care that are the focus of QIHE activities. Some studies are initiated based on performance measured as part of contractual requirements (e.g., HEDIS). Other studies are initiated based on analyses of the demographic and epidemiologic characteristics of Alliance members, health disparities, or identified through surveys and dialogue with our member and provider communities (e.g., CAHPS, provider satisfaction survey). Particular attention is paid to those areas in which members are high risk, high volume, high cost, or problem prone.

Data Sources and Systems

The Alliance utilizes various resources to develop clinical and quality reporting and analyses that provide meaningful and actionable insights. Resources to support the QIHE Program include, but are not limited to the following:

- ODS (Operational Data Store) and Datawarehouse: These are the main databases and the primary sources for all data including member, eligibility, encounter, provider, pharmacy data, lab data, vision, encounters, etc. and claims. The databases are used for storing data required for quality reporting.
- HealthSuite: Claims and eligibility processing system
- CareAnalyzer (DST): used to inform Population Health Management and Population Needs Assessment initiatives and provide QI/UM/CM access to risk-stratified, segmented data that can be effectively applied to target high-risk members for early intervention and improve the overall coordination of care.
- TruCare: in-house medical record and care management system.
- Cotiviti: AAH's NCQA-certified HEDIS software that produces HEDIS/MCAS measure data and outcomes. Data integrity is audited annually through the HEDIS reporting audit process.
- CAHPS 5.1H and CG-CAHPS: Member experience survey via SPH vendor support
- California Immunization Registry (CAIR): Immunization registry information.
- Laboratory results: Data files from Quest, Foundation, and AHS
- Cactus: credentialing database.
- Provider satisfaction and coordination of care surveys via SHP vendor support
- Pre-service, concurrent, post-service and utilization review data (TruCare).
- Member and provider grievance and appeal data.
- Potential Quality of Care Issue Application database used for tracking/trending data.
- Internally developed reports (e.g., asthma and diabetes).
- Provider Appointment Availability Survey (PAAS), after-hours access and emergency instructions. Other clinical or administrative data.

Evaluation

The Analytics Department compiles various data sources to produce reporting and analyses. Quality performance staff analyzes the data to determine variances from established criteria, performance goals, and for clinical issues. Data is analyzed to determine priorities or achievement of a desired outcome. Data is also analyzed to identify disparities based on ethnicity and language. Subsets of our membership may be examined when they are deemed to be particularly vulnerable or at risk.

HEDIS related analyses include investigating trends in provider and member profiling, data preparation (developing business rules for file creation, file creation for HEDIS vendors, mapping proprietary data to vendor and NCQA specifications, data quality review and data clean-up). These activities involve data sets maintained by the Alliance and supplemental files submitted by various trading partners, such as delegated provider organizations and various external health registries and programs (e.g., Quest Diagnostics, and the California Immunization Registry).

Aggregated reports are forwarded to the QIHEC. Status and final reports are submitted to regulatory

agencies as contractually required. Evaluation is documented in committee minutes and attachments.

ACTIONS TAKEN AS A RESULT OF QIHE ACTIVITIES

Action plans are developed and implemented when opportunities for improvement are identified. Each performance improvement plan specifies who or what is expected to change, the person responsible for implementing the change, the appropriate action, and when the action is to take place. Actions will be prioritized according to possible impact on the member or provider in terms of urgency and severity.

Actions taken are documented in reports, minutes, attachments to minutes, and other similar documents.

An evaluation of the effectiveness of each QIHE activity is performed. A re-evaluation will take place after an appropriate interval between implementation of an intervention and remeasurement. The evaluation of effectiveness is described qualitatively and quantitatively, in most cases, compared to previous measurements, with an analysis of statistical significance when indicated.

Based on the HEDIS data presented, areas of focus for 2024 include but are not limited to the following:

- Childhood Immunizations: Combo 10
- Well-Child Visits in the First 15 months of Life
- Well-Child Visits in members 3-15 months of Life
- Well Child Visit 3-21 Years of Age
- Topical Fluoride for Children
- Breast Cancer Screening
- Cervical Cancer Screening
- HbA1c Testing for Diabetics
- Controlling Blood Pressure
- Other non-HEDIS related measures of focus will include but not be limited to:
- Initial Health Appointment
- Emergency Department Visits per 1,000 Members
- PCP Visits per 1,000 Members
- Readmission Rate
- Member Satisfaction Survey: Non-Urgent Appointment Availability
- Screening for Depression
- EPSDT Service Utilization
- Under and Over Service Utilization
- Behavioral Health Care Coordination

TYPES OF QI MEASURES AND ACTIVITIES

Healthcare Effectiveness Data Information Set (HEDIS)

The Managed Care Accountability Set (MCAS) Performance Measures, a subset of HEDIS (Health Effectiveness Data Information Set) are calculated, audited, and reported annually as required by DHCS. Additional measures from HEDIS are also reviewed. A root cause analysis may be performed, and improvement activities initiated for measures not meeting benchmarks.

Consumer Assessment of Health Plan Survey (CAHPS 5.1H and CG-CAHPS)

The Alliance evaluates member experience periodically. Third party vendors conduct the Consumer Assessment of Health Plan Survey (CAHPS). The Alliance assists in the administration of these surveys, receives, and analyzes the results, and follows up with prioritized improvement initiatives. Survey results are distributed to the QIHEC and made available to members and providers upon request. The CAHPS survey is conducted annually for the entire Medi-Cal population and the results from the CAHPS are reported in the annual QIHEC evaluation and used to identify opportunities to improve health care and service for our members.

State of California Measures

DHCS has developed several non-HEDIS measures that the Alliance evaluates. These measures, specified in the Alliance contract with DHCS, involve reporting rates for Developmental Screening in the First Three Years of Life, Topical Fluoride and Under/Over-Utilization Monitoring Measure Set.

State Quality Improvement Activities

DHCS requires Medi-Cal Managed Care plans to conduct at least two QI projects each year. Forms provided by DHCS are used for QI project milestones.

Annually, the Alliance submits its QIHE Program Description, an evaluation of the prior year's QIHE Work Plan and a QIHE Work Plan for the next year. The QIHE Work Plan is updated throughout the year as QIHE activities are designed, implemented, and reassessed.

The Alliance complies with the requirements described in the regulatory All Plan Letters.

Monitoring Satisfaction

The QIHE Program measures member and provider satisfaction using several sources of satisfaction, including the results of the CAHPS survey, the Population Needs Assessment (PNA), the annual DMHC Timely Access survey, plan member and provider satisfaction surveys, complaint and grievance data, disenrollment and retention data, ad hoc member feedback surveys, Community Advisory Committee (CAC), and other data as available. These data sets are presented to the QIHEC and BOG at quarterly and annual intervals. The plan may administer topic specific satisfaction surveys depending on findings of other QIHE studies and activities.

Health Education Activities

The Health Education Program at the Alliance operates as part of the Population and Health Equity Unit of the Quality Improvement Department. The primary goal of Health Education is to improve members' health and well-being through the lifespan through promotion of appropriate use of health care services, preventive health care guidelines: Bright Futures/American Academy of Pediatrics and

U.S. Preventive Services Task Force, healthy lifestyles and condition self-care and management. The primary goal of Health Education is to provide the knowledge needed for Alameda Alliance members to maintain and support their health.

Health education programs include individual, provider, and community-focused health education and disease management activities which address health concerns such as nutrition, injury prevention, maternal health, diabetes, pre-diabetes, asthma, hypertension, and mental health. The Alliance also collaborates on community projects to develop and distribute important health education messages for at risk populations.

Cultural and Linguistic Activities

The Alliance Cultural and Linguistic Services Program operates under the Health Care Services Department. It reflects the Alliance's adherence and commitment to the U.S. Department of Health & Human Services *National Standards for Culturally and Linguistically Appropriate Services* (CLAS). The program offers services and conducts activities designed to ensure that all members have access to quality health care services that are culturally and linguistically appropriate. These activities encompass efforts within the organization, as well as with Alliance members, providers, and our community partners.

Objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer our members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Identify, inform, and assist limited English proficient (LEP) members in accessing quality interpretation services and written information materials in threshold languages.
- Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic services program through cultural sensitivity training.
- Integrate community and Alliance member input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities and services aimed at achieving cultural competence and reducing health care disparities.

The objectives for cultural and linguistic activities are addressed and monitored in the Cultural and Linguistic Services work plan, updated annually.

Disease Surveillance

The Alliance maintains procedures to ensure accurate, timely, and complete reporting of any disease or condition to public health authorities as required by State law. The Provider Manual describes requirements and lists the Public Health Department contact phone and fax numbers.

Patient Safety and Quality of Care

The Alliance QI process incorporates several mechanisms to review incidents that pose potential risk or safety concerns for members. The following activities are performed to demonstrate the Alliance's commitment to improve quality of care and safety of its members via monitoring, investigation, track, and trending of:

- Complaints and grievances and determining quality of care impact.
- Iatrogenic events such as hospital-acquired infections reported on claims and reviewing encounter submissions.
- Inpatient admissions to evaluate and monitor the medical necessity and appropriateness of ongoing care and services. Safety issues may be identified during this review.
- Identified potential quality of care issues.
- Auditing Alliance internal processes/systems and delegated providers.
- Credentialing and re-credentialing of malpractice, license suspension registries, loss of hospital privileges for providers.
- Site review of provider offices for compliance with safety, infection control, emergency, and access standards.
- Operations compliance with local regulatory practices.
- Medication usage (e.g., monitoring the number of rescue medications used by asthmatics).
- Pharmacy benefit management to notify members and providers of medication recalls and warnings.
- Reviewing hospital readmission reports.
- Improve continuity and coordination of care between practitioners.
- Quality of care issues related to Long Term Care
- In addition to providing educational outreach to members (e.g., member newsletter, telephonic outreach) on patient safety topics including questions asked prior to surgery and questions asked about drug-drug interaction.

Quality issues are referred to the QI Department to evaluate the issue, develop an intervention and involve the CMO when necessary.

LONG TERM CARE QUALITY MONITORING

The Alliance maintains a comprehensive Quality Assurance Performance Improvement (QAPI) monitoring program for Long Term Care (LTC) services which includes on-going review of the following:

- A table-top review of quality assurance and improvement findings from California Department of Public Health (CDPH) to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings.
- Review of QAPI programs in LTC (i.e. SNFs and Subacute) based on an attestation of compliance by the facilities of the five key elements identified by CMS:
  - Element 1: Design and Scope
  - Element 2: Governance and Leadership
  - Element 3: Feedback, Data Systems and Monitoring
  - Element 4: Performance Improvement Projects (PIPs)
  - Element 5: Systematic Analysis and Systemic Action
- Review of CMS Quality Star ratings
- Monitoring of quality measures for LTC within the Managed Care Accountability Set (MCAS) of

performance measures, such as emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions.
- Review and investigation of Potential Quality Issues (PQIs)
- In collaboration with the LTC team, the Alliance monitors the quality and appropriateness of care furnished to members using LTSS, including:
  - Assessment of care between care settings and a comparison of services and supports received with those set forth, and
  - Efforts supporting member community integration.
    When significant trends or non-compliance related to the QAPI program are noted, medical chart reviews or on-site visits will be conducted for LTC facilities as appropriate. Corrective action plans may be issued to address and resolve deficiencies in the quality of care of residents.

For Intermediate Care Facility for Developmentally Disabled (ICF/DD) Homes, quality monitoring includes the review of compliance findings and data from CDPH as well as service delivery findings from the Regional Centers established in the Memoranda of Understanding. Monitoring includes, but not limited to:

- Any applicable performance measures (as mutually agreed upon)
- QI initiatives as well as reports that track cross-system referrals.
- Member engagement
- Service utilization and to prevent duplication of services rendered.

On-going monitoring reports are reported to the quality committees, including IQIC and QIHEC on an as needed basis.

HEALTH EQUITY ACTIVITIES

The Alliance is committed to Health Equity by mitigating social determinants of health to prevent and reduce health disparities and health inequities that adversely affect vulnerable populations. Health Equity is integrated throughout the organization and is a collaborative effort across multiple departments. As part of the QIHE Program, the Alliance monitors and addresses member access, experience, and clinical outcome disparities by analyzing data stratified by race, ethnicity, and language (REL). According to specific standards and/or strategies, the QIHE Program involves implementing systematic and continuous activities to monitor, evaluate, and improve upon the health equity and health care delivered to our members. There is alignment with the Alliance Population Health Strategy and related activities. The QIHEC is responsible for overseeing the QIHE Program, including activities to identify and close health disparity gaps, providing feedback to meet goals/benchmarks as set forth by governing agencies (i.e., DHCS, DMHC, or NCQA), and to recommend required actions.

ACCESS AND AVAILABILITY

The Alliance implements mechanisms to maintain an adequate network of primary care providers (PCP) and high volume and high impact specialty care providers. Alliance policy defines the types of practitioners who may serve as PCPs. Policies and procedures establish standards for the number and geographic distribution of PCPs and high-volume specialists. The Alliance monitors and assesses the cultural, ethnic, racial, and linguistic needs and preferences of members, and adjusts availability of network providers, if necessary.

The following services are also monitored for access and availability:

- Children's preventive periodic health assessments/EPSDT
- Adult preventative health screenings
- Initial health appointments

The QIHE Program collaborates with the Provider Services Department to monitor access and availability of care including member wait times and access to practitioners for routine, urgent, emergent, and preventive, specialty, and after-hours care. Access to medical care is ensured by monitoring compliance with timely access standards for practitioner office appointments, telephone practices, and appointment availability. The QIHEC also oversees appropriate access standards for appointment wait times. Alliance appointment access standards are no longer than DMHC and DHCS established standards. The Provider Manual, virtual/onsite visits and periodic fax blasts to educate providers on Timely Access Standards.

The QIHEC reviews the following data and makes recommendations for intervention and quality activities when network availability and access improvement is indicated:

- Member complaints about access.
- CAHPS 5.1H and CG-CAHPS results for wait times and telephone practices.
- HEDIS measures for well child and adolescent primary care visits.
- Immunizations.
- Emergency room utilization.
- Facility site review findings.
- The review of specialty care authorization denials and appeals.
- Additional studies and surveys may be designed to measure and monitor access.

BEHAVIORAL HEALTH QUALITY

The Alliance maintains procedures for monitoring the coordination and quality of behavioral healthcare provided to all members including, but not limited to, all medically necessary services across the health care network. The Alliance reports activities in behavioral healthcare at QIHEC meetings to monitor, support, and improve behavioral healthcare aspects of QI.

Prior to April 1, 2023, behavioral health services were delegated to Beacon Health Strategies, an NCQA Accredited MBHO, except for Specialty Behavioral Health for Medi-Cal members, which is excluded from the Alliance contract with DHCS. The Specialty Behavioral Health Services are coordinated under a Memorandum of Understanding between the Alliance and Alameda County Behavioral Health (ACBH).

Some primary care physicians may choose to treat mild mental health conditions. As of April 1, 2023, Behavioral Health Services were insourced and became the responsibility of the health plan. The Alliance includes the involvement of a Senior Director of Behavioral Health in program oversight and implementation. The Alliance will review behavioral health quality, utilization, and member satisfaction quarterly reports in its standing sub-committee meetings to ensure members obtain necessary and appropriate behavioral health services.

Please see the UM / CM Program Description for additional information.

COORDINATION, CONTINUITY OF CARE AND TRANSITIONS

Member care transitions present the greatest opportunity to improve quality of care and decrease safety risks by ensuring coordination and continuity of health care as members transfer between different locations or different levels of care within the same location and/or across the healthcare continuum.

The Alliance Health Care Services focuses on interventions that support planned and unplanned transitions and promote chronic disease self-management. Primary goals of the department are to reduce unplanned transitions, prevent avoidable transitions and maintain members in the least restrictive setting possible.

Comprehensive case management services are available to each member. It is the PCP's responsibility to act as the primary case manager to all assigned members. Members have access to these services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. All services are provided in a culturally and linguistically appropriate manner.

Members who may need or are receiving services from out-of-network providers are identified. Procedures ensure these members receive medically necessary coordinated services and joint case management, if indicated. Written policies and procedures direct the coordination of care for the following:

- Services for Children with Special Health Care Needs (CSHCN).
- California Children's Service (CCS) eligible children are identified and referred to the local CCS program.
- Overall coordination and case management for members who obtain Child Health and Disability Prevention Program (CHDP) services through local school districts or sites.
- Early Start eligible children are identified and referred to the local program.
- Members with developmental difficulties are referred to the Regional Center of the East Bay for evaluation and access to developmental services.

All new Medi-Cal members are expected to receive an Initial Health Appointment (IHA) within 120 days of their enrollment with the plan. Members are informed of the importance of scheduling and receiving an IHA from their PCP. The Provider Manual informs the PCP about the IHA, the HRA (for SPDs), and recommended forms. All new Medi-Cal members also receive a Health Information Form\Member Information Tool (HIF\MET) in the New Member Packet upon enrollment. The Alliance ensures coordination of care with primary care for all members who return the form with a condition that requires follow up.

The Alliance coordinates with PCPs to encourage members to schedule their IHA appointment. The medical record audit of the site review process is used to monitor whether baseline assessments and evaluations are sufficient to identify CCS eligible conditions, and if medically necessary follow-up services and referrals are documented in the member's medical record.

COMPLEX CASE MANAGEMENT PROCESS

All Alliance members are potentially eligible for participation in the complex case management program. The purpose of the complex case management program is to provide the case management process and structure to a member who has complex health issues and medical conditions. The components of the Alliance complex case management program encompass member identification and selection; member assessment; member-centered care plan development, implementation, and management; evaluation of the member care plan; and closure of the case. Program structure is designed to promote quality case management, client satisfaction and cost efficiency using collaborative communication, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

The complex case management program's objectives are concrete measures that assess effectiveness and progress toward the overall program goal of making high-quality health care services accessible and affordable to Alliance membership. The Chief Medical Officer, Senior Director of Health Care Services, Director of Social Determinants of Health, and Manager of Case and Disease Management develop and monitor the objectives. The QIHEC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with case management services as measured by member satisfaction rates.
- Improving functional health status of complex case management members as measured by member self-reports of health condition.

The complex case management program is a supportive and dynamic resource that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.

The Alliance annually measures the effectiveness of its complex case management program based on the following measures (detailed information can be found in the Comprehensive Case Management Program Description):

1. Satisfaction with case management services - members are mailed a survey after case closure and are asked to rate experiences and various aspects of the program's service.
2. All-cause readmission rates - the Alliance measures admission rates for all causes within six months of being enrolled in complex case management.
3. Emergency room visit rate - the Alliance measures emergency room visit rates among members enrolled in complex case management.
4. Health status rate - the Alliance measures the percentage of members who received complex case management services and responded that their health status improved because of complex case management services.
5. Use of appropriate health care services - The Alliance measures enrolled members' office visit activity, to ensure members seek ongoing clinical care within the Alliance network.

The Chief Medical Officer and the Senior Director of Health Care Services collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the QIHEC for review and feedback. The QIHEC makes recommendations for improvement and interventions to improve program performance, as appropriate.

DISEASE MANAGEMENT PROGRAM

The Alliance offers its members a disease management program. The purpose of the disease management program is to provide coordinated health care interventions and communications to both pediatric and adult members with chronic asthma and adults with diabetes to support disease self-management and promote healthy outcomes. This is accomplished through the provision of interventions based on member acuity level. The intervention activities range from case management for those members at high risk, offering health coaching, educational materials, and care coordination to those members who may have gaps in care. The components of the Alliance disease management program include member identification and risk stratification, identification of gaps in care and health inequities, member outreach, provision of case management and health coaching services, and condition-specific education.

Program structure is designed to follow the National Committee for Quality and Assurance (NCQA) Population Health Management (PHM) standards. The program promotes quality condition management, member satisfaction and cost efficiency using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes. In 2024 the Alliance Disease Management Program focuses on four conditions Asthma, Diabetes, Perinatal Depression and Cardiovascular Disease.

The objectives of the disease management program are concrete measures that assess effectiveness and progress toward the overall program goals of meeting the health care needs of members and actively supporting members and practitioners to manage chronic asthma and diabetes. The QIHEC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the disease management program include:

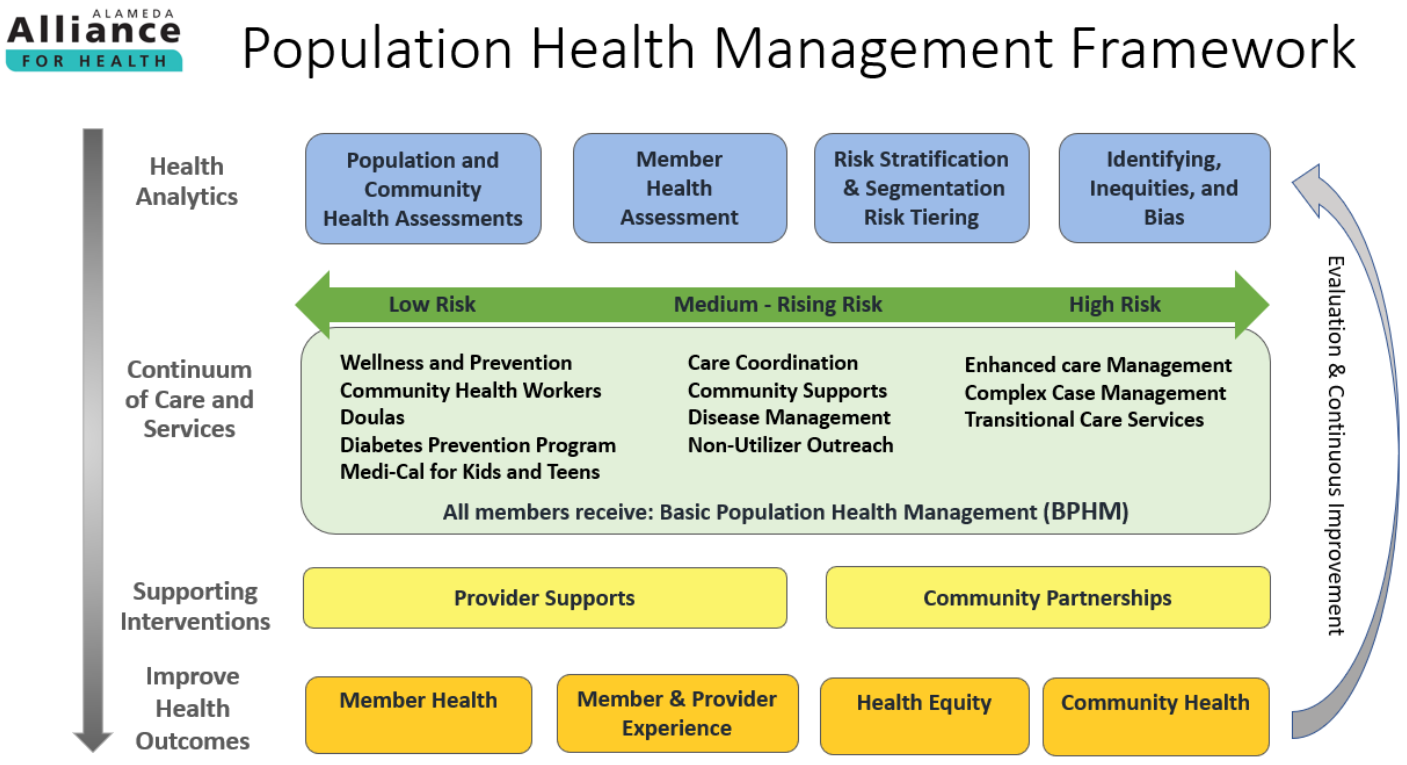
- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with disease management services as measured by member satisfaction rates.
- Reducing gaps in care as measured by HEDIS clinical effectiveness measures specific to the management of asthma and diabetes.
- Addressing inequities related to chronic conditions.

POPULATION HEALTH MANAGEMENT (PHM) PROGRAM

Alameda Alliance for Health has a Population Health Management (PHM) Program that identifies member needs across the continuum of care and ensures access to a comprehensive set of services with the aim of improving health outcomes and supporting an enhanced quality of life. This continuum includes intensive case management and support for members with the highest levels of needs, programs and interventions for those with emerging risks, and basic population health management for all members. The Alliance PHM Program follows the NCQA 2024 Population Health Program Standards and Guidelines and aligns with the California Department of Health Care Services Population Health Management Policy Guide.

The PHM Program strives to target and close gaps in care and address upstream drivers of health disparities by addressing the social drivers of health (SDOH) that cause those disparities. The PHM Program is monitored via the Population Health Committee, which is comprised of representatives from Quality Improvement, Utilization Management, Case Management, Behavioral Health, Pharmacy and Quality Assurance. In addition, overall outcomes, and findings from the Alliance population health assessments, population health strategy and evaluations are presented, reviewed, and approved by the Quality Improvement Health Equity Committee (QIHEC).

The Alliance PHM Framework illustrates how health analytics, a continuum of care and services, and supporting interventions, and evaluation lead to improved health outcomes. The Alliance's continuum of care and services aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through best practice and culturally affirming member's needs.



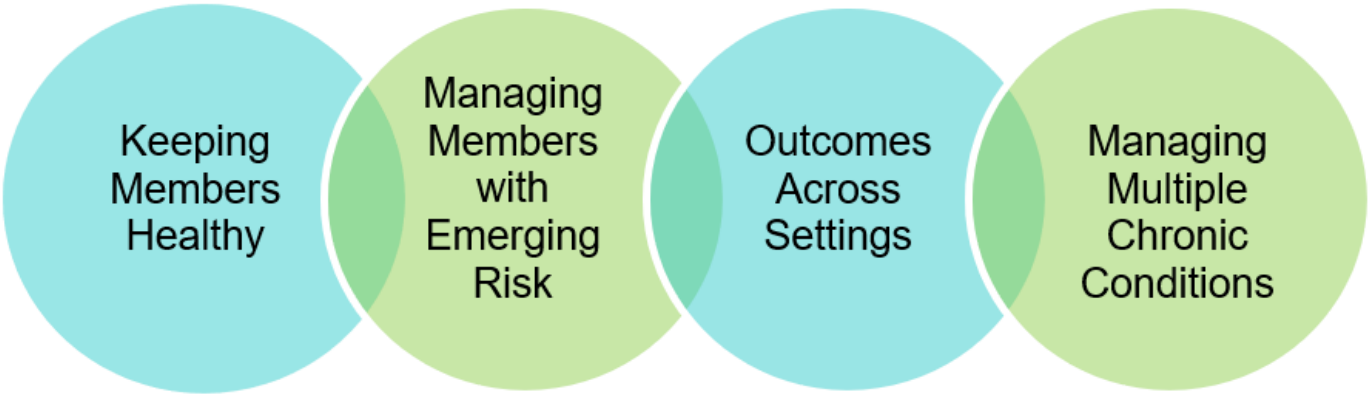
Addressing social determinants of health to promote health equity.

The Alliance updates its PHM Strategy annually and uses it to:

- Improve case management programs including Complex Case Management (CCM), Enhanced Care Management (ECM), Community Supports (CS), and Transitional Care Services (TCS).
- Support development of basic population health activities to promote self-management of conditions and preventative care.
- Inform quality improvement projects.
- Guide development of health education materials and programs.
- Influence interventions that target member safety and outcomes across settings.
- Better understand utilization and identify high-risk members.
- Address identified health inequities.

The Alliance PHM strategy addresses four focus areas of population health that promote a whole-person approach to identify members at risk, and to provide strategies, programs, and services to mitigate or reduce that risk. The strategy has 4 areas of focus:

Four Areas of Focus



The Population Health Strategy includes:

- Population health assessment
- Population risk stratification and segmentation
- PHM Strategy goals and programs
- Integration of Community Resources
- Delivery systems provider support structures:
- Sharing data – provider measures and gaps in care
- Quality Dashboards – HEDIS measure-specific data
- Comparable Data – Peer performance, local averages, and national benchmarks
- Value-Based Payment Programs
- Ongoing Education/Support – Provider Newsletters & Education

The Alliance Population Health Management Assessment and Strategy can be found in separate documents. The Alliance Population Health Evaluation is included in the QI Evaluation.

SENIORS AND PERSONS WITH DISABILITY (SPD)

The Alliance categories all new SPD members as high risk. High risk members are contacted for an HRA within 45 calendar days and low risk members are contacted within 105 calendar days from their date of enrollment. Existing SPD members receive an annual HRA on their anniversary date. The objectives of an HRA are to assess the health status, estimate health risk, and address members' needs relating to medical, specialty, pharmacy, and community resources. Alliance staff uses the responses to the HRAs, along with any relevant clinical information, to generate care plans with interventions to decrease health risks and improve care management.

DHCS has established performance measures to evaluate the quality of care delivered to the SPD population using HEDIS measures and a hospital readmissions measure.

PROVIDER COMMUNICATION

The Alliance contracts with its providers to foster open communication and cooperation with QIHE activities:

- Provider cooperation with QIHE activities.
- Plan access to provider medical records to the extent permitted by state and federal law.
- Provider maintenance of medical record confidentiality.
- Open provider-patient communication about treatment alternatives for medically necessary and appropriate care.
- Provider regulatory requirements

Provider involvement in the QIHE Program occurs through membership in standing and ad-hoc committees, Joint Operating Committee meetings, and attendance at BOG and QIHEC meetings. Providers and members may request copies of the QIHE Program description, work plan, and annual evaluation. Provider participation is essential to the success of QIHE studies including HEDIS and those that focus on improving aspects of member care. Additionally, providing feedback on surveys and questionnaires is encouraged as a means of continuously improving the QIHE Program.

Providers have an opportunity to review the findings of the QIHE Program through a variety of mechanisms. The QIHEC reports findings from QIHE activities to the BOG, at least quarterly. Findings include aggregate results, comparisons to benchmarks, deviation from threshold, drill-down results for provider group or type, race/ethnicity, and language, and other demographic or clinical factors. Findings are distributed directly to the provider when data is provider specific. Findings are included in an annual evaluation of the QIHE Program and made available to providers and members upon request. The Provider Bulletin contains a calendar of future BOG and standing committee dates and times.

EVALUATION OF QIHE PROGRAM (SEPARATE DOCUMENT)

The QIHEC reviews, makes recommendations, and approves a written evaluation of the overall effectiveness of the QIHE Program on an annual basis. The evaluation includes, at a minimum:

- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Allocation of resources to support the program.
- Comparison of results with goals and targets.
- Tracking and trending of key indicators.
- Description of completed and ongoing QIHE activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or opportunities.
- Recommendations for goals, targets, activities, or priorities in subsequent QIHE Work Plan.

The review and revision of the program may be conducted more frequently as deemed appropriate by the QIHEC, CMO, CHEO, CEO, or BOG. The QIHEC's recommendations for revision are incorporated into the QIHE Program Description, as appropriate, which is reviewed by the BOG and submitted to DHCS on an annual basis.

ANNUAL QIHE WORK PLAN (SEPARATE DOCUMENT)

A QIHE Work Plan is received and approved annually by the QIHEC. The work plan describes the QIHE goals and objectives, planned projects, and activities for the year, including continued follow-up on previously identified quality issues, and a mechanism for adding new activities to the plan as needed. The QIHE work plan delineates the responsible party and the time frame in which planned activities will be implemented.

The work plan is included as a separate document and addresses the following:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Members’ experience
- Health equity activities
- Yearly planned activities and objectives
- Time frame within which each activity is to be achieved.
- The staff member responsible for each activity
- Monitoring previously identified issues.
- Evaluation of the QIHE Program

Progress on completion of activities in the QIHE work plan is reported to the QIHEC quarterly. A summary of this progress will be reported by the CMO to the BOG.

SUPPORTING DOCUMENTS

In addition to this program description, the annual evaluation and work plan, the other additional documents important in communicating QI policies and procedures include:

- "Provider Manual" provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's QIHE Program is included in the provider manual. It is distributed to all contracted provider sites.
- "Provider Bulletin" is a newsletter distributed to all contracted provider sites on topics of relevance to the provider community, and can include QI policies, procedures, and activities.
- "Alliance Alert" is the member newsletter that also serves as a vehicle to inform members of QI policies and activities.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the QIHE Program information is available on the Alliance website.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All employees, contracted providers, delegated medical groups and sub-contractors of the Alliance maintain the confidentiality of personally identifiable health information, medical records, peer review, internal and external, and internal electronic transmissions, and quality improvement records. They will ensure that these records and information are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. All information used in QIHE activities is maintained as confidential in compliance with applicable federal and state laws and regulations.

Access to member or provider-specific peer review and other QI information is restricted to individuals and/or committees responsible for these activities. Outside parties asking for information about QIHE activities must submit a written request to the CMO. Release of all information will be in accordance with state and federal laws.

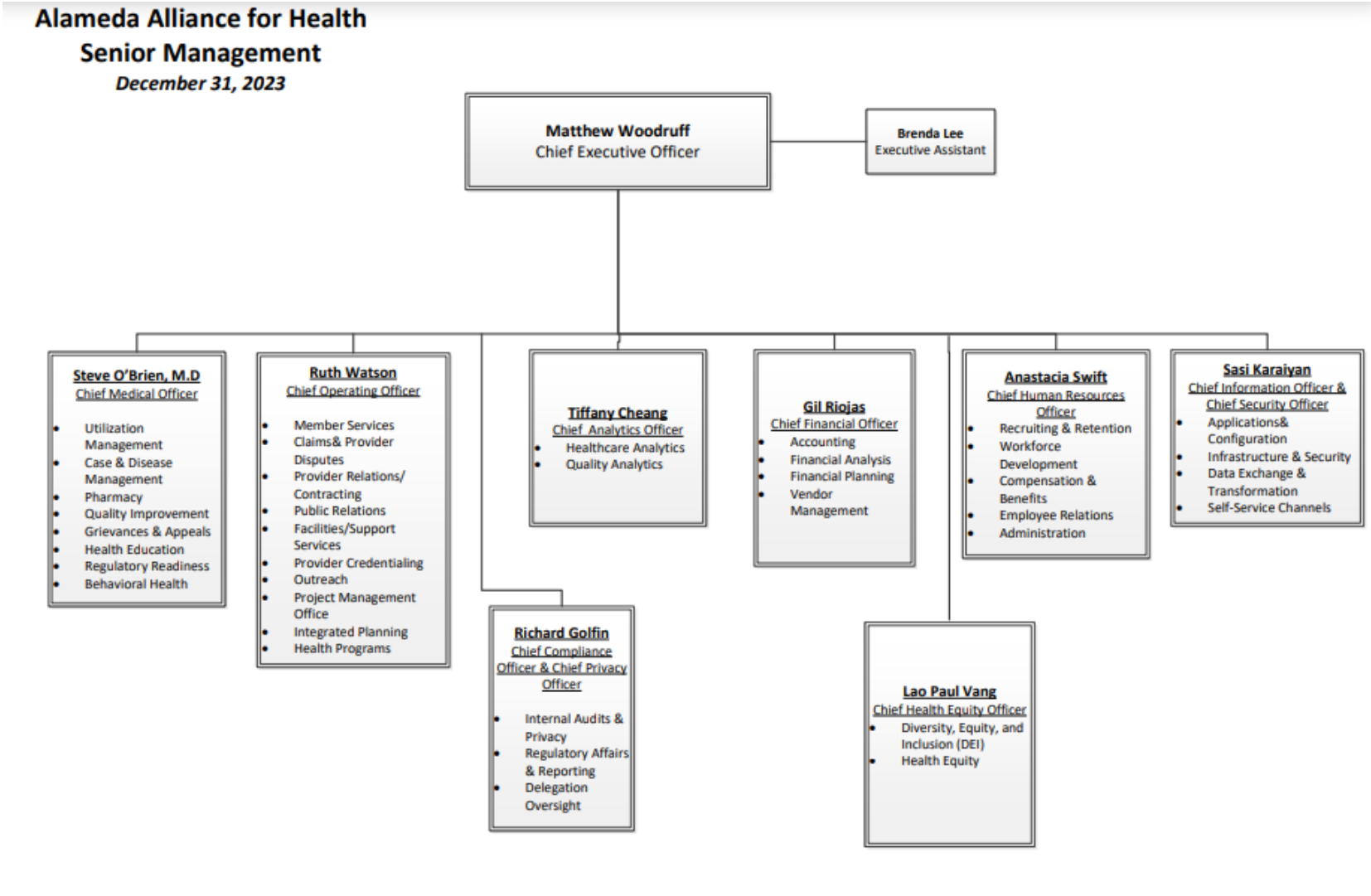
All providers participating in the QIHEC or any of its subcommittees, or other QIHE Program activities involving review of member or provider records, will be required to sign and annually renew confidentiality and conflict of interest agreements. Guests or additional Alliance staff attending QIHEC meetings will sign a confidentiality agreement.

Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

All QIHEC meeting materials and minutes are marked with the statement "Confidential". Copies of QIHE meeting documents and other QIHE data are maintained separately and secured to ensure strict confidentiality.

APPENDIX A: Organizational Charts

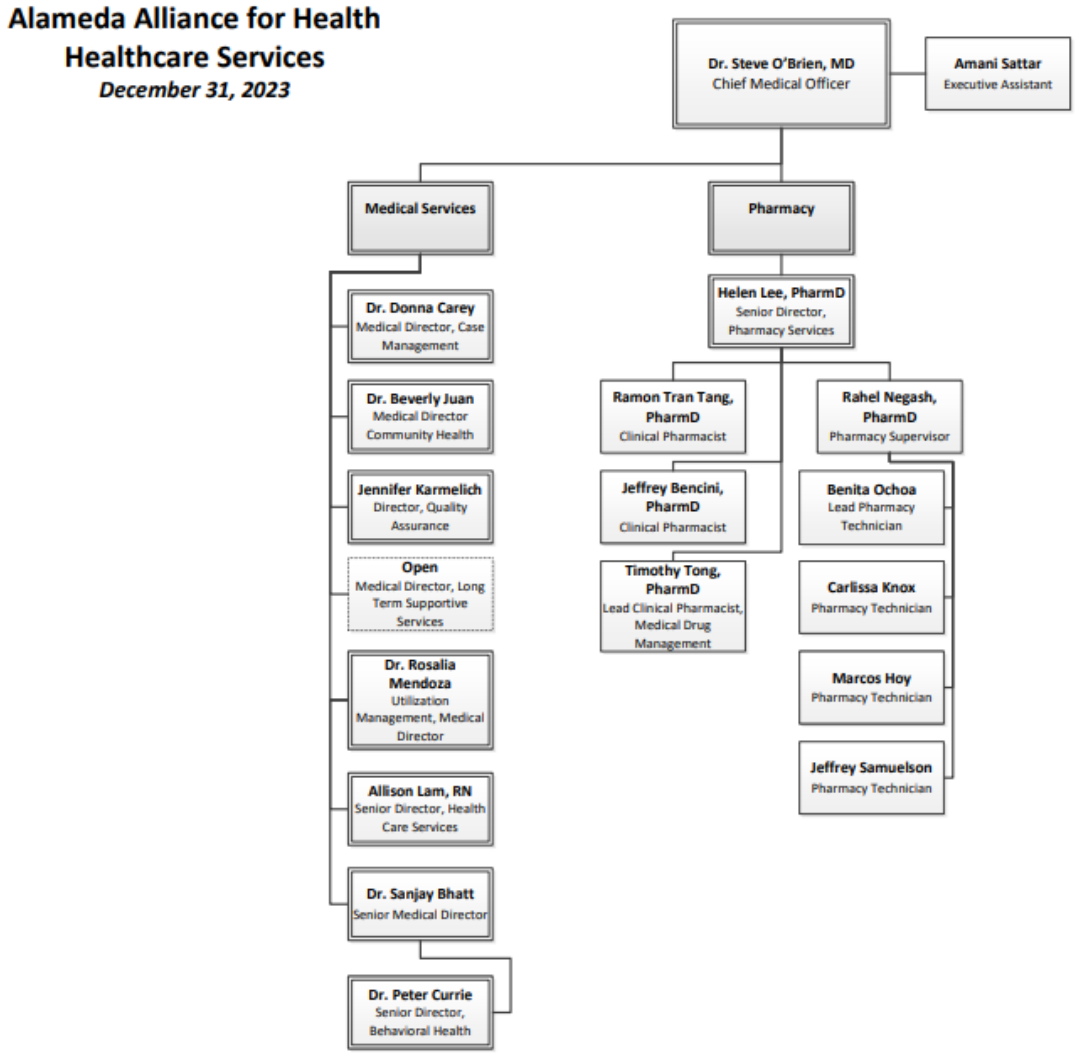
Senior Management



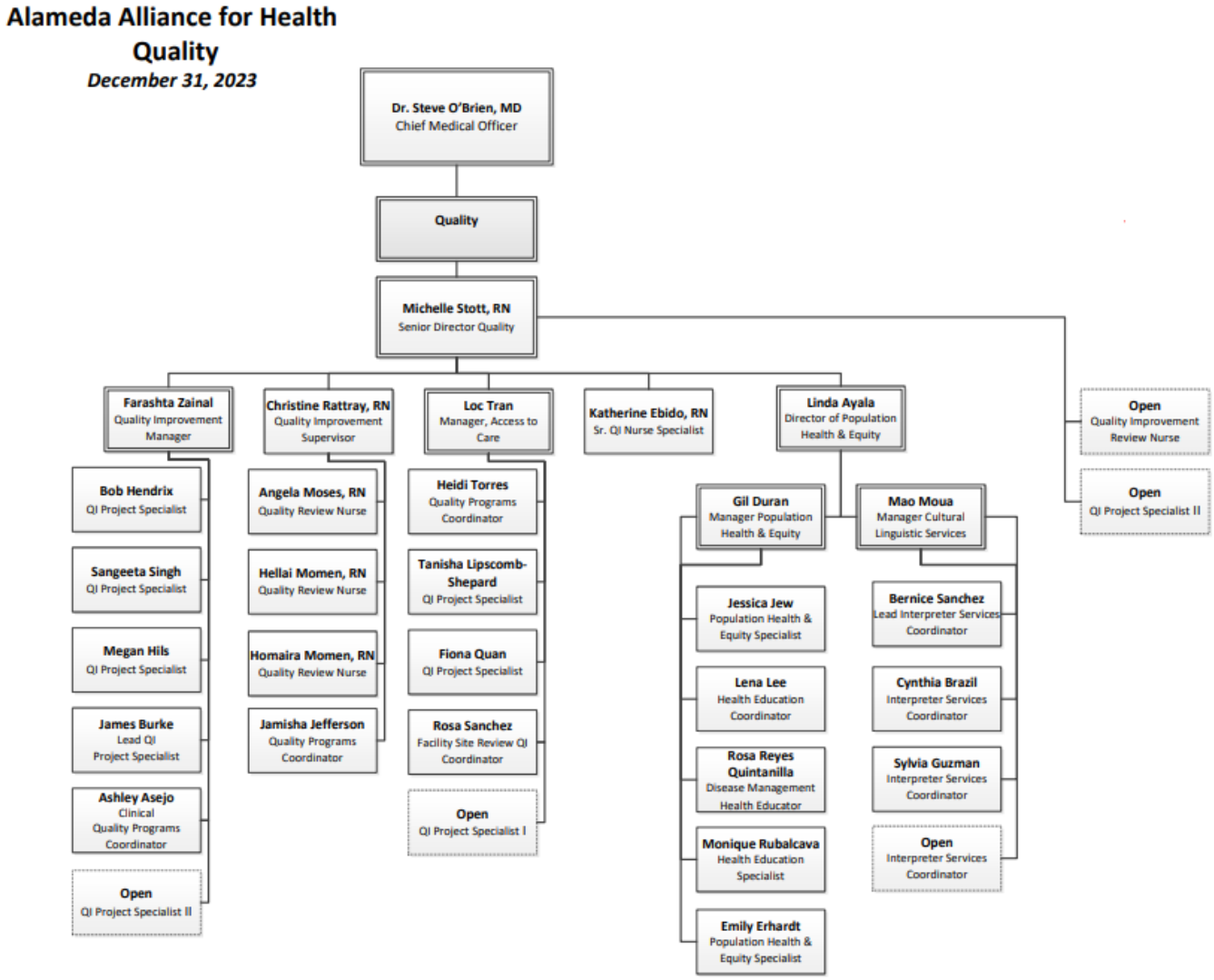
Health Equity

Alameda Alliance for Health
Health Equity
December 31, 2023

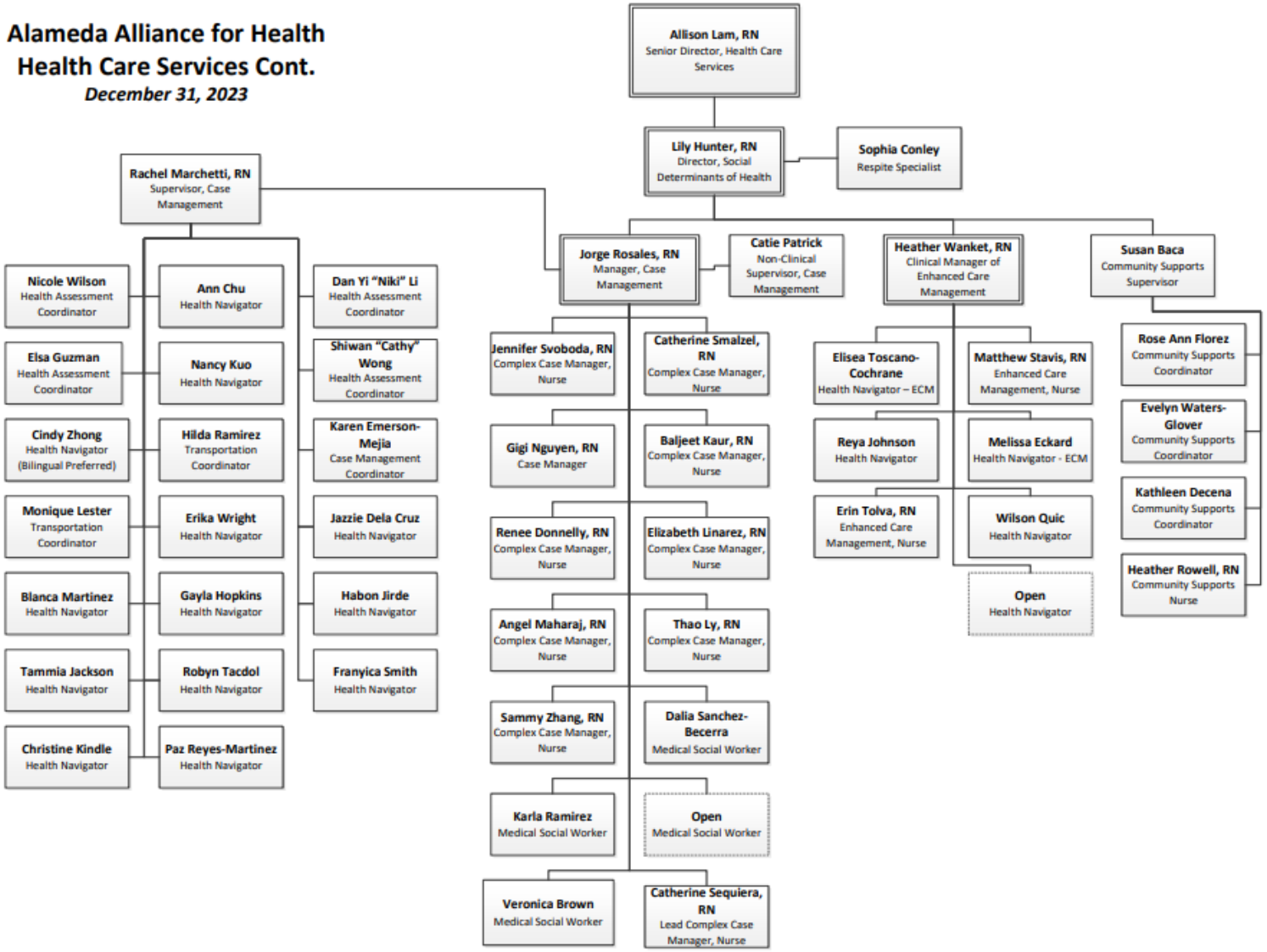
Medical Services and Pharmacy



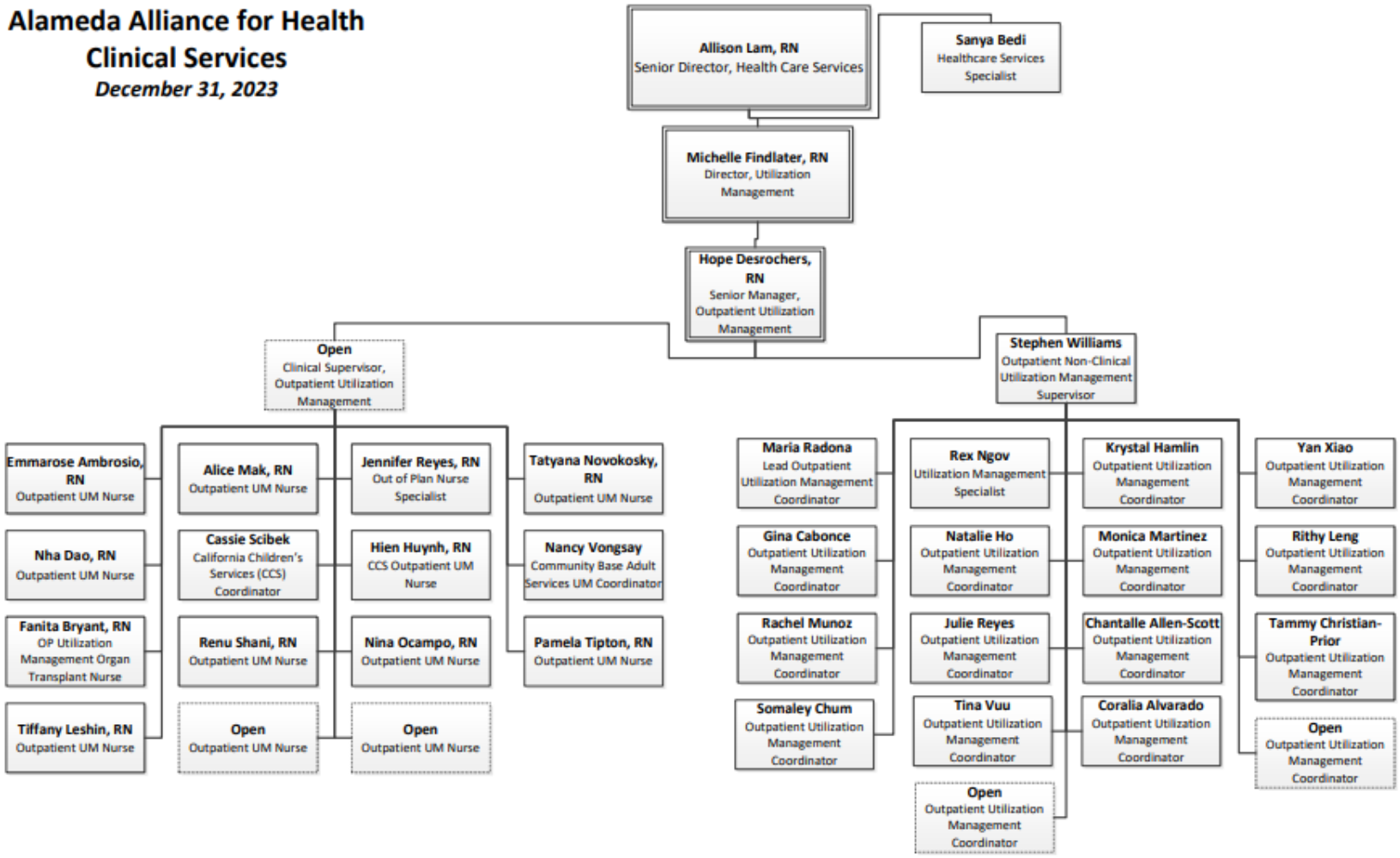
Health Care Services – Quality



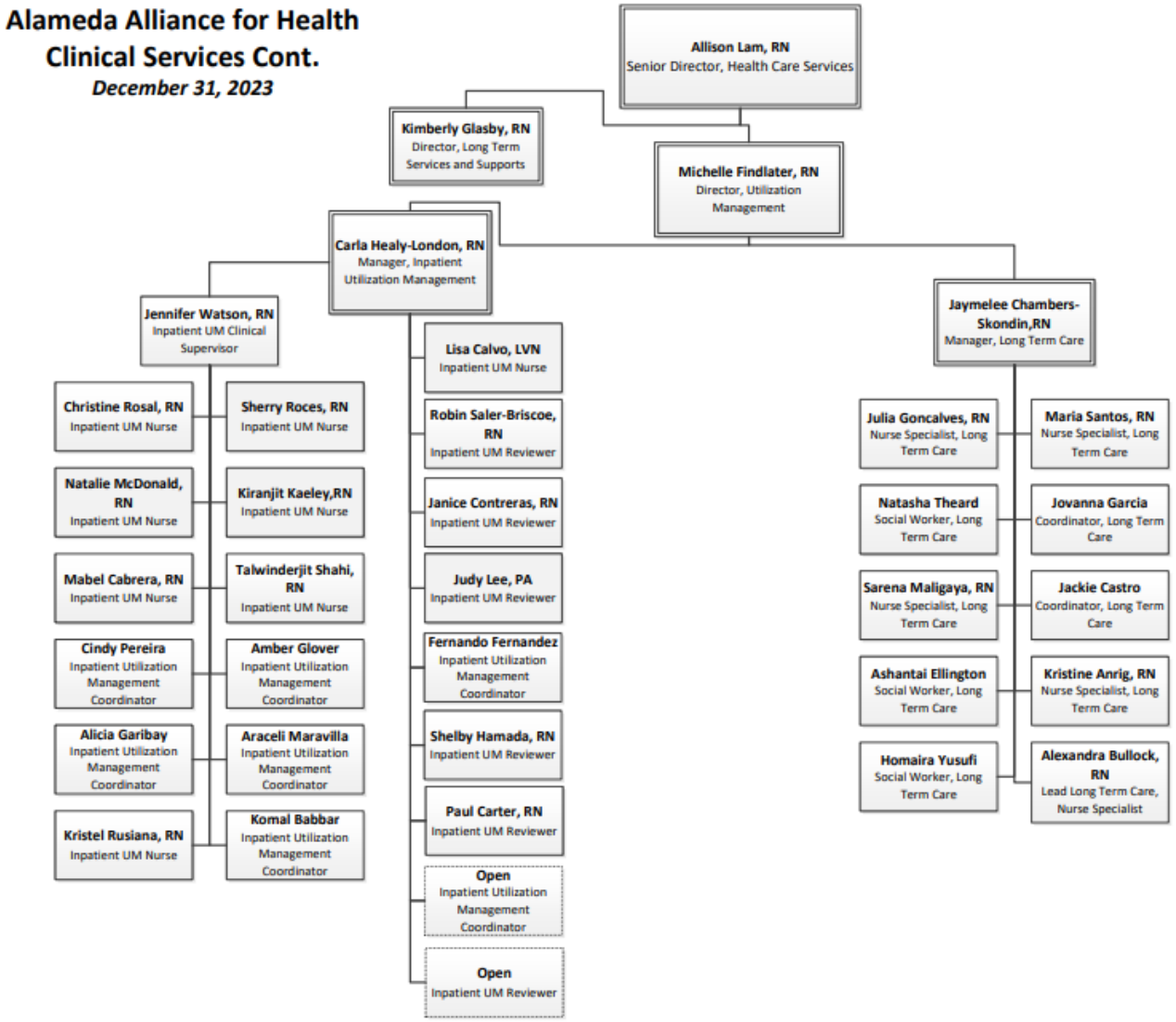
Case Management



Utilization Management - Outpatient

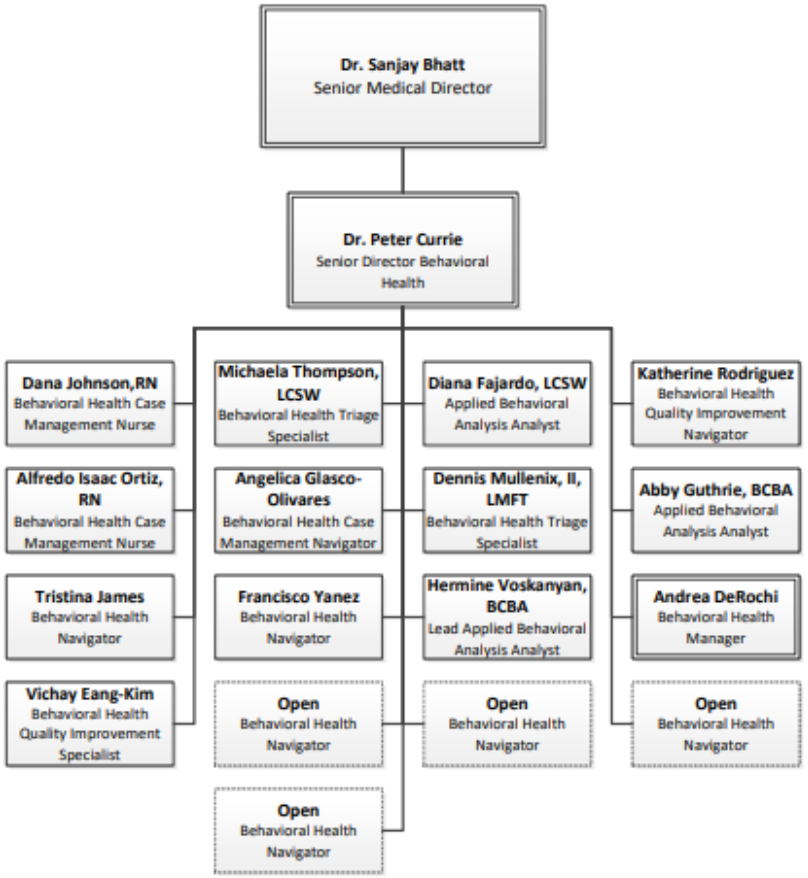


Utilization Management – Inpatient and Long Term Care

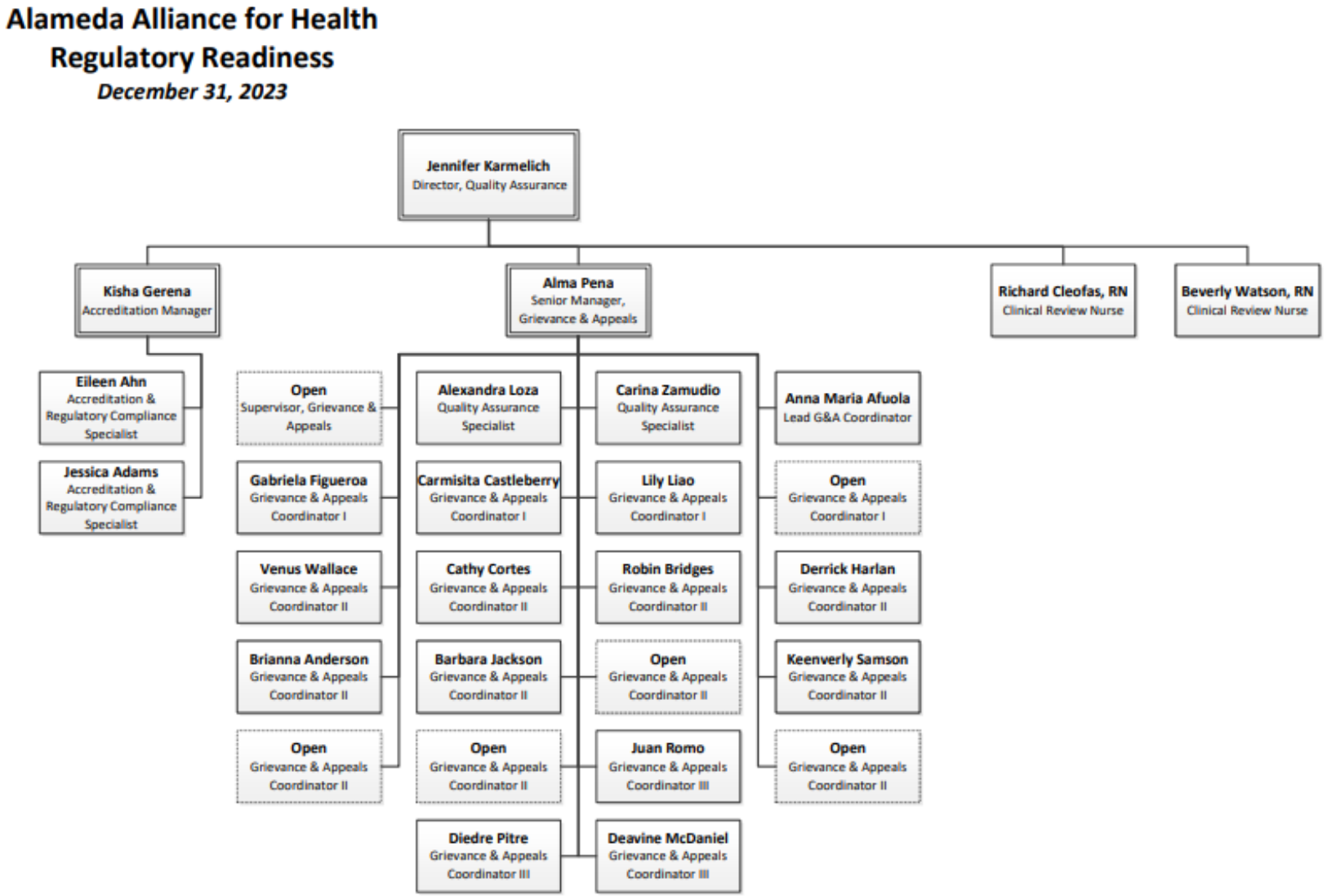


Behavioral Health

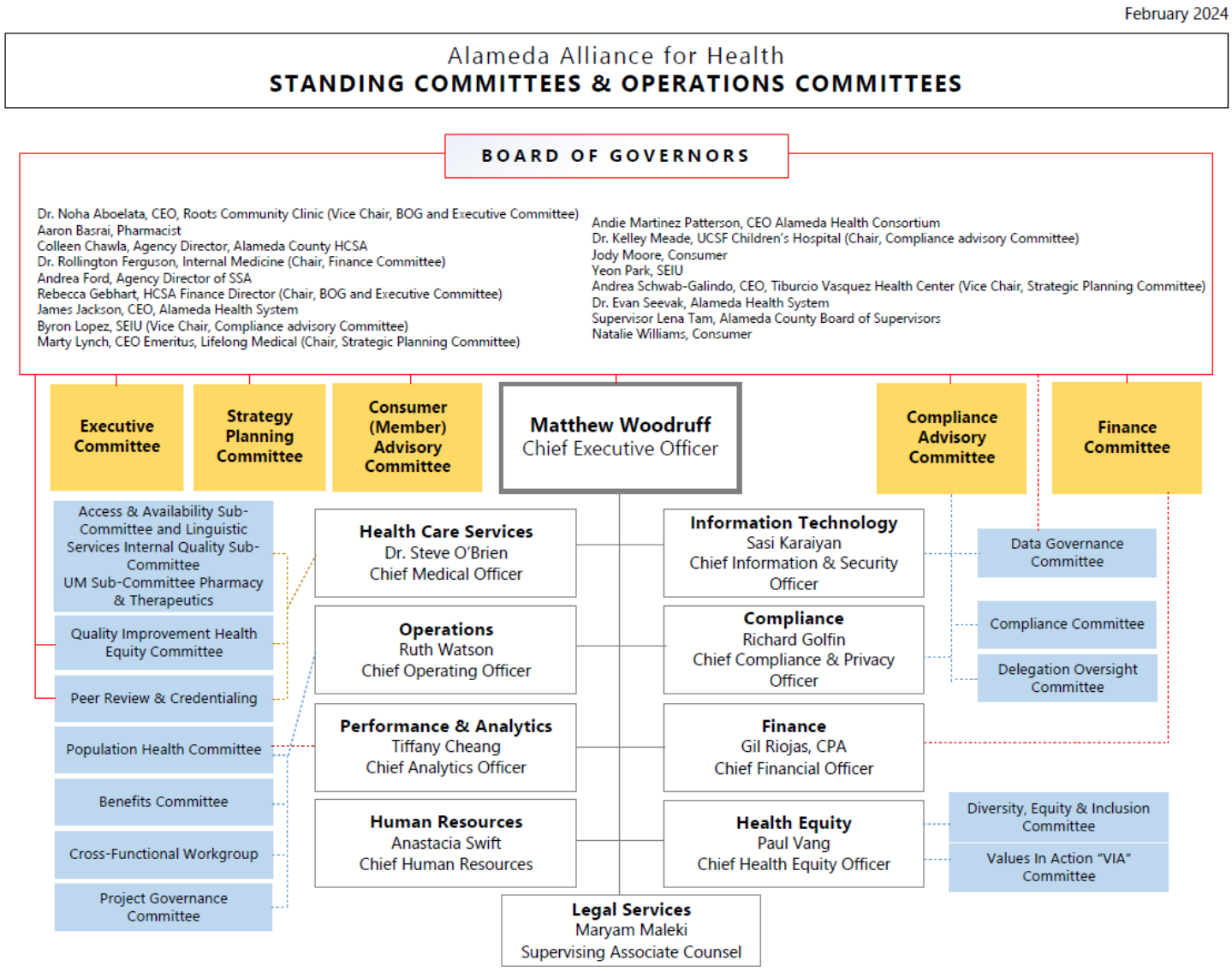
Alameda Alliance for Health
Behavioral Health
December 31, 2023



Regulatory Readiness



APPENDIX B: Alameda Alliance Committees



2024 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2024	Q2, 2024	Q3, 2024	Q4, 2024	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	**Y**	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.				All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
Quality of Care													
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Manager Name: Farashta Zainal	**HEDIS Rates MY 2024**	**N**	**Continued**	Increase the HEDIS/MCAS measures below MPL in MY2023 to meet or exceed MPL by December 31, 2024					Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	Due to the pandemic AAH saw a decline in HEDIS measures with multiple years of service. Furthermore, state wide insufficent lead screening kits may be a factor in declining lead screening rates.
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**HEDIS Retrieval and Overreads MY 2024**	**N**	**Continued**	Alongside the analytics team, provide HEDIS support related to medical record retrieval, abstraction, and overreads. The goal is to overread 20% of the abstracted charts for the hybrid measures.	CHCN record retrievals completed. Change Healthcare experienced a data breach in February which impacted measure trainings and completing abstractions and overreads; access to all Change Healthcare systems was cut off. Team is now working with Datavant for abstraction and overreads as of March. Measure training and overread process will begin in April.				Internal Quality Improvement Committee Quality Improvement Health Equity Committee	5/02/2024	The quality analytics team benefits from QI partnership in completing their goal of 100% overreads to reduce errors in the HEDIS data submission
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Lead QI Project Specialist Name: James Burke	**Pay For Performance (P4P) 2024**	**N**	**Continued**	Incentivizes providers to improve care on P4P measures with quarterly QI oversight. Facilitate webinars to discuss P4P updates, best practices and answer questions. - meet with 100% of the delegates by December 31, 2024 - meet with at least 30% of Directs by January 30, 2025	Trainings in January completed for Direct providers on 01/11/24 and 01/24/24. Total Providers in Attendance of both sessions: 19				Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	The P4P program has been a successful tool used to support providers improve HEDIS rates
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal 2024: Linda Ayala(?)	Title: Lead QI Project Specialist Name: James Burke	**Health Equity Incentive Pilot**	**Y**	**New**	Incentivizes providers to close care gaps on 3 measures (W15, CCS and CBP) with a focus on race/ethnicities that were 5% below the overal admin rate in 2022. - Facilitate webinars to discuss Health Equity Incentive Pilot - Share care gap reports - Support providers on meeting equity goals	Training provided to Delegates in December of 2024 and Directs in January of 2024.				Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**QI PDSA Cycle Training**	**N**	**Continued**	By December 31, 2024, offer two training opportunities for provider participation in learning and applying the PDSA methodology.	ABCs of QI Collaboration completed with CHCN in the month of Feburary 2024: -02/13/24: 20 attendees -02/20/24: 11 attendees -02/27/24: 12 attendees	Planning for ABCs of QI series in July 2024, open to all providers and all Alliance employees.			All Sub-Committees	6/30/2024	As quality improvement (QI) projects spread throughout the Health Care Service team, it is essential that all staff have an understanding of the PDSA model for improvement. The model provides a vehical to drive QI projects
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Priority PIP: Improve FUA/FUM - improve 30 day follow-up rate**	**N**	**Continued**	Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 30 days of emergency department (ED) by December 31, 2025	Baseline data submission due Sep 11, 2024. HSAG will conduct training in June 2024 to review submission requirements. New QIPS staff member Kalkidan (Kalé) Asrat will co-lead work on PIP. Megan and Kalé will meet to complete causal/barrier analysis.				Internal Quality Improvement Committee	12/31/2025	This is a newly assigned PIP. PIP topic was assigned by the state based on low performance
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Bob Hendrix	**Equity PIP: Improve Well Child - W15 (6) for African American Children**	**Y**	**Continued**	To address the disparity that exists with Well Child visits, by December 31, 2025, increase the percentage of well-child visits (W30-6) amongst African American children between the ages of 0-15 months from 30.54% to MPL.					Internal Quality Improvement Committee	12/31/2025	This is a newly assigned PIP. PIP topic was assigned by the state based on low performance
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Sangeeta Singh	**Workgroup: Women's Health**	**N**	**Continued**	By December 31, 2024, the Alliance will improve on women's health measures in the MCAS/P4P, by conducting improvement projects to increase the low performing measures to above the MPL and to further increase rates to meet the 90th percentile Women's Health Measures: CCS, BCS, PPC 1 and PPC 2 and CHL.					Internal Quality Improvement Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke Title: QI Project Specialist Name: Bob Hendrix	**Workgroup: Well Child**	**N**	**Continued**	By December 31, 2024 the Alliance will improve on well-child measures in the MCAS, by conducting improvement projects to increase the rates from below the MPL and to further increase rates to meet the 90th percentile: Well Child Measures: W15, W30, WCV, CIS10, IMA, DEV, TFL	The Well-Child Workgroup completed: -Evaluate the '23 Project Charter -Updated the '24 Project Charter and Driver Diagram -Developed a plan for an Organization-wide Campaign on Well-Visits -Reviewed gaps in data on the CIS measure				Internal Quality Improvement Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Workgroup: Chronic Disease Management**	**N**	**Continued**	By December 31, 2024, Alameda Alliance for Health (AAH) will improve on chronic disease management measures in the MCAS/P4P to meet MPL and to further increase rates to meet the 90th percentile. Chronic Disease Measures: AMR, CBP, HBD 2, CRC	The Workgroup completed: - Evaluated the '23 Project Charter - Created diabetes gap in care and med adherence report - Began root cause analysis of AMR rate decline - Continuing to pursue collaboration with Exact Sciences and Let's Get Checked - Began planning for BP monitor outreach PDSA - Created DM and HTN comorbidity report				Internal Quality Improvement Committee	12/31/2024	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department teams.
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Workgroup: Behavioral Health**	**N**	**New**	By December 31, 2024 Alameda Alliance for Health will improve on behavioral health measures in the MCAS to meet MPL and to further increase rates to reach the 75th percentile. Behavioral Health Measures: (FUA, FUM) Collaborate with BH Department in development of disease management for depression.	Continued exploration of providing FUA and FUM follow-up in-house Met with other health plans and providers to understand high performance on follow-up measures Reestablished regular meetings with ACBH Considered participation in DHCS/IHI Learning Collaborative but declined Explored FUA/FUM ED utilization New staff member Kalkidan (Kalé) Asrat joined QI Performance team, transitioning to workgroup lead Began work to establish ED navigator program/partnerships				Internal Quality Improvement Committee	12/31/2024	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department teams.

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Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	**Y**	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.				All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**Engagement Outreach Program**	**N**	**New**	Annually, the Alliance QIHE Engagement Program will help close care gaps in the California Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures, and Health Equity gaps, by reaching or exceeding the MPLs through: •Engaging with members through outcalls and collaborating with provider and community partners on member focused campaigns. •Participate in quality improvement projects related to member engagement. •Participate and collaborate in QI Department initiatives.	In process of developing program description and onboarding program. Job Description were re-submitted to HR for grading, pending completion.				Internal Quality Improvement Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: Lead QI Project Specialist Name: James Burke	**Provider Training on HEDIS measures**	**N**	**Continued**	By December 31, 2024, the QI Peformance team will offer learning opportunities to the provider network on HEDIS measures, including measures specification and best and promising practices in and out of the Alameda Alliance network.	MY2024 Measure Highlight Webinar Series: -W30 on 02/07/24: 13 attendees -WCV on 03/13/24: 14 attendees				Internal Quality Improvement Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	Title: QI Project Specialist Name: Megan Hils	**Non / Under Utilization Outreach**	**N**	**Continued**	Member outreach to at least 20% of non-utilizers over the age of fifty, and connect 2% to primary care services; outreach to 20% of non-utilizers ages six and under, connect % to pediatric primary care services by 6/30/24	Worked with Xaqt to update script and tracking sheet. Calls began in March focusing on adults first. As of March 26 working with Xaqt to understand which call list is being used- there may have been a mix up between 2023 call list and the current year's list.				Internal Quality Improvement Committee	12/31/2024	More than half of members have not seen a PCP, which contributes to low IHA rates and may contribute to low performance in other indicators, including iincreased ED use.
Population Health Management													
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Needs Assessment**	**N**	**New**	Define meaningful participation in Alameda County and City of Berkeley CHA/CHIP processes in coordination with Kaiser by August 1, 2024. Establish project plans with Alameda County and City of Berkeley by September 30, 2024.	Conducted monthly meetings with ACPH, City of Berkeley, and Kaiser to discuss shared goals and opportunities for meaningful participation.	Shared objective developed with City of Berkeley. Shared objective proposed to ACPHD.			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	9/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - PHM Monitoring**	**Y**	**Continued**	Expand PHM monitoring and evaluation processes to include further analysis for understanding KPIs, Quality Measures, PHM Strategy goals, and identifying barriers and opportunities for action by the end of 2024.	Collaborated with the PHM workgroup to develop the PHM Evaluation of the 2023 PHM Strategy. Provided feedback to DHCS re: KPI specifications.	Worked with NCQA consultants to ensure compliance with NQCA requirements. Submitted PHM Evaluation to QIHEC.			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	9/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Population Health Management - PHM Strategy**	**Y**	**Continued**	Develop the Alliance 2024 PHM Strategy to address priority gaps in care and disparities in compliance with DHCS and NCQA requirements.	Completed the annual PHM assessment to identify gaps in care and disparities. Collaborated with the PHM workgroup to update strategies, activities and resources in the 2024 PHM strategy.	Developed and updated the 2024 PHM strategy in compliance with NCQA requirements. Submitted to QIHEC for approval.			Internal Quality Improvement Committee Quality Improvement Health Equity Committee	5/30/2024	
Quality of Service													
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Manager Name: Farashta Zainal	TBD	**QIP #4: Increase Initial Health Appointment rates**	**N**	**Continued**	By 12/31/2024 Improve IHA completion rates from MY2023 to MY2024 by 3%.					Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	State issued CAP for IHA
Safety of Care													
Title: Sr. Director, Pharmacy Services Name: Helen Lee Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	**QIP #5: Opioid / SUD - Continuation**	**N**	**Continued**	Goal 1: By 12/31/24, educate chronic opioid users on health habits, management of chronic pain, and alternative therapy and care (>120 MME) daily). Goal 2: By 12/31/24, educate opioid users at risk of becoming chronic users (i.e., 50 to 119 MME/day).					Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/24	Staff bandwidth and staffing transistion
Title: Sr. Director, Pharmacy Services Name: Helen Lee Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	**QIP #5: Opioid / SUD - Continuation**	**N**	**Continued**	Goal 3: By 12/31/24, educate providers who are assigned members that utilize high dose opioids (>120MME) and who are presenting to the Emergency Department with opioid and / or benzodiazepine overdose.					Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/24	Staff bandwidth and staffing transition
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Potential Quality Issues (PQIs) Continuation- Quarterly**	**N**	**Continued**	Monitor, evaluate, and take effective action with >/= 95% PQI closure within 120 days to address any needed improvements in the quality of care delivered by all providers rendering services on behalf of the Alliance in any setting along with internal data validation.					Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/24	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Exempt Grievances Auditing- Biannual**	**N**	**Continued**	Ensure clinical monitoring of Exempt Grievances for Quality of Care, Service, Access and Language issues per P&P QI-104 through bi-annual review of 100 randomly selected Exempt Grievances.	Presented at IQIC on 1/17/24-next audit due Q3 2024 (audit period Q4 2023 & Q1 2024)				Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/24	

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Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	**Y**	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.				All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Potential Quality Issues (PQIs) Annual Training**	**N**	**Continued**	Plan provides documented evidence of ongoing annual training on PQIs by clinical staff for both new and seasoned customer service staff who serve as the front-line entry for the intake of all potential quality of care grievances	Annual training provided to HCS Dept in January. Plan to offer training to MSD and LTC in April				Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q4	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**PQI ModivCare Focus**	**N**	**New**	On tracking and trending of PQI cases as well as a review of grievances, we note a substantial number of C1 / C2 cases and member complaints related to missed rides.					Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q4	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: Sr. QI Nurse Specialist Name:Kathy Ebido	**Facility Site Review (FSR) Continuation**	**N**	**Continued**	100% of corrective action plans for periodic (full-scope) site reviews (FSR/MRR) are received within 30 days and closed within 90 days of FSR/MRR Report. CAP closure do not exceed 120 days from FSR/MRR Report.					Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q4	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name: Sanjay Bhatt	Title: QI Supervisor Name: Christine Rattray	**Inter-rater Reliability (IRR) Continuation-Annual**	**N**	**Continued**	IRR is performed annually to ensure >/=90% IRR consistency and accuracy of review criteria applied by all clinical reviewers - physicians and non-physicians - who are responsible for conducting clinical reviews and to act on improvement opportunities identified through this monitoring.					Internal Quality Improvement Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. QI Nurse Name: Kathy Ebido	**Skilled Nursing Facility/Long Term Care (SNF/LTC) Quality Monitoring**	**N**	**New**	Develop quality monitoring tools for SNF/LTC to meet APL 23-004 SNF/LTC Benefit Standardization: 1) Obtain 100% of the SNF attestation by7/1/24. 2) Develop site audit tool for SNF and SubAcute and visit low performing sites (as needed) by 9/1/2024. 3) Monitor quality measures (i.e. HEDIS/MCAS) once programmed by Analytics by June 30. 2024.	As of 3/18/2024, 52 (52%) attestations were received out of 100 SNF sites.				Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2024	
Member Experience													
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Tanisha Shepard	**CG-CAHPS Survey Continuation (Quarterly)**	**N**	**Continued**	Ensure that quarterly survey questions align with DMHC timely access and language requirements to evaluate member clinical & group satisfaction/experience with Timely Access Standards - Office Wait Time, Call Return Time, Time to Answer Call. To ensure that the survey results are actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. *Starting Q3 2022, the compliance threshold goal was changed from 80% to 70% (with a stretch goal of 80%) for Call Return Time and Time to Answer Call. In Office Wait Time goal remains 80% for 2023.	**Call Return Time** 4th Quarter 2023 Numerator: 1,145 Denominator: 1,522 Compliance Rate: 75.2% Goal Met: Y Gap to goal: 0% **In Office Wait Time** 4th Quarter 2023 Numerator: 2,920 Denominator: 3,172 Compliance Rate: 92% Goal Met: Y Gap to goal: 0% **Time to Answer Call** 4th Quarter 2023 Numerator: 1,781 Denominator: 2,468 Compliance Rate: 72.2% Goal Met: Y				Access to Care Sub-Committee Quality Improvement Health Equity Committee	3/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Tanisha Shepard	**Provider Satisfaction Survey Continuation (Annual)**	**N**	**Continued**	Annually, timely completion of measures for provider and staff satisfaction/experience with the health plan and department services. To ensure that the survey meets NCQA requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. **Fielding Oct - December 2022.** Goal: 88.3% (2% increase from MY 2022)	Results received Feb, 2024. Overall Satisfaction Plan Rating 78.4% down by 7.9% points from 2022 - 86.3%. Met or significantly higher scores compared to benchmark scores. Results shared with COO/CEO for review and evaluation of next steps. Meeting with SPH to discuss survey results on Apri18, 2024	Met with SPH on April 18, 2024, unable to discuss unable to discuss about survey results as representatisve for the survey was out. SPH will send out meeting invite to discuss on Survey Results. Provider Services will be presenting data at the Q3 2023 A&A Sub-Committee.			Access to Care Sub-Committee Quality Improvement Health Equity Committee	01/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Fiona Qian	**CAHPS 5.1 (Member Satisfaction Survey) Continuation (Annual)**	**N**	**Continued**	Measures member experience with health plan and affiliated providers. To ensure that the annual survey aligns with NCQA standards and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities for member experience. **Fielding: Feb. - May of 2023.** Goal TBD.	MY2023 Survey Results still in pending from SPH				Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/30/2024	

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Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Tanisha Shepard	**After Hours Care Continuation (Annual)**	**N**	**Continued**	Audits provide after hours protocols (Emegency Instructions/Access to Provider) and availability according to DMHC/NCQA methodology/standards for PCP, Spec. and BH providers. To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Maintains 80% compliance rate for After Hour Survey. **Fielding Oct - Nov 2022**	**Primary Care Providers** Numerator: 68 Denominator: 69 Compliance Rate: 98.6% Goal Met: Y Goal: 80% **Specialists** Numerator: 166 Denominator: 178 Compliance Rate: 93.3% Goal Met: Y Goal: 80% **Behavioral Health** Numerator: 65 Denominator: 78 Compliance Rate: 83.3% Goal Met: Y Goal: 80%				Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title:QI Specialist Name: Fiona Qian	**Initial Pre-Natal Visits Continuation (Annual)**	**N**	**Continued**	To ensure that the survey aligns with DHCS requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities related to OB/GYN appts offered according to Timely Access Standards. Reach or exceed 75% compliance rate for First Prenatal appointment. **Fielding Sep - Nov. 2022** **HEDIS Prenatal visits: 85.36 baseline to 85.40 admin (MPL) - increase by 3%**	MY2023 Survey Results for were presented at the March 6, 2024 A&A Sub Committee				Access to Care Sub-Committee Quality Improvement Health Equity Committee	3/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Fiona Qian	**Oncology Survey Continuation (Annual)**	**N**	**Continued**	To ensure that the survey aligns with DHCS requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities related to timeliness of Oncology routine and urgent care appointments. Maintains a 75% compliance rate for urgent & non-urgent appointment. **Fielding Sep - Nov.**	MY2023 Survey Result pending from QMetrics				Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q4	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title:QI Specialist Name: Fiona Qian	**PAAS (Provider Appt Availability Survey) Continuation (Annual)**	**N**	**Continued**	To ensure that the annual survey aligns with DHCS requirements to assess appointment availability is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Maintains a 75% compliance rate for urgent and non-urgent appointment. **Fielding Aug - Dec. 2022**	MY2023 Survey Result pending from QMetrics				Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q4	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title:QI Specialist Name: Fiona Qian	**Provider Visits and Training**	**N**	**New**	Conduct at least 2 site visits per quarter to provider offices/clinics and provide training on timely access standards through the end of 2024.	**1/12/24 - Training:** Robert Phillips (WOHC), Amit Pabla (AXIS), Shanna Cruz (Lifelong), Mayra Castrejon and Tania Martinez (La Clinica) **1/19/24 - Training:** Zenaida Aguilera (La Clinica), Danae Rodrigues (Lifelong), Isela Diaz and Ivonne Spedalieri (TVHC) **3/19/24** - Onsite Visit: AmCare Medical Group	**4/11/24** - Virutal Visit: La Clinica			Access to Care Sub-Committee Quality Improvement Health Equity Committee	End of Q5	
Health Education													
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Operations**	**N**	**Continued**	1.1 - Maintain a 95% fulfillment rate for health education material requests and referrals within 10 business days for threshold languages and within 15 business days for translated materials through the end of 2024. 1.3 - Support coordination and logistics of Community Advisory Committee meetings, monthly and quarterly team meetings through the end of 2024.	TBD				Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**	**N**	**Continued**	2.1 - Implement the Health Education Intake form and enable reporting on Health Education activities by Q2 of 2024.	Not started				Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	6/30/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**	**N**	**New**	2.2 - Develop one new health education inatitive by the end of 2024.	Reviewed health education programming and contracts with Compliance. Idnetified gaps in contractual relationships. Developed research into maternal mental health peer support coaching and inequities to support program development.				Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	6/30/2024	

2024 Quality Improvement & Health Equity (QIHE) Work Plan

Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification	Q1, 2024	Q2, 2024	Q3, 2024	Q4, 2024	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. QI Director Name: (Michelle N. Stott) Title: Sr. Medical Director Name: Sanjay Bhatt	N/A	**Annual QIHE Program Evaluation**	**Y**	**New**	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee (aka Member Advisory Committee)	QIHE Trilogy documents: evaluation (2023), program description (2024), workplan (2024) drafted in collaboration with other departments. Finalized documents will be presented to QIHEC in April 2024.				All Sub-Committees and QIHEC	Q2 2024	Incorporated BH and SNF/LTC Quality Monitoring
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Health Education Programs**	**Y**	**New**	2.3 - Support CBOs in the training (eligibility and PAVE enrollment) of community Doulas who will contract with the Alliance to expand our provider network by 125% by Q3 2024. 2.4 - Develop and implement a maternal and child health equity program utilizing Doulas by the end of 2024.	Completed stakeholder engagement listening session with Doula CBOs and ACPHD. Developed Doula RFQ. Developed Doula initial and ongoing training.				Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management**	**Y**	**New**	3.1 - Collaboratively develop a strategy to support Disease Management populations with closing care gaps and addressing inequities by the end of 2024.	Reviewing disease management disparities data and building a disease management health equity data index. Refining current reports to include information on vulnerable populations (e.g. risk criteria for perinatal population).				Utilization Management/Quality Improvement and Health Equity Committee	12/31/2024	
Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	**Disease Management**	**N**	**New**	3.2 - Develop a comprehensive Disease Management dashboard that can track all applicable measures. Each DM program will utilize the dashboard to find and analyze 75% of the data they will require for reporting by the end of 2024.	Submitted disease management poupulation dashboard request. Working with CM and analytics to refine data requests and develop a comprehensive dashboard that can be utilizied across departments.				Utilization Management/Quality Improvement and Health Equity Committee	12/31/2024	
Cultural and Linguistic Servcies													
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Member Cultural and Linguistic Assessment**	**Y**	**Continued**	Assess the cultural and linguistic needs of plan enrollees.	1. CLS needs assessed at 01/24/2024 CLSS Meeting.				Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services**	**Y**	**Continued**	Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.	1. Q1- 97% fulfillment rate for all modalities.				Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services**	**Y**	**New**	Ensure tracking of interpreter services utilization for behavioral health services.	1. Met with vendor to discuss options for tracking behavioral health services provided via on-demand telephonic and in-person interpreter services.				Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Provider Language Capacity (Member Satisfaction)**	**Y**	**Continued**	Based on the Member CG-CAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.	1. Planned implementation Q2.				Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Language Assistance Services (Member Satisfaction)**	**Y**	**New**	Based on the Timely Access Requirement (TAR) Survey results, develop and implement action steps, as needed, to address member's satisfaction with: a)scheduling appointments with an interpreter; b)availability of interpreters who speak member's preferred spoken language; c)knowledge, skill, and quality of interpreters.	1. Planned implementation Q2.				Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	6/30/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Provider Language Capacity and Race and/or Ethnicity (Provider Network)**	**Y**	**Continued**	Complete NCQA NET 1 A Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic needs of members.	1. Submitted a new analytics report to pull provider race/ethnicity from credentialing process for active providers in 2023. 2. Started to pull data and reports.				Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	4/1/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Community Engagement: Community Advisory Committee (CAC)**	**Y**	**Continued**	Ensure implementation of DHCS 2024 Contract updates to CAC and community engagement.	1. Developed CAC Selection Committee proposal. 2. Started planning for CAC Selection Committee recruitment. 3. Completed CAC Demographic Survey.				Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	6/30/2024	
Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name: Sanjay Bhatt, MD	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Moua	**Potential Quality Issues-Quality of Language (PQI-QOL)**	**Y**	**New**	Monitor, evaluate, and conduct appropriate interventions for PQI-QOLs with a closure rate of 95% or more within 30 business days.	1. Q1-96% closure rate.				Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	6/30/2024	

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CEO Update

Matthew Woodruff

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

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

Date: **June 14th, 2024**

Subject: **CEO Report**

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

	April	YTD
Medi-Cal	($8.3M)	$18.0M
Group Care	$71K	$3.2M
Total	($8.3M)	$21.2M

  - **Revenue was $159.6 million in April 2024 and $1.5 billion Year-to-Date (YTD)**.
    - Medical expenses were $165.4 million in April and $1.4 billion for the fiscal year-to-date; the medical loss ratio is 103.6% for the month and 94.9% for the fiscal year-to-date.
    - Administrative expenses were $10.2 million in April and $79.4 million year-to-date; the administrative loss ratio is 6.4% of net revenue for the month and 5.3% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 554% of the required DMHC minimum, representing $282.8 million in excess TNE.
  - **Total enrollment in April 2024 was 405,174**, an increase of 1,233 Medi-Cal members compared to March.

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - All Regulatory Metrics were met.
  - **Non-Regulatory Metrics:**
    - All non-Regulatory Metrics were met.

- **Program Implementations:**
  - **Single Plan Model**
    - See Power Point
  - **Demographics**

        - Please attached power point describing the demographics of the Alliance employees
    - **DHCS Audit**
        - The teams are preparing for our June DHCS audit. Our goal is to have no repeat findings and bring down the overall number of findings from previous years.
    - **Pay Equity Salary Survey**
        - We will work to implement the needed changes during our annual review process this July and August.

- **Medicare Overview**
    - **<u>D-SNP Readiness</u>**
        - Full Presentation in Board Packet

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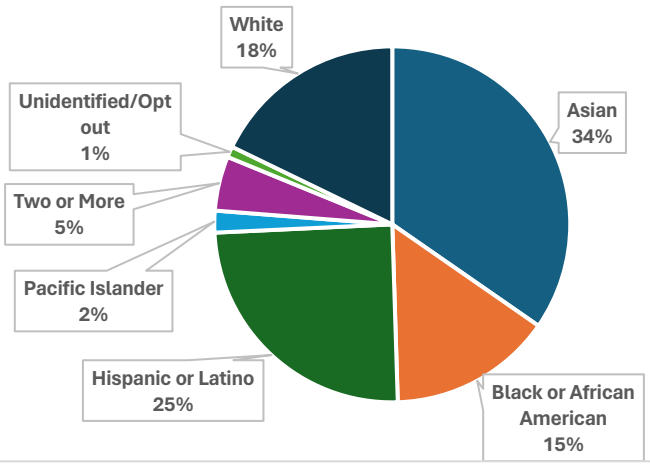
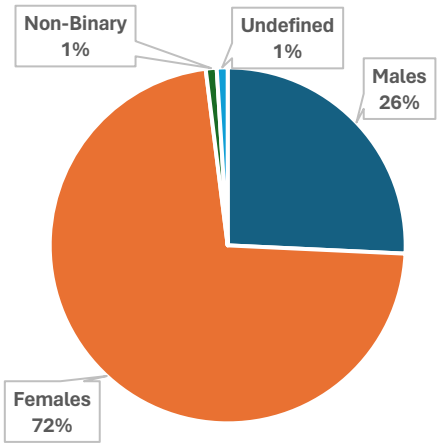
EMPLOYEE DEMOGRAPHICS DATA REPORT

AAH Employee Demographics Data Report May 2024

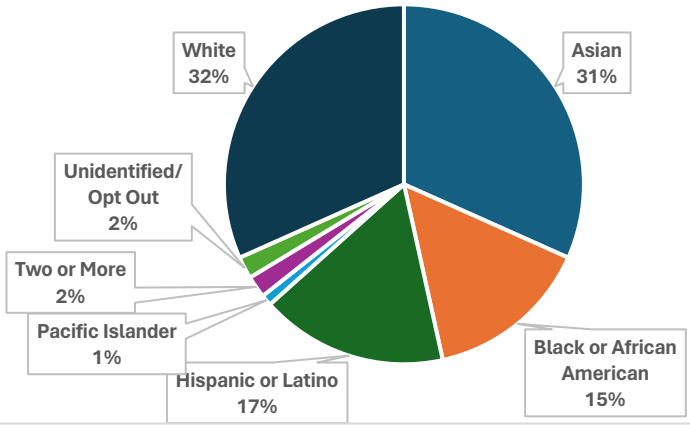
Employee Ethnicity - 597
May 2024



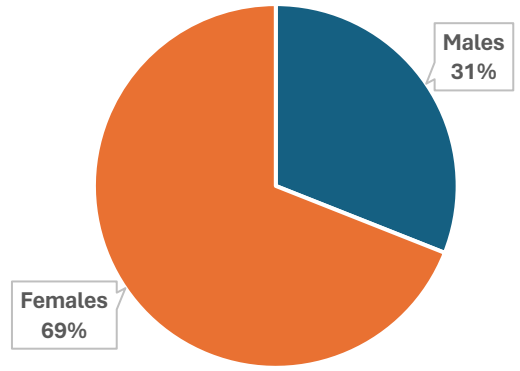
Employee Gender - 597
May 2024

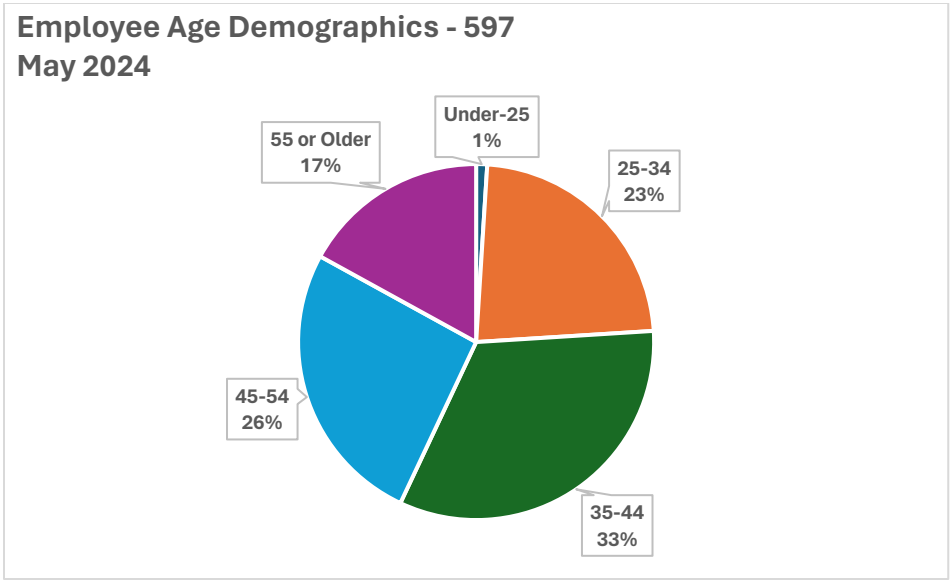


Managers Ethnicity - 119
May 2024



Managers Gender - 119
May 2024




Employee Age Demographics - 597
May 2024
Under-25
1%
25-34
23%
35-44
33%
45-54
26%
55 or Older
17%

Alliance CEO Update

Matthew Woodruff, Chief Executive Officer

June 14th, 2024

Single Plan Model

- Total membership as of April 2024 is 405,174.
- Approximately 81,000 members transitioned from Anthem to Alameda Alliance on January 1, 2024.
- Prior to MCP transition, 54,620 Anthem members assigned to Alameda Health System (AHS), or Community Health Center Network (CHCN) have been reassigned to AHS and CHCN since transition to the Alliance.
- Undocumented members
  - In December 2023, 30,565 undocumented residents were enrolled into the Alliance. As of April 1st, 64,815 undocumented residents are Alliance members.
  - 7,334 undocumented Anthem members assigned to AHS or CHCN have been reassigned to AHS and CHCN since joining the Alliance.

Single Plan Model

- Authorization changes – The total authorization volume (includes Inpatient, Outpatient, and Long-Term Care) in December 2023 was 5,098 compared to 7,393 in April 2024 – a 45% percent increase since the single plan transition.
- Claims Changes – The Claims Department received 215,246 claims in December 2023 compared to 322,786 in April 2024 - a 50% percent increase since the single plan transition.
- New Providers – Since January 2024, we have added approximately 380 providers.
- Community Supports – In the fourth quarter of 2023, confirmed member utilization for CS services was 2,669 members compared to 2,696 in the first quarter of 2024 - a1% percent increase since the single plan transition.
- In the fourth quarter of 2023, there were 2,034 confirmed members enrolled in ECM compared to 2,833 in the first quarter of 2024 – a 39% percent increase since the single plan transition.

Single Plan Model

- Total CS Providers = 18
- Total ECM Providers = 20
- Currently on conversations with another 8 ECM and CS providers.

Community Supports

- As of January 1, 2024, the Alliance is receiving $7 million in FY25 funding (Jul-Dec 2024) from DHCS for Community Supports.
  - DHCS Funding for FY 22 = $8.1 million (January-June)
  - DHCS Funding for FY23 = $10.5 million
  - DHCS Funding for FY24 = $7.0 million
- The Alliance estimates that we will spend approximately $35 million to support the CS program in Fiscal Year 2025, as compared to $24 million in Fiscal Year 2024.
  - Based on additional services
  - Based on rate increase previously negotiated
- Preliminary Guidance from CMS Medicaid Managed Care Final Rule states that we must provide documentation on the cost effectiveness of In Lieu of Services (ILOS), reporting date unknown.

Community Supports

- As of January 2024, the Alliance is offering the following CS Services:
  - Housing Transitions Navigation Services
  - Housing Deposits
  - Housing Tenancy and Sustaining Services
  - Recuperative Care (Medical Respite)
  - Medically Tailored Meals/Medically-Supportive Food
  - Asthma Remediation
  - (Caregiver) Respite Services
  - Personal Care & Homemaker Services
  - Environmental Accessibility Adaptations (Home Modifications)
  - Nursing Facility Transition/Diversion to Assisted Living Facilities
  - Community Transition Services/Nursing Facility to a Home
- Starting July 1st, 2024, the Alliance will offer the following CS:
  - Sobering Centers
- Starting January 1st, 2025, the Alliance will offer the following CS
  - Short Term Post Stabilization Housing
  - Day Habilitation

Budget Changes for end of FY 24

- Rates
  - State recouped $59 million for Calendar Year 2023 and Calendar Year 2024 from the Alliance in the months of April and May ($36 million without notice)
  - Our members were healthier than they thought (acuity adjustment)
  - Our biggest recoupment was in long-term care services (the money went to Anthem)
    - January – April 2024 showed that members transitioned from Anthem had higher long-term care utilization. This would support a transfer of funds for CY 2023 from AAH to Anthem
- For FY24, we had projected a year-end net income of $23 million and are now looking at a potential $5.5 million loss.

FY25 Budget Changes

- Rates

  What do these changes mean?

  - For FY25, we are projecting that we will break even
  - Programs that have been cut:
    - Board Grants
    - Community Reinvestment
    - Other Grants, and provider grants
  - Programs that we will continue to fund:
    - Provider Recruiting Incentive Program - $2 million in FY25 and another $2 million FY26
    - Violence Prevention Grants in Conjunction with Alameda County Health
      - $500,000 for grants to CBOs to help with infrastructure and billing

FY25 Budget Changes

- Internal Changes
  - FY25 travel will be subject to CEO/CFO approval
  - Employee benefit cost sharing may need to increase depending on contract negotiations
  - The Board will be made aware of any additional changes that may need to be put into place during the final budget adoption in December

State Advocacy

- The Alliance submitted the following position letters:
  - Support for AB 1975 which would transition medically supportive food and nutrition interventions from pilot services in CalAIM to permanent Medi-Cal benefits.
  - Support for AB 2271 which would approve the forgiveness of two loans – the California Facility Construction Loan Insurance Law and the Distressed Hospital Loan Program – for St. Rose Hospital in the City of Hayward.
  - Support for SB 1308 which would direct the California Air Resources Board (CARB) to adopt regulations to protect public health from ozone emitted by portable air cleaners.
  - Support for AB 2685 which will establish a demonstration program administered by the California Department of Aging (CDA) in multiple regions of the state to expand case management services to older individuals.
  - Signed onto partner letter to Governor and legislature in response to proposed cuts to aging and disability services.

Questions

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Executive Dashboard

OPERATIONS DASHBOARD

JUNE 2024

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Financials

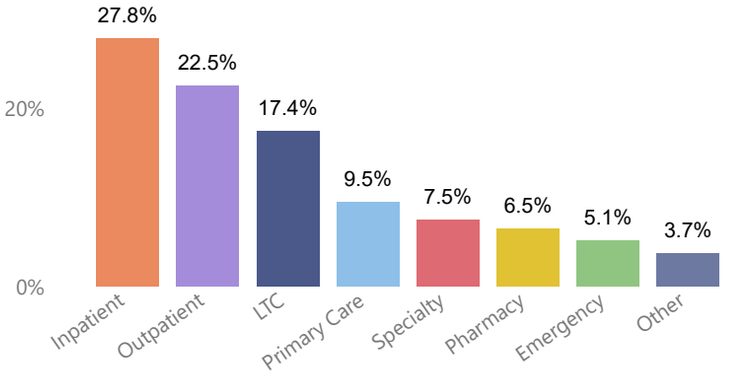
Income & Expenses

	APRIL 2024	FISCAL YTD
REVENUE	$ 273.3 M	$ 1.9 B
MEDICAL EXPENSE	$ (165.4) M	$ (1.4) B
ADMIN EXPENSE	$ (10.2) M	$ (79.4) M
OTHER/TAX	$ (105.9) M	$ (362.0) M
NET INCOME	$ (8.3) M	$ 21.2 M

Medical Loss % (Fiscal YTD)

94.9%

Medical Expenses



Liquid Reserves

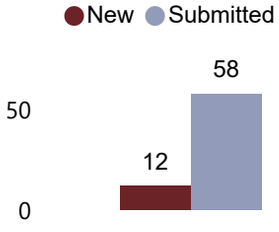
TNE %

553.5%

TNE $

$345.2M

Reinsurance Cases



Balance Sheet

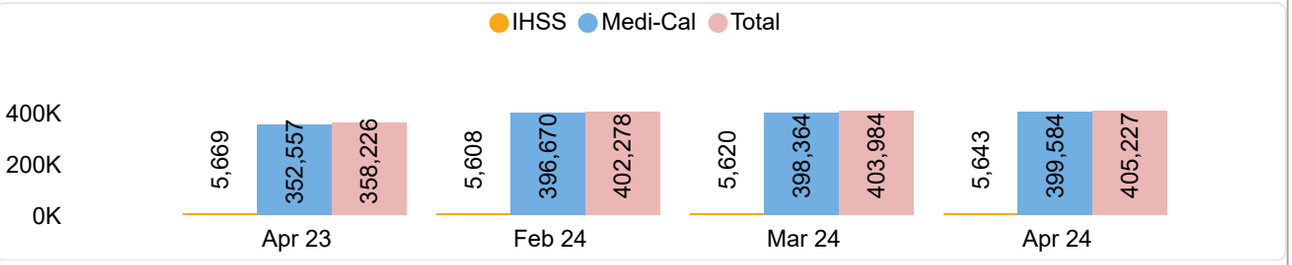
Cash Equivalents	$609.8M
Pass-Through Liabilities	$185.0M
Uncommitted Cash	$424.8M
Working Capital	$318.0M

Current Ratio

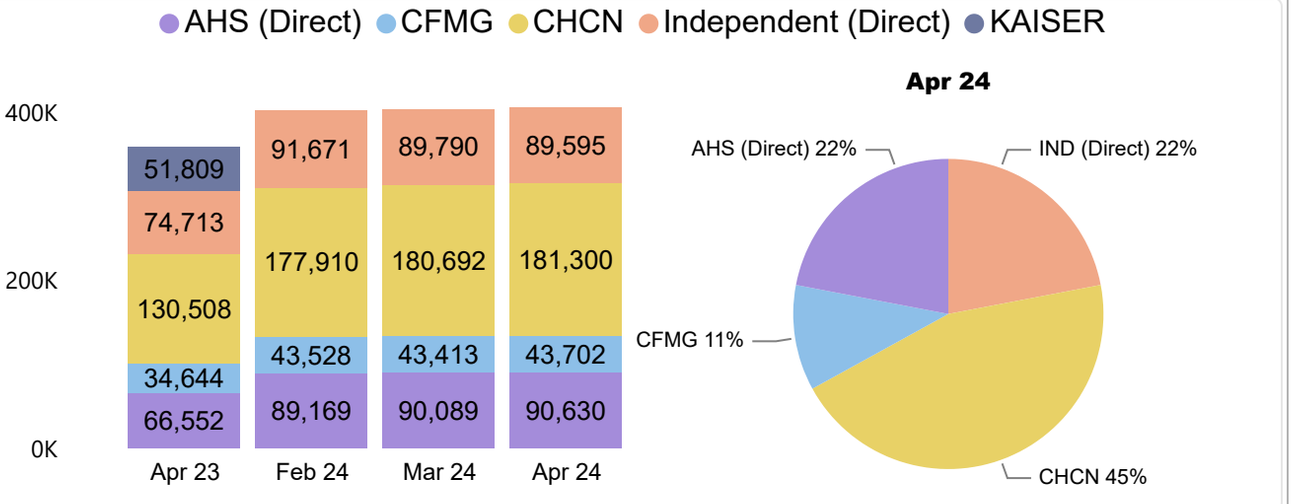
1.58

Membership

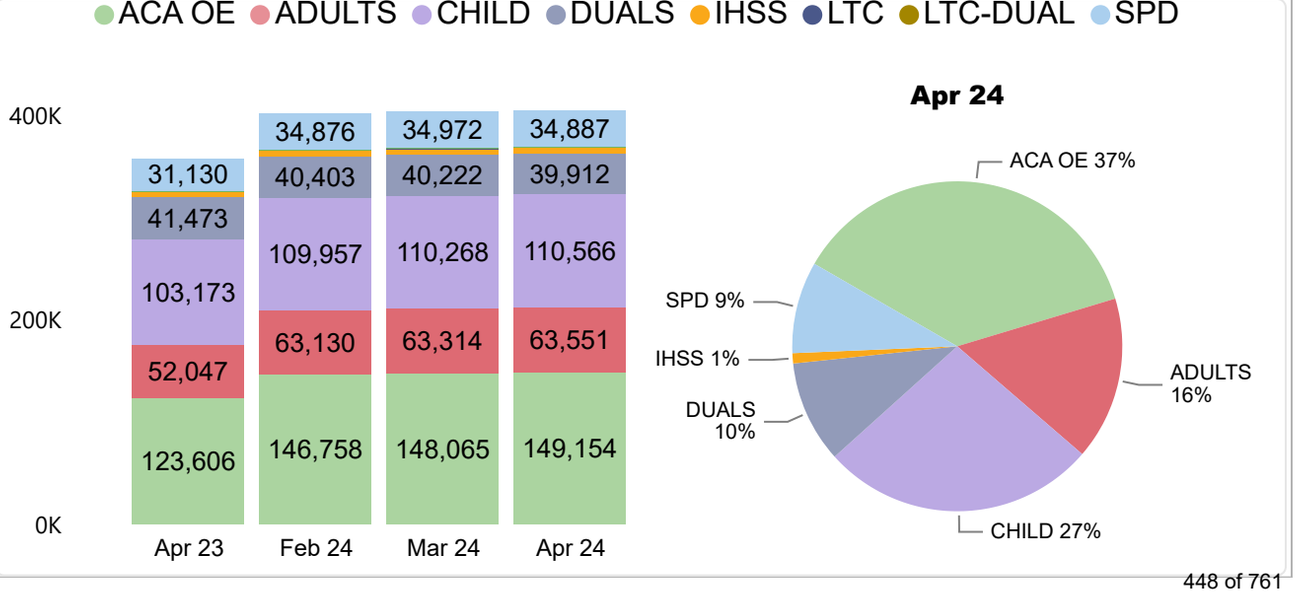
By Plan



By Network



By Category



OPERATIONS DASHBOARD

JUNE 2024

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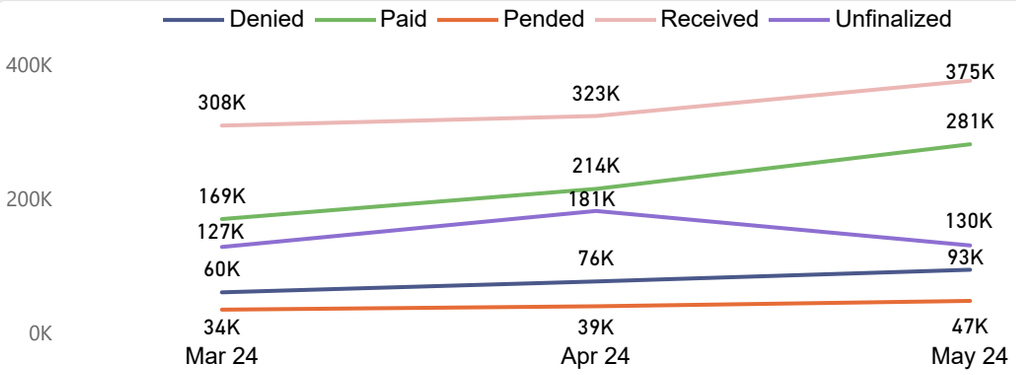
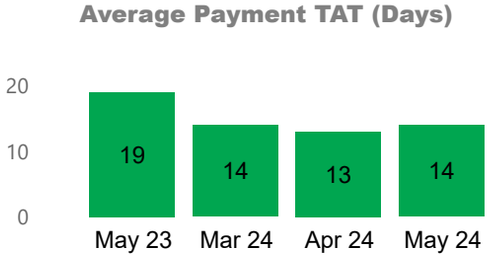
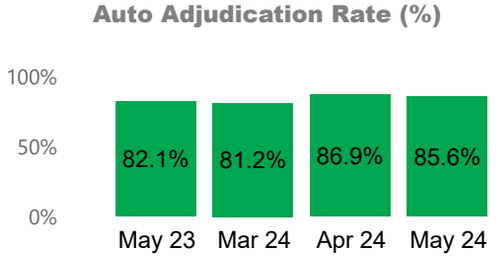
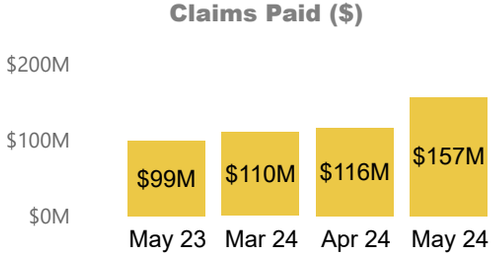
Claims

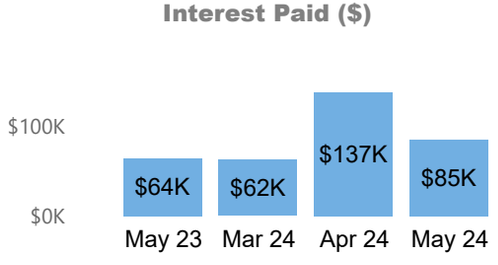
Claims Processing



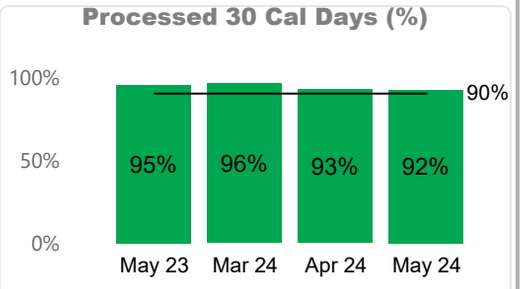


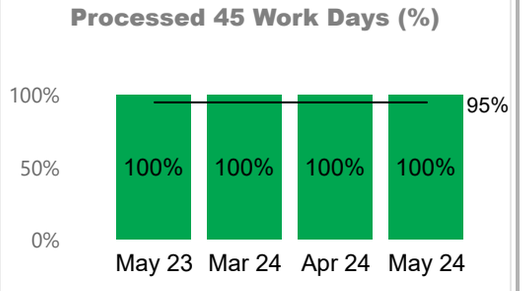




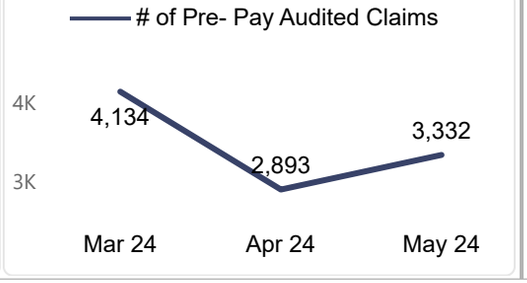


Claims Compliance

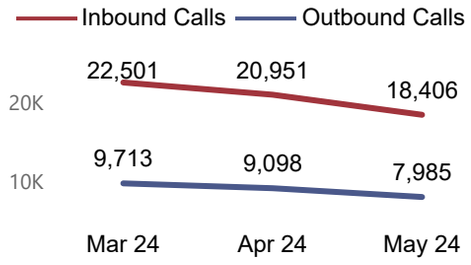


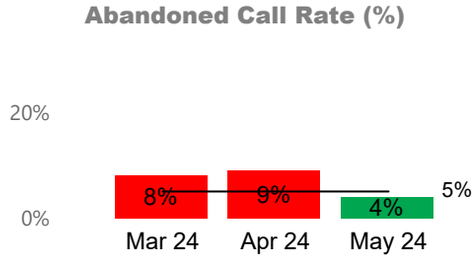


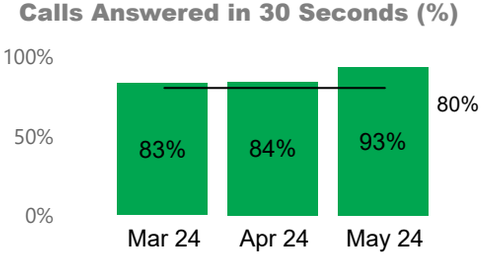
Claims Auditing



Member Services

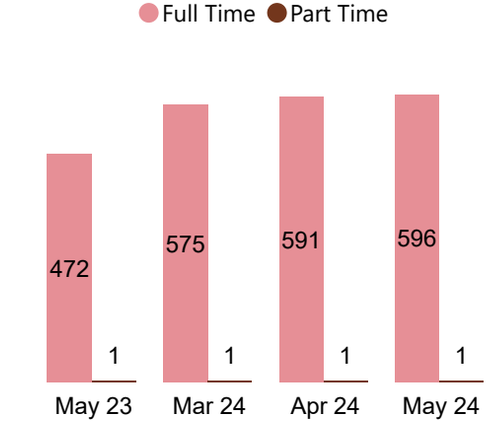


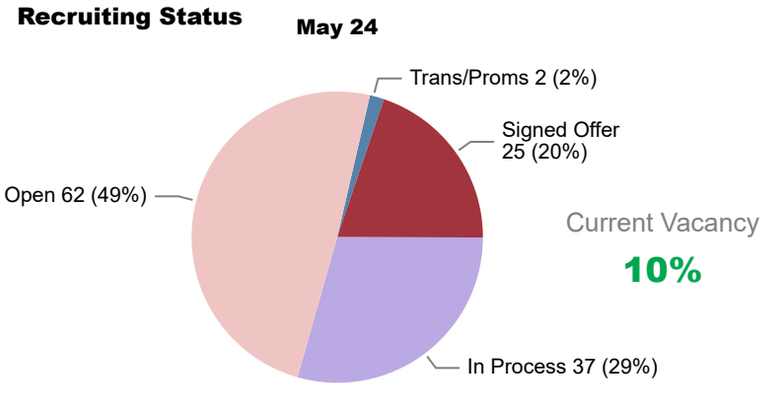


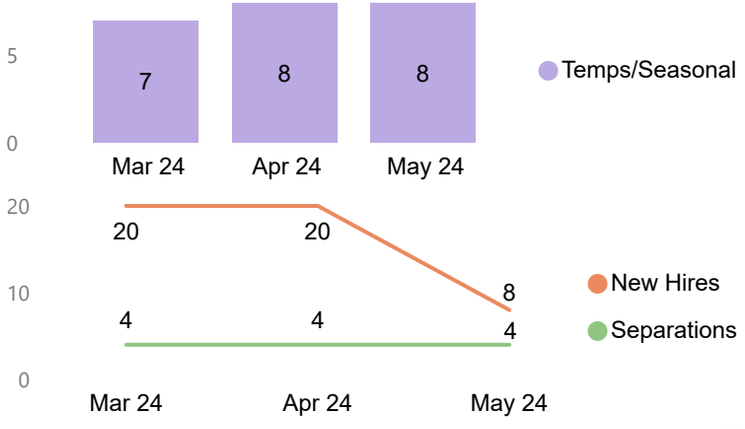


Average Call Times	Mar 24	Apr 24	May 24
Wait Time	00:49	00:50	00:19
Call Duration	07:02	06:57	06:48

Human Resources







OPERATIONS DASHBOARD

JUNE 2024

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Provider Services

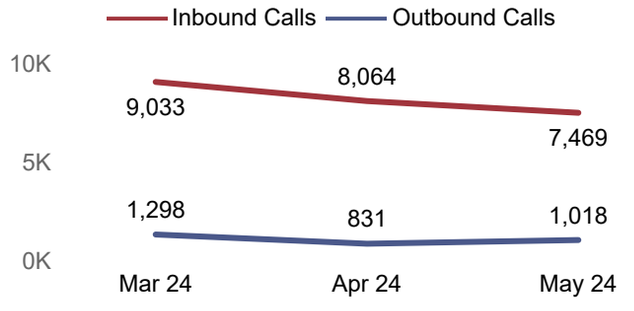
Provider Network

Hospital	17
Specialist	9,943
Primary Care Physician	769
Skilled Nursing Facility	104
Urgent Care	9
Health Centers (FQHCs and Non-FQHCs)	68
TOTAL	**10,910**

Provider Credentialing

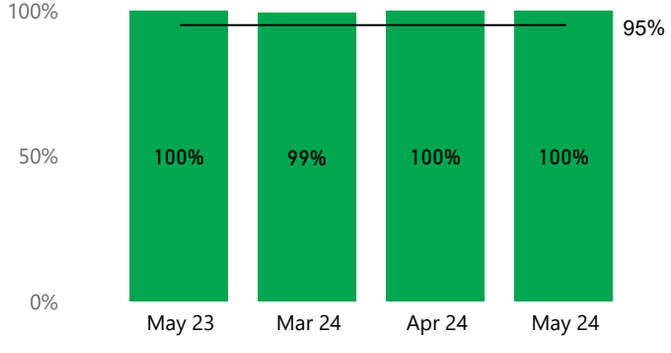
3,545

Provider Call Center



Provider Disputes & Resolutions

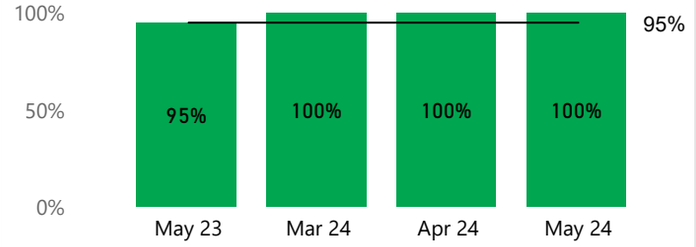
Turnaround Compliance (45 business days)



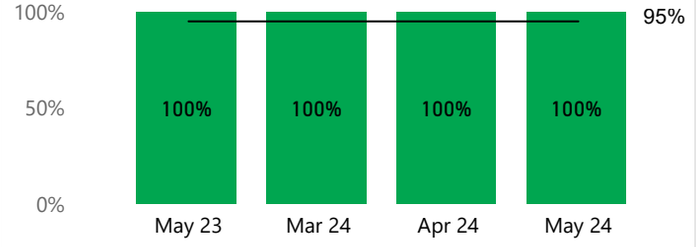
Compliance

Member Grievances

Standard (30 calendar days)

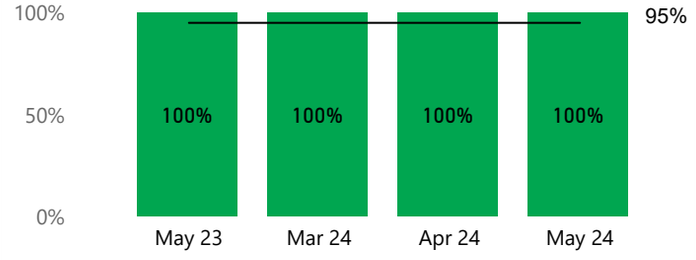


Expedited (3 calendar days)



Member Appeals

Standard (30 calendar days)



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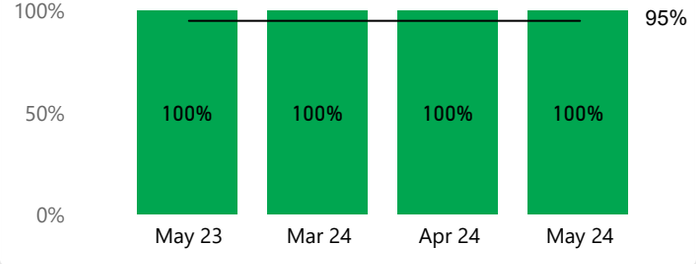
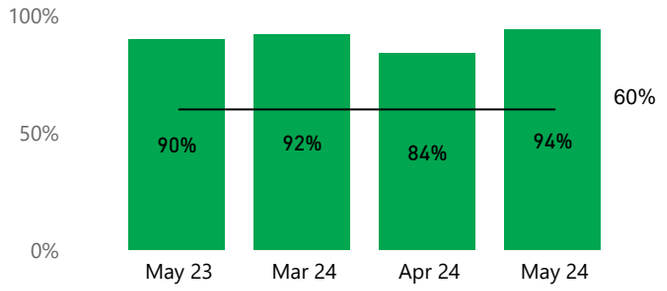
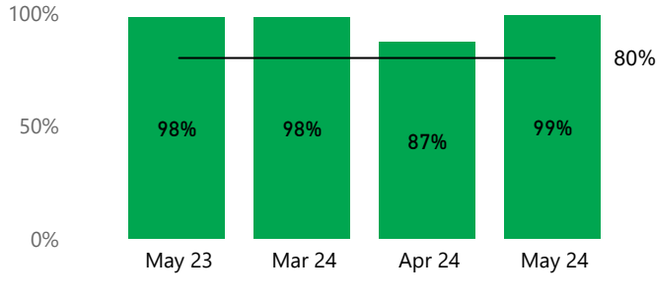


Encounter Data

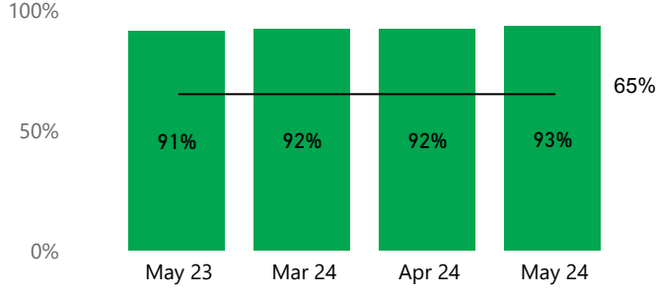
Institutional 0-90 days



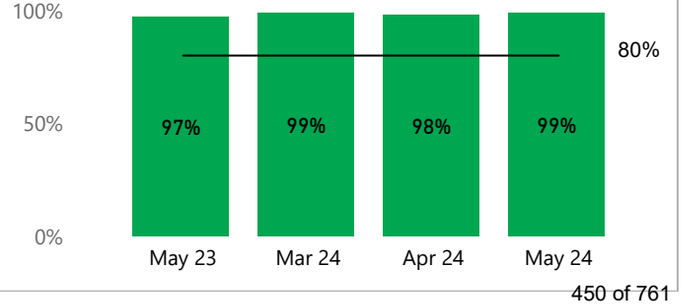
Institutional 0-180 days



Professional 0-90 days



Professional 0-180 days



OPERATIONS DASHBOARD

JUNE 2024

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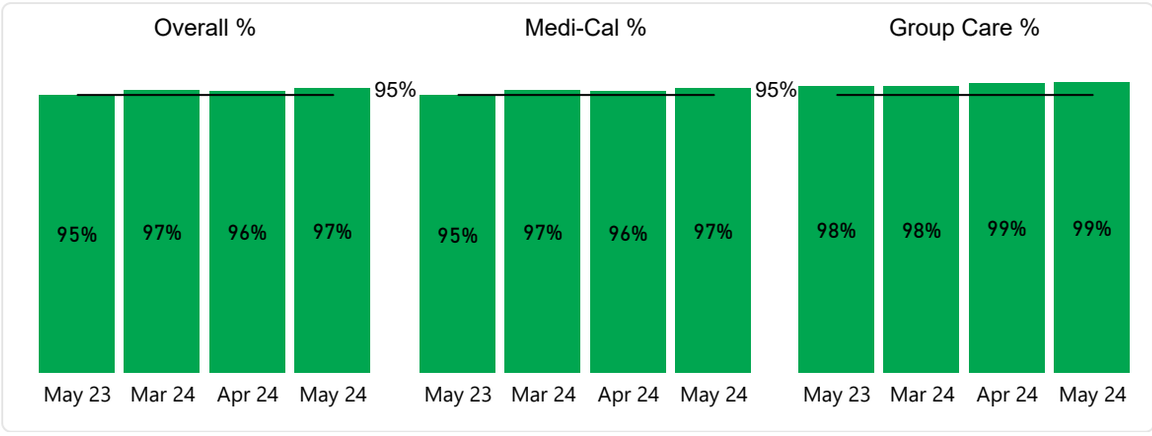
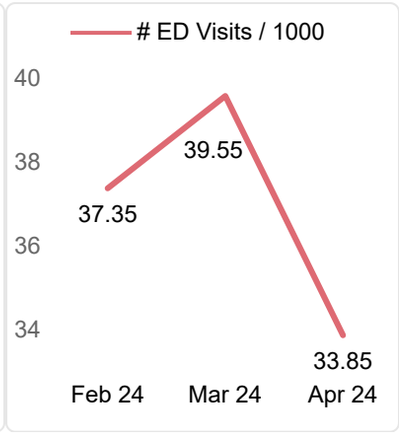
Health Care Services

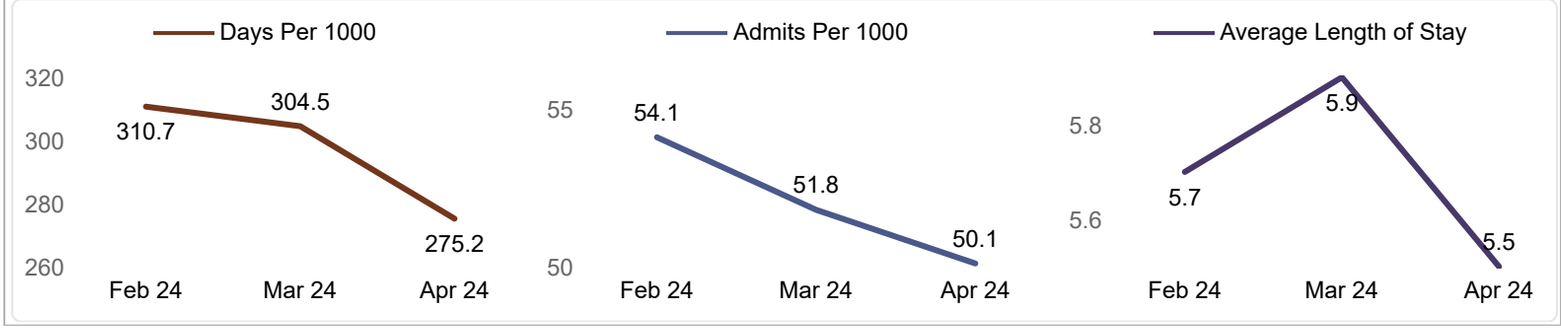
Authorization Turnaround



ED Utilization

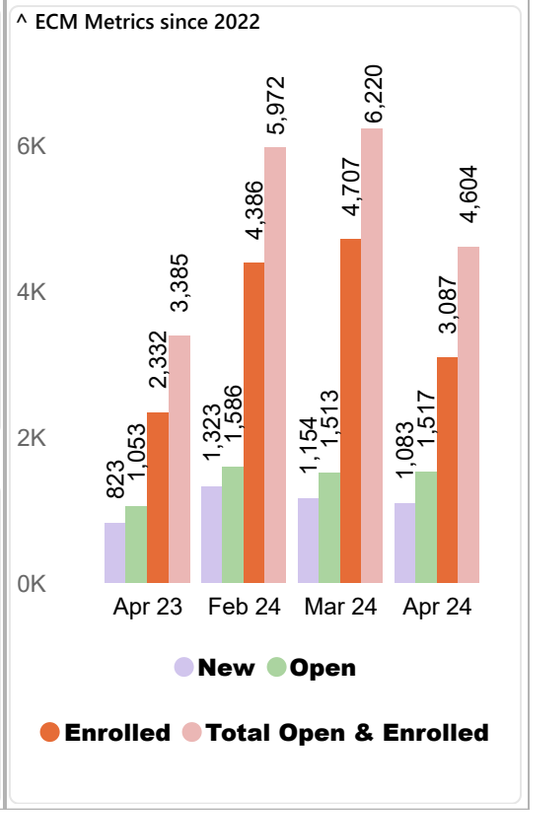


Inpatient Utilization

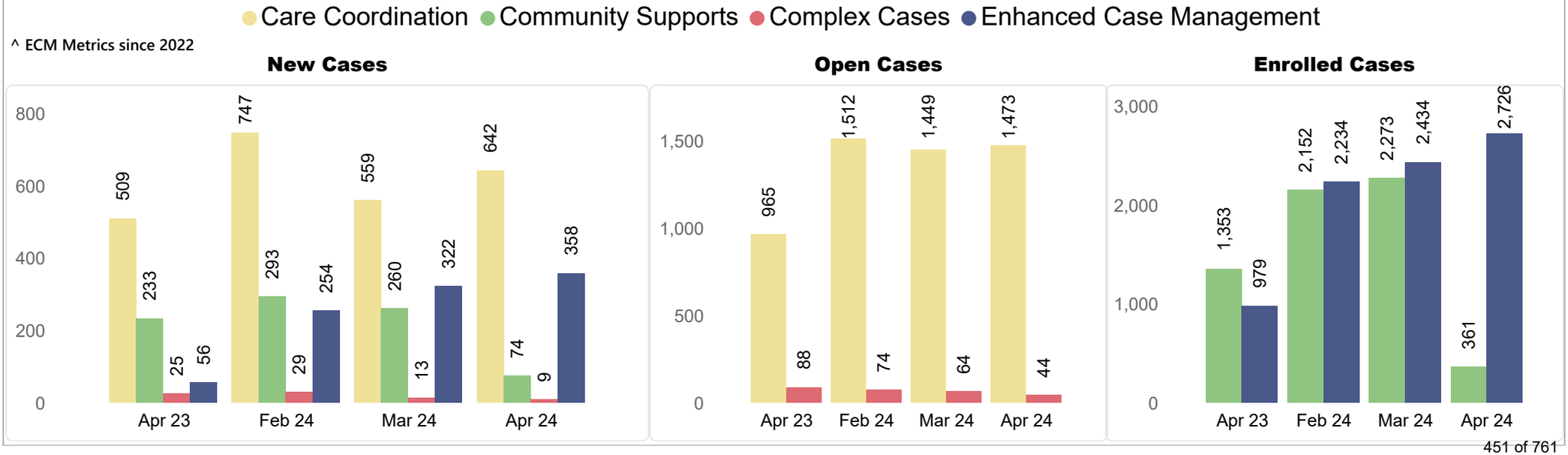


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	May 23	Mar 24	Apr 24	May 24
HEALTHsuite System	100.0%	100.0%	97.8%	100.0%
Other Applications	98.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	98.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	May 23	Mar 24	Apr 24	May 24
Denial Rate Excluding Partial Denials (%)	3.8%	3.4%	2.8%	2.8%
Overall Denial Rate (%)	4.0%	3.7%	3.0%	3.0%
Partial Denial Rate (%)	0.2%	0.4%	0.2%	0.2%

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

Pharmacy Authorizations

Authorizations	May 23	Mar 24	Apr 24	May 24
Approved Prior Authorizations	33	34	35	39
Closed Prior Authorizations	117	109	76	92
Denied Prior Authorizations	50	80	43	48
Total Prior Authorizations	200	223	154	179

Governor's 2024-25 Proposed Budget: May Revise & Legislature's Joint Budget Plan

Alliance Public Affairs Department

ALAMEDA Alliance FOR HEALTH

Governor's May Revise Highlights

- On May 10th, Governor Newsom released his May Revision for the 2024-25 state Budget.
- The total revised budget is $288.1 billion for FY 2024-25
- In January, the Governor estimated a $37.5 billion budget deficit. A deal between the administration and legislature addressed $17.3 billion through an early action bucket package – leaving $20.2 unaddressed.
- Since then, revenues have come in below previous projections increasing the deficit to an estimated $27.6 billion in addition to $1.2 billion that had not been addressed for a total deficit of $28.4 billion.

Governor's May Revise Highlights

- Governor Newsom's proposed budget solutions included cuts to government operations, reductions to programs, and pauses to new investments.
- Governor's Budget 2024-25 Solutions:
  - Reserves: $13.8 billion
  - Reductions: $8.5 billion
  - Revenue/Borrowing: $5.7 billion
  - Delays: $5.1 billion
  - Fund Shifts: $3.4 billion
  - Deferrals: $2.1 billion

Medi-Cal Budget Items

- **Managed Care Organization (MCO) Tax** – Reducing $6.7 billion over multiple years from the Medi-Cal provider rate increases planned to begin January 1st, 2025, and the Graduate Medical Education and Medi-Cal workforce.
  - Amendment to the MCO that would include health plan Medicare revenue in total revenue limit calculation that increases allowable size of the tax resulting in additional state net befit of $689.9 million in FY 24-25 and $950 million in FY 25-26.
  - Overall, revised budget includes an additional $9.7 billion in MCO Tax funds over multiple years to support the Medi-Cal program.

Medi-Cal Budget Items (Behavioral Health)

- **Children and Youth Behavioral Health Initiative** – Proposed to reduced $72.3 million one-time funding in 23-24, $348.6 million in 24-25 and $5 million in 25-26 for school linked health partnerships and capacity grants for higher education institutions, behavioral health services and supports platform, evidence-based and community-defined grants, public education and change campaign, and youth suicide reporting and crisis response pilot.
- **Behavioral Health Continuum Infrastructure Program (BHCIP)** – Proposed to eliminate $450.7 million one-time funding from the last round of the BHCIP, while maintaining $30 million one-time General Fund in 24-25.
- **Behavioral Health Bridge Housing Program (BHBH):** Proposed to reduced $132.5 million in 24-25 and $207.5 million in 25-26 for the BHBH Program, while maintaining $132.5 million General Fund in 24-25 and $117.5 million ($90 million Mental Health Services Fund and $27.5 million General Fund) in 25-26.

Medi-Cal Budget Items

- **Equity and Practice Transformation Payments to Providers** – Proposes to eliminate $280 million one-time over multiple years for grants to Medi-Cal providers for quality, health equity, and primary care infrastructure. Maintains $70 million General Fund included in the 2022 Budget Act.
- **In-Home Supportive Services (IHSS) for Undocumented Individuals** – Proposes to reduce $94.7 million ongoing by eliminating the IHSS undocumented coverage for all ages.
- **Foster Care Permanent Rate Structure** – Including statutory language that would make the proposed foster care rate structure subject to a trigger-on, based on the availability of General Fund in Spring 2026.

Additional Health Care Items

- **Healthcare Workforce Reduction** – Proposes to eliminate $300.9 million in 23-24, $302.7 million in 24-25, $216 million in 25-26, $19 million in 26-27, and $16 million in 27-28 for various healthcare workforce initiatives including CHWs, nursing, social work, Song-Brown residencies, Health Professions Career Opportunity Program, and California Medicine Scholars Program.
- **Public Health Funding** – Proposes to eliminate $52.5 million in 23-24 and $300 million ongoing for sate and local public health.
- **CalWORKs Mental Health and Substance Abuse Services** – proposes to reduce $126.6 million ongoing for the CalWORKs Mental Health and Substance Abuse Services.
- **Trailer Bill Language**
  - **CYBHI Fee Schedule MCP Fee** – proposed trailer bill language would amend the CYBHI statute to include authority for the Department of Health Care Services to charge a "reasonable" fee to health plans to sustain the third-party administrator infrastructure (Carelon Behavioral Health).

Joint Legislative Budget Plan

- On May 29th, State Assembly and Senate leaders unveiled a Joint Budget Plan in response to the Governor's May Revise.
- Legislature's balanced budget solutions:
  - Reductions: 24-25: $16.6 billion and 25-26: $11.6 billion
  - Revenues: 24-25: $10.6 billion and 25-26: $7.8 billion
  - Delayed: 24-25: $5.6 billion and 25-26: $0.6 billion
  - Fund Shift: 24-25: $7.2 billion and 25-26: $1.8 billion
  - Deferral: 24-25: $1.6 billion and 25-26: $0.5 billion
  - Reserves: 24-25: $5.3 billion and 25-26: $7.4 billion

Joint Legislative Budget Plan

MCO Health Investments

- Delays most rate increases projected to begin January 1, 2025, to January 1, 2026, with some $200 million of rates taking effect in the budget year.
- Expands the MCO tax to Medicare providers, generating an additional $689 million in General Fund savings in the budget year.
- Reflects $3.8 billion in General Fund savings from the extension of the MCO tax and the drawdown of reserve funds in the budget year, as adopted in Early Action.
- Does not include $115 million for the Children's Hospital New Directed Payment, as proposed in the May Revision.

Joint Legislative Budget Plan

- Children and Youth Behavioral Health Initiative
  - Adopts trailer bill language to allow school districts to use a 3rd party for billing related to the CYBHI fee schedule.
  - Eliminates funding for School-Linked Partnership and Capacity Grants for Community Colleges ($100 million) and UC/CSU's ($50 million).
  - Eliminates funding for CYBHI Services and Supports Platform.
  - Reduces CYBHI: Public Education and Change Campaign by $25.4 million of $73.8 budgeted, $34.7 million in 24-25 and $13.7 million in 25-26.
- Equity and Practice Transformation – Reduce funding for EPT payments by $111.3 million, eliminating remaining funding from the program.

Joint Legislative Budget Plan

- Proposition 56 – Approves the May Revise proposal to cut $13.5 million ongoing General Fund to backfill lowered Prop 56 funds to support graduate medical education.
- Quality Sanctions Penalties – Reflects $1 million General Fund from Quality Sanctions, including trailer bill language to implement change.
- Acupuncture Benefit – Retains Acupuncture optional Medi-Cal benefit.
- Rejects the May Revisions proposed cuts to Public Health Programs.

What happens next?

- Over the month of June, the legislature will negotiate with the governor to agree on a budget package.
- They must vote on a balance budget bill and send to the Governor by June 15th
- Once the budget passes through the legislature, the Governor will have 15 days to sign into law before the beginning of the new fiscal year which starts July 1st, 2024.
- **Budget Bill Junior and Trailer Bills** – The Legislature may use other policy specific bills (trailer bills) to provide additional details about expenses within the budget bill and/or a budget bill junior to revise the main budget bill which do not have to be sent to the Governor by June 15th and may be passed before the Legislative Session ends in August.

ALAMEDA Alliance FOR HEALTH

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

Legislative Tracking

2024 Legislative Tracking List

Between bill hearings and working to put together a joint state budget package, the 2024 California State Legislative Session has kept legislators busy. Lawmakers have until June 15th to pass a Budget Bill and July 3rd is the last day for policy committees to meet and report on bills. The following is a list of state bills tracked by the Public Affairs and Compliance Departments. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership.

AB 4 **(Arambula D) Covered California: expansion.**
Current Text: Amended: 7/13/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. on 7/13/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

Summary: Current federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Current state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Current law requires the Exchange to apply for a federal waiver to allow persons otherwise not able to obtain coverage through the Exchange because of their immigration status to obtain coverage from the Exchange. This bill would delete that requirement and would instead require the Exchange to administer a program to allow persons otherwise not able to obtain coverage by reason of immigration status to enroll in health insurance coverage in a manner as substantially similar to other Californians as feasible given existing federal law and rules.

AB 47 **(Boerner D) Pelvic floor physical therapy coverage.**
Current Text: Introduced: 12/5/2022 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, to provide coverage for pelvic floor physical therapy after pregnancy. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

AB 55 **(Rodriguez D) Medi-Cal: workforce adjustment for ground ambulance transports.**
Current Text: Amended: 4/27/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

Summary: Current law requires, with exceptions, that Medi-Cal reimbursement to providers of emergency medical transports be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. Under

current law, those increased payments are funded solely from a quality assurance fee (QAF), which emergency medical transport providers are required to pay based on a specified formula, and from federal reimbursement and any other related federal funds. Current law sets forth separate provisions for increased Medi-Cal reimbursement to providers of ground emergency medical transportation services that are owned or operated by certain types of public entities. This bill would establish, for dates of service on or after July 1, 2024, a workforce adjustment, serving as an additional payment, for each ground ambulance transport performed by a provider of medical transportation services, excluding the above-described public entity providers. The bill would vary the rate of adjustment depending on the point of pickup and whether the service was for an emergency or nonemergency, with the workforce adjustment being equal to 80% of the lowest maximum allowance established by the federal Medicare Program reduced by the fee-for-service payment schedule amount, as specified.

AB 236 **(Holden D) Health care coverage: provider directories.**
Current Text: Amended: 1/22/2024 html pdf
Status: 5/1/2024-Referred to Com. on HEALTH.
Location: 5/1/2024-S. HEALTH

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Current law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories and would require a provider directory to be 60% accurate on July 1, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2025, unless specified criteria applies. The bill would require a plan or insurer to arrange care and provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the contracted amount for those services.

AB 365 **(Aguiar-Curry D) Medi-Cal: diabetes management.**
Current Text: Amended: 9/8/2023 html pdf
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/12/2023)(May be acted upon Jan 2024)
Location: 9/14/2023-S. 2 YEAR

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

Summary: Would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program for the treatment of diabetes when medically necessary, subject to utilization controls. The bill would require the State Department of Health Care Services, by July 1, 2024, to review, and update as appropriate, coverage policies for continuous glucose monitors, as specified. The bill would authorize the department to require a manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. The bill would limit its implementation to the extent that any necessary federal approvals are obtained, and federal financial participation is available.

AB 412 **(Soria D) Distressed Hospital Loan Program.**
Current Text: Amended: 4/24/2023 html pdf
Status: 6/14/2023-Referred to Com. on HEALTH.
Location: 6/14/2023-S. HEALTH

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

Summary: The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority to, among other things, make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions, as defined, for financing or refinancing the acquisition, construction, or remodeling of health facilities. This bill would create the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. The bill would require, subject to an appropriation by the Legislature, the Department of Health Care Access and Information to administer the program and would require the department to enter into an interagency agreement with the authority to implement the program. The bill would require the department, in collaboration with the State Department of Health Care Services, the Department of Managed Health Care, and the State Department of Public Health, to develop a methodology to evaluate an at-risk hospital's potential eligibility for state assistance from the program, as specified.

AB 488 **(Nguyen, Stephanie D) Medi-Cal: skilled nursing facilities: vision loss.**
Current Text: Introduced: 2/7/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: Current law requires the State Department of Health Care Services, subject to any necessary federal approvals, for managed care rating periods that begin between January 1, 2023, and December 31, 2026, inclusive, to establish and implement the Workforce and Quality Incentive Program under which a network provider furnishing skilled nursing facility services to a Medi-Cal managed care enrollee may earn performance-based directed payments from the Medi-Cal managed care plan with which they contract, as specified. Current law, subject to appropriation, requires the department to set the amounts of those directed payments under a specified formula. Current law requires the department to establish the methodology or methodologies, parameters, and eligibility criteria for the directed payments, including the milestones and metrics that network providers of skilled nursing facility services must meet in order to receive a directed payment from a Medi-Cal managed care plan, with at least 2 of these milestones and metrics tied to workforce measures. This bill would require that the measures and milestones include program access, staff training, and capital improvement measures aimed at addressing the needs of skilled nursing facility residents with vision loss.

AB 564 **(Villapudua D) Medi-Cal: claim or remittance forms: signature.**
Current Text: Amended: 4/5/2023 html pdf
Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/14/2023)(May be acted upon Jan 2024)
Location: 7/14/2023-S. 2 YEAR

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

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Current law requires the Director of Health Care Services to develop and implement standards for the timely processing and payment of each claim type. Current law requires that the standards be sufficient to meet minimal federal requirements for the timely processing of claims. Current law states the intent of the Legislature that claim forms for use by physicians and hospitals

be the same as claim forms in general use by other payors, as specified. This bill would require the department to allow a provider to submit an electronic signature for a claim or remittance form under the Medi-Cal program, to the extent not in conflict with federal law.

AB 586 **(Calderon D) Medi-Cal: community supports: climate change or environmental remediation devices.**
Current Text: Amended: 3/30/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the State Department of Health Care Services is authorized to approve include, among other things, housing deposits, environmental accessibility adaptations or home modifications, and asthma remediation. This bill would add climate change or environmental remediation devices to the above-described list of community supports. For purposes of these provisions, the bill would define “climate change or environmental remediation devices” as coverage of devices and installation of those devices, as necessary, to address health-related complications, barriers, or other factors linked to extreme weather, poor air quality, or climate events, including air conditioners, electric heaters, air filters, or backup power sources, among other specified devices for certain purposes.

AB 815 **(Wood D) Health care coverage: provider credentials.**
Current Text: Amended: 4/20/2023 html pdf
Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/7/2023)(May be acted upon Jan 2024)
Location: 7/14/2023-S. 2 YEAR

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

Summary: Would require the California Health and Human Services Agency to create and maintain a provider credentialing board, with specified membership, to certify private and public entities for purposes of credentialing physicians and surgeons in lieu of a health care service plan’s or health insurer’s credentialing process. The bill would require the board to convene by July 1, 2024, develop criteria for the certification of public and private credentialing entities by January 1, 2025, and develop an application process for certification by July 1, 2025.

AB 1022 **(Mathis R) Medi-Cal: Program of All-Inclusive Care for the Elderly.**
Current Text: Introduced: 2/15/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: Current federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center so that they may continue living in the community. Federal law authorizes states to implement PACE as a Medicaid state option. Current state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the state’s Medi-Cal state plan. Current law requires the department to develop and pay capitation rates to entities contracted through the PACE program using actuarial methods and that reflect the level of care associated with the specific populations served pursuant to the contract. Current law authorizes a PACE

organization approved by the department to use video telehealth to conduct initial assessments and annual reassessments for eligibility for enrollment in the PACE program. This bill, among other things relating to the PACE program, would require those capitation rates to also reflect the frailty level and risk associated with those populations. The bill would also expand an approved PACE organization's authority to use video telehealth to conduct all assessments, as specified.

AB 1091 **(Wood D) Health Care Consolidation and Contracting Fairness Act of 2023.**
Current Text: Introduced: 2/15/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: This bill, the Health Care Consolidation and Contracting Fairness Act of 2023, would prohibit a contract issued, amended, or renewed on or after January 1, 2024, between a health care service plan or health insurer and a health care provider or health facility from containing terms that, among other things, restrict the plan or insurer from steering an enrollee or insured to another provider or facility or require the plan or insurer to contract with other affiliated providers or facilities. The bill would authorize the appropriate regulating department to refer a plan's or insurer's contract to the Attorney General, and would authorize the Attorney General or state entity charged with reviewing health care market competition to review a health care practitioner's or health facility's entrance into a contract that contains specified terms. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 1092 **(Wood D) Health care service plans: consolidation.**
Current Text: Amended: 6/28/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

Summary: Current law requires a health care service plan that intends to merge with, consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, an entity, to give notice to, and secure prior approval from, the Director of the Department of Managed Health Care. Current law authorizes the director to disapprove the transaction or agreement if the director finds it would substantially lessen competition in health care service plan products or create a monopoly in this state. Current law authorizes the director to conditionally approve the transaction or agreement, contingent upon the health care service plan's agreement to fulfill one or more conditions to benefit subscribers and enrollees of the health care service plan, provide for a stable health care delivery system, and impose other conditions specific to the transaction or agreement, as specified. This bill would additionally require a health care service plan that intends to acquire or obtain control of an entity, as specified, to give notice to, and secure prior approval from, the director. Because a willful violation of this provision would be a crime, the bill would impose a state-mandated local program.

AB 1110 **(Arambula D) Public health: adverse childhood experiences.**
Current Text: Amended: 7/10/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

Summary: Would, subject to an appropriation and until January 1, 2027, require the office and the State Department of

Health Care Services, while administering the ACEs Aware initiative and in collaboration with subject matter experts, to review available literature on ACEs, as defined, and ancestry or ethnicity-based data disaggregation practices in ACEs screenings, develop guidance for culturally and linguistically competent ACEs screenings through improved data collection methods, post the guidance on the department's internet website and the ACEs Aware internet website, and make the guidance accessible, as specified.

AB 1122 **(Bains D) Commercial harbor craft: equipment.**
Current Text: Amended: 5/29/2024 html pdf
Status: 5/29/2024-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on TRANS.
Location: 5/8/2024-S. TRANS.

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

Summary: Current law generally regulates the operation of vessels and associated equipment used, to be used, or carried in vessels used on waters subject to the jurisdiction of the state. Current regulations require the installation of a new engine or the retrofit of an existing engine in certain harbor craft to reduce emissions of air pollutants, as specified. This bill would require a diesel particulate filter that is retrofitted onto the engine of certain commercial harbor craft to include an override or bypass safety system that ensures that the commercial harbor craft can maintain a safe level of propulsion in the event of an emergency situation, as specified. The bill would require the manufacturer of an override or bypass safety system to design, install, and provide certain documentation regarding the override or bypass safety system, as specified. The bill would require the owner or operator of a commercial harbor craft that uses an override or bypass safety system to report the use and retain records regarding the use, as specified.

AB 1157 **(Ortega D) Rehabilitative and habilitative services: durable medical equipment and services.**
Current Text: Amended: 7/13/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

Summary: Current law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under existing law, essential health benefits includes, among other things, rehabilitative and habilitative services. Current law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define "durable medical equipment" to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.

AB 1282 **(Lowenthal D) Mental health: impacts of social media.**
Current Text: Amended: 9/1/2023 html pdf
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/11/2023)(May be acted upon Jan 2024)
Location: 9/14/2023-S. 2 YEAR

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

Summary: Would require the Mental Health Services Oversight and Accountability Commission to report to specified policy committees of the Legislature, on or before July 1, 2025, a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. The bill would require the report to include, among other things, (1) the degree to which individuals negatively impacted by social media are accessing and receiving mental health services and (2) recommendations to strengthen children and youth resiliency strategies and California's use of mental health services to reduce the negative outcomes that may result from untreated mental illness, as specified. The bill would require the commission to explore, among other things, the persons and populations that use social media and the negative mental health risks associated with social media and artificial intelligence, as defined.

AB 1313 **(Ortega D) Older individuals: case management services.**
Current Text: Amended: 4/27/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 7/3/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

Summary: The Mello-Granlund Older Californians Act requires the California Department of Aging to designate various private nonprofit or public agencies as area agencies on aging to work within a planning and service area and provide a broad array of social and nutritional services. Under the act, the department's mission is to provide leadership to those agencies in developing systems of home- and community-based services that maintain individuals in their own homes or least restrictive homelike environments. This bill would, until January 1, 2030, and subject to an appropriation, require the department to establish a case management services pilot program. Under the bill, the purpose of the program would be to expand statewide the local capacity of supportive services programs by providing case management services to older individuals who need assistance to maintain health and economic stability. The bill would require the Counties of Alameda, Marin, and Sonoma to participate in the pilot program.

AB 1316 **(Irwin D) Emergency services: psychiatric emergency medical conditions.**
Current Text: Amended: 5/20/2024 html pdf
Status: 5/29/2024-In committee: Set, first hearing. Hearing canceled at the request of author.
Location: 5/1/2024-S. HEALTH

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

Summary: Pursuant to a schedule of covered benefits, current law requires Medi-Cal coverage for inpatient hospital services, subject to utilization controls, and with respect to fee-for service beneficiaries, coverage for emergency services and care necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition, as specified. Current law provides for the licensing and regulation of health facilities by the State Department of Public Health and makes a violation of those provisions a crime. Current law defines "psychiatric emergency medical condition," for purposes of providing treatment for emergency conditions, as a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either an immediate danger to the patient or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Current law includes various circumstances under which a patient is required to be treated by, or may be transferred to, specified health facilities for treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition. This bill would revise the definition of "psychiatric emergency medical condition" to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment, under prescribed circumstances. The bill would make conforming changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local program.

AB 1338 **(Petrie-Norris D) Medi-Cal: community supports.**
Current Text: Amended: 4/20/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under current law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, recuperative care, respite, day habilitation programs, and medically supportive food and nutrition services.

AB 1359 **(Papan D) California Environmental Quality Act: geothermal exploratory projects: lead agency.**
Current Text: Amended: 5/29/2024 html pdf
Status: 6/5/2024-Re-referred to Coms. on N.R. & W. and E.Q.
Location: 5/30/2024-S. N.R. & W.

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

Summary: The California Environmental Quality Act (CEQA) requires a lead agency to prepare a mitigated negative declaration for a project that may have a significant effect on the environment if revisions in the project would avoid or mitigate that effect and there is no substantial evidence that the project, as revised, would have a significant effect on the environment. Current law establishes the Geologic Energy Management Division in the Department of Conservation, under the direction of the State Oil and Gas Supervisor, who is required to supervise the drilling, operation, maintenance, and abandonment of wells so as to permit the owners or operators of those wells to utilize all methods and practices known to the industry for the purpose of increasing the ultimate recovery of geothermal resources, as provided. Current law requires the division to be the lead agency for all geothermal exploratory projects for purposes of CEQA, as specified. This bill would repeal the requirement that the division be the lead agency for all geothermal exploratory projects for purposes of CEQA. This bill would declare that it is to take effect immediately as an urgency statute.

AB 1450 **(Jackson D) Behavioral health: behavioral health and wellness screenings: notice.**
Current Text: Amended: 1/3/2024 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: Current law requires the Medical Board of California, in determining its continuing education requirements, to consider including a course in integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues and exposure to trauma in children and young adults and their appropriate care and treatment. Current law requires a physician and surgeon to provide notice to patients at an initial office visit regarding a specified database. Current law requires the State Department of Public Health to license and regulate health facilities, including general acute care hospitals. Current law requires a general acute care hospital to establish and adopt written policies and procedures to screen patients who are 12 years of age and older for purposes of detecting a risk for suicidal ideation and behavior. The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would require a physician and surgeon, a general acute care hospital, a health care service plan, and a health insurer to provide to each legal guardian of a patient, enrollee, or insured, 10 to 18 years of age, a written or electronic notice regarding the benefits of a behavioral health and wellness screening. The bill would require the providers to provide the notice at least once every 2 years in the preferred method of the legal guardian.

AB 1608 **(Patterson, Joe R) Medi-Cal: managed care plans.**
Current Text: Amended: 1/3/2024 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: The Lanterman Developmental Disabilities Services Act makes the State Department of Developmental Services responsible for providing various services and supports to individuals with developmental disabilities, and for ensuring the appropriateness and quality of those services and supports. Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes, reduce health disparities, and increase flexibility. Current law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with specified requirements and the CalAIM Terms and Conditions. Existing law, if the department standardizes those populations subject to mandatory enrollment, exempts certain dual and non-dual beneficiary groups, as defined, from that mandatory enrollment. This bill would additionally exempt dual and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage.

AB 1644 **(Bonta D) Medi-Cal: medically supportive food and nutrition services.**
Current Text: Amended: 4/27/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

Summary: Would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, upon issuance of final guidance by the State Department of Health Care Services. The bill would require medically supportive food and nutrition interventions to be covered when determined to be medically necessary by a health care provider or health care plan, as specified. In order to qualify for coverage under the Medi-Cal program, the bill would require a patient to be offered at least 3 of 6 specified medically supportive food and nutrition interventions and for the interventions to be provided for a minimum duration of 12 weeks, as specified. The bill would only provide coverage for nutrition support interventions when paired with the provision of food through one of the 3 offered interventions. The bill would require a health care provider to match the acuity of a patient's condition to the intensity and duration of the medically supportive food and nutrition intervention and include culturally appropriate foods whenever possible.

AB 1690 **(Kalra D) Universal health care coverage.**
Current Text: Introduced: 2/17/2023 html pdf
Status: 2/1/2024-Died at Desk.
Location: 1/18/2024-A. DEAD

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

Summary: Would state the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program that benefits every resident of the state.

AB 1698 **(Wood D) Medi-Cal.**
Current Text: Introduced: 2/17/2023 html pdf
Status: 2/1/2024-Died at Desk.
Location: 1/18/2024-A. DEAD

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

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would make specified findings and would express the intent of the Legislature to enact future legislation relating to Medi-Cal.

AB 1783 **(Essayli R) Health care: immigration.**
Current Text: Introduced: 1/3/2024 html pdf
Status: 5/2/2024-Failed Deadline pursuant to Rule 61(b)(6). (Last location was PRINT on 1/3/2024)
Location: 5/2/2024-A. DEAD

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

Summary: Would state the intent of the Legislature to enact legislation to remove all taxpayer funding for health care for illegal immigrants from the California State Budget.

AB 1842 **(Reyes D) Health care coverage: Medication-assisted treatment.**
Current Text: Amended: 5/20/2024 html pdf
Status: 5/29/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (May 29). Re-referred to Com. on APPR.
Location: 5/29/2024-S. APPR.

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

Summary: Current law authorizes health care service plans and health insurers that cover prescription drugs to utilize reasonable medical management practices, including prior authorization and step therapy, consistent with applicable law. This bill would prohibit a medical service plan and a health insurer from subjecting a naloxone product or another opioid antagonist approved by the United States Food and Drug Administration, or a buprenorphine product or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder, to prior authorization or step therapy. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

AB 1895 **(Weber D) Public health: maternity ward closures.**
Current Text: Amended: 5/16/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

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

Summary: Would require an acute care hospital that offers maternity services, when those services are at risk of closure, as defined, in the next 6 months to provide specified information to the Department of Health Care Access and Information as well as the State Department of Public Health, including, but not limited to, the number of medical staff and employees working in the maternity ward and the hospital's prior and projected performance on financial metrics. The bill would require this information be kept confidential to the extent permitted by law. The bill would require, within 6 months of receiving this notice from the hospital, the Department of Health Care Access and Information, in conjunction with the State Department of Public Health, to conduct a community impact assessment to determine the 3 closest hospitals offering maternity services in the geographic area and their distance from the at-risk facility. The bill would require the hospital to provide public notice of the potential closure, including the results of the community

impact assessment, and other specified information on the hospital's internet website 90 days in advance of the proposed closure. The bill would require the public to be permitted to comment on the potential closure for 60 days after the notice is given and would require at least one noticed public hearing be conducted by the hospital. The bill would also require the hospital to accept written public comment. By creating a new crime, this bill would impose a state-mandated local program.

AB 1926 **(Connolly D) Health care coverage: regional enteritis.**
Current Text: Amended: 3/19/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

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

Summary: Current law requires a health care service plan contract and disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after July 1, 2000, to provide coverage for the testing and treatment of phenylketonuria, including coverage for the formulas and special food products that are part of a prescribed diet, as specified. This bill would require a health care service plan contract or disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after July 1, 2025, to provide coverage for dietary enteral formulas, as defined, for the treatment of regional enteritis, as specified. The bill would specify that these provisions do not apply to Medi-Cal managed care plans to the extent that the services are excluded from coverage under the contract between the Medi-Cal managed care plan and the State Department of Health Care Services. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 1943 **(Weber D) Medi-Cal: telehealth.**
Current Text: Amended: 6/6/2024 html pdf
Status: 6/6/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/5/2024-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, in-person, face-to-face contact is not required under the Medi-Cal program when covered health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. This bill would require the State Department of Health Care Services to, by October 1, 2025, produce a public report on telehealth in the Medi-Cal program that includes analyses of, among other things, (1) telehealth access and utilization, (2) the effect of telehealth on timeliness of, access to, and quality of care, and (3) the effect of telehealth on clinical outcomes, as specified. The bill would authorize the department, in collaboration with the California Health and Human Services Agency, to issue policy recommendations based on the report's findings.

AB 1970 **(Jackson D) Mental Health: Black Mental Health Navigator Certification.**
Current Text: Amended: 6/3/2024 html pdf
Status: 6/3/2024-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires the Department of Health Care Access and Information to develop and approve statewide requirements for community health worker certificate programs. Current law defines "community health worker" to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. This bill would require the department to, on or before July 1, 2025, develop criteria for a specialty certificate program and specialized training requirements for a Black Mental Health Navigator Certification, as specified. The bill would require the department to

collect and regularly publish data, not less than annually, including, but not limited to, the number of individuals certified, including those who complete a specialty certificate program, as specified, and the number of individuals who are actively employed in a community health worker role.

AB 1975 **(Bonta D) Medi-Cal: medically supportive food and nutrition interventions.**
Current Text: Amended: 6/5/2024 html pdf
Status: 6/5/2024-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

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

Summary: Current law requires the State Department of Health Care Services to establish the Medically Tailored Meals Pilot Program and the Short-Term Medically Tailored Meals Intervention Services Program, to operate in specified counties and during limited periods for the purpose of providing medically tailored meal intervention services to eligible Medi-Cal beneficiaries with certain health conditions, including congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease. Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under current law, community supports that the department is authorized to approve include, among other things, medically supportive food and nutrition services, including medically tailored meals. This bill would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, through both the fee-for-service and managed care delivery systems, no sooner than July 1, 2026, upon appropriation and subject to federal approval and the issuance of final guidance by the department. The bill would require those interventions to be covered if determined to be medically necessary by a health care provider or health care plan, as specified. The bill would require the provision of interventions for 12 weeks, or longer if deemed medically necessary. The bill would require a Medi-Cal managed care plan to offer at least 3 of 6 listed interventions, with certain conditions for a 7th intervention.

AB 1977 **(Ta R) Health care coverage: behavioral diagnoses.**
Current Text: Amended: 5/30/2024 html pdf
Status: 5/30/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 5/29/2024-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from requiring an enrollee or insured previously diagnosed with pervasive developmental disorder or autism to be reevaluated or receive a new behavioral diagnosis to maintain coverage for behavioral health treatment for their condition. The bill would require a treatment plan to be made available to the plan or insurer upon request. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2028 **(Ortega D) Medical loss ratios.**
Current Text: Introduced: 2/1/2024 html pdf
Status: 4/25/2024-Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/12/2024)
Location: 4/25/2024-A. DEAD

Desk	Dead	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: The federal Patient Protection and Affordable Care Act requires a health insurance issuer to comply with minimum medical loss ratios (MLRs) and to provide an annual rebate to each insured if the MLR of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as

specified. Current law requires health care service plans and health insurers that issue, sell, renew, or offer a contract or policy, excluding specialized dental and vision contracts and policies, to comply with a minimum MLR of 85% and provide specified rebates. Current law requires a health care service plan or health insurer that issues, sells, renews, or offers a contract or policy covering dental services to annually report MLR information to the appropriate department. This bill would require a health care service plan or health insurer that issues, sells, renews, or offers a specialized dental health care service plan contract or specialized dental health insurance policy to comply with a minimum MLR of 85% and to provide a specified rebate to an enrollee or insured.

AB 2043 **(Boerner D) Medi-Cal: nonmedical and nonemergency medical transportation.**
Current Text: Amended: 4/1/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law covers emergency or nonemergency medical transportation, and nonmedical transportation, under the Medi-Cal program, as specified. This bill would require the State Department of Health Care Services to ensure that the fiscal burden of nonemergency medical transportation or nonmedical transportation is not unfairly placed on public paratransit service operators and would authorize the department to direct Medi-Cal managed care plans to reimburse public paratransit service operators who are enrolled as Medi-Cal providers at the fee-for-service rates for conducting that transportation, as described. The bill would require the department to engage with public paratransit service operators to understand the challenges as public operators of nonemergency medical transportation or nonmedical transportation services and would require the department to issue new guidance to ensure the fiscal burden is not unfairly placed on public operators on or before June 1, 2026.

AB 2063 **(Maienschein D) Health care coverage.**
Current Text: Introduced: 2/1/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law authorizes the Director of the Department of Managed Health Care, no later than May 1, 2021, to authorize 2 pilot programs, one in northern California and one in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a voluntary employees' beneficiary association with enrollment of more than 100,000 lives, notwithstanding the fee-for-service requirement as described, or a trust fund that is a welfare plan and a multiemployer plan with enrollment of more than 25,000 lives, for independent periods of time beginning no earlier than January 1, 2022, to December 31, 2025, inclusive, if certain criteria are met. Current law requires the association or trust fund and each health care provider participating in each pilot program to report to the department information regarding cost savings and clinical patient outcomes compared to a fee-for-service payment model, and requires the department to report those findings to the Legislature no later than January 1, 2027. Current law repeals these provisions on January 1, 2028. This bill would extend that repeal date to January 1, 2030. The bill would extend the period of time authorized for those pilot programs to operate from December 31, 2025, to December 31, 2027. The bill would extend the deadline for the department to report the findings to the Legislature from January 1, 2027, to January 1, 2029.

AB 2105 **(Lowenthal D) Coverage for PANDAS and PANS.**
Current Text: Amended: 4/18/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on

or after January 1, 2025, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as specified. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name. 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 2110 **(Arambula D) Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.**
Current Text: Introduced: 2/5/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/1/2024)
Location: 5/16/2024-A. DEAD

1st House				2nd House				Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires that Medi-Cal provider payments and payments for specified non-Medi-Cal programs be reduced by 10% for dates of service on and after June 1, 2011, and conditions implementation of those payment reductions on receipt of any necessary federal approvals. Current law, for dates of service on and after July 1, 2022, authorizes the maintenance of the reimbursement rates or payments for specified services, including, among others, Adverse Childhood Experiences (ACEs) trauma screenings and specified providers, using General Fund or other state funds appropriated to the State Department of Health Care Services as the state share, at the payment levels in effect on December 31, 2021, as specified, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 that were implemented with funds from the Healthcare Treatment Fund, as specified. Current law requires the department to develop the eligibility criteria, methodologies, and parameters for the payments and rate increases maintained, and would authorize revisions, as specified. This bill would require the department, as part of its above-described duties, to include (1)community-based organizations and local health jurisdictions that provide health services through community health workers and (2)doulas, that are enrolled Medi-Cal providers, as providers qualified to provide, and eligible to receive payments for, ACEs trauma screenings pursuant to the provisions described above. The bill would require the department to file a state plan amendment and seek any federal approvals it deems necessary to implement these provisions and condition implementation on receipt of any necessary federal approvals and the availability of federal financial participation.

AB 2115 **(Haney D) Controlled substances: clinics.**
Current Text: Amended: 5/20/2024 html pdf
Status: 6/5/2024-Referred to Coms. on B., P. & E. D. and HEALTH.
Location: 6/5/2024-S. B., P. & E.D.

1st House				2nd House				Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: The Pharmacy Law provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy and makes a violation of the act a crime. Under current law, specified clinics, including surgical clinics, may purchase drugs at wholesale for administration or dispensing to the clinic's patients. Current law requires these clinics to maintain certain records and to obtain a license from the board. Current law prohibits specified substances from being dispensed by a nonprofit or free clinic, as defined. This bill would authorize a practitioner authorized to prescribe a narcotic drug at a nonprofit or free clinic, as specified, to dispense the narcotic drug from clinic supply for the purpose of relieving acute withdrawal symptoms while arrangements are being made for referral for treatment, as described, and would require the clinic dispensing the narcotic to be subject to specified reporting, labeling, and recordkeeping requirements.

AB 2129 **(Petrie-Norris D) Immediate postpartum contraception.**
Current Text: Amended: 4/11/2024 html pdf

Status: 6/5/2024-From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 11. Noes 0.) (June 5). Re-referred to Com. on APPR.
Location: 6/5/2024-S. APPR.

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

Summary: Would require a contract between a health care service plan or health insurer and a health care provider issued, amended, or renewed on or after January 1, 2025, to authorize a provider to separately bill for devices, implants, or professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or accredited birthing center. The bill would prohibit that provider contract from considering those devices, implants, or services to be part of a payment for a general obstetric procedure. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2132 **(Low D) Health care services.**
Current Text: Amended: 2/27/2024 html pdf
Status: 6/4/2024-In committee: Set, first hearing. Hearing canceled at the request of author.
Location: 5/29/2024-S. HEALTH

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

Summary: Current law requires an adult patient receiving primary care services in certain health care settings to be offered a screening test for hepatitis B and hepatitis C, as specified. This bill would require an adult patient receiving primary care services in a facility, clinic, unlicensed clinic, center, office, or other setting, as specified, to be offered a tuberculosis (TB) risk assessment and TB screening test, if TB risk factors are identified, to the extent these services are covered under the patient's health insurance, unless the health care provider reasonably believes certain conditions apply. The bill would also require the health care provider to offer the patient followup health care or refer the patient to a health care provider who can provide followup health care if a screening test is positive, as specified. The bill would prohibit a health care provider who fails to comply with these provisions from being subject to any disciplinary action related to their licensure or certification, or to any civil or criminal liability for that failure.

AB 2169 **(Bauer-Kahan D) Prescription drug coverage: dose adjustments.**
Current Text: Amended: 3/21/2024 html pdf
Status: 6/5/2024-Referred to Com. on HEALTH.
Location: 6/5/2024-S. HEALTH

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

Summary: Current law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law 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. The bill would authorize a licensed health care professional to request, and would require that they be granted, the authority to adjust the dose or frequency of a drug to meet the specific medical needs of the enrollee or insured without prior authorization if specified conditions are met. Under the bill, if the enrollee or insured has been continuously using a prescription drug selected by their prescribing provider for the medical condition under consideration while covered by their current or previous health coverage, the health care service plan or health insurance policy would be prohibited from limiting or excluding coverage of that prescription. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts.

AB 2180 **(Weber D) Health care coverage: cost sharing.**
Current Text: Amended: 4/30/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on

5/15/2024)
Location: 5/16/2024-A. DEAD

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

Summary: Current law generally prohibits a person who manufactures a prescription drug from offering in California any discount, repayment, product voucher, or other reduction in an individual's out-of-pocket expenses associated with the individual's health insurance, health care service plan, or other health coverage, including, but not limited to, a copayment, coinsurance, or deductible, for any prescription drug if a lower cost generic drug is covered under the individual's health insurance, health care service plan, or other health coverage on a lower cost-sharing tier that is designated as therapeutically equivalent to the prescription drug manufactured by that person or if the active ingredients of the drug are contained in products regulated by the federal Food and Drug Administration, are available without prescription at a lower cost, and are not otherwise contraindicated for the condition for which the prescription drug is approved. This bill would require a health care service plan, health insurance policy, or pharmacy benefit manager that administers pharmacy benefits for a health care service plan or health insurer to apply any amounts paid by the enrollee, insured, or a third-party patient assistance program for prescription drugs toward the enrollee's or insured's cost-sharing requirement, and would only apply those requirements with respect to enrollees or insureds who have a chronic disease or terminal illness. The bill would limit the application of the section to health care service plans and health insurance policies issued, amended, delivered, or renewed on or after January 1, 2025. The bill would repeal those provisions on January 1, 2035.

AB 2198 **(Flora R) Health information.**
Current Text: Amended: 6/3/2024 html pdf
Status: 6/3/2024-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

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

Summary: Current law requires health care service plans and health insurers to establish and maintain specified application programming interfaces (API), including patient access API, for the benefit of enrollees, insureds, and contracted providers. This bill would, except for Medi-Cal dental managed care contracts, exclude a specialized plan or insurer that issues, sells, renews, or offers a contract or policy covering dental or vision services from the above-described API requirements, and would instead require a specialized plan or insurer that issues, sells, renews, or offers a contract or policy covering dental or vision services and meets specified enrollment requirements to comply with the above-described API requirements beginning January 1, 2027, or when final federal rules are implemented, whichever is later.

AB 2200 **(Kalra D) Guaranteed Health Care for All.**
Current Text: Amended: 4/30/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. Under the bill, CalCare would be a health care service plan subject to Knox-Keene. The bill, among other things, would provide that CalCare

cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare Program. The bill would make specified persons eligible to enroll as CalCare members during the implementation period, and would provide for automatic enrollment. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds.

AB 2237 **(Aguiar-Curry D) Children and youth: transfer of specialty mental health services.**
Current Text: Amended: 4/11/2024 html pdf
Status: 5/29/2024-Referred to Coms. on HEALTH and G.O.
Location: 5/29/2024-S. HEALTH

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

Summary: Under current law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age. This bill would require, when a child or youth 21 years of age or younger who is receiving Medi-Cal specialty mental health services changes residence from one county to another, the receiving county to provide specialty mental health services to the child or youth, if the transfer of those services from one county to another is not otherwise governed by a process established in statute. The bill also would require the State Department of Health Care Services to collect specified data related to the receipt of specialty mental health services by children and youth who move outside of the county where they originally received specialty mental health services, and to include the data in the department's Medi-Cal specialty mental health services performance dashboard. The bill would require the department to issue guidance, as specified, to define the requirements on a receiving county for the continued provision of specialty mental health services, to coordinate and expedite the transfer of services from one county to another, and reduce the burden on children and youth and their caregivers to reestablish services in the receiving county. The bill would authorize the department to implement, interpret, or make specific its provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until regulations are adopted, as specified.

AB 2246 **(Ramos D) Medical Practice Act: health care providers: qualified autism service paraprofessionals.**
Current Text: Amended: 3/18/2024 html pdf
Status: 5/22/2024-Referred to Com. on B., P. & E. D.
Location: 5/22/2024-S. B., P. & E.D.

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

Summary: Current law establishes requirements for the delivery of medical services, including via telehealth by specified health care providers. A violation of the Medical Practice Act is a crime. Under existing law, a "health care provider," for purpose of the act, includes a qualified autism service provider or a qualified autism service professional that is certified by a national entity, as specified. This bill would expand that definition of "health care provider" to also include a qualified autism service paraprofessional. By expanding the scope of a crime under the act, the bill would impose a state-mandated local program.

AB 2250 **(Weber D) Social determinants of health: screening and outreach.**
Current Text: Amended: 6/6/2024 html pdf
Status: 6/6/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/5/2024-S. APPR.

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

Summary: Current law requires health care service plans and health insurers to include coverage for screening for various conditions and circumstances, including adverse childhood experiences. Current law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income

individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use specified tools or protocols when documenting patient responses to questions asked in these screenings. The bill would require a health care service plan or health insurer to provide physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or community health workers in counties where the plan or insurer has enrollees or insureds, as specified. The bill would authorize the respective departments to adopt guidance to implement its provisions until regulations are adopted, and would require the departments to coordinate in the development of guidance and regulations.

AB 2258 **(Zbur D) Health care coverage: cost sharing.**
Current Text: Amended: 4/1/2024 html pdf
Status: 6/5/2024-Referred to Com. on HEALTH.
Location: 6/5/2024-S. HEALTH

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a group or individual non-grandfathered health care service plan contract or health insurance policy to provide coverage for and prohibits a contract or policy from imposing cost-sharing requirements for, specified preventive care services and screenings. This bill would prohibit a group or individual non-grandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement for items or services that are integral to the provision of the above-described preventive care services and screenings. The bill would require those contracts and policies to cover items and services for those preventive care services and screenings, including home test kits for sexually transmitted diseases and specified cancer screenings.

AB 2271 **(Ortega D) St. Rose Hospital.**
Current Text: Amended: 5/16/2024 html pdf
Status: 6/4/2024-In committee: Hearing postponed by committee.
Location: 5/29/2024-S. HEALTH

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

Summary: Current law creates the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. Current law requires the Department of Health Care Access and Information to administer this loan program. This bill would require the department to approve the forgiveness of any loans under this program for the St. Rose Hospital in the City of Hayward.

AB 2303 **(Carrillo, Juan D) Health and care facilities: prospective payment system rate increase.**
Current Text: Amended: 4/2/2024 html pdf
Status: 4/25/2024-Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/26/2024)
Location: 4/25/2024-A. DEAD

Desk	Dead	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law provides that federally qualified health center services and rural health clinic services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis and at a per-visit prospective payment system rate, as defined.

Current law establishes 5 separate minimum wage schedules for covered health care employees, as defined, depending on the nature of the employer and includes increases beginning on June 1, 2024. Current law generally requires the State Department of Public Health to license, regulate, and inspect health and care facilities. This bill would, upon appropriation, require the State Department of Health Care Services to develop a minimum wage add-on as an alternative payment methodology to increase rates of payment for specified health care facilities to account for the costs of complying with the minimum wage schedules described above. The bill would require that the alternative methodology be applied retroactively to January 1, 2025, until those costs are included in the prospective payment system rate. The bill would require the department to seek all necessary federal approvals or amendments to the state Medi-Cal plan to implement these provisions and would require the department to make any state plan amendments or waiver requests public 45 days prior to submitting them to the federal Centers for Medicare and Medicaid Services.

AB 2319 **(Wilson D) California Dignity in Pregnancy and Childbirth Act.**
Current Text: Amended: 5/20/2024 html pdf
Status: 6/5/2024-Referred to Coms. on HEALTH and JUD.
Location: 6/5/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an evidence-based implicit bias program, as specified, for all health care providers involved in perinatal care of patients within those facilities. Existing law requires the health care provider to complete initial basic training through the program and a refresher course every 2 years thereafter, or on a more frequent basis if deemed necessary by the facility. Current law requires the facility to provide a certificate of training completion upon request, to accept certificates of completion from other facilities, and to offer training to physicians not directly employed by the facility. Current law requires the State Department of Public Health to track and publish data on pregnancy-related death and severe maternal morbidity, as specified. This bill would make a legislative finding that the Legislature recognizes all birthing people, including nonbinary persons and persons of transgender experience. The bill would extend the evidence-based implicit bias training requirements to specified health care providers at hospitals that provide perinatal care, alternative birth centers, or primary care clinics, as specified. The bill would require an implicit bias program to include recognition of intersecting identities and the potential associated biases. The bill would require initial basic training for the implicit bias program to be completed by June 1, 2025, for current health care providers, and within 6 months of their start date for new health care providers, unless exempted. The bill would require specified facilities to, by February 1 of each year, commencing in 2026, provide the Attorney General with proof of compliance with these provisions, as specified. The bill would authorize the Attorney General to pursue civil penalties for violations of these provisions, as specified. The bill would authorize the Attorney General to post on its internet website a list of facilities that did not timely submit proof of compliance or were assessed penalties under these provisions, as specified. The bill would authorize the Attorney General to post any other compliance data they deem necessary and would authorize the Attorney General to biennially publish a report outlining compliance data related to these provisions. The bill would make the provisions of the act severable.

AB 2332 **(Connolly D) Corrections: health care.**
Current Text: Amended: 3/21/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/1/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law establishes the Division of Health Care Operations and the Division of Health Care Policy and Administration within the Department of Corrections and Rehabilitation (CDCR) under the supervision of the Undersecretary of Health Care Services. Current law requires the department to expand substance abuse treatment services in prisons to accommodate at least 4,000 additional inmates who have histories of substance abuse. Current law requires the department to establish a 3-year pilot program to provide a medically assisted substance use disorder treatment model for the treatment of inmates, as specified. This bill would require the CDCR to take specific actions in the provision of substance use treatment, such as ensuring uniform application of the California Correctional Health Care Services Care Guide and retaining at least one full-time addiction medicine physician and surgeon at each facility to be

assigned medication-assisted treatment patients exclusively. The bill would require the CDCR to provide physicians and surgeons clear guidance on interpretation of certain toxicology tests, the misuse, abuse, and illegal distribution of substances, and access to alternative medication. The bill would require the CDCR to provide physicians and surgeons training consisting of at least 8 hours of integrated substance use disorder treatment didactic training, 3 days of shadowing an integrated substance use disorder treatment practice, and an annual training of at least 8 hours covering specified topics.

AB 2339 **(Aguiar-Curry D) Medi-Cal: telehealth.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, subject to federal approval, in-person, face-to-face contact is not required under Medi-Cal when covered health care services are provided by video synchronous interaction, asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. Current law defines "asynchronous store and forward" as the transmission of a patient's medical information from an originating site to the health care provider at a distant site. This bill would expand that definition, for purposes of the above-described Medi-Cal provisions, to include asynchronous electronic transmission initiated directly by patients, including through mobile telephone applications.

AB 2340 **(Bonta D) Medi-Cal: EPSDT services: informational materials.**
Current Text: Amended: 4/4/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered under Medi-Cal for an individual under 21 years of age in accordance with certain federal provisions. Current federal regulations require the state to provide for a combination of written and oral methods designed to inform individuals eligible for EPSDT services, or their families, about the EPSDT program, within 60 days of the individual's initial Medicaid eligibility determination and, in the case of families that have not utilized EPSDT services, annually thereafter, as specified. Under those regulations, required information includes, among other components, the benefits of preventive health care and the services available under the EPSDT program and where and how to obtain those services. This bill would require the department to prepare written informational materials that effectively explain and clarify the scope and nature of EPSDT services, as defined, that are available under the Medi-Cal program. Under the bill, the materials would include, but would not be limited to, the information required in the above-described federal regulations or their successor. Under the bill, the informational materials would also include content designed for youth, for purposes of delivery of that content to a beneficiary who is eligible for EPSDT services and who is 12 years of age or older but under 21 years of age.

AB 2342 **(Lowenthal D) Medi-Cal: critical access hospitals: islands.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 4/25/2024-Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/26/2024)
Location: 4/25/2024-A. DEAD

Desk	Dead	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, a hospital designated by the State Department of Health Care Services as a critical access hospital and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, is eligible for supplemental payments for Medi-Cal covered

outpatient services rendered to Medi-Cal eligible persons. Current law conditions those payments on receipt of federal financial participation and an appropriation in the annual Budget Act for the nonfederal share of those payments, with supplemental payments being apportioned among critical access hospitals based on their number of Medi-Cal outpatient visits. This bill, subject to appropriation and the availability of federal funding, would require the department to provide an annual supplemental payment, for services covered under Medi-Cal, to each critical access hospital that operates on an island that is located more than 10 miles offshore of the mainland coast of the state but is still within the jurisdiction of the state. The bill would specify the formula of the payment amount, which would be in addition to any supplemental payment described above.

AB 2352 **(Irwin D) Mental health and psychiatric advance directives.**
Current Text: Amended: 4/25/2024 html pdf
Status: 5/29/2024-Referred to Coms. on JUD. and HEALTH.
Location: 5/29/2024-S. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law establishes the requirements for executing a written advance health care directive that is legally sufficient to direct health care decisions. Current law provides a form that an individual may use or modify to create an advance health care directive. Under existing law, a written advance health care directive is legally sufficient if specified requirements are satisfied, may be revoked by a patient having capacity at any time, and is revoked to the extent of a conflict with a later executed directive. Current law requires a supervising health care provider who knows of the existence of an advance health care directive or its revocation to record that fact in the patient's health record. Existing law sets forth requirements of witnesses to a written advance health care directive. A written advance health care directive or similar instrument executed in another jurisdiction is valid and enforceable in this state under existing law. A person who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health care directive or its revocation without the individual's consent is subject to liability of up to $10,000 or actual damages, whichever is greater, plus reasonable attorney's fees. Current law authorizes an appeal of specified orders relating to an advance health care directive. Current law generally prohibits involuntary civil placement of a ward, conservatee, or person with capacity in a mental health treatment facility, subject to a valid and effective advance health care directive. Under current law, an advance psychiatric directive is a legal document, executed on a voluntary basis by a person who has the capacity to make medical decisions and in accordance with the requirements for an advance health care directive, that allows a person with mental illness to protect their autonomy and ability to direct their own care by documenting their preferences for treatment in advance of a mental health crisis. An individual may execute both an advance health care directive and a voluntary standalone psychiatric advance directive. This bill would extend the above-described advance health care directive provisions to psychiatric advance directives and would make conforming changes. The bill would specify that a psychiatric advance directive is a legal written or digital document, executed as specified, that allows a person with behavioral health illness to document their preferences for treatment and identify a health care advocate in advance of a behavioral health crisis.

AB 2356 **(Wallis R) Medi-Cal: monthly maintenance amount: personal and incidental needs.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/8/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Qualified individuals under the Medi-Cal program include medically needy persons and medically needy family persons who meet the required eligibility criteria, including applicable income requirements. Current law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Current law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs.

This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $50, and would require that the amount be increased annually, as specified. The bill would make these changes subject to receipt of necessary federal approvals.

AB 2376 **(Bains D) Chemical dependency recovery hospitals.**
Current Text: Amended: 3/21/2024 html pdf
Status: 6/5/2024-Referred to Com. on HEALTH.
Location: 6/5/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law provides for the licensure and regulation by the State Department of Public Health of certain health facilities, including a chemical dependency recovery hospital, which is defined to mean a health facility that provides 24-hour inpatient care for persons who have a dependency on alcohol or other drugs, or both alcohol and other drugs. Current law requires all beds in a chemical dependency recovery hospital to be designated for chemical dependency recovery services, as specified. Current law authorizes chemical dependency recovery services to be provided in a freestanding facility, within a hospital building that only provides chemical recovery services, or within a distinct part of a hospital, as defined. Current law also authorizes chemical dependency recovery services to be provided within a hospital building that has been removed from general acute care use. Existing law requires chemical dependency recovery services to comply with specified regulatory requirements for basic services, and optional services if the facility is approved by the department to provide them. Current law only authorizes the colocation of chemical dependency recovery services as a distinct part with other services or distinct parts of its parent hospital, as specified. Current law requires a separately licensed chemical dependency recovery hospital that is not a distinct part of a general acute care hospital to have agreements with one or more general acute care hospitals to provide specified additional services. This bill would expand the definition of "chemical dependency recovery services" to include medications for addiction treatment and medically managed voluntary inpatient detoxification.

AB 2446 **(Ortega D) Medi-Cal: diapers.**
Current Text: Amended: 5/16/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law establishes a schedule of covered benefits under the Medi-Cal program, including incontinence supplies. This bill would add to the schedule of Medi-Cal benefits diapers for infants or toddlers with certain conditions, such as a urinary tract infection and diseases of the skin. The bill would establish diapers as a covered benefit for a child greater than 3 years of age who has been diagnosed with a condition that contributes to incontinence and would establish diapers as a covered benefit for individuals under 21 years of age, if necessary to correct or ameliorate a condition pursuant to specified standards. The bill would limit the diapers provided pursuant to these provisions to an appropriate supply based on the diagnosed condition and the age of the beneficiary. The bill would require the department to seek any necessary federal approval to implement this section.

AB 2449 **(Ta R) Health care coverage: qualified autism service providers.**
Current Text: Amended: 6/3/2024 html pdf
Status: 6/4/2024-Re-referred to Com. on APPR pursuant to Joint Rule 10.5.
Location: 6/4/2024-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires a health care service plan contract or health insurance policy to provide coverage for

behavioral health treatment provided for pervasive developmental disorder or autism and requires a plan or policy to maintain an adequate network of qualified autism service providers. Under current law, a "qualified autism service provider" means, among other things, a person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies. This bill would clarify that the Qualified Applied Behavior Analysis Credentialing Board is also a national entity that may certify a qualified autism service provider, and would authorize the certification to be accredited by another national accrediting entity approved by the Secretary of California Health and Human Services.

AB 2466 **(Carrillo, Wendy D) Medi-Cal managed care: network adequacy standards.**
Current Text: Amended: 4/18/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law authorizes the Director of Health Care Services to terminate a contract or impose sanctions if the director finds that a Medi-Cal managed care plan fails to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause. Current law establishes, until January 1, 2026, certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. Under this bill, a Medi-Cal managed care plan would be deemed to be not in compliance with the appointment time standards if either (1) fewer than 85% of the network providers had an appointment available within the standards or (2) the department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees, as specified. Under the bill, failure to comply with the appointment time standard may result in contract termination or the issuance of sanctions as described above.

AB 2467 **(Bauer-Kahan D) Health care coverage for menopause.**
Current Text: Amended: 5/20/2024 html pdf
Status: 6/5/2024-Referred to Com. on HEALTH.
Location: 6/5/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require a health care service plan contract or health insurance policy, except for a specialized contract or policy, that is issued, amended, or renewed on or after January 1, 2025, to include coverage for treatment of perimenopause and menopause. 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 2556 **(Jackson D) Behavioral health and wellness screenings: notice.**
Current Text: Amended: 6/6/2024 html pdf
Status: 6/6/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/5/2024-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require a health care service plan, except as specified, or health insurer to provide to enrollees and insureds a written or electronic notice regarding the benefits of a behavioral health and wellness screening, as defined, for children and adolescents 8 to 18 years of age. The bill would require a health care service plan or insurer to provide the notice on an annual basis. Because a violation of the bill's requirements relative to a health care service plan would be crimes, the bill would impose a state-mandated local program.

AB 2668 **(Berman D) Coverage for cranial prostheses.**

Current Text: Introduced: 2/14/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/8/2024)
Location: 5/16/2024-A. DEAD

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to cover cranial prostheses, as defined, for individuals experiencing permanent or temporary medical hair loss. The bill would require a licensed provider to prescribe the cranial prosthesis for an individual's course of treatment for a diagnosed health condition, chronic illness, or injury, as specified. The bill would limit coverage to once every 12 months and $750 for each instance of coverage. The bill would not apply these provisions to a specialized health care service plan or specialized health insurance policy. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2699 **(Carrillo, Wendy D) Hazardous materials: reporting: civil liability.**
Current Text: Amended: 4/1/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: (1) Existing law requires the Secretary for Environmental Protection to implement a unified hazardous waste and hazardous materials management regulatory program, known as the unified program. Existing law requires every county to apply to the secretary to be certified to implement the unified program and authorizes a city or local agency that meets specified requirements to apply to the secretary to be certified to implement the unified program, as a certified unified program agency. Existing law authorizes a state or local agency that has a written agreement with a certified unified program agency, and is approved by the secretary, to implement or enforce one or more of the unified program elements as a participating agency. Existing law defines "unified program agency" to mean a certified unified program agency or its participating agencies, as provided. This bill would require this reporting to be made to the California Environmental Protection Agency instead of the Office of Emergency Services. The bill would delete the requirement on the Office of Emergency Services to adopt regulations and would instead require the California Environmental Protection Agency to be responsible for the adoption and revision of the regulations and for the oversight of the enforcement of the regulations. The bill would require the California Environmental Protection Agency, on or before January 1, 2028, to review and revise the regulations that implement the reporting requirements. This bill contains other related provisions and other existing laws.

AB 2701 **(Villapudua D) Medi-Cal: dental cleanings and examinations.**
Current Text: Amended: 5/16/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, and under which qualified low-income individuals receive health care services, including certain dental services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would expand the above-described dental benefits, for beneficiaries 21 years of age or older, to 2 cleanings and 2 examinations per year when medically necessary, as specified in the Medi-Cal Dental Manual of Criteria.

AB 2703 **(Aguiar-Curry D) Federally qualified health centers and rural health clinics: psychological associates.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 6/5/2024-Referred to Com. on HEALTH.
Location: 6/5/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires the State Department of Health Care Services to seek any necessary federal approvals and issue appropriate guidance to allow a federally qualified health center (FQHC) or a rural health clinic (RHC) to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when certain conditions are met, including, among others, that the FQHC or RHC is otherwise authorized to bill for services provided by the supervising practitioner as a separate visit. This bill would add a psychological associate to those provisions, requiring the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill for an encounter between a patient and a psychological associate under those conditions. The bill would make conforming changes with regard to supervision by a licensed psychologist as required by the Board of Psychology.

AB 2726 **(Flora R) Specialty care networks: telehealth and other virtual services.**
Current Text: Amended: 4/25/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would, subject to an appropriation, require the California Health and Human Services Agency, in collaboration with the Department of Health Care Access and Information and the State Department of Health Care Services, to establish a demonstration project for a grant program. Under the bill, the grant program would be aimed at facilitating a telehealth and other virtual services specialty care network or networks that are designed to serve patients of safety-net providers consisting of qualifying providers, as defined.

AB 2753 **(Ortega D) Rehabilitative and habilitative services: durable medical equipment and services.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 4/17/2024)
Location: 5/16/2024-A. DEAD

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

Summary: Current law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under current law, essential health benefits include, among other things, rehabilitative and habilitative services. Current law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define “durable medical equipment” to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.

AB 2843 **(Petrie-Norris D) Health care coverage: rape and sexual assault.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require a health care service plan or health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2025, to provide coverage without cost sharing for emergency room medical care and follow-up health care treatment for an enrollee or insured who is treated following a rape or sexual assault. The bill would prohibit a health care service plan or health insurer from requiring, as a condition of providing coverage, (1) an enrollee or insured to file a police report, (2) charges to be brought against an assailant, (3) or an assailant to be convicted of rape or sexual assault. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2914 **(Bonta D) Health care coverage: essential health benefits.**
Current Text: Amended: 4/10/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires the Department of Insurance to regulate health insurers. Current law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Current law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified. This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.

AB 2930 **(Bauer-Kahan D) Automated decision tools.**
Current Text: Amended: 6/3/2024 html pdf
Status: 6/3/2024-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on JUD.
Location: 5/29/2024-S. JUD.

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

Summary: The Unruh Civil Rights Act provides that all persons within the jurisdiction of this state are free and equal and, regardless of their sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, or immigration status, are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever. The California Fair Employment and Housing Act establishes the Civil Rights Department within the Business, Consumer Services, and Housing Agency and requires the department to, among other things, bring civil actions to enforce the act. This bill would, among other things, require, as prescribed, a deployer, as defined, and a developer of an automated decision tool, as defined, to perform an impact assessment on any automated decision tool before first using it and annually thereafter that includes, among other things, a statement of the purpose of the automated decision tool and its intended benefits, uses, and deployment contexts. The bill would require a deployer or developer to provide the impact assessment to the Civil Rights Department within 7 days of a request by the department and would punish a violation of that provision with an administrative fine of not more than $10,000 to be recovered in an administrative enforcement action brought by the Civil Rights Department.

AB 2956 **(Boerner D) Medi-Cal eligibility: redetermination.**
Current Text: Amended: 4/18/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

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

Summary: Current law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their Medi-Cal eligibility. Current law conditions implementation of the redetermination provisions on the availability of federal financial participation and receipt of any necessary federal approvals. Under current law, if a county has facts clearly demonstrating that a Medi-Cal beneficiary cannot be eligible for Medi-Cal due to an event, such as death or change of state residency, Medi-Cal benefits are terminated without a redetermination. Current law requires the department, subject to federal funding, to extend continuous eligibility to children 19 years of age or younger for a 12-month period, as specified. Under current law, operative on January 1, 2025, or the date that the State Department of Health Care Services certifies that certain conditions have been met, a child is continuously eligible for Medi-Cal up to 5 years of age. Under those provisions, a redetermination is prohibited during this time, unless certain circumstances apply, including, voluntary disenrollment, death, or change of state residency. This bill would require the department to seek federal approval to extend continuous eligibility to individuals over 19 years of age. Under the bill, subject to federal funding, and except as described above with regard to death, change of state residency, or other events, an individual would remain eligible from the date of a Medi-Cal eligibility determination until the end of a 12-month period, as specified.

AB 2976 **(Jackson D) Mental health care.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 5/2/2024-Failed Deadline pursuant to Rule 61(b)(6). (Last location was PRINT on 2/16/2024)
Location: 5/2/2024-A. DEAD

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

Summary: Current law establishes various state and local programs for the provision of mental health services within the jurisdiction of the State Department of Health Care Services, the State Department of Public Health, the California Behavioral Health Planning Council, the Department of Health Care Access and Information, and county public health or behavioral health departments, among other entities. This bill would state the intent of the Legislature to enact legislation relating to access to mental health care.

AB 3030 **(Calderon D) Health care services: artificial intelligence.**
Current Text: Amended: 4/25/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

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

Summary: Would require a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence to generate written or verbal patient communications to ensure that those communications include both (1) a disclaimer that indicates to the patient that a communication was generated by generative artificial intelligence, as specified, and (2) clear instructions permitting a patient to communicate with a human health care provider. Because a violation of these requirements would be a crime, this bill would impose a state-mandated local program.

AB 3059 **(Weber D) Human milk.**
Current Text: Amended: 3/11/2024 html pdf
Status: 6/5/2024-Referred to Com. on HEALTH.
Location: 6/5/2024-S. HEALTH

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

Summary: Current law licenses and regulates tissue banks and generally makes a violation of the requirements

applicable to tissue banks a crime. Existing law exempts a "mothers' milk bank," as defined, from paying a licensing fee to be a tissue bank. This bill would specify that a general acute care hospital is not required to have a license to operate a tissue bank to store or distribute pasteurized human milk that was obtained from a mothers' milk bank.

AB 3129 **(Wood D) Health care system consolidation.**
Current Text: Amended: 4/24/2024 html pdf
Status: 5/29/2024-Referred to Coms. on HEALTH and JUD.
Location: 5/29/2024-S. HEALTH

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

Summary: Current law requires a nonprofit corporation that operates or controls a health facility or other facility that provides similar health care to provide written notice to, and to obtain the written consent of, the Attorney General prior to entering into any agreement or transaction to sell, transfer, lease, exchange, option, convey, or otherwise dispose of the asset, or to transfer control, responsibility, or governance of the asset or operation, to a for-profit corporation or entity, to a mutual benefit corporation or entity, or to a nonprofit corporation, as specified. This bill would require a private equity group or a hedge fund, as defined, to provide written notice to, and obtain the written consent of, the Attorney General prior to a change of control or an acquisition between the private equity group or hedge fund and a health care facility or provider group, as those terms are defined, except as specified. The bill would require the notice to be submitted at the same time that any other state or federal agency is notified pursuant to state or federal law, and otherwise at least 90 days before the change in control or acquisition. The bill would authorize the Attorney General to extend that 90-day period under certain circumstances. The bill would additionally require a private equity group or hedge fund to provide advance written notice to the Attorney General prior to a change of control or acquisition between a private equity group or hedge fund and a nonphysician provider, or a provider with specified annual revenue.

AB 3149 **(Garcia D) Promotores and Promotoras Advisory and Oversight Workgroup.**
Current Text: Amended: 4/18/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/8/2024)
Location: 5/16/2024-A. DEAD

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

Summary: Current law defines "community health worker" as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery and who is a frontline health worker either trusted by, or who has a close understanding of, the community served. Current law includes in the definition of community health worker Promotores, Promotores de Salud, Community Health Representatives, navigators, and other non-licensed health workers with specified qualifications. This bill would require the State Department of Health Care Services, by no later than January 1, 2025, and until December 31, 2026, to convene the Promotores and Promotoras Advisory and Oversight Workgroup to provide perspective and guidance to changes in the health and human services delivery system, including, but not limited to, the Medi-Cal program. The bill would require the secretary to appoint no fewer than 9 individuals to the workgroup who have at least ten years' experience working in California as, or with, Promotores or Promotoras. The bill would require the workgroup to be comprised of no less than 51% Promotores or Promotoras, as specified, and require the appointees to be from geographically diverse areas of the state. The bill would require the workgroup to advise the departments under the agency to ensure that services provided by Promotores or Promotoras are available and accessible to all eligible populations. The bill would also require the workgroup to advise the agency to ensure that Promotores and Promotoras training and outreach materials are culturally and linguistically appropriate, to make recommendations on outreach efforts, as specified, and to provide input on issues that should be informed by community representatives who have lived experience with using and navigating Promotores or Promotoras services and the Medi-Cal program.

AB 3156 **(Patterson, Joe R) Medi-Cal managed care plans: beneficiaries with other primary coverage.**
Current Text: Amended: 4/25/2024 html pdf
Status: 6/5/2024-Referred to Com. on HEALTH.
Location: 6/5/2024-S. HEALTH

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

Summary: Under current federal law, in accordance with third-party liability rules, Medicaid is generally the payer of last resort if a beneficiary has another source of health care coverage in addition to Medicaid coverage. Under this bill, in the case of an enrollee of a Medi-Cal managed care plan who has other health care coverage and for whom the Medi-Cal program is a secondary payer, the State Department of Health Care Services would be required to ensure that a provider billing the managed care plan for allowable costs not paid by the other health care coverage does not face administrative requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system. The bill, in the case of an enrollee of a Medi-Cal managed care plan who has coverage under the federal Medicare Program or another primary form of health care coverage and for whom the Medi-Cal program is a secondary payer, would prohibit a provider participating in the Medi-Cal fee-for-service delivery system or in the federal Medicare Program from being required to contract with the Medi-Cal managed care plan in order to provide services to that enrollee and to bill the managed care plan.

AB 3215 **(Soria D) Medi-Cal: mental health services for children.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 5/2/2024-Failed Deadline pursuant to Rule 61(b)(6). (Last location was PRINT on 2/16/2024)
Location: 5/2/2024-A. DEAD

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

Summary: Would express the intent of the Legislature to enact legislation to expand access to behavioral mental health services to children receiving Medi-Cal benefits.

AB 3221 **(Pellerin D) Department of Managed Health Care: review of records.**
Current Text: Amended: 4/1/2024 html pdf
Status: 5/22/2024-Referred to Com. on HEALTH.
Location: 5/22/2024-S. HEALTH

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (hereafter the act), 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. Existing law requires the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director of the department during normal business hours. This bill would instead require the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director, including through electronic means. The bill would require a plan and other specified entities to furnish in electronic media records, books, and papers that are possessed in electronic media and to conduct a diligent review of records, books, and papers and make every effort to furnish those responsive to the director's request. The bill would require records, books, and papers to be furnished in a format that is digitally searchable, to the greatest extent feasible. The bill would require records, books, and papers to be preserved until furnished, if requested by the department. The bill would authorize the director to inspect and copy these records, books, and papers, and to seek relief in an administrative law proceeding if, in the director's determination, a plan or other specified entity fails to fully or timely respond to a duly authorized request for production of records, books, and papers. Because a willful violation of these requirements would be a crime, the bill would impose a state-mandated local program.

AB 3245 **(Patterson, Joe R) Coverage for colorectal cancer screening.**
Current Text: Amended: 4/25/2024 html pdf
Status: 6/6/2024-From committee: Amend and do pass as amended and re-refer to Com. on APPR. (Ayes 10. Noes 0.) (June 5).
Location: 6/5/2024-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered

1st House	2nd House	Conc.			

Summary: Current law generally requires a health care service plan contract, or a health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage without cost sharing for a colorectal cancer screening test, and for a colorectal cancer screening examination in specified circumstances, assigned either a grade of A or a grade of B by the United States Preventive Services Task Force. This bill would additionally require that coverage if the test or screening examination is assigned either a grade of A or a grade of B, or equivalent, in accordance with the most current recommendations established by another accredited or certified guideline agency.

AB 3260 **(Pellerin D) Health care coverage: reviews and grievances.**
Current Text: Amended: 5/16/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

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

Summary: Existing law, 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. Existing law generally authorizes a health care service plan or disability 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. Existing law requires these decisions to be made within 30 days, or less than 72 hours, when the enrollee faces an imminent and serious threat to their health. Existing law requires a health care service plan to establish a grievance system to resolve grievances within 30 days but limits that timeframe to 3 days when the enrollee faces an imminent and serious threat to their health. Existing law requires a plan to provide a written explanation for its grievance decisions, as specified. This bill would require that utilization review decisions be made within 72 hours from the health care service plan's receipt of the clinical information reasonably necessary to make the determination when the enrollee's condition is urgent and would make a determination of urgency by the enrollee's health care provider binding on the health care service plan. If the plan lacks the information reasonably necessary to make a decision regarding an urgent request, the bill would require the plan to notify the enrollee and provider about the information necessary to complete the request within 24 hours of receiving the request. The bill would require the plan to notify the enrollee and the provider of the decision within a reasonable amount of time, but not later than 48 hours after specified circumstances occur. If a health care service plan fails to make a utilization review decision, or provide notice of a decision, within the specified timelines, the bill would require the health care service plan to treat the request for authorization as a grievance and provide notice with specified information to the enrollee that a grievance has commenced. This bill contains other related provisions and other existing laws.

AB 3275 **(Soria D) Health care coverage: claim reimbursement.**
Current Text: Amended: 5/16/2024 html pdf
Status: 5/29/2024-Referred to Com. on HEALTH.
Location: 5/29/2024-S. HEALTH

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

Summary: Existing law, 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. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health insurer or health care service plan, including a specialized health care service plan, to reimburse a claim or portion of a claim no later than 30 working days after receipt of the claim, unless the plan contests or denies the claim, in which case the plan is required to notify the claimant within 30 working days that the claim is contested or denied. Under existing law, if a claim or portion thereof is contested on the basis that a health insurer or health care service plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided, the health insurer or health care service plan has 30 working days after receipt of the additional information to complete reconsideration of the claim. Existing law extends these timelines to 45 working days for a health care service plan that is a health maintenance organization. Under existing law, if a claim is not reimbursed,

contested, or denied pursuant to these timelines, as specified, interest accrues at a rate of 15% per annum for a health care service plan and 10% per annum for a health insurer. This bill would increase that interest accrual rate for a health insurer to 15% per annum. The bill would delete the provisions that extend the timelines for a health maintenance organization. The bill would require a health care service plan or health insurer to reimburse a claim within 15 working days after receipt of the claim, or, if the health care service plan or health insurer contests or denies the claim, to notify the claimant within 15 working days that the claim is contested or denied. Under the bill, if a claim for reimbursement is contested on the basis that the health care service plan or health insurer has not received all information necessary to determine payer liability for the claim and notice has been provided, the health care service plan or health insurer would have 15 working days after receipt of the additional information to complete reconsideration of the claim. The bill would require the departments to develop respective lists for categories of claims that, commencing January 1, 2026, would be required to be paid by a health insurer or health care service plan no later than 5 days after receipt of the claim, as specified. This bill contains other related provisions and other existing laws.

SB 70 **(Wiener D) Prescription drug coverage.**

Current Text: Amended: 6/29/2023 html pdf

Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/16/2023)(May be acted upon Jan 2024)

Location: 9/1/2023-A. 2 YEAR

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

Summary: Current law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law prohibits a health care service plan contract that covers prescription drug benefits or a specified health insurance policy from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which it was approved by the federal Food and Drug Administration if specified conditions are met. Current law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. This bill would additionally prohibit limiting or excluding coverage of a drug, dose of a drug, or dosage form of a drug that is prescribed for off-label use if the drug has been previously covered for a chronic condition or cancer, as specified, regardless of whether or not the drug, dose, or dosage form is on the plan's or insurer's formulary. The bill would prohibit a health care service plan contract or health insurance policy from requiring additional cost sharing not already imposed for a drug that was previously approved for coverage.

SB 136 **(Committee on Budget and Fiscal Review) Medi-Cal: managed care organization provider tax.**

Current Text: Chaptered: 3/25/2024 html pdf

Status: 3/25/2024-Chaptered by Secretary of State - Chapter 6, Statutes of 2024

Location: 3/25/2024-S. CHAPTERED

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

Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Current law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department. Under current law, all revenues, less refunds, derived from the taxes are deposited into the Managed Care Enrollment Fund, to be available to the department, upon appropriation, for the purpose of funding specified subcomponents to support the Medi-Cal program. Current law sets forth certain taxing tiers and tax amounts for purposes of the tax periods of April 1, 2023, to December 31, 2023, inclusive, and the 2024, 2025, and 2026 calendar years. Under current law, the Medi-Cal per enrollee tax amount for Medi-Cal taxing tier II, as defined, is $182.50 for the 2024 calendar year, $187.50 for the 2025 calendar year, and $192.50 for the 2026 calendar year. This bill would raise that tax amount for that tier to $205 for all 3 of those calendar years.

SB 238 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 6/19/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/23/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

Summary: Current law provides for the regulation of disability insurers by the Department of Insurance. Current law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill, commencing July 1, 2024, would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified. The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts.

SB 282 **(Eggman D) Medi-Cal: federally qualified health centers and rural health clinics.**
Current Text: Amended: 3/13/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/16/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

Summary: Under current law of the Medi-Cal program, to the extent that federal financial participation is available, federally qualified health center (FQHC) and rural health clinic (RHC) services are reimbursed on a per-visit basis, as specified. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and a physician or other specified health care professionals. Under existing law, "visit" also includes an encounter using video or audio-only synchronous interaction or an asynchronous store and forward modality, as specified. This bill would authorize reimbursement for a maximum of 2 visits that take place on the same day at a single site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit, as defined. The bill would require the department, by July 1, 2024, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting those provisions. The bill would include a licensed acupuncturist within those health care professionals covered under the definition of a "visit." The bill would also make a change to the provision relating to physicians and would make other technical changes.

SB 294 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 5/24/2024 html pdf
Status: 6/5/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 3.) (June 4). Re-referred to Com. on APPR.

Location: 6/4/2024-A. APPR.

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

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 provides for the regulation of disability insurers by the Department of Insurance. Current law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill, commencing January 1, 2026, would require a health care service plan or a disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider.

SB 339 **(Wiener D) HIV preexposure prophylaxis and postexposure prophylaxis.**
Current Text: Chaptered: 2/6/2024 html pdf
Status: 2/6/2024-Chaptered by Secretary of State - Chapter 1, Statutes of 2024
Location: 2/6/2024-S. CHAPTERED

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

Summary: The Pharmacy Law provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. Current law authorizes a pharmacist to furnish at least a 30-day supply of HIV preexposure prophylaxis, and up to a 60-day supply of those drugs if certain conditions are met. Current law also authorizes a pharmacist to furnish postexposure prophylaxis to a patient if certain conditions are met. This bill would authorize a pharmacist to furnish up to a 90-day course of preexposure prophylaxis, or preexposure prophylaxis beyond a 90-day course, if specified conditions are met. The bill would require the California State Board of Pharmacy to adopt emergency regulations to implement these provisions by October 31, 2024.

SB 363 **(Eggman D) Facilities for inpatient and residential mental health and substance use disorder: database.**
Current Text: Amended: 5/18/2023 html pdf
Status: 9/1/2023-September 1 hearing: Held in committee and under submission.
Location: 8/23/2023-A. APPR. SUSPENSE FILE

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

Summary: Would require, by January 1, 2026, the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a real-time, internet-based database to collect, aggregate, and display information about beds in specified types of facilities, such as chemical dependency recovery hospitals, acute psychiatric hospitals, and mental health rehabilitation centers, among others, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the database to include a minimum of specific information, including the contact information for a facility's designated employee, the types of diagnoses or treatments for which the bed is appropriate, and the target populations served at the facility, and have the capacity to, among other things, enable searches to identify beds that are appropriate for individuals in need of inpatient or residential mental health or substance use disorder treatment.

SB 424 **(Durazo D) Medi-Cal: Whole Child Model program.**
Current Text: Amended: 5/25/2023 html pdf

Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/8/2023)(May be acted upon Jan 2024)
Location: 7/14/2023-A. 2 YEAR

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

Summary: Current law establishes the California Children's Services (CCS) Program, administered by the State Department of Health Care Services and a designated agency of each county, to provide medically necessary services for persons under 21 years of age who have any of specified medical conditions and who meet certain financial eligibility requirements. Current law establishes the Medi-Cal program, which is administered by the department and under which qualified low-income individuals receive health care services. Current law requires the department to establish a statewide Whole Child Model program stakeholder advisory group that includes specified persons, including CCS case managers, and to consult with that advisory group on prescribed matters. Current law terminates the advisory group on December 31, 2023. This bill would extend the operation of the advisory group until December 31, 2026.

SB 427 **(Portantino D) Health care coverage: antiretroviral drugs, drug devices, and drug products.**
Current Text: Amended: 4/4/2024 html pdf
Status: 5/13/2024-Ordered to the Assembly. In Assembly. Held at Desk.
Location: 5/13/2024-A. DESK

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

Summary: Current law generally prohibits a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy. Under current law, a health care service plan or health insurer is not required to cover all the therapeutically equivalent versions of those drugs without prior authorization or step therapy if at least one is covered without prior authorization or step therapy. This bill would prohibit a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs, drug devices, or drug products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of HIV/AIDS, to prior authorization or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the plan or insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, drug device, or drug product without cost sharing pursuant to an exception request. The bill would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, drug devices, or drug products, including by supplying participating providers directly with a drug, drug device, or drug product, as specified.

SB 516 **(Skinner D) Health care coverage: prior authorization.**
Current Text: Amended: 9/13/2023 html pdf
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. on 9/14/2023)(May be acted upon Jan 2024)
Location: 9/14/2023-A. 2 YEAR

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

Summary: Would, on or after January 1, 2026, prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior

authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

SB 551 **(Portantino D) Beverage containers: recycling.**
Current Text: Amended: 3/21/2024 html pdf
Status: 3/21/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 3/19/2024-A. APPR.

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

Summary: The California Beverage Container Recycling and Litter Reduction Act requires plastic beverage containers sold by a beverage manufacturer, as specified, to contain a specified average percentage of postconsumer recycled plastic per year. The act requires the manufacturer of a beverage sold in a plastic beverage container subject to the California Redemption Value to report to the Department of Resources Recycling and Recovery certain information about the amounts of virgin plastic and postconsumer recycled plastic used for plastic beverage containers subject to the California Redemption Value for sale in the state in the previous calendar year. Current law provides that a violation of the act or a regulation adopted pursuant to the act is a crime. This bill would authorize certain beverage manufacturers to submit with other beverage manufacturers a consolidated report, in lieu of individual reports, that identifies the postconsumer recycled plastic content for beverage containers and the amounts of virgin plastic and postconsumer recycled plastic used in beverage containers, as specified. The bill would require the consolidated report to be submitted under penalty of perjury and pursuant to standardized forms prescribed by the department.

SB 729 **(Menjivar D) Health care coverage: treatment for infertility and fertility services.**
Current Text: Amended: 8/14/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/23/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

Summary: Would require large and small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after January 1, 2024, to provide coverage for the diagnosis and treatment of infertility and fertility services. With respect to large group health care service plan contracts and disability insurance policies, the bill would require coverage for a maximum of 3 completed oocyte retrievals, as specified. The bill would revise the definition of infertility and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and disability insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contract holders and policyholders. The bill would prohibit a health care service plan or disability insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified. The bill would make these requirements inapplicable to a religious employer, as defined, and specified contracts and policies.

SB 966 **(Wiener D) Pharmacy benefits.**
Current Text: Amended: 4/29/2024 html pdf
Status: 6/3/2024-Referred to Coms. on HEALTH and JUD.
Location: 6/3/2024-A. HEALTH

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

Summary: The Knox-Keene Act requires a pharmacy benefit manager under contract with a health care service plan to,

among other things, register with the Department of Managed Health Care. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would additionally require a pharmacy benefit manager, as defined by the bill, to apply for and obtain a license from the Department of Insurance to operate as a pharmacy benefit manager on and after January 1, 2026. The bill would establish application qualifications and requirements and would require initial license and renewal fees to be collected into the newly created Pharmacy Benefit Manager Fund to be available to the department for use, upon appropriation by the Legislature, for costs related to licensing and regulating pharmacy benefit managers.

SB 980 **(Wahab D) Medi-Cal: dental crowns and implants.**
Current Text: Amended: 5/16/2024 html pdf
Status: 6/3/2024-Referred to Com. on HEALTH.
Location: 6/3/2024-A. HEALTH

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

Summary: Under current law, for persons 21 years of age or older, laboratory-processed crowns on posterior teeth are a covered benefit when medically necessary to restore a posterior tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria. This bill, for purposes of the above-described Medi-Cal coverage for laboratory-processed crowns, would remove the condition that the tooth be posterior and would apply the coverage to persons 13 years of age or older.

SB 999 **(Cortese D) Health coverage: mental health and substance use disorders.**
Current Text: Amended: 4/8/2024 html pdf
Status: 5/28/2024-Referred to Com. on HEALTH.
Location: 5/28/2024-A. HEALTH

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

Summary: Would require a health care service plan and a disability insurer, and an entity acting on a plan's or insurer's behalf, to ensure compliance with specific requirements for utilization review, including maintaining telephone access and other direct communication access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conducting peer-to-peer discussions regarding specific patient issues related to treatment. 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 1008 **(Bradford D) Obesity Treatment Parity Act.**
Current Text: Amended: 4/29/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/6/2024)
Location: 5/16/2024-S. DEAD

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

Summary: Would require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include specified coverage for the treatment of obesity, including coverage for at least one FDA-approved anti-obesity medication.

SB 1017 **(Eggman D) Available facilities for inpatient and residential mental health or substance use disorder treatment.**
Current Text: Introduced: 2/5/2024 html pdf
Status: 5/16/2024-May 16 hearing: Held in committee and under submission.
Location: 4/15/2024-S. APPR. SUSPENSE FILE

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

Summary: Current law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. This bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a solution to collect, aggregate, and display information about beds in specified types of facilities, including licensed community care facilities and licensed residential alcoholism or drug abuse recovery or treatment facilities, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the solution to be operational by January 1, 2026, or the date the State Department of Health Care Services communicates to the Department of Finance in writing that the solution has been implemented to meet these provisions, whichever date is later.

SB 1112 **(Menjivar D) Medi-Cal: families with subsidized childcare.**
Current Text: Amended: 5/16/2024 html pdf
Status: 6/3/2024-Referred to Coms. on HEALTH and HUM. S.
Location: 6/3/2024-A. HEALTH

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

Summary: Current law establishes a system of childcare and development services, administered by the State Department of Social Services, for children from infancy to 13 years of age. Existing law authorizes, upon departmental approval, the use of appropriated funds for alternative payment programs to allow for maximum parental choice. Current law authorizes those programs to include, among other things, a subsidy that follows the family from one childcare provider to another, or choices among hours of service. Current law requires the department to contract with local contracting agencies for alternative payment programs so that services are provided throughout the state. Under existing law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered Medi-Cal benefits for individuals under 21 years of age. This bill, subject to any necessary federal approvals and the availability of federal funding, would require the State Department of Health Care Services and the State Department of Social Services to develop a model memorandum of understanding (MOU), and would require the department to authorize Medi-Cal managed care plans and alternative payment agencies to enter an MOU that includes, at a minimum, the provisions included in the model.

SB 1120 **(Becker D) Health care coverage: utilization review.**
Current Text: Amended: 4/15/2024 html pdf
Status: 6/3/2024-Referred to Coms. on HEALTH and P. & C.P.
Location: 6/3/2024-A. HEALTH

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, 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 requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Current law authorizes the Director of the Department of Managed Health Care or the Insurance Commissioner to assess an administrative penalty to a health care service plan or health insurer, as applicable, for failure to comply with those requirements. This bill would require algorithms, artificial intelligence, and other software tools used for utilization review or utilization management decisions to comply with specified requirements, including that they be fairly and equitably applied.

SB 1131 **(Gonzalez D) Medi-Cal providers: family planning.**
Current Text: Amended: 5/16/2024 html pdf

Status: 6/5/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 2.) (June 4). Re-referred to Com. on APPR.
Location: 6/4/2024-A. APPR.

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

Summary: Current law establishes, under the Medi-Cal program, the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department. Under Family PACT, comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level and who meets other eligibility criteria to receive those services. Current law makes the Family PACT Program inoperative if the program is determined to no longer be cost effective, as specified. If the program becomes inoperative, existing law requires all persons who have received, or are eligible to receive, comprehensive clinical family planning services pursuant to Family PACT to receive family planning services under other specified provisions of the Medi-Cal program or under the State-Only Family Planning Program, which is also established within the department. Current law requires enrolled providers in the Family PACT Program or the State-Only Family Planning Program to attend a specific orientation approved by the department and requires providers who conduct certain services to have prior training in those services. This bill would, for both of the above-described programs, require the department to allow a provider a minimum of 6 months from the date of enrollment to complete the orientation. The bill would, for the Family PACT Program, require a site certifier of a primary care clinic or affiliate primary care clinic, as those terms are defined, to be a clinician who oversees the provision of Family PACT services and would authorize certain clinic corporations to enroll multiple service addresses under a single site certifier. The bill would require any orientation or training that the department requires of a site certifier to comply with specified requirements, including, among others, being offered through a virtual platform and being offered at least once per month.

SB 1180 **(Ashby D) Health care coverage: emergency medical services.**
Current Text: Amended: 5/16/2024 html pdf
Status: 5/28/2024-Referred to Com. on HEALTH.
Location: 5/28/2024-A. HEALTH

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to establish a process to reimburse for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program, as defined. The bill would require those contracts and policies to require an enrollee or insured who receives covered services from a noncontracting program to pay no more than the same cost-sharing amount that they would pay for the same covered services received from a contracting program. The bill would specify the reimbursement process and amount for a noncontracting program. 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 1213 **(Atkins D) Health care programs: cancer.**
Current Text: Amended: 4/8/2024 html pdf
Status: 6/5/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (June 4). Re-referred to Com. on APPR.
Location: 6/4/2024-A. APPR.

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

Summary: Current law requires the State Department of Health Care Services to perform various health functions, including providing breast and cervical cancer screening and treatment for low-income individuals. Current law provides that an individual is eligible to receive treatment services if, among other things, the individual has a family income at or below 200% of the federal poverty level as determined by the provider performing the screening and diagnosis. This bill would provide that an individual is eligible to receive treatment services if the individual has a family income at or below 300% of the federal poverty level as determined by the provider performing the screening and diagnosis.

SB 1236 **(Blakespear D) Medicare supplement coverage: open enrollment periods.**
Current Text: Amended: 4/29/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/13/2024)
Location: 5/16/2024-S. DEAD

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

Summary: Current federal law specifies different parts of Medicare that cover specific services, such as Medicare Part B, which generally covers medically necessary services and supplies and preventive services. 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. Existing law provides for the regulation of health insurers by the Department of Insurance. Current federal law additionally provides for the issuance of Medicare supplement policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program for the hospital, medical, or surgical expenses of persons eligible for the Medicare Program, including coverage of Medicare deductible, copayment, or coinsurance amounts, as specified. Current law, among other provisions, requires supplement benefit plans to be uniform in structure, language, designation, and format with the standard benefit plans, as prescribed. Current law prohibits an issuer from denying or conditioning the offering or effectiveness of any Medicare supplement contract, policy, or certificate available for sale in this state, or discriminating in the pricing of a contract, policy, or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Current law requires an issuer to make available specified Medicare supplement benefit plans to a qualifying applicant under those circumstances who is 64 years of age or younger who does not have end stage renal disease. This bill would delete the exclusion of otherwise qualified applicants who have end stage renal disease, thereby making the specified Medicare supplement benefit plans available to those individuals. The bill, on and after January 1, 2025, would prohibit an issuer of Medicare supplement coverage in this state from denying or conditioning the issuance or effectiveness of any Medicare supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for coverage is submitted during an open enrollment period, as specified in the bill.

SB 1258 **(Dahle R) Medi-Cal: unrecovered payments: interest rate.**
Current Text: Amended: 4/8/2024 html pdf
Status: 6/3/2024-Referred to Com. on HEALTH.
Location: 6/3/2024-A. HEALTH

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

Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under current law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under current law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department. In the case of an assessment against any unrecovered overpayment due to the department, this bill would authorize the department to waive the interest, as part of a repayment agreement entered into with the provider, if the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, after taking into account specified factors, including the impact of the repayment amounts on the fiscal solvency of the provider, and whether the overpayment was caused by a policy change or departmental error that was not the fault of the billing provider.

SB 1268 **(Nguyen R) Medi-Cal managed care plans: contracts with safety net providers.**
Current Text: Amended: 4/15/2024 html pdf

Status: 4/25/2024-Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 4/3/2024)
Location: 4/25/2024-S. DEAD

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

Summary: Would require a Medi-Cal managed care plan to offer a network provider contract to, and maintain a network provider contract with, each safety net provider, as defined, operating within the plan's contracted geographic service areas if the safety net provider agrees to provide its applicable scope of services in accordance with the same terms and conditions that the Medi-Cal managed care plan requires of other similar providers. The bill would set forth exceptions to that requirement in the case of a safety net provider no longer being willing to accept those terms and conditions, its license being revoked or suspended, or the department determining that the health or welfare of a Medi-Cal enrollee is threatened by the provider. The bill would require the plan to follow certain notification procedures if it terminates the network provider contract. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

SB 1269 **(Padilla D) Safety net hospitals.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 5/2/2024-Failed Deadline pursuant to Rule 61(b)(6). (Last location was HEALTH on 2/29/2024)
Location: 5/2/2024-S. DEAD

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

Summary: Would establish a definition for "safety net hospital" and would state the intent of the Legislature that this definition serve as a recommended definition for policymakers to elect to utilize when crafting policy aimed at focusing on or supporting those hospitals. Under the bill, the definition would not be construed as affecting existing or new references to safety net hospitals, unless future legislation or other action expressly makes reference to this definition, as specified.

SB 1290 **(Roth D) Health care coverage: essential health benefits.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 5/28/2024-Referred to Com. on HEALTH.
Location: 5/28/2024-A. HEALTH

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

Summary: Would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year. This bill contains other related provisions and other existing laws.

SB 1300 **(Cortese D) Health facility closure: public notice: inpatient psychiatric and maternity services.**
Current Text: Amended: 4/8/2024 html pdf
Status: 6/3/2024-Referred to Com. on HEALTH.
Location: 6/3/2024-A. HEALTH

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

Summary: Current law requires the State Department of Public Health to license, regulate, and inspect health facilities, as specified, including general acute care hospitals. Under current law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Current law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Current regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. Current law requires a health facility to provide 90 days of public notice of the proposed closure or elimination of a supplemental service, and 120 days of public notice of the

proposed closure or elimination of an acute psychiatric hospital. This bill would change the notice period required before proposed closure or elimination of the supplemental service of inpatient psychiatric service or maternity service from 90 days to 120 days. By changing the definition of a crime, this bill would impose a state-mandated local program.

SB 1320 **(Wahab D) Mental health and substance use disorder treatment.**
Current Text: Amended: 3/18/2024 html pdf
Status: 5/6/2024-Referred to Com. on HEALTH.
Location: 5/6/2024-A. HEALTH

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

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 provides for the regulation of disability insurers by the Department of Insurance. Current law requires a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. This bill would require a plan or insurer subject to the above-described coverage requirement, and its delegates, to establish a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services and provided under a contract or policy issued, amended, or renewed on or after July 1, 2025.

SB 1339 **(Allen D) Supportive community residences.**
Current Text: Amended: 5/16/2024 html pdf
Status: 6/3/2024-Referred to Com. on HEALTH.
Location: 6/3/2024-A. HEALTH

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

Summary: Current law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, defined to include, among other types of health facilities, an acute psychiatric hospital. Current law requires the State Department of Health Care Services to license and establish regulations for psychiatric residential treatment facilities. Current law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. Current law also requires the department to implement a voluntary certification program for alcohol and other drug treatment recovery services. The California Community Care Facilities Act generally provides for the licensing and regulation of community care facilities by the State Department of Social Services, to provide 24-hour nonmedical care of persons in need of personal services, supervision, or assistance. Existing regulation includes an adult residential facility as a community care facility for those purposes. This bill would require the State Department of Health Care Services (department), by January 1, 2027, and in consultation with relevant public agencies and stakeholders, to establish, and provide for the administration of, a voluntary certification program for supportive community residences. The bill would define a “supportive community residence” as specified residential dwellings providing housing for adults with a substance use disorder, mental health diagnosis, or dual diagnosis seeking a cooperative living arrangement that does not provide medical care or a level of support for activities of daily living that require state licensing.

SB 1354 **(Wahab D) Long-term health care facilities: payment source and resident census.**
Current Text: Amended: 4/29/2024 html pdf
Status: 6/3/2024-Referred to Com. on HEALTH.
Location: 6/3/2024-A. HEALTH

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

Summary: Current law provides for the licensing and regulation of long-term health care facilities, including, among others, skilled nursing facilities and intermediate care facilities, by the State Department of Public Health. A violation of those provisions is generally a crime. Current law prohibits a long-term health care facility that participates as a provider under the Medi-Cal program from discriminating against a Medi-Cal patient on the basis of the source of payment for the facility's services that are required to be provided to individuals entitled to services under the Medi-Cal program. Current law prohibits that facility from seeking to evict out of the facility, or transfer within the facility, any resident as a result of the resident changing their manner of purchasing the services from private payment or Medicare to Medi-Cal, except as specified. This bill would require the facility to provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source.

SB 1355 **(Wahab D) Medi-Cal: in-home supportive services: redetermination.**
Current Text: Amended: 4/25/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/6/2024)
Location: 5/16/2024-S. DEAD

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

Summary: Current law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. Current law provides for the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, and disabled persons are provided with supportive services in order to permit them to remain in their own homes. Current law authorizes certain Medi-Cal beneficiaries to receive IHSS as a covered Medi-Cal benefit. This bill would, to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized, require an IHSS recipient to be continuously eligible for Medi-Cal for 3 years, if they have a fixed income, and would prohibit a redetermination of Medi-Cal eligibility before 3 years, except as specified. The bill would make the implementation of its provisions contingent upon the department obtaining all necessary federal approvals, the department determining that systems have been programmed to implement these provisions, and the Legislature has appropriated funding to implement these provisions after a determination that ongoing General Fund resources are available to support the ongoing implementation of these provisions.

SB 1397 **(Eggman D) Behavioral health services coverage.**
Current Text: Amended: 4/15/2024 html pdf
Status: 6/3/2024-Referred to Com. on HEALTH.
Location: 6/3/2024-A. HEALTH

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after July 1, 2025, that covers medically necessary mental health and substance use disorder services to comply with rate and timely reimbursement requirements for services delivered by a county behavioral health agency, as specified. The bill would require in-network cost sharing, capped at the in-network deductible and in-network out-of-pocket maximum, to apply to these services. Unless an enrollee or insured is referred or authorized by the plan or insurer, the bill would require a county behavioral health agency to contact a plan or insurer before initiating services. The bill would authorize a plan or insurer to conduct a post claim review to determine appropriate payment of a claim, and would authorize the use of prior authorization as permitted by the regulating department. The bill would require the departments to issue guidance to plans and insurers regarding compliance with these provisions no later than April 1, 2025. Because a willful violation of these provisions by a health care service plan would be a crime, and the bill would impose a higher level of service on a county behavioral health agency, this bill would impose a state-mandated local program.

SB 1423 **(Dahle R) Medi-Cal: critical access hospitals.**
Current Text: Amended: 5/16/2024 html pdf

Status: 6/3/2024-Referred to Com. on HEALTH.
Location: 6/3/2024-A. HEALTH

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

Summary: Under current law, each hospital designated by the State Department of Health Care Services as a critical access hospital and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, is eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons. Current law conditions those payments on receipt of federal financial participation and an appropriation in the annual Budget Act for the nonfederal share of those payments, with supplemental payments being apportioned among critical access hospitals based on their number of Medi-Cal outpatient visits. This bill would require that each critical access hospital that elects to participate receive a base reimbursement at 100% of the hospital's projected reasonable and allowable costs for covered Medi-Cal services, as defined, furnished in the Medi-Cal fee-for-service and managed care delivery systems for each subject calendar year, effective for dates of service on or after January 1, 2026. The bill would require the department to develop and maintain one or more reimbursement methodologies or revise one or more existing reimbursement methodologies applicable to participating critical access hospitals, or both, to implement the cost-based payment levels.

SB 1428 **(Atkins D) Health care coverage: triggering events.**
Current Text: Amended: 3/18/2024 html pdf
Status: 6/5/2024-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 15. Noes 0.) (June 4). Re-referred to Com. on APPR.
Location: 6/4/2024-A. APPR.

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a health care service plan or a health insurer to allow an individual to enroll in or change individual health benefit plans as a result of specified triggering events, including a loss of minimum essential coverage, as defined, gaining a dependent or becoming a dependent, or being mandated to be covered as a dependent pursuant to a valid state or federal court order. Current law allows an individual 60 days from the date of a triggering event to apply for subsequent coverage. This bill would allow an individual 60 days before or after the date of a triggering event to apply for subsequent coverage. coverage, to the extent no conflicts with the availability and length of specified special enrollment periods exist. 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 1492 **(Menjivar D) Medi-Cal reimbursement rates: private duty nursing.**
Current Text: Amended: 4/15/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/6/2024)
Location: 5/16/2024-S. DEAD

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

Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Current law sets forth requirements for private duty nursing and home health care under the Medi-Cal program. Current law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department to provide full-scope Medi-Cal services. Under existing law, proceeds from the MCO provider tax may be used, upon appropriation by the Legislature, for the increased costs incurred as a result of reimbursement requirements, among other things. This bill would provide that private duty nursing services provided to a child under 21 years of age by a home health agency are included as an eligible category for Medi-Cal reimbursement through the above-described scheme.

Total Measures: 122

Total Tracking Forms: 122

ALAMEDA Alliance FOR HEALTH

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

Board Business

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

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

Date: **June 14th, 2024**

Subject: **Finance Report – April 2024**

Executive Summary

- For the month ended April 30th, 2024, the Alliance had enrollment of 405,174 members, a Net Loss of $8.3 million and 554% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$273,286	$1,872,095
Medical Expense	165,392	1,409,438
Admin. Expense	10,208	79,434
MCO Tax Expense	108,310	387,114
Other Inc. / (Exp.)	2,364	25,088
Net Income	**($8,259)**	**$21,196**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	($8,330)	$18,036
Group Care	71	3,160
	($8,259)	**$21,196**

*Includes costs for Medicare implementation.

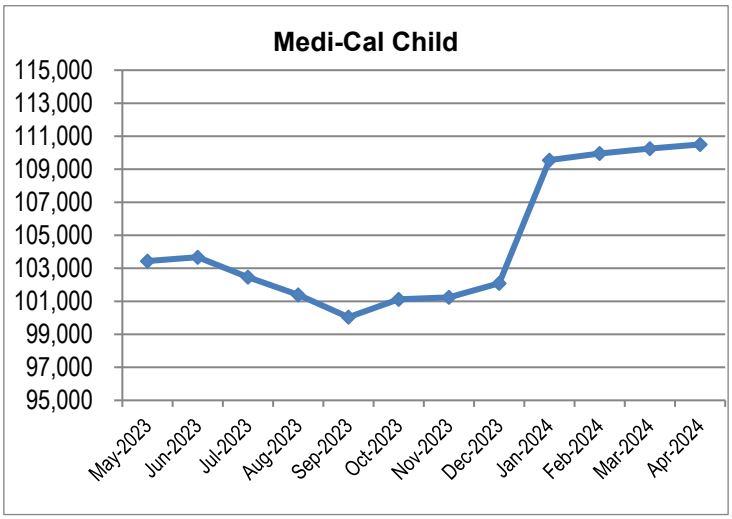
Enrollment

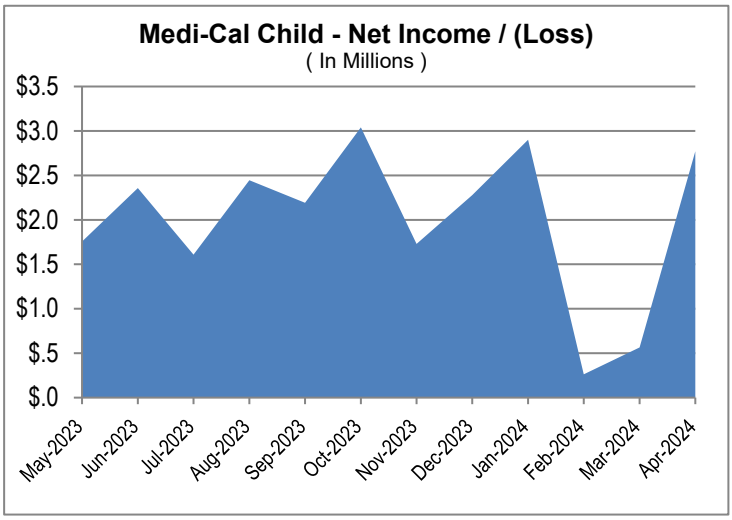
- Total enrollment increased by 1,233 members since March 2024.
- Total enrollment increased by 43,489 members since July 2023.

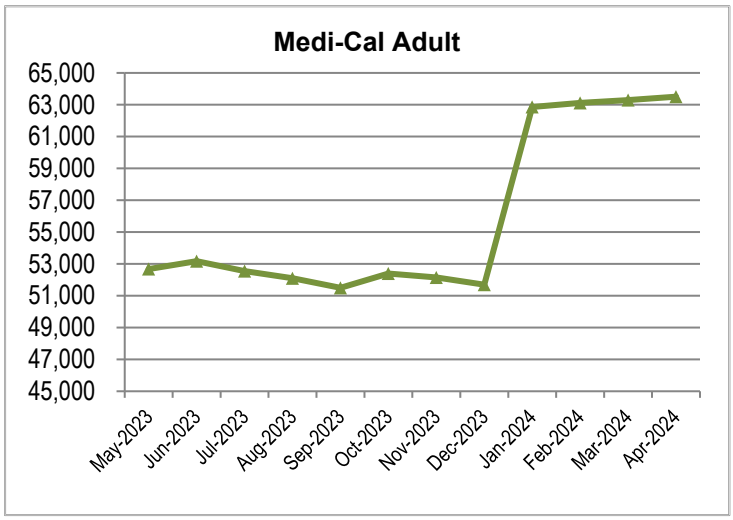
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

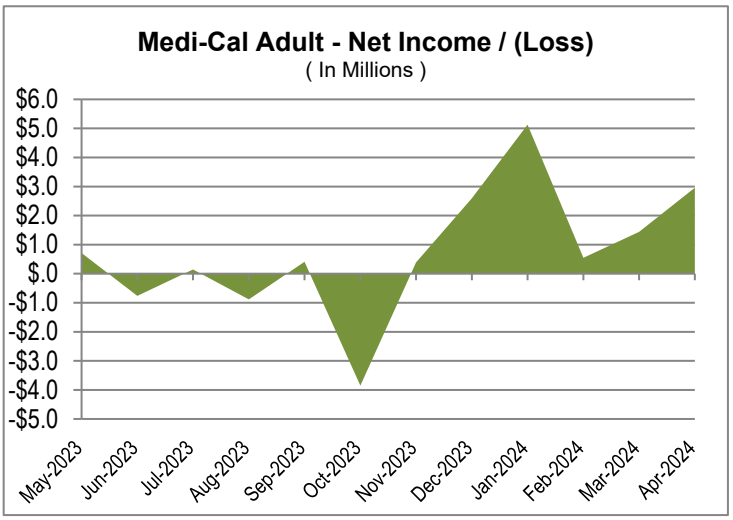
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
63,507	55,434	8,073	14.6%	Adult	565,171	537,527	27,644	5.1%
110,502	98,725	11,777	11.9%	Child	1,048,603	1,005,771	42,832	4.3%
34,888	41,462	(6,574)	-15.9%	SPD	324,834	352,461	(27,627)	-7.8%
39,951	45,506	(5,555)	-12.2%	Duals	409,192	431,850	(22,658)	-5.2%
149,168	144,328	4,840	3.4%	ACA OE	1,317,041	1,314,771	2,270	0.2%
224	175	49	28.0%	LTC	1,701	1,520	181	11.9%
1,291	1,142	149	13.0%	LTC Duals	11,217	10,680	537	5.0%
399,531	**386,772**	**12,759**	**3.3%**	**Medi-Cal Total**	**3,677,759**	**3,654,580**	**23,179**	**0.6%**
5,643	5,521	122	2.2%	Group Care	56,231	55,886	345	0.6%
405,174	**392,293**	**12,881**	**3.3%**	**Total**	**3,733,990**	**3,710,466**	**23,524**	**0.6%**

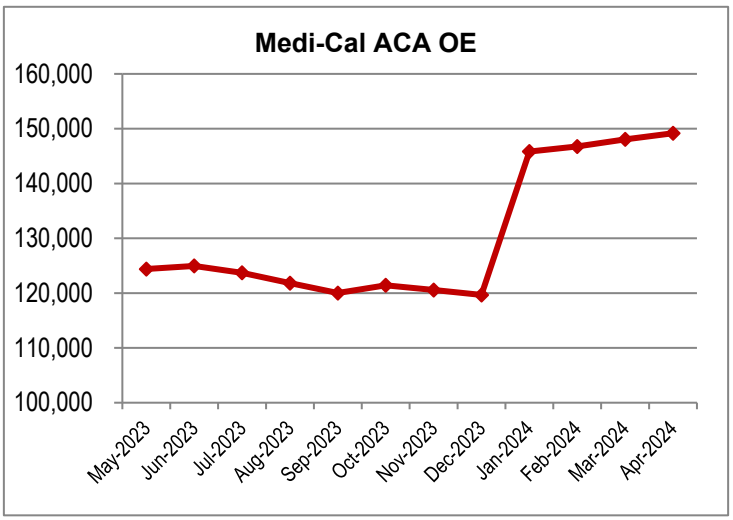
Enrollment and Profitability by Program and Category of Aid

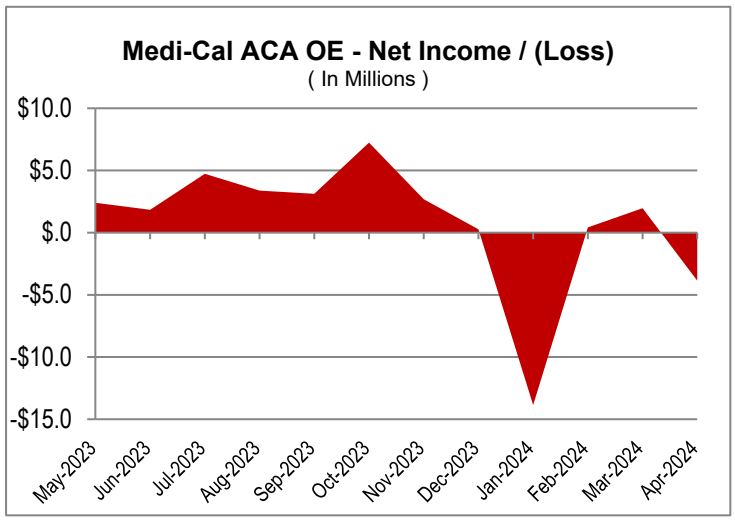




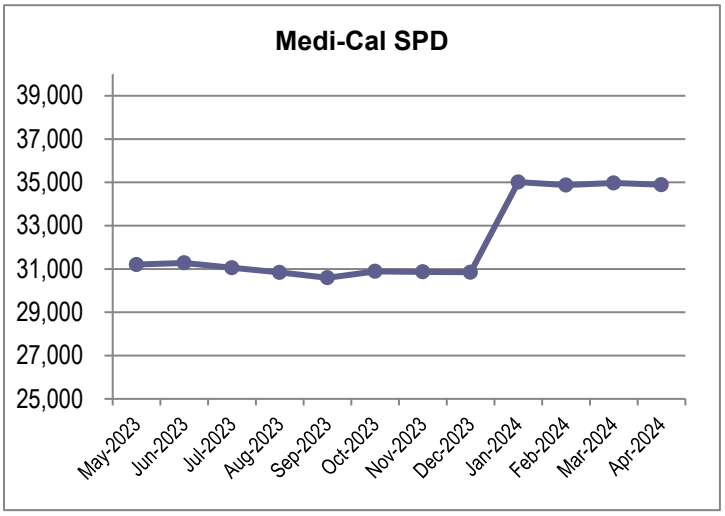


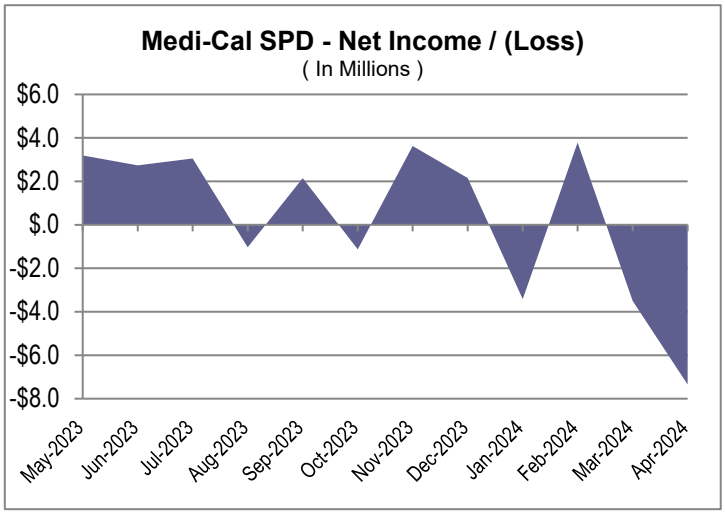


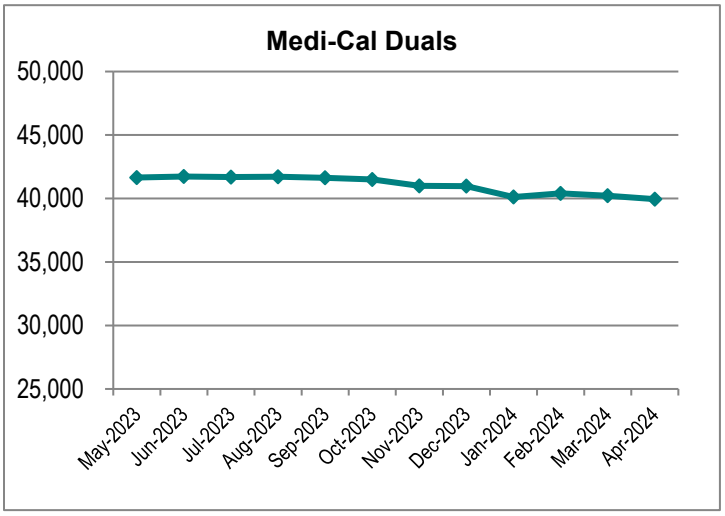


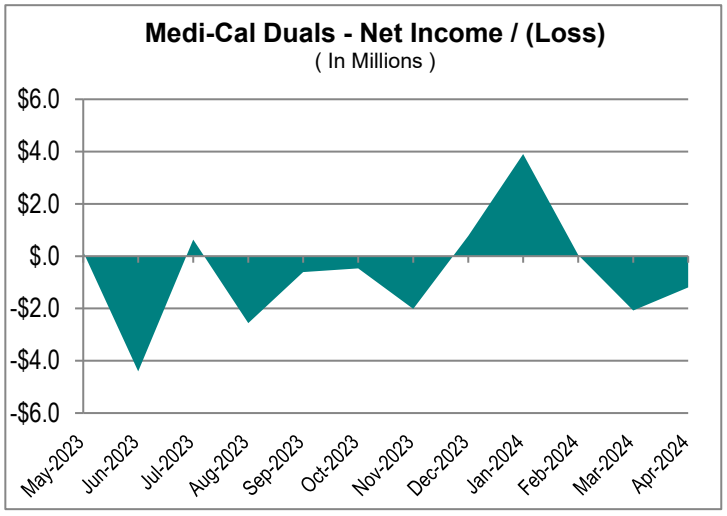


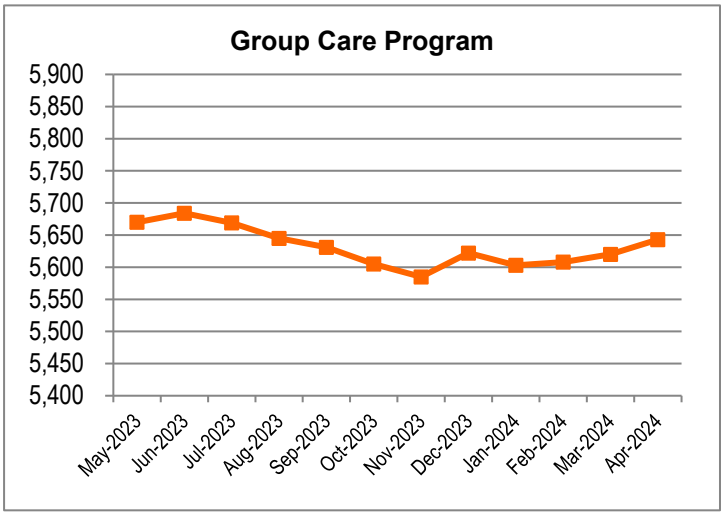
Enrollment and Profitability by Program and Category of Aid

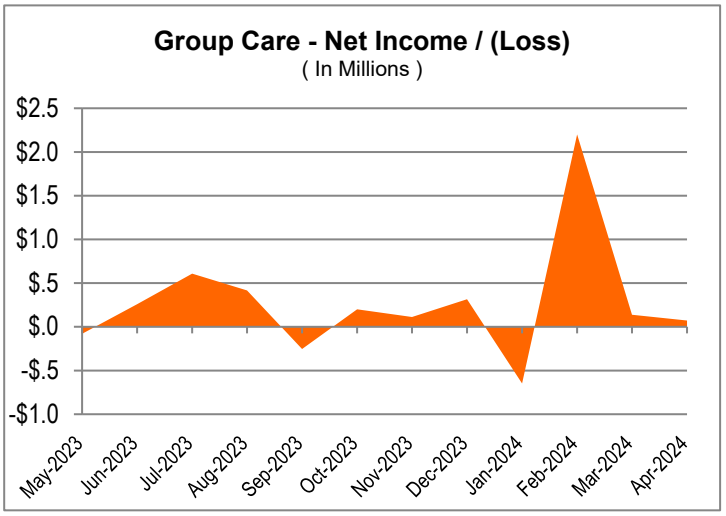












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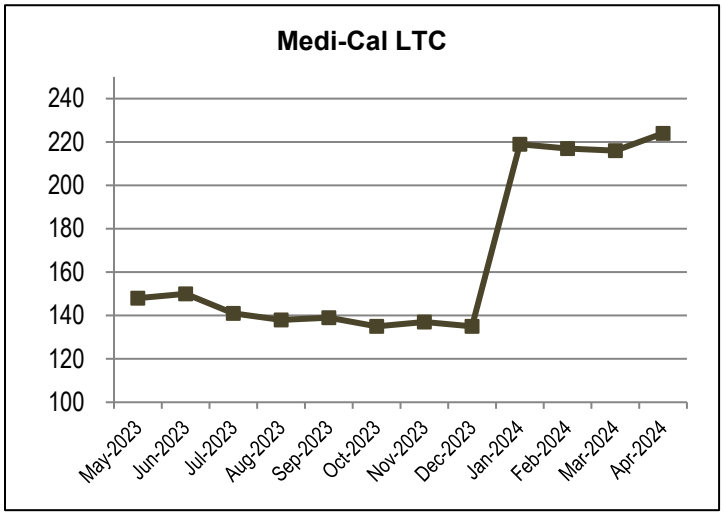
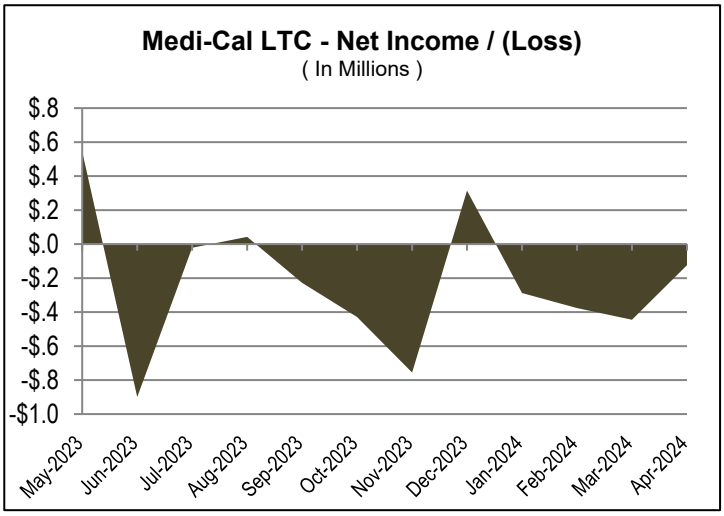
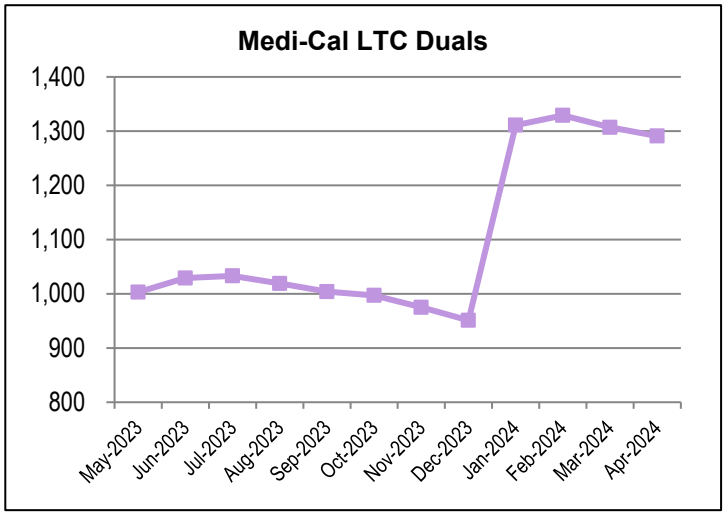
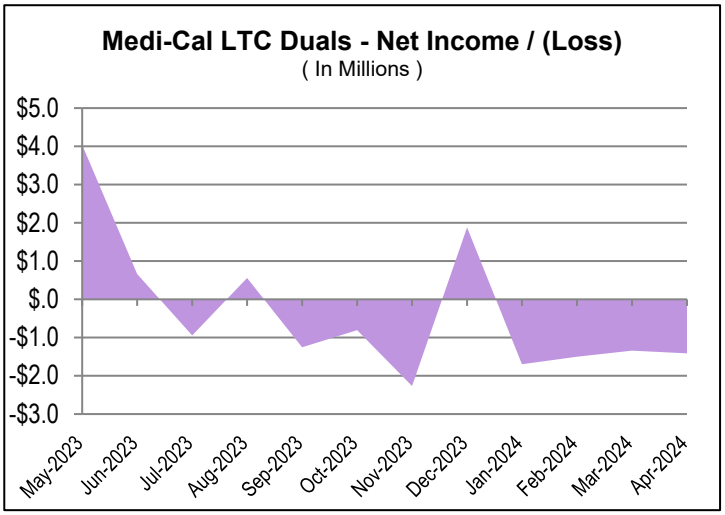
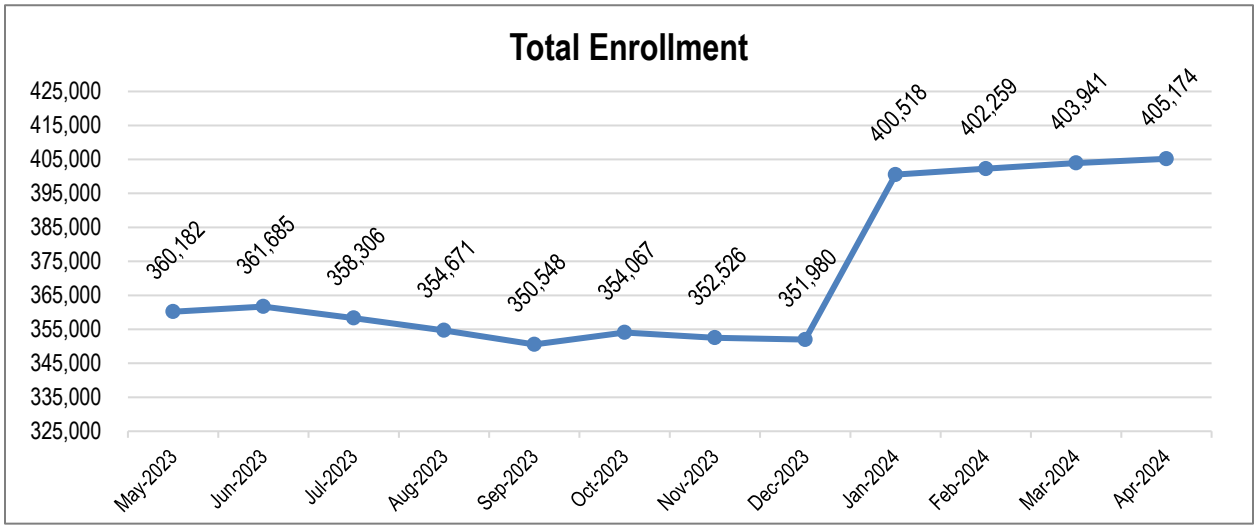
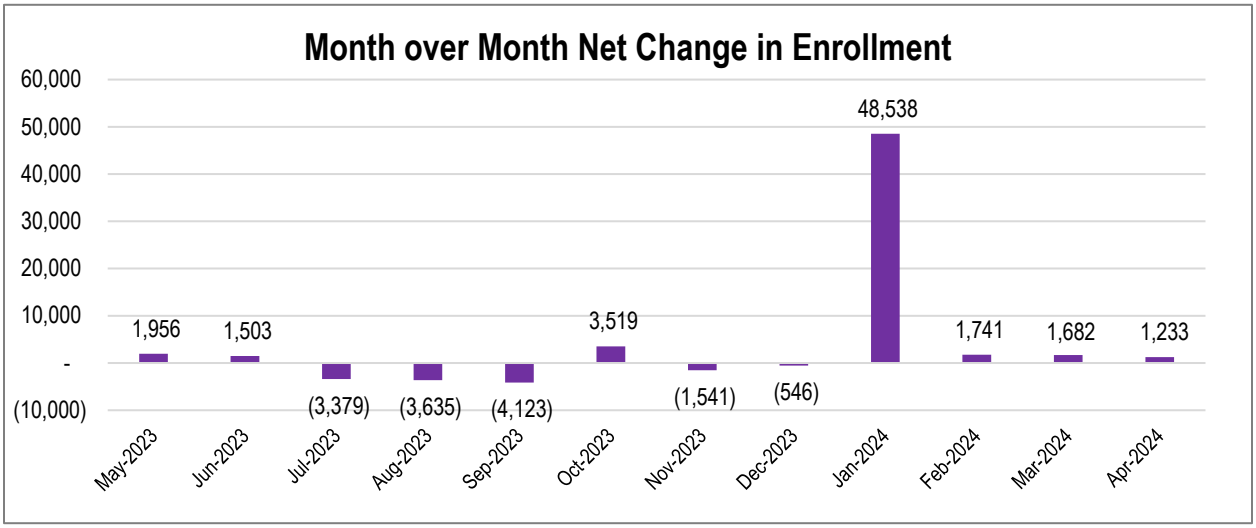








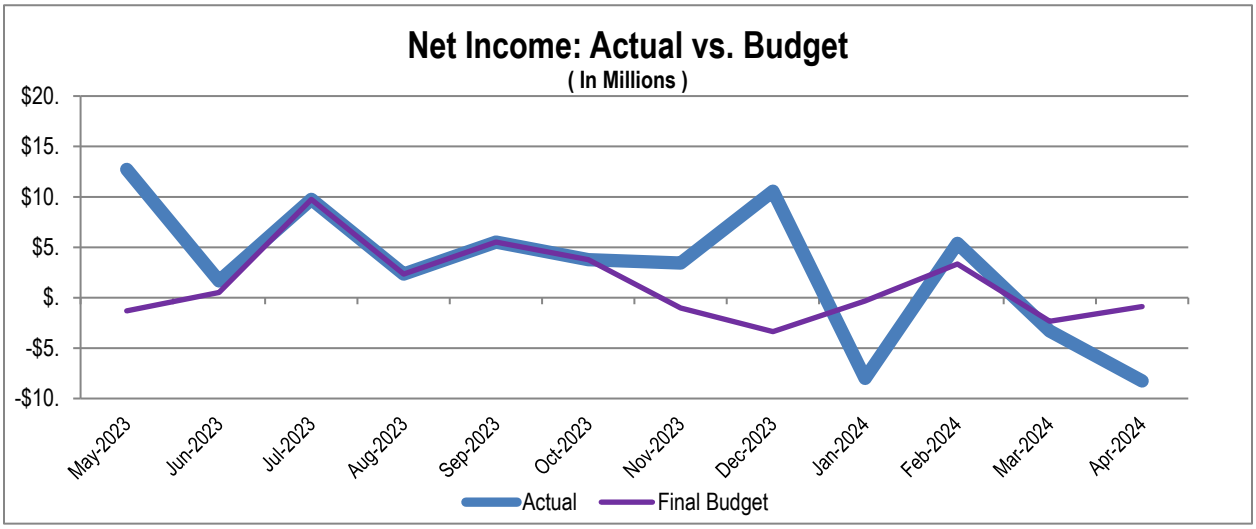




- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and will continue through May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the Alliance.
- In January 2024, enrollment significantly increased due to transition to Single Plan Model and expansion of full scope Medi-Cal to California residents 26-49 regardless of immigration status. Kaiser's transition to a direct contract with the State resulted in a partially offsetting membership reduction.

Net Income

- For the month ended April 30th, 2024:
  - Actual Net Loss $8.3 million.
  - Budgeted Net Loss $876,000.
- For the fiscal YTD ended April 30th, 2024:
  - Actual Net Income $21.2 million.
  - Budgeted Net Income $16.8 million.

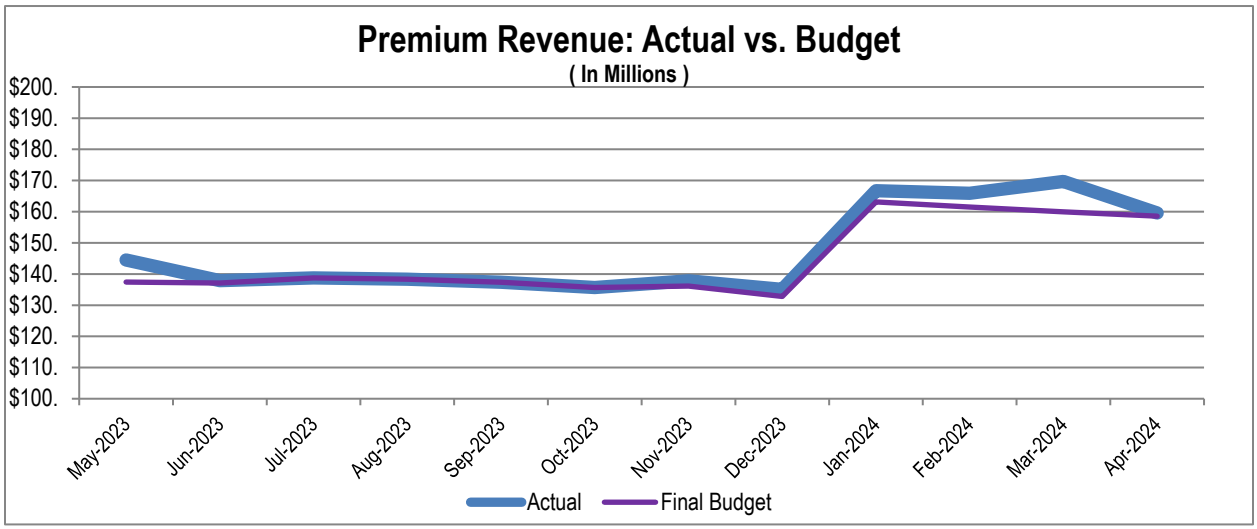


- The unfavorable variance of $7.4 million in the current month is primarily due to:
    - Favorable $5.4 million for net of unbudgeted MCO Tax Revenue and MCO Tax Expense.
    - Favorable $1.0 million higher than anticipated Premium Revenue.
    - Unfavorable $12.4 million higher than anticipated Medical Expense.
    - Unfavorable $1.3 million higher than anticipated Administrative Expense.

Premium Revenue

- For the month ended April 30th, 2024:
    - Actual Revenue: $159.6 million.
    - Budgeted Revenue: $158.6 million.

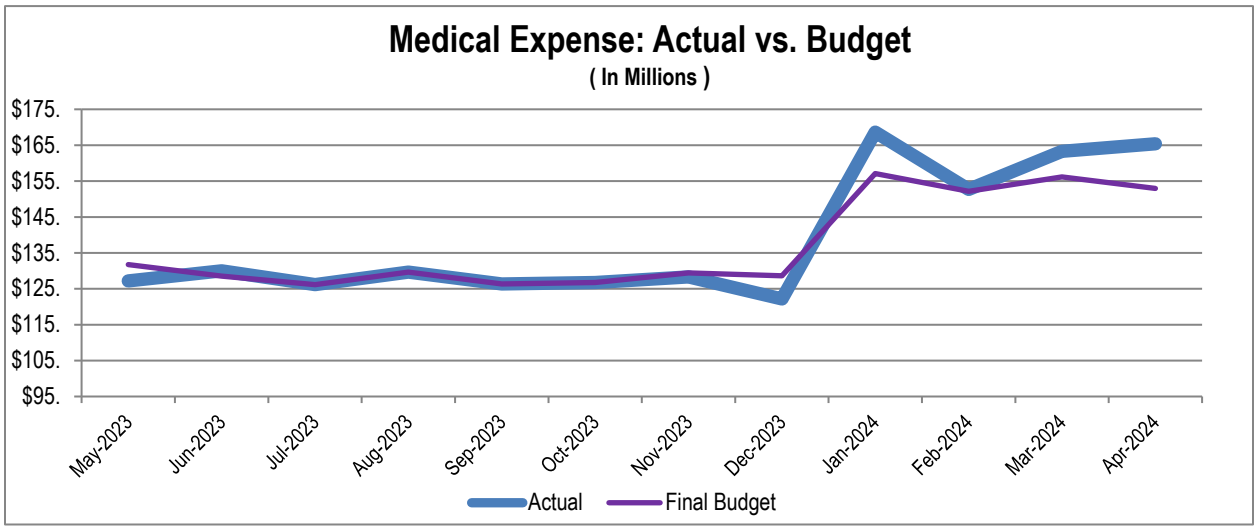
- For the fiscal YTD ended April 30th, 2024:
    - Actual Revenue: $1.5 billion
    - Budgeted Revenue: $1.5 billion.



- For the month ended April 30th, 2024, the favorable Premium Revenue variance of $1.0 million is primarily due to the following:
    - Favorable Medi-Cal Capitation Rate variance. Rates were not available at the time of budget and the magnitude of upcoming Targeted Rate Increase (TRI) revenue and expense was unknown and therefore not budgeted.
    - Retroactive payments for the period of December 2022 to February 2024 enrollment.
    - Unfavorable accrual for reduction of CY 2023 Medi-Cal rates.
    - Unfavorable accrual for the Bridge Period Risk Corridor.
    - The risk corridor analysis for 2022 Major Organ Transplant was completed and an additional accrual was made.

Medical Expense

- For the month ended April 30th, 2024:
  - Actual Medical Expense: $165.4 million.
  - Budgeted Medical Expense: $153.0 million.
- For the fiscal YTD ended April 30th, 2024:
  - Actual Medical Expense: $1.4 billion.
  - Budgeted Medical Expense: $1.4 billion.



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

- For April, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $9.3 million. Year to date, the estimate for prior years increased by $9.8 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)

Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$231,175,003	$0	$231,175,003	$219,737,292	($11,437,711)	-5.2%
Primary Care FFS	$55,482,652	$18,704	$55,501,357	$60,172,973	$4,690,321	7.8%
Specialty Care FFS	$58,195,804	$81,299	$58,277,103	$61,731,896	$3,536,092	5.7%
Outpatient FFS	$89,141,624	$412,464	$89,554,089	$97,424,662	$8,283,037	8.5%
Ancillary FFS	$120,799,008	$762,614	$121,561,622	$121,894,440	$1,095,432	0.9%
Pharmacy FFS	$90,519,883	$471,857	$90,991,740	$101,022,356	$10,502,473	10.4%
ER Services FFS	$72,370,018	$15,484	$72,385,502	$65,004,934	($7,365,084)	-11.3%
Inpatient Hospital & SNF FFS	$388,294,950	$4,204,362	$392,499,312	$392,739,618	$4,444,668	1.1%
Long Term Care FFS	$241,568,408	$3,808,901	$245,377,309	$210,490,858	($31,077,550)	-14.8%
Other Benefits & Services	$49,196,719	$0	$49,196,719	$49,861,134	$664,414	1.3%
Net Reinsurance	($81,289)	$0	($81,289)	$2,321,578	$2,402,867	103.5%
Provider Incentive	$3,000,000	$0	$3,000,000	$3,000,000	$0	0.0%
	$1,399,662,782	**$9,775,685**	**$1,409,438,467**	**$1,385,401,741**	**($14,261,041)**	**-1.0%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

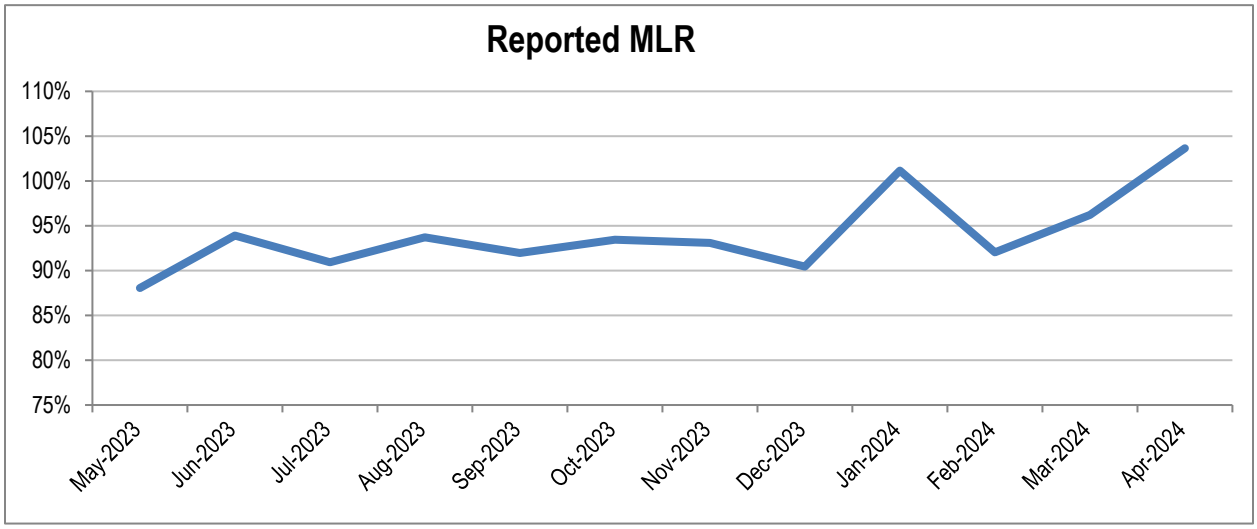
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$61.91	$0.00	$61.91	$59.22	($2.69)	-4.5%
Primary Care FFS	$14.86	$0.01	$14.86	$16.22	$1.36	8.4%
Specialty Care FFS	$15.59	$0.02	$15.61	$16.64	$1.05	6.3%
Outpatient FFS	$23.87	$0.11	$23.98	$26.26	$2.38	9.1%
Ancillary FFS	$32.35	$0.20	$32.56	$32.85	$0.50	1.5%
Pharmacy FFS	$24.24	$0.13	$24.37	$27.23	$2.98	11.0%
ER Services FFS	$19.38	$0.00	$19.39	$17.52	($1.86)	-10.6%
Inpatient Hospital & SNF FFS	$103.99	$1.13	$105.12	$105.85	$1.86	1.8%
Long Term Care FFS	$64.69	$1.02	$65.71	$56.73	($7.97)	-14.0%
Other Benefits & Services	$13.18	$0.00	$13.18	$13.44	$0.26	2.0%
Net Reinsurance	($0.02)	$0.00	($0.02)	$0.63	$0.65	103.5%
Provider Incentive	$0.80	$0.00	$0.80	$0.81	$0.01	0.6%
	$374.84	**$2.62**	**$377.46**	**$373.38**	**($1.47)**	**-0.4%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $14.3 million unfavorable to budget. On a PMPM basis, medical expense is -0.4% unfavorable to budget. For per-member-per-month expense:
    - Capitated Expense is over budget, largely driven by unfavorable PCP Capitation expense due to unbudgeted Provider Targeted Rate Increases (TRI), partially offset by favorable FQHC expense.

- Primary Care Expense is under budget driven by low utilization in the ACA OE, SPD and Child aid code categories.
- Specialty Care Expense is below budget, driven by less than expected SPD and Dual aid code category utilization.
- Outpatient Expense is under budget due to low lab and radiology utilization and facility other unit cost in all populations except for LTC.
- Ancillary Expense is over budget mostly due to higher than expected utilization in all populations except for the Child category of aid.
- Pharmacy Expense is under budget due to low Non-PBM expense due to lower utilization in the SPD and ACA OE aid code categories.
- Emergency Room Expense is over budget driven by high utilization in the ACA OE, Adult, SPD and Child categories of aid.
- Inpatient Expense is over budget driven by high utilization and unit cost in the ACA OE aid code category.
- Long Term Care Expense is over budget due to high utilization and unit cost in the SPD, ACA OE and Duals categories of aid.
- Other Benefits & Services is under budget, due to favorable community relations, other purchased, professional and interpreter services offset by higher HHIP, IPP and other employee expense.
- Net Reinsurance year-to-date is under budget because more recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported medical expense divided by Premium revenue) was 103.6% for the month and 94.9% for the fiscal year-to-date.



Administrative Expense

- For the month ended April 30th, 2024:
  - Actual Administrative Expense: $10.2 million.
  - Budgeted Administrative Expense: $8.9 million.

- For the fiscal YTD ended April 30th, 2024:
  - Actual Administrative Expense: $79.4 million.
  - Budgeted Administrative Expense: $84.7 million.

Summary of Administrative Expense (In Dollars) For the Month and Fiscal Year-to-Date Favorable/(Unfavorable)								
Current Month					**Year-to-Date**			
Actual	**Budget**	**Variance $**	**Variance %**		**Actual**	**Budget**	**Variance $**	**Variance %**
$5,206,658	$5,661,511	$454,852	8.0%	Employee Expense	$49,954,693	$53,602,714	$3,648,021	6.8%
75,882	72,495	(3,387)	-4.7%	Medical Benefits Admin Expense	1,751,604	1,469,155	(282,449)	-19.2%
1,605,952	810,808	(795,144)	-98.1%	Purchased & Professional Services	12,256,365	10,496,675	(1,759,690)	-16.8%
3,319,082	2,365,831	(953,251)	-40.3%	Other Admin Expense	15,471,513	19,139,995	3,668,482	19.2%
$10,207,575	$8,910,646	($1,296,929)	-14.6%	Total Administrative Expense	$79,434,175	$84,708,539	$5,274,364	6.2%

The year-to-date variances include:

- Consultants, Computer Support Services and Purchased Services are unfavorable as the result prepaid accruals issued in March and April for balances ending over the next few months for the IT organization.
- Favorable Employee and Temporary Services variances and delayed Training, Travel, Recruitment, and other employee-related expenses.
- Unfavorable Purchased and Professional Services expense realized primarily as result of change in asset definition for IT Licenses and Subscriptions (formerly being booked under: Licenses, Insurance & Fees).
- Unfavorable variance of Supplies and Other Expenses primarily due to unplanned Equity and Practice Transformation Payment Program (EPT).

The Administrative Loss Ratio (ALR) is 6.4% of net revenue for the month and 5.3% of net revenue year-to-date.

Other Income / (Expense)

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

- Fiscal year-to-date net investments show a gain of $25.8 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $691,000.

Managed Care Organization (MCO) Provider Tax

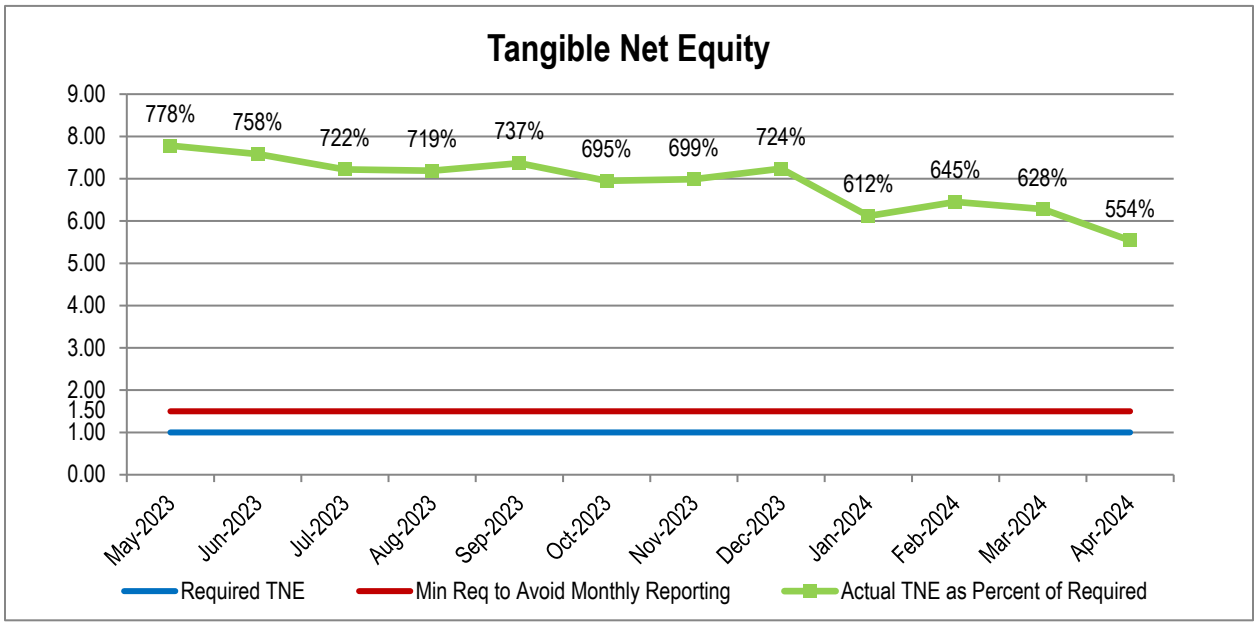
- For the month ended April 30th, 2024:
  - $113.7 million unbudgeted MCO Tax Revenue.
  - $108.3 million unbudgeted MCO Tax Expense.

Tangible Net Equity (TNE)

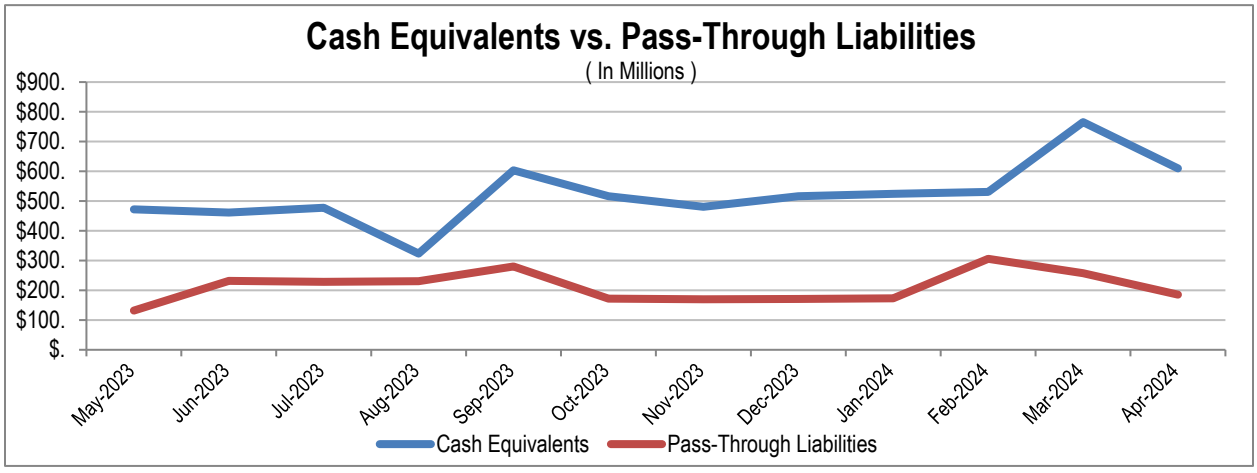
- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to

providers. TNE is a calculation of a company's total tangible assets minus a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.

- Required TNE $62.4 million
- Actual TNE $345.2 million
- Excess TNE $282.8 million
- TNE % of Required TNE 554%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
  - Cash & Cash Equivalents $609.8 million
  - Pass-Through Liabilities $185.0 million
  - Uncommitted Cash $424.8 million
  - Working Capital $318.0 million
  - Current Ratio 1.58 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $1.2 million.
- Annual capital budget: $1.6 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

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

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED APRIL 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
399,531	386,772	12,759	3.3%	1. Medi-Cal	3,677,759	3,654,580	23,179	0.6%
5,643	5,521	122	2.2%	2. GroupCare	56,231	55,886	345	0.6%
405,174	**392,293**	**12,881**	**3.3%**	**3. TOTAL MEMBER MONTHS**	**3,733,990**	**3,710,466**	**23,524**	**0.6%**
				REVENUE				
159,568,661	158,560,831	1,007,830	0.6%	4. Premium Revenue	1,484,956,940	1,462,238,378	22,718,562	1.6%
113,717,817	0	113,717,817	0.0%	5. MCO Tax Revenue AB119	387,137,922	0	387,137,922	0.0%
$273,286,478	**$158,560,831**	**$114,725,648**	**72.4%**	**6. TOTAL REVENUE**	**$1,872,094,862**	**$1,462,238,378**	**$409,856,484**	**28.0%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$19,459,040	$15,893,717	($3,565,323)	(22.4%)	7. Capitated Medical Expense	$231,175,003	$219,737,292	($11,437,711)	(5.2%)
				Fee for Service Medical Expenses:				
$52,214,312	$48,009,538	($4,204,774)	(8.8%)	8. Inpatient Hospital Expense	$392,499,312	$392,739,618	$240,306	0.1%
$5,001,080	$6,623,205	$1,622,125	24.5%	9. Primary Care Physician Expense	$55,501,357	$60,172,973	$4,671,617	7.8%
$6,885,586	$7,604,753	$719,166	9.5%	10. Specialty Care Physician Expense	$58,277,103	$61,731,896	$3,454,793	5.6%
$14,528,286	$14,098,570	($429,716)	(3.0%)	11. Ancillary Medical Expense	$121,561,622	$121,894,440	$332,818	0.3%
$11,106,898	$12,188,782	$1,081,885	8.9%	12. Outpatient Medical Expense	$89,554,089	$97,424,662	$7,870,573	8.1%
$9,663,854	$7,626,559	($2,037,294)	(26.7%)	13. Emergency Expense	$72,385,502	$65,004,934	($7,380,568)	(11.4%)
$9,070,915	$12,237,023	$3,166,108	25.9%	14. Pharmacy Expense	$90,991,740	$101,022,356	$10,030,616	9.9%
$32,621,920	$23,593,045	($9,028,875)	(38.3%)	15. Long Term Care Expense	$245,377,309	$210,490,858	($34,886,451)	(16.6%)
$141,092,851	$131,981,476	($9,111,375)	(6.9%)	16. Total Fee for Service Expense	$1,126,148,034	$1,110,481,737	($15,666,297)	(1.4%)
$4,559,560	$4,742,908	$183,348	3.9%	17. Other Benefits & Services	$49,196,719	$49,861,134	$664,415	1.3%
$280,632	$357,946	$77,315	21.6%	18. Reinsurance Expense	($81,289)	$2,321,577	$2,402,867	103.5%
$0	$0	$0	0.0%	19. Risk Pool Distribution	$3,000,000	$3,000,000	$0	(0.0%)
$165,392,082	**$152,976,047**	**($12,416,035)**	**(8.1%)**	**20. TOTAL MEDICAL EXPENSES**	**$1,409,438,467**	**$1,385,401,741**	**($24,036,726)**	**(1.7%)**
$107,894,396	**$5,584,783**	**$102,309,613**	**1,831.9%**	**21. GROSS MARGIN**	**$462,656,395**	**$76,836,637**	**$385,819,757**	**502.1%**
				ADMINISTRATIVE EXPENSES				
$5,206,658	$5,661,511	$454,852	8.0%	22. Personnel Expense	$49,954,693	$53,602,716	$3,648,023	6.8%
$75,882	$72,495	($3,387)	(4.7%)	23. Benefits Administration Expense	$1,751,604	$1,469,155	($282,449)	(19.2%)
$1,605,952	$810,808	($795,144)	(98.1%)	24. Purchased & Professional Services	$12,256,365	$10,496,675	($1,759,690)	(16.8%)
$3,319,082	$2,365,831	($953,251)	(40.3%)	25. Other Administrative Expense	$15,471,513	$19,139,995	$3,668,482	19.2%
$10,207,575	**$8,910,646**	**($1,296,929)**	**(14.6%)**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$79,434,175**	**$84,708,541**	**$5,274,366**	**6.2%**
$108,309,817	**$0**	**($108,309,817)**	**0.0%**	**27. MCO TAX EXPENSES**	**$387,113,922**	**$0**	**($387,113,922)**	**0.0%**
($10,622,997)	**($3,325,863)**	**($7,297,134)**	**(219.4%)**	**28. NET OPERATING INCOME / (LOSS)**	**($3,891,702)**	**($7,871,904)**	**$3,980,202**	**50.6%**
				OTHER INCOME / EXPENSES				
$2,364,175	**$2,450,000**	**($85,825)**	**(3.5%)**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$25,088,126**	**$24,688,843**	**$399,284**	**1.6%**
($8,258,822)	**($875,863)**	**($7,382,959)**	**(842.9%)**	**30. NET SURPLUS (DEFICIT)**	**$21,196,424**	**$16,816,938**	**$4,379,486**	**26.0%**
103.6%	96.5%	-7.1%	-7.4%	31. Medical Loss Ratio	94.9%	94.7%	-0.2%	-0.2%
6.4%	5.6%	-0.8%	-14.3%	32. Administrative Expense Ratio	5.3%	5.8%	0.5%	8.6%
-3.0%	-0.6%	-2.4%	-400.0%	33. Net Surplus (Deficit) Ratio	1.1%	1.2%	0.1%	8.3%

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED APRIL 30, 2024

	4/30/2024	3/31/2024	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$211,550,770	($11,347,297)	$222,898,067	-1,964.33%
Short-Term Investments	398,292,940	776,723,919	(378,430,978)	-48.72%
Interest Receivable	1,202,330	2,503,458	(1,301,128)	-51.97%
Premium Receivables	242,419,235	140,446,549	101,972,686	72.61%
Reinsurance Receivables	3,468,708	6,927,005	(3,458,297)	-49.92%
Other Receivables	1,536,054	1,478,194	57,861	3.91%
Prepaid Expenses	1,025,943	295,422	730,522	247.28%
CalPERS Net Pension Assets	(5,286,448)	(5,286,448)	0	0.00%
Deferred Outflow	14,099,056	14,099,056	0	0.00%
TOTAL CURRENT ASSETS	**$868,308,589**	**$925,839,858**	**($57,531,269)**	**-6.21%**
OTHER ASSETS:				
Long-Term Investments	17,177,578	5,191,724	11,985,854	230.86%
Restricted Assets	350,000	350,000	0	0.00%
GASB 87-Lease Assets (Net)	938,750	1,004,664	(65,913)	-6.56%
GASB 96-SBITA Assets (Net)	4,045,341	4,250,151	(204,809)	-4.82%
TOTAL OTHER ASSETS	**$22,511,669**	**$10,796,538**	**$11,715,131**	**108.51%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,167,264	10,167,264	0	0.00%
Furniture And Equipment	12,960,779	12,960,779	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	$38,854,491	$38,854,491	$0	0.00%
Less: Accumulated Depreciation	($33,091,473)	($33,028,320)	($63,153)	0.19%
NET PROPERTY AND EQUIPMENT	**$5,763,018**	**$5,826,171**	**($63,153)**	**-1.08%**
TOTAL ASSETS	**$896,583,276**	**$942,462,567**	**($45,879,290)**	**-4.87%**
CURRENT LIABILITIES:				
Accounts Payable	4,022,658	3,886,653	136,005	3.50%
Other Accrued Liabilities	41,220,647	31,874,325	9,346,322	29.32%
GASB 87 ST Lease Liabilities	920,407	918,888	1,519	0.17%
GASB 96 ST SBITA Liabilities	2,059,611	2,232,804	(173,193)	-7.76%
Claims Payable	34,190,754	34,420,590	(229,836)	-0.67%
IBNP Reserves	261,876,611	237,048,314	24,828,297	10.47%
Pass-Through Liabilities	185,036,972	257,208,099	(72,171,128)	-28.06%
Risk Sharing - Providers	6,629,337	6,629,337	0	0.00%
Payroll Liabilities	9,323,110	8,602,659	720,451	8.37%
Deferred Inflow	5,004,985	5,004,985	0	0.00%
TOTAL CURRENT LIABILITIES	**$550,285,092**	**$587,826,655**	**($37,541,562)**	**-6.39%**
LONG TERM LIABILITIES:				
GASB 87 LT Lease Liabilities	161,150	240,057	(78,907)	-32.87%
GASB 96 LT SBITA Liabilities	983,568	983,568	0	0.00%
TOTAL LONG TERM LIABILITIES	**$1,144,719**	**$1,223,625**	**($78,907)**	**-6.45%**
TOTAL LIABILITIES	**$551,429,811**	**$589,050,280**	**($37,620,469)**	**-6.39%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	323,116,808	323,116,808	0	0.00%
Year-to Date Net Income / (Loss)	21,196,424	29,455,246	(8,258,822)	-28.04%
TOTAL NET WORTH	**$345,153,465**	**$353,412,287**	**($8,258,822)**	**-2.34%**
TOTAL LIABILITIES AND NET WORTH	**$896,583,276**	**$942,462,567**	**($45,879,290)**	**-4.87%**
Cash Equivalents	$609,843,710	$765,376,622	($155,532,912)	-20.32%
Pass-Through	$185,036,972	$257,208,099	($72,171,128)	-28.06%
Uncommitted Cash	$424,806,738	$508,168,523	($83,361,784)	-16.40%
Working Capital	$318,023,496	$338,013,203	($19,989,707)	-5.91%
Current Ratio	157.8%	157.5%	0.3%	0.2%

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
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FOR THE MONTH AND FISCAL YTD ENDED APRIL 30, 2024

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Current Ratio	157.8%	157.5%	0.3%	0.2%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF APRIL 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	110,502	63,507	34,888	149,168	39,951	224	1,291	399,531	5,643	-	405,174
Revenue	$46,158,967	$39,957,490	$50,386,981	$94,254,251	$25,982,513	$2,335,311	$11,633,558	$270,709,073	$2,577,406	$0	$273,286,478
Medical Expense	12,110,732	19,527,286	45,660,742	56,723,601	14,559,255	2,292,824	12,146,817	163,021,257	2,369,825	1,000	$165,392,082
Gross Margin	$34,048,235	$20,430,205	$4,726,239	$37,530,650	$11,423,259	$42,487	($513,258)	$107,687,815	$207,580	($1,000)	$107,894,396
Administrative Expense	$527,647	$1,132,287	$3,328,103	$3,238,372	$832,765	$148,425	$707,627	$9,915,226	$176,995	$115,354	$10,207,575
MCO Tax Expense	$30,870,561	$16,620,437	$9,525,655	$38,952,264	$11,963,020	$51,091	$326,790	$108,309,817	$0	$0	$108,309,817
Operating Income / (Expense)	$2,650,027	$2,677,481	($8,127,519)	($4,659,986)	($1,372,526)	($157,029)	($1,547,675)	($10,537,228)	$30,586	($116,354)	($10,622,997)
Other Income / (Expense)	$122,036	$283,856	$776,130	$795,654	$177,726	$33,134	$134,759	$2,323,295	$40,880	$0	$2,364,175
Net Income / (Loss)	$2,772,063	$2,961,337	($7,351,390)	($3,864,333)	($1,194,800)	($123,895)	($1,412,916)	($8,213,933)	$71,465	($116,354)	($8,258,822)
PMPM Metrics:											
Revenue PMPM	$417.72	$629.18	$1,444.25	$631.87	$650.36	$10,425.50	$9,011.28	$677.57	$456.74	$0.00	$674.49
Medical Expense PMPM	$109.60	$307.48	$1,308.78	$380.27	$364.43	$10,235.82	$9,408.84	$408.03	$419.96	$0.00	$408.20
Gross Margin PMPM	$308.12	$321.70	$135.47	$251.60	$285.93	$189.67	($397.57)	$269.54	$36.79	$0.00	$266.29
Administrative Expense PMPM	$4.77	$17.83	$95.39	$21.71	$20.84	$662.61	$548.12	$24.82	$31.37	$0.00	$25.19
MCO Tax Expense PMPM	$279.37	$261.71	$273.04	$261.13	$299.44	$228.08	$253.13	$271.09	$0.00	$0.00	$267.32
Operating Income / (Expense) PMPM	$23.98	$42.16	($232.96)	($31.24)	($34.36)	($701.02)	($1,198.82)	($26.37)	$5.42	$0.00	($26.22)
Other Income / (Expense) PMPM	$1.10	$4.47	$22.25	$5.33	$4.45	$147.92	$104.38	$5.82	$7.24	$0.00	$5.83
Net Income / (Loss) PMPM	$25.09	$46.63	($210.71)	($25.91)	($29.91)	($553.10)	($1,094.44)	($20.56)	$12.66	$0.00	($20.38)
Ratio:											
Medical Loss Ratio	88.3%	86.7%	113.1%	106.2%	108.8%	100.5%	107.6%	103.8%	91.9%	0.0%	103.6%
Administrative Expense Ratio	3.8%	5.0%	8.2%	6.1%	6.2%	6.5%	6.3%	6.3%	6.9%	0.0%	6.4%
Net Income Ratio	6.0%	7.4%	-14.6%	-4.1%	-4.6%	-5.3%	-12.1%	-3.0%	2.8%	0.0%	-3.0%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE APRIL 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	1,048,603	565,171	324,834	1,317,041	409,192	1,701	11,217	3,677,759	56,231	-	3,733,990
Revenue	$249,352,571	$254,607,662	$413,349,683	$638,500,923	$175,604,722	$18,095,225	$96,873,576	$1,846,384,362	$25,710,500	$0	$1,872,094,862
Medical Expense	116,078,218	180,231,541	363,836,743	475,911,696	131,614,277	19,470,313	100,858,471	1,388,001,259	21,431,208	6,000	$1,409,438,467
Gross Margin	$133,274,352	$74,376,121	$49,512,940	$162,589,228	$43,990,445	($1,375,089)	($3,984,895)	$458,383,102	$4,279,293	($6,000)	$462,656,395
Administrative Expense	$4,747,609	$8,614,554	$25,203,003	$25,251,461	$7,239,807	$1,119,597	$5,331,766	$77,507,797	$1,542,038	$384,340	$79,434,175
MCO Tax Expense	$110,129,648	$59,603,943	$34,137,485	$139,258,317	$42,613,525	$183,809	$1,187,194	$387,113,922	$0	$0	$387,113,922
Operating Income / (Expense)	$18,397,095	$6,157,624	($9,827,547)	($1,920,551)	($5,862,888)	($2,678,495)	($10,503,855)	($6,238,617)	$2,737,255	($390,340)	($3,891,702)
Other Income / (Expense)	$1,394,861	$2,713,152	$8,155,021	$8,021,484	$2,296,350	$367,769	$1,716,296	$24,664,932	$423,195	$0	$25,088,126
Net Income / (Loss)	$19,791,956	$8,870,776	($1,672,526)	$6,100,933	($3,566,538)	($2,310,727)	($8,787,559)	$18,426,315	$3,160,449	($390,340)	$21,196,424
PMPM Metrics:											
Revenue PMPM	$237.80	$450.50	$1,272.50	$484.80	$429.15	$10,637.99	$8,636.32	$502.04	$457.23	$0.00	$501.37
Medical Expense PMPM	$110.70	$318.90	$1,120.07	$361.35	$321.64	$11,446.39	$8,991.57	$377.40	$381.13	$0.00	$377.46
Gross Margin PMPM	$127.10	$131.60	$152.43	$123.45	$107.51	($808.40)	($355.25)	$124.64	$76.10	$0.00	$123.90
Administrative Expense PMPM	$4.53	$15.24	$77.59	$19.17	$17.69	$658.20	$475.33	$21.07	$27.42	$0.00	$21.27
MCO Tax Expense PMPM	$105.03	$105.46	$105.09	$105.74	$104.14	$108.06	$105.84	$105.26	$0.00	$0.00	$103.67
Operating Income / (Expense) PMPM	$17.54	$10.90	($30.25)	($1.46)	($14.33)	($1,574.66)	($936.42)	($1.70)	$48.68	$0.00	($1.04)
Other Income / (Expense) PMPM	$1.33	$4.80	$25.11	$6.09	$5.61	$216.21	$153.01	$6.71	$7.53	$0.00	$6.72
Net Income / (Loss) PMPM	$18.87	$15.70	($5.15)	$4.63	($8.72)	($1,358.45)	($783.41)	$5.01	$56.20	$0.00	$5.68
Ratio:											
Medical Loss Ratio	83.4%	92.4%	95.9%	95.3%	99.0%	108.7%	105.4%	95.1%	83.4%	0.0%	94.9%
Administrative Expense Ratio	3.4%	4.4%	6.6%	5.1%	5.4%	6.3%	5.6%	5.3%	6.0%	0.0%	5.3%
Net Income Ratio	7.9%	3.5%	-0.4%	1.0%	-2.0%	-12.8%	-9.1%	1.0%	12.3%	0.0%	1.1%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$5,206,658	$5,661,511	$454,852	8.0%	Personnel Expenses	$49,954,693	$53,602,716	$3,648,023	6.8%
75,882	72,495	(3,387)	(4.7%)	Benefits Administration Expense	1,751,604	1,469,155	(282,449)	(19.2%)
1,605,952	810,808	(795,144)	(98.1%)	Purchased & Professional Services	12,256,365	10,496,675	(1,759,690)	(16.8%)
606,365	512,076	(94,289)	(18.4%)	Occupancy	4,451,924	5,025,931	574,007	11.4%
1,760,506	1,049,325	(711,181)	(67.8%)	Printing Postage & Promotion	4,611,292	6,197,174	1,585,882	25.6%
656,390	780,812	124,423	15.9%	Licenses Insurance & Fees	5,933,011	7,664,226	1,731,215	22.6%
295,822	23,618	(272,203)	(1,152.5%)	Supplies & Other Expenses	475,287	252,665	(222,622)	(88.1%)
$5,000,917	$3,249,135	($1,751,782)	(53.9%)	Total Other Administrative Expense	$29,479,482	$31,105,825	$1,626,343	5.2%
$10,207,575	$8,910,646	($1,296,929)	(14.6%)	Total Administrative Expenses	$79,434,175	$84,708,541	$5,274,366	6.2%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
3,423,766	3,246,615	(177,151)	(5.5%)	Salaries & Wages	32,369,965	32,010,296	(359,669)	(1.1%)
375,620	356,165	(19,455)	(5.5%)	Paid Time Off	3,248,639	3,432,375	183,736	5.4%
3,137	4,935	1,798	36.4%	Compensated Incentives	18,523	1,939,032	1,920,509	99.0%
0	0	0	0.0%	Severance Pay	6,160	842,000	835,840	99.3%
56,468	53,068	(3,400)	(6.4%)	Payroll Taxes	631,178	627,704	(3,474)	(0.6%)
31,633	19,467	(12,166)	(62.5%)	Overtime	326,328	251,794	(74,534)	(29.6%)
321,071	274,993	(46,078)	(16.8%)	CalPERS ER Match	2,809,251	2,723,436	(85,815)	(3.2%)
856,744	1,022,509	165,764	16.2%	Employee Benefits	7,596,698	8,207,370	610,672	7.4%
2,996	0	(2,996)	0.0%	Personal Floating Holiday	178,006	169,701	(8,305)	(4.9%)
17,719	23,500	5,781	24.6%	Premium Bi/Multilingual Pay	131,180	132,500	1,320	1.0%
0	0	0	0.0%	Prizes	154	0	(154)	0.0%
3,000	0	(3,000)	0.0%	Med Ins Opted Out Stipend	13,000	0	(13,000)	0.0%
0	0	0	0.0%	Holiday Bonus	1,402,961	0	(1,402,961)	0.0%
35,470	0	(35,470)	0.0%	Sick Leave	92,696	0	(92,696)	0.0%
(195)	37,270	37,465	100.5%	Compensated Employee Relations	55,803	288,533	232,730	80.7%
17,780	23,100	5,320	23.0%	Work from Home Stipend	166,080	193,495	27,415	14.2%
1,734	4,337	2,603	60.0%	Mileage, Parking & LocalTravel	11,153	29,518	18,365	62.2%
8,316	22,122	13,806	62.4%	Travel & Lodging	104,854	208,215	103,361	49.6%
27,569	190,482	162,913	85.5%	Temporary Help Services	455,160	1,566,648	1,111,489	70.9%
14,128	305,585	291,457	95.4%	Staff Development/Training	221,645	683,772	462,127	67.6%
9,704	77,365	67,660	87.5%	Staff Recruitment/Advertising	115,261	296,326	181,064	61.1%
$5,206,658	**$5,661,511**	**$454,852**	**8.0%**	**Total Employee Expenses**	**$49,954,693**	**$53,602,716**	**$3,648,023**	**6.8%**
				Benefit Administration Expense				
23,512	21,497	(2,015)	(9.4%)	RX Administration Expense	215,292	210,604	(4,688)	(2.2%)
0	0	0	0.0%	Behavioral Hlth Administration Fees	1,093,429	817,710	(275,719)	(33.7%)
52,370	50,998	(1,372)	(2.7%)	Telemedicine Admin Fees	442,884	440,842	(2,042)	(0.5%)
$75,882	**$72,495**	**($3,387)**	**(4.7%)**	**Total Benefit Administration Expenses**	**$1,751,604**	**$1,469,155**	**($282,449)**	**(19.2%)**
				Purchased & Professional Services				
492,526	296,626	(195,901)	(66.0%)	Consultant Fees - Non Medical	2,530,509	3,395,060	864,551	25.5%
152,256	160,787	8,531	5.3%	Computer Support Services	4,497,264	3,372,229	(1,125,035)	(33.4%)
11,875	12,500	625	5.0%	Audit Fees	118,750	122,500	3,750	3.1%
0	33	33	100.0%	Consultant Fees - Medical	0	200	200	100.0%
259,525	55,863	(203,662)	(364.6%)	Other Purchased Services	1,610,451	799,324	(811,127)	(101.5%)
(3,627)	1,574	5,201	330.4%	Maint.& Repair-Office Equipment	6,549	12,100	5,551	45.9%
0	0	0	0.0%	Maint.&Repair-Computer Hardware	1,180	1,180	0	0.0%
124,669	116,583	(8,086)	(6.9%)	Medical Refund Recovery Fees	893,032	1,120,649	227,617	20.3%
420,347	0	(420,347)	0.0%	Software - IT Licenses & Subsc	1,425,397	0	(1,425,397)	0.0%
26,836	69,928	43,092	61.6%	Hardware (Non-Capital)	584,821	844,579	259,757	30.8%
79,613	44,565	(35,048)	(78.6%)	Provider Relations-Credentialing	335,751	381,888	46,137	12.1%
38,932	52,350	13,418	25.6%	Legal Fees	225,696	446,966	221,270	49.5%
3,000	0	(3,000)	0.0%	Interpretive Services	26,964	0	(26,964)	0.0%
$1,605,952	**$810,808**	**($795,144)**	**(98.1%)**	**Total Purchased & Professional Services**	**$12,256,365**	**$10,496,675**	**($1,759,690)**	**(16.8%)**
				Occupancy				
63,153	53,159	(9,994)	(18.8%)	Depreciation	614,348	553,491	(60,858)	(11.0%)
60,880	62,639	1,759	2.8%	Building Lease	552,540	624,228	71,688	11.5%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED April 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
6,902	5,870	(1,032)	(17.6%)	Leased and Rented Office Equipment	28,396	67,639	39,243	58.0%
20,762	17,982	(2,780)	(15.5%)	Utilities	191,233	194,080	2,847	1.5%
206,564	86,510	(120,054)	(138.8%)	Telephone	734,169	831,481	97,312	11.7%
43,295	36,780	(6,515)	(17.7%)	Building Maintenance	236,374	319,934	83,560	26.1%
204,809	249,136	44,327	17.8%	SBITA Amortization Expense-GASB 96	2,094,862	2,435,077	340,215	14.0%
$606,365	**$512,076**	**($94,289)**	**(18.4%)**	**Total Occupancy**	**$4,451,924**	**$5,025,931**	**$574,007**	**11.4%**
				Printing Postage & Promotion				
303,368	113,146	(190,222)	(168.1%)	Postage	690,974	813,985	123,012	15.1%
1,590	30,300	28,711	94.8%	Design & Layout	32,670	73,716	41,046	55.7%
650,771	138,072	(512,699)	(371.3%)	Printing Services	1,341,606	1,166,394	(175,212)	(15.0%)
34,097	6,910	(27,187)	(393.4%)	Mailing Services	93,905	91,681	(2,224)	(2.4%)
16,854	12,580	(4,274)	(34.0%)	Courier/Delivery Service	93,001	97,960	4,959	5.1%
0	333	333	100.0%	Pre-Printed Materials and Publications	1,038	833	(204)	(24.5%)
(4,293)	0	4,293	0.0%	Promotional Products	3,248	24,121	20,874	86.5%
(1,450)	150	1,600	1,066.7%	Promotional Services	(1,253)	5,350	6,603	123.4%
735,698	724,500	(11,198)	(1.5%)	Community Relations	1,608,110	3,665,139	2,057,030	56.1%
24,038	23,333	(705)	(3.0%)	Translation - Non-Clinical	247,995	257,993	9,997	3.9%
(167)	0	167	0.0%	Community Reinvestment Expense	500,000	0	(500,000)	0.0%
$1,760,506	**$1,049,325**	**($711,181)**	**(67.8%)**	**Total Printing Postage & Promotion**	**$4,611,292**	**$6,197,174**	**$1,585,882**	**25.6%**
				Licenses Insurance & Fees				
0	0	0	0.0%	Regulatory Penalties	80,000	750,000	670,000	89.3%
26,000	29,000	3,000	10.3%	Bank Fees	292,098	279,587	(12,511)	(4.5%)
99,960	89,101	(10,859)	(12.2%)	Insurance Premium	1,057,904	845,423	(212,481)	(25.1%)
492,903	488,782	(4,121)	(0.8%)	Licenses, Permits and Fees	3,303,786	3,990,623	686,837	17.2%
37,526	173,930	136,404	78.4%	Subscriptions and Dues - NonIT	1,199,223	1,798,594	599,371	33.3%
$656,390	**$780,812**	**$124,423**	**15.9%**	**Total Licenses Insurance & Postage**	**$5,933,011**	**$7,664,226**	**$1,731,215**	**22.6%**
				Supplies & Other Expenses				
15,135	4,209	(10,926)	(259.6%)	Office and Other Supplies	89,463	68,664	(20,799)	(30.3%)
4,630	2,000	(2,630)	(131.5%)	Furniture and Equipment	16,994	37,753	20,759	55.0%
13,708	1,200	(12,508)	(1,042.3%)	Ergonomic Supplies	31,683	21,025	(10,658)	(50.7%)
14,531	15,743	1,212	7.7%	Meals and Entertainment	57,230	79,425	22,195	27.9%
0	0	0	0.0%	Miscellaneous Expense	22,500	27,948	5,447	19.5%
0	0	0	0.0%	Member Incentive Expense	9,600	14,550	4,950	34.0%
247,818	0	(247,818)	0.0%	Equity & Practice Transformation (EPT)	247,818	0	(247,818)	0.0%
0	100	100	100.0%	Covid-19 IT Expenses	0	600	600	100.0%
0	367	367	100.0%	Covid-19 Non IT Expenses	0	2,700	2,700	100.0%
$295,822	**$23,618**	**($272,203)**	**(1,152.5%)**	**Total Supplies & Other Expense**	**$475,287**	**$252,665**	**($222,622)**	**(88.1%)**
$10,207,575	**$8,910,646**	**($1,296,929)**	**(14.6%)**	**TOTAL ADMINISTRATIVE EXPENSE**	**$79,434,175**	**$84,708,541**	**$5,274,366**	**6.2%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED JUNE 30, 2024

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Catalyst 9300 - Catalyst Switches	IT-FY24-01	$ -	$ -	**$ -**	$ 50,000	$ 50,000
	Cisco Catalyst 8500 - Routers	IT-FY24-02	$ -	$ -	**$ -**	$ 60,000	$ 60,000
	Cisco AP-9166 - Access Point	IT-FY24-03	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 426,471	$ -	**$ 426,471**	$ 426,371	$ (100)
	PURE Storage array	IT-FY24-05	$ -	$ -	**$ -**	$ 300,000	$ 300,000
	PKI management	IT-FY24-06	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	IBM Power Hardware Upgrade	IT-FY24-07	$ 560,652	$ -	**$ 560,652**	$ 288,629	$ (272,023)
	Misc Hardware	IT-FY24-08	$ 7,119	$ -	**$ 7,119**	$ 15,000	$ 7,881
	Network / AV Cabling	IT-FY24-09	$ 95,054	$ -	**$ 95,054**	$ 30,000	$ (65,054)
	Training Room Projector	IT-FY24-10	$ 12,546	$ -	**$ 12,546**	$ 13,000	$ 454
	Conference room upgrades	IT-FY24-11	$ -	$ -	**$ -**	$ 107,701	$ 107,701
Hardware Subtotal			**$ 1,101,842**	**$ -**	**$ 1,101,842**	**$ 1,320,701**	**$ 218,859**
2. Software:							
	Zerto renewal and Tier 2 add	AC-FY24-01	$ -	$ -	**$ -**	$ 126,000	$ 126,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 126,000**	**$ 126,000**
3. Building Improvement:							
	Appliances over 1k new/replacement (all buildings/suites)	FA-FY24-01	**$ -**	$ -	**$ -**	$ -	$ -
	ACME Security: Readers, HID boxes, Cameras, Doors (planned/unplanned	FA-FY24-02	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	HVAC: Replace VAV boxes, duct work, replace old equipment	FA-FY24-03	$ 18,295	$ -	**$ 18,295**	$ 20,000	$ 1,705
	Electrical work for projects, workstations requirement	FA-FY24-04	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	1240 Interior blinds replacement	FA-FY24-05	**$ -**	$ -	**$ -**	$ 25,000	$ 25,000
	EV Charging stations, if not completed in FY23 and carried over to FY24	FA-FY24-06	**$ 35,399**	$ -	**$ 35,399**	$ 50,000	$ 14,601
Building Improvement Subtotal			**$ 53,694**	**$ -**	**$ 53,694**	**$ 125,000**	**$ 71,306**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)	FA-FY24-17	$ 3,860	$ -	**$ 3,860**	$ 10,000	$ 6,140
	Replace, reconfigure, re-design workstations	FA-FY24-18	$ -	$ -	**$ -**	$ 20,000.00	$ 20,000
Furniture & Equipment Subtotal			**$ 3,860**	**$ -**	**$ 3,860**	**$ 30,000**	**$ 26,140**
GRAND TOTAL			**$ 1,159,395**	**$ -**	**$ 1,159,395**	**$ 1,601,701**	**$ 442,306**

5. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 4/30/24	**$ 38,854,491**
Fixed Assets @ Cost - 6/30/23	**$ 37,695,096**
Fixed Assets Acquired YTD	**$ 1,159,395**

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

TANGIBLE NET EQUITY (TNE)	Jul-23	Aug-23	QTR. END Sep-23	Oct-23	Nov-23	QTR. END Dec-23	Jan-24	Feb-24	QTR. END Mar-24	Apr-24
Current Month Net Income / (Loss)	$9,746,933	$2,343,460	$5,514,335	$3,776,499	$3,440,910	$10,563,766	($8,009,058)	$5,392,121	($3,313,721)	($8,258,822)
YTD Net Income / (Loss)	$9,746,933	$12,090,393	$17,604,728	$21,381,227	$24,822,137	$35,385,903	$27,376,845	$32,768,966	$29,455,245	$21,196,423
Actual TNE										
Net Assets	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178	$359,342,945	$351,333,888	$356,726,008	$353,412,287	$345,153,466
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$333,703,974**	**$336,047,435**	**$341,561,770**	**$345,338,268**	**$348,779,178**	**$359,342,945**	**$351,333,888**	**$356,726,008**	**$353,412,287**	**$345,153,466**
Increase/(Decrease) in Actual TNE	$9,746,933	$2,343,460	$5,514,335	$3,776,499	$3,440,910	$10,563,766	($8,009,058)	$5,392,121	($3,313,721)	($8,258,822)
Required TNE[(1)]	**$46,228,233**	**$46,744,204**	**$46,352,062**	**$49,676,617**	**$49,894,371**	**$49,622,261**	**$57,429,796**	**$55,347,714**	**$56,252,051**	**$62,358,321**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$69,342,350	$70,116,307	$69,528,093	$74,514,926	$74,841,557	$74,433,391	$86,144,695	$83,021,571	$84,378,076	$93,537,481
TNE Excess / (Deficiency)	$287,475,741	$289,303,231	$295,209,708	$295,661,651	$298,884,807	$309,720,684	$293,904,092	$301,378,294	$297,160,236	$282,795,145
Actual TNE as a Multiple of Required	**7.22**	**7.19**	**7.37**	**6.95**	**6.99**	**7.24**	**6.12**	**6.45**	**6.28**	**5.54**

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	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178	$359,342,945	$351,333,888	$356,726,008	$353,412,287	$345,153,466
Fixed Assets at Net Book Value	(5,169,098)	(5,539,264)	(5,608,622)	(5,653,388)	(6,079,010)	(5,997,733)	(7,085,899)	(6,961,780)	(5,826,171)	(5,763,018)
Net Lease Assets/Liabilities/Interest	(711,429)	(475,037)	(1,115,074)	(727,353)	(662,463)	(1,135,481)	(1,193,576)	(1,033,509)	(879,498)	(859,354)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$328,184,876**	**$330,158,171**	**$335,603,148**	**$339,334,880**	**$342,350,168**	**$352,995,212**	**$343,897,989**	**$349,414,228**	**$347,236,116**	**$339,040,448**
Liquid TNE as Multiple of Required	**7.10**	**7.06**	**7.24**	**6.83**	**6.86**	**7.11**	**5.99**	**6.31**	**6.17**	**5.44**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2024

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

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	102,463	101,393	100,038	101,120	101,243	102,088	109,553	109,953	110,250	110,502			1,048,603
Adult	52,550	52,102	51,499	52,396	52,151	51,696	62,860	63,117	63,293	63,507			565,171
SPD	31,055	30,840	30,592	30,888	30,865	30,846	35,013	34,875	34,972	34,888			324,834
ACA OE	123,707	121,819	120,016	121,430	120,573	119,668	145,842	146,757	148,061	149,168			1,317,041
Duals	41,688	41,715	41,629	41,496	40,997	40,974	40,117	40,403	40,222	39,951			409,192
MCAL LTC	141	138	139	135	137	135	219	217	216	224			1,701
MCAL LTC Duals	1,033	1,019	1,004	997	975	951	1,311	1,329	1,307	1,291			11,217
Medi-Cal Program	352,637	349,026	344,917	348,462	346,941	346,358	394,915	396,651	398,321	399,531			3,677,759
Group Care Program	5,669	5,645	5,631	5,605	5,585	5,622	5,603	5,608	5,620	5,643			56,231
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**	**400,518**	**402,259**	**403,941**	**405,174**			**3,733,990**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)	1,082	123	845	7,465	400	297	252			6,832
Adult	(624)	(448)	(603)	897	(245)	(455)	11,164	257	176	214			10,333
SPD	(225)	(215)	(248)	296	(23)	(19)	4,167	(138)	97	(84)			3,608
ACA OE	(1,260)	(1,888)	(1,803)	1,414	(857)	(905)	26,174	915	1,304	1,107			24,201
Duals	(43)	27	(86)	(133)	(499)	(23)	(857)	286	(181)	(271)			(1,780)
MCAL LTC	(9)	(3)	1	(4)	2	(2)	84	(2)	(1)	8			74
MCAL LTC Duals	4	(14)	(15)	(7)	(22)	(24)	360	18	(22)	(16)			262
Medi-Cal Program	(3,364)	(3,611)	(4,109)	3,545	(1,521)	(583)	48,557	1,736	1,670	1,210			43,530
Group Care Program	(15)	(24)	(14)	(26)	(20)	37	(19)	5	12	23			(41)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**	**48,538**	**1,741**	**1,682**	**1,233**			**43,489**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	29.1%	29.1%	29.0%	29.0%	29.2%	29.5%	27.7%	27.7%	27.7%	27.7%			28.5%
Adult % of Medi-Cal	14.9%	14.9%	14.9%	15.0%	15.0%	14.9%	15.9%	15.9%	15.9%	15.9%			15.4%
SPD % of Medi-Cal	8.8%	8.8%	8.9%	8.9%	8.9%	8.9%	8.9%	8.8%	8.8%	8.7%			8.8%
ACA OE % of Medi-Cal	35.1%	34.9%	34.8%	34.8%	34.8%	34.6%	36.9%	37.0%	37.2%	37.3%			35.8%
Duals % of Medi-Cal	11.8%	12.0%	12.1%	11.9%	11.8%	11.8%	10.2%	10.2%	10.1%	10.0%			11.1%
Medi-Cal Program % of Total	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%	98.6%	98.6%	98.6%	98.6%			98.5%
Group Care Program % of Total	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.4%	1.4%	1.4%	1.4%			1.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**			**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2024

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

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027	72,504	78,530	75,141	76,228	104,906	91,656	89,759	89,551			825,849
Alameda Health System	66,089	65,344	64,133	63,271	63,903	63,545	83,981	89,168	90,086	90,631			740,151
	140,636	138,371	136,637	141,801	139,044	139,773	188,887	180,824	179,845	180,182			1,566,000
Delegated:													
CFMG	34,810	34,649	34,144	34,035	35,105	35,399	42,148	43,527	43,412	43,700			380,929
CHCN	130,230	129,183	127,430	126,705	127,641	128,331	169,483	177,908	180,684	181,292			1,478,887
Kaiser	52,630	52,468	52,337	51,526	50,736	48,477	0	0	0	0			308,174
Delegated Subtotal	217,670	216,300	213,911	212,266	213,482	212,207	211,631	221,435	224,096	224,992			2,167,990
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**	**400,518**	**402,259**	**403,941**	**405,174**			**3,733,990**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(939)	(2,265)	(1,734)	5,164	(2,757)	729	49,114	(8,063)	(979)	337			38,607
Delegated:													
CFMG	(441)	(161)	(505)	(109)	1,070	294	6,749	1,379	(115)	288			8,449
CHCN	(1,721)	(1,047)	(1,753)	(725)	936	690	41,152	8,425	2,776	608			49,341
Kaiser	(278)	(162)	(131)	(811)	(790)	(2,259)	(48,477)	0	0	0			(52,908)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	1,216	(1,275)	(576)	9,804	2,661	896			4,882
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**	**48,538**	**1,741**	**1,682**	**1,233**			**43,489**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	39.3%	39.0%	39.0%	40.0%	39.4%	39.7%	47.2%	45.0%	44.5%	44.5%			41.9%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	10.0%	10.1%	10.5%	10.8%	10.7%	10.8%			10.2%
CHCN	36.3%	36.4%	36.4%	35.8%	36.2%	36.5%	42.3%	44.2%	44.7%	44.7%			39.6%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.4%	13.8%	0.0%	0.0%	0.0%	0.0%			8.3%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	60.6%	60.3%	52.8%	55.0%	55.5%	55.5%			58.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**			**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2024	FINAL BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program by Category of Aid:													
Child	102,463	101,393	100,038	101,120	100,109	99,008	102,159	100,933	99,823	98,725	97,639	96,565	1,199,975
Adult	52,550	52,102	51,499	52,396	51,872	51,301	57,478	56,788	56,107	55,434	54,769	54,112	646,408
SPD	31,055	30,840	30,592	30,888	30,734	30,488	42,473	42,133	41,796	41,462	41,130	40,801	434,392
ACA OE	123,707	121,819	120,016	121,430	121,180	119,605	149,197	147,556	145,933	144,328	142,740	141,170	1,598,681
Duals	41,688	41,715	41,629	41,496	41,410	41,325	45,787	45,694	45,600	45,506	45,412	45,318	522,580
MCAL LTC	141	138	139	135	136	137	172	173	174	175	176	177	1,873
MCAL LTC Duals	1,033	1,019	1,004	997	985	971	1,194	1,176	1,159	1,142	1,125	1,108	12,913
Medi-Cal Program	352,637	349,026	344,917	348,462	346,426	342,835	398,460	394,453	390,592	386,772	382,991	379,251	4,416,822
Group Care Program	5,669	5,645	5,631	5,605	5,591	5,577	5,563	5,549	5,535	5,521	5,507	5,493	66,886
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,017**	**348,412**	**404,023**	**400,002**	**396,127**	**392,293**	**388,498**	**384,744**	**4,483,708**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)	1,082	(1,011)	(1,101)	3,151	(1,226)	(1,110)	(1,098)	(1,086)	(1,074)	(7,105)
Adult	(624)	(448)	(603)	897	(524)	(571)	6,177	(690)	(681)	(673)	(665)	(657)	938
SPD	(225)	(215)	(248)	296	(154)	(246)	11,985	(340)	(337)	(334)	(332)	(329)	9,521
ACA OE	(1,260)	(1,888)	(1,803)	1,414	(250)	(1,575)	29,592	(1,641)	(1,623)	(1,605)	(1,588)	(1,570)	16,203
Duals	(43)	27	(86)	(133)	(86)	(85)	4,462	(93)	(94)	(94)	(94)	(94)	3,587
MCAL LTC	(9)	(3)	1	(4)	1	1	35	1	1	1	1	1	27
MCAL LTC Duals	4	(14)	(15)	(7)	(12)	(14)	223	(18)	(17)	(17)	(17)	(17)	79
Medi-Cal Program	(3,364)	(3,611)	(4,109)	3,545	(2,036)	(3,591)	55,625	(4,007)	(3,861)	(3,820)	(3,781)	(3,740)	23,250
Group Care Program	(15)	(24)	(14)	(26)	(14)	(14)	(14)	(14)	(14)	(14)	(14)	(14)	(191)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(2,050)**	**(3,605)**	**55,611**	**(4,021)**	**(3,875)**	**(3,834)**	**(3,795)**	**(3,754)**	**23,059**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	29.1%	29.1%	29.0%	29.0%	28.9%	28.9%	25.6%	25.6%	25.6%	25.5%	25.5%	25.5%	27.2%
Adult % (Medi-Cal)	14.9%	14.9%	14.9%	15.0%	15.0%	15.0%	14.4%	14.4%	14.4%	14.3%	14.3%	14.3%	14.6%
SPD % (Medi-Cal)	8.8%	8.8%	8.9%	8.9%	8.9%	8.9%	10.7%	10.7%	10.7%	10.7%	10.7%	10.8%	9.8%
ACA OE % (Medi-Cal)	35.1%	34.9%	34.8%	34.8%	35.0%	34.9%	37.4%	37.4%	37.4%	37.3%	37.3%	37.2%	36.2%
Duals % (Medi-Cal)	11.8%	12.0%	12.1%	11.9%	12.0%	12.1%	11.5%	11.6%	11.7%	11.8%	11.9%	11.9%	11.8%
MCAL LTC % (Medi-Cal)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MCAL LTC Duals % (Medi-Cal)	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Medi-Cal Program % of Total	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.5%
Group Care Program % of Total	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2024	FINAL BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027	72,504	78,530	78,174	77,543	103,987	103,154	102,341	101,536	100,739	99,949	1,066,031
Alameda Health System	66,089	65,344	64,133	63,271	62,977	62,254	86,850	85,925	85,022	84,129	83,245	82,371	891,610
	140,636	138,371	136,637	141,801	141,151	139,797	190,837	189,079	187,363	185,665	183,984	182,320	1,957,641
Delegated:													
CFMG	34,810	34,649	34,144	34,035	33,709	33,339	43,104	42,595	42,131	41,671	41,217	40,767	456,171
CHCN	130,230	129,183	127,430	126,705	125,969	124,637	170,082	168,328	166,633	164,957	163,297	161,657	1,759,108
Kaiser	52,630	52,468	52,337	51,526	51,188	50,639	0	0	0	0	0	0	310,788
Delegated Subtotal	217,670	216,300	213,911	212,266	210,866	208,615	213,186	210,923	208,764	206,628	204,514	202,424	2,526,067
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,017**	**348,412**	**404,023**	**400,002**	**396,127**	**392,293**	**388,498**	**384,744**	**4,483,708**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	305	(1,520)	(523)	6,026	(356)	(631)	26,444	(833)	(813)	(805)	(797)	(790)	25,707
Alameda Health System	(1,244)	(745)	(1,211)	(862)	(294)	(723)	24,596	(925)	(903)	(893)	(884)	(874)	15,038
	(939)	(2,265)	(1,734)	5,164	(650)	(1,354)	51,040	(1,758)	(1,716)	(1,698)	(1,681)	(1,664)	40,745
Delegated:													
CFMG	(441)	(161)	(505)	(109)	(326)	(370)	9,765	(509)	(464)	(460)	(454)	(450)	5,516
CHCN	(1,721)	(1,047)	(1,753)	(725)	(736)	(1,332)	45,445	(1,754)	(1,695)	(1,676)	(1,660)	(1,640)	29,706
Kaiser	(278)	(162)	(131)	(811)	(338)	(549)	(50,639)	0	0	0	0	0	(52,908)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	(1,400)	(2,251)	4,571	(2,263)	(2,159)	(2,136)	(2,114)	(2,090)	(17,686)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(2,050)**	**(3,605)**	**55,611**	**(4,021)**	**(3,875)**	**(3,834)**	**(3,795)**	**(3,754)**	**23,059**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	20.8%	20.6%	20.7%	22.2%	22.2%	22.3%	25.7%	25.8%	25.8%	25.9%	25.9%	26.0%	23.8%
Alameda Health System	18.4%	18.4%	18.3%	17.9%	17.9%	17.9%	21.5%	21.5%	21.5%	21.4%	21.4%	21.4%	19.9%
	39.3%	39.0%	39.0%	40.0%	40.1%	40.1%	47.2%	47.3%	47.3%	47.3%	47.4%	47.4%	43.7%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	9.6%	9.6%	10.7%	10.6%	10.6%	10.6%	10.6%	10.6%	10.2%
CHCN	36.3%	36.4%	36.4%	35.8%	35.8%	35.8%	42.1%	42.1%	42.1%	42.0%	42.0%	42.0%	39.2%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.5%	14.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	59.9%	59.9%	52.8%	52.7%	52.7%	52.7%	52.6%	52.6%	56.3%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2024

	Variance Jul-23	Variance Aug-23	Variance Sep-23	Variance Oct-23	Variance Nov-23	Variance Dec-23	Variance Jan-24	Variance Feb-24	Variance Mar-24	Variance Apr-24	Variance May-24	Variance Jun-24	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	1,134	3,080	7,394	9,020	10,427	11,777			42,832
Adult	0	0	0	0	279	395	5,382	6,329	7,186	8,073			27,644
SPD	0	0	0	0	131	358	(7,460)	(7,258)	(6,824)	(6,574)			(27,627)
ACA OE	0	0	0	0	(607)	63	(3,355)	(799)	2,128	4,840			2,270
Duals	0	0	0	0	(413)	(351)	(5,670)	(5,291)	(5,378)	(5,555)			(22,658)
MCAL LTC	0	0	0	0	1	(2)	47	44	42	49			181
MCAL LTC Duals	0	0	0	0	(10)	(20)	117	153	148	149			537
Medi-Cal Program	0	0	0	0	515	3,523	(3,545)	2,198	7,729	12,759			23,179
Group Care Program	0	0	0	0	(6)	45	40	59	85	122			345
Total	**0**	**0**	**0**	**0**	**509**	**3,568**	**(3,505)**	**2,257**	**7,814**	**12,881**			**23,524**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted										180,182			
Directly Contracted (DCP)	0	0	0	0	(3,033)	(1,315)	919	(11,498)	(12,582)	(11,985)			(39,494)
Alameda Health System	0	0	0	0	926	1,291	(2,869)	3,243	5,064	6,502			14,157
	0	0	0	0	(2,107)	(24)	(1,950)	(8,255)	(7,518)	(5,483)			(25,337)
Delegated:													
CFMG	0	0	0	0	1,396	2,060	(956)	932	1,281	2,029			6,742
CHCN	0	0	0	0	1,672	3,694	(599)	9,580	14,051	16,335			44,733
Kaiser	0	0	0	0	(452)	(2,162)	0	0	0	0			(2,614)
Delegated Subtotal	0	0	0	0	2,616	3,592	(1,555)	10,512	15,332	18,364			48,861
Total	**0**	**0**	**0**	**0**	**509**	**3,568**	**(3,505)**	**2,257**	**7,814**	**12,881**			**23,524**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED APRIL 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$5,189,884	$1,393,392	($3,796,492)	(272.5%)	PCP Capitation	$27,598,050	$12,556,853	($15,041,197)	(119.8%)
6,171,338	6,164,077	(7,260)	(0.1%)	PCP Capitation FQHC	50,337,587	51,527,013	1,189,426	2.3%
379,207	361,812	(17,396)	(4.8%)	Specialty-Capitation	3,306,056	3,247,186	(58,870)	(1.8%)
5,406,158	5,538,636	132,478	2.4%	Specialty-Capitation FQHC	43,853,466	45,606,646	1,753,180	3.8%
709,260	705,406	(3,854)	(0.5%)	Laboratory Capitation	6,055,789	5,921,383	(134,406)	(2.3%)
339,266	326,605	(12,662)	(3.9%)	Vision Cap	2,873,543	2,840,146	(33,397)	(1.2%)
110,331	105,381	(4,950)	(4.7%)	CFMG Capitation	961,738	945,483	(16,255)	(1.7%)
266,989	270,571	3,583	1.3%	Anc IPA Admin Capitation FQHC	2,171,753	2,243,932	72,180	3.2%
0	0	0	0.0%	Kaiser Capitation	83,773,193	84,015,590	242,397	0.3%
0	0	0	0.0%	BHT Supplemental Expense	4,672	0	(4,672)	0.0%
9,318	0	(9,318)	0.0%	Maternity Supplemental Expense	2,433,101	2,311,103	(121,999)	(5.3%)
877,289	1,027,837	150,548	14.6%	DME Cap	7,806,055	8,521,959	715,904	8.4%
$19,459,040	**$15,893,717**	**($3,565,323)**	**(22.4%)**	**5 - TOTAL CAPITATED EXPENSES**	**$231,175,003**	**$219,737,292**	**($11,437,711)**	**(5.2%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
12,040,629	0	(12,040,629)	0.0%	IBNR Inpatient Services	22,768,527	(2,306,298)	(25,074,825)	1,087.2%
361,219	0	(361,219)	0.0%	IBNR Settlement (IP)	683,055	(69,188)	(752,243)	1,087.2%
0	0	0	0.0%	IBNR Claims Fluctuation (IP)	858,234	(184,504)	(1,042,738)	565.2%
36,011,654	48,009,538	11,997,885	25.0%	Inpatient Hospitalization FFS	334,810,199	382,229,850	47,419,651	12.4%
2,505,971	0	(2,505,971)	0.0%	IP OB - Mom & NB	21,354,205	7,462,632	(13,891,572)	(186.1%)
224,824	0	(224,824)	0.0%	IP Behavioral Health	1,933,772	895,483	(1,038,289)	(115.9%)
1,070,016	0	(1,070,016)	0.0%	IP Facility Rehab FFS	10,091,321	4,711,642	(5,379,678)	(114.2%)
$52,214,312	**$48,009,538**	**($4,204,774)**	**(8.8%)**	**6 - Inpatient Hospital & SNF Expense**	**$392,499,312**	**$392,739,618**	**$240,306**	**0.1%**
(132,109)	0	132,109	0.0%	IBNR PCP	485,872	46,983	(438,889)	(934.1%)
(3,963)	0	3,963	0.0%	IBNR Settlement (PCP)	14,575	1,409	(13,166)	(934.4%)
0	0	0	0.0%	IBNR Claims Fluctuation (PCP)	49,440	3,759	(45,681)	(1,215.2%)
4,897,784	2,673,410	(2,224,374)	(83.2%)	Primary Care Non-Contracted FF	28,607,857	22,283,467	(6,324,390)	(28.4%)
615,482	317,139	(298,344)	(94.1%)	PCP FQHC FFS	4,431,567	3,804,803	(626,764)	(16.5%)
0	0	0	0.0%	Phys Extended Hours Incentive	3,500	6,000	2,500	41.7%
(818,409)	3,632,657	4,451,066	122.5%	Prop 56 Physician	13,073,855	30,354,465	17,280,610	56.9%
16,306	0	(16,306)	0.0%	Prop 56 Hyde	241,387	58,257	(183,130)	(314.3%)
51,747	0	(51,747)	0.0%	Prop 56 Trauma Screening	749,872	316,945	(432,927)	(136.6%)
48,540	0	(48,540)	0.0%	Prop 56 Develop. Screening	847,576	383,782	(463,793)	(120.8%)
624,679	0	(624,679)	0.0%	Prop 56 Family Planning	7,294,261	2,905,675	(4,388,586)	(151.0%)
(298,978)	0	298,978	0.0%	Prop 56 VBP	(298,405)	7,428	305,834	4,117.1%
$5,001,080	**$6,623,205**	**$1,622,125**	**24.5%**	**7 - Primary Care Physician Expense**	**$55,501,357**	**$60,172,973**	**$4,671,617**	**7.8%**
(507,401)	0	507,401	0.0%	IBNR Specialist	1,594,349	(704,271)	(2,298,620)	326.4%
349,107	0	(349,107)	0.0%	Psychiatrist FFS	2,846,831	927,497	(1,919,334)	(206.9%)
3,034,388	7,502,582	4,468,194	59.6%	Specialty Care FFS	24,624,825	50,302,749	25,677,924	51.0%
276,678	0	(276,678)	0.0%	Specialty Anesthesiology	1,843,459	733,088	(1,110,371)	(151.5%)
1,427,075	0	(1,427,075)	0.0%	Specialty Imaging FFS	11,589,126	4,332,553	(7,256,572)	(167.5%)
34,755	0	(34,755)	0.0%	Obstetrics FFS	203,819	71,825	(131,995)	(183.8%)
393,443	0	(393,443)	0.0%	Specialty IP Surgery FFS	2,914,576	1,146,377	(1,768,198)	(154.2%)
1,130,805	0	(1,130,805)	0.0%	Specialty OP Surgery FFS	6,748,521	2,380,160	(4,368,362)	(183.5%)
581,430	0	(581,430)	0.0%	Spec IP Physician	4,854,210	1,804,945	(3,049,265)	(168.9%)
180,528	102,170	(78,358)	(76.7%)	SCP FQHC FFS	841,414	814,442	(26,972)	(3.3%)
(15,221)	0	15,221	0.0%	IBNR Settlement (SCP)	47,834	(21,127)	(68,961)	326.4%
0	0	0	0.0%	IBNR Claims Fluctuation (SCP)	168,139	(56,342)	(224,481)	398.4%
$6,885,586	**$7,604,753**	**$719,166**	**9.5%**	**8 - Specialty Care Physician Expense**	**$58,277,103**	**$61,731,896**	**$3,454,793**	**5.6%**
762,426	0	(762,426)	0.0%	IBNR Ancillary	5,627,875	2,122,555	(3,505,320)	(165.1%)
22,872	0	(22,872)	0.0%	IBNR Settlement (ANC)	168,838	63,677	(105,161)	(165.1%)
0	0	0	0.0%	IBNR Claims Fluctuation (ANC)	389,235	169,805	(219,430)	(129.2%)
324,951	0	(324,951)	0.0%	IBNR Transportation FFS	585,629	45,720	(539,910)	(1,180.9%)
1,549,609	0	(1,549,609)	0.0%	Behavioral Health Therapy FFS	13,021,125	4,951,126	(8,069,999)	(163.0%)
1,439,122	0	(1,439,122)	0.0%	Psychologist & Other MH Prof.	11,572,254	4,215,464	(7,356,790)	(174.5%)
311,014	0	(311,014)	0.0%	Acupuncture/Biofeedback	2,899,130	1,075,338	(1,823,792)	(169.6%)
83,374	0	(83,374)	0.0%	Hearing Devices	1,175,980	381,525	(794,455)	(208.2%)
50,839	0	(50,839)	0.0%	Imaging/MRI/CT Global	461,515	141,544	(319,971)	(226.1%)
110,750	0	(110,750)	0.0%	Vision FFS	555,599	164,593	(391,006)	(237.6%)
0	0	0	0.0%	Family Planning	69	30	(40)	(133.3%)
487,730	0	(487,730)	0.0%	Laboratory-FFS	5,043,270	1,917,612	(3,125,658)	(163.0%)
119,032	0	(119,032)	0.0%	ANC Therapist	970,404	395,200	(575,204)	(145.5%)
1,266,285	0	(1,266,285)	0.0%	Transportation (Ambulance)-FFS	11,111,803	3,746,485	(7,365,317)	(196.6%)
2,047,018	0	(2,047,018)	0.0%	Transportation (Other)-FFS	16,421,559	5,929,067	(10,492,492)	(177.0%)
1,803,940	0	(1,803,940)	0.0%	Hospice	14,494,943	5,779,983	(8,714,960)	(150.8%)

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED APRIL 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,511,638	0	(1,511,638)	0.0%	Home Health Services	13,044,524	4,994,036	(8,050,488)	(161.2%)
603	12,258,924	12,258,321	100.0%	Other Medical-FFS	12,077	67,728,583	67,716,506	100.0%
(140,625)	0	140,625	0.0%	Medical Refunds through HMS	(100,606)	(309,963)	(209,357)	67.5%
(182,758)	0	182,758	0.0%	Medical Refunds	(768,177)	(565,083)	203,094	(35.9%)
10,632	0	(10,632)	0.0%	DME & Medical Supplies	238,016	116,689	(121,327)	(104.0%)
0	0	0	0.0%	GEMT FFS	(373,988)	(373,988)	0	0.0%
1,786,451	1,829,645	43,194	2.4%	ECM Base/Outreach FFS Anc.	15,736,158	15,424,367	(311,791)	(2.0%)
20,315	0	(20,315)	0.0%	CS Housing Deposits FFS Ancillary	(4,169,712)	135,985	4,305,697	3,166.3%
313,151	0	(313,151)	0.0%	CS Housing Tenancy FFS Ancillary	6,556,955	1,183,089	(5,373,865)	(454.2%)
128,106	0	(128,106)	0.0%	CS Housing Navigation Services FFS Ancillary	32,290	257,647	225,357	87.5%
198,213	0	(198,213)	0.0%	CS Medical Respite FFS Ancillary	1,898,266	377,892	(1,520,374)	(402.3%)
109,024	0	(109,024)	0.0%	CS Medically Tailored Meals FFS Ancillary	(206,714)	128,446	335,160	260.9%
6,980	0	(6,980)	0.0%	CS Asthma Remediation FFS Ancillary	(241,179)	11,648	252,827	2,170.6%
0	10,000	10,000	100.0%	MOT Wrap Around (Non Medical MOT Cost)	0	60,000	60,000	100.0%
96,651	0	(96,651)	0.0%	CS Personal Care & Homemaker Services FFS Ancillary	1,554,394	0	(1,554,394)	0.0%
598	0	(598)	0.0%	CS Caregiver Respite Services FFS Ancillary	11,944	0	(11,944)	0.0%
290,344	0	(290,344)	0.0%	Community Based Adult Services (CBAS)	3,800,681	1,425,263	(2,375,419)	(166.7%)
0	0	0	0.0%	CS Pilot LTC Diversion Expense	0	15,291	15,291	100.0%
0	0	0	0.0%	CS Pilot LTC Transition Expense	37,463	23,701	(13,762)	(58.1%)
0	0	0	0.0%	Justice Involved Pilot	0	161,111	161,111	100.0%
$14,528,286	**$14,098,570**	**($429,716)**	**(3.0%)**	**9 - Ancillary Medical Expense**	**$121,561,622**	**$121,894,440**	**$332,818**	**0.3%**
72,092	0	(72,092)	0.0%	IBNR Outpatient	4,889,181	422,626	(4,466,555)	(1,056.9%)
2,164	0	(2,164)	0.0%	IBNR Settlement (OP)	146,674	12,677	(133,997)	(1,057.0%)
0	0	0	0.0%	IBNR Claims Fluctuation (OP)	385,366	33,811	(351,555)	(1,039.8%)
2,300,934	12,188,782	9,887,848	81.1%	Out Patient FFS	17,526,230	72,029,809	54,503,579	75.7%
2,356,253	0	(2,356,253)	0.0%	OP Ambul Surgery FFS	17,981,982	6,937,396	(11,044,586)	(159.2%)
2,137,940	0	(2,137,940)	0.0%	OP Fac Imaging Services FFS	17,805,959	6,670,623	(11,135,336)	(166.9%)
25,056	0	(25,056)	0.0%	Behav Health FFS	124,183	(21,966)	(146,150)	665.3%
720,258	0	(720,258)	0.0%	OP Facility Lab FFS	5,764,231	2,081,864	(3,682,367)	(176.9%)
232,904	0	(232,904)	0.0%	OP Facility Cardio FFS	1,617,358	608,098	(1,009,260)	(166.0%)
152,939	0	(152,939)	0.0%	OP Facility PT/OT/ST FFS	1,541,726	270,230	(1,271,495)	(470.5%)
3,106,358	0	(3,106,358)	0.0%	OP Facility Dialysis FFS	21,771,200	8,379,495	(13,391,705)	(159.8%)
$11,106,898	**$12,188,782**	**$1,081,885**	**8.9%**	**10 - Outpatient Medical Expense Medical Expense**	**$89,554,089**	**$97,424,662**	**$7,870,573**	**8.1%**
924,061	0	(924,061)	0.0%	IBNR Emergency	3,960,104	30,260	(3,929,844)	(12,986.9%)
27,722	0	(27,722)	0.0%	IBNR Settlement (ER)	118,804	910	(117,894)	(12,955.4%)
0	0	0	0.0%	IBNR Claims Fluctuation (ER)	242,890	2,423	(240,467)	(9,924.3%)
1,196,235	0	(1,196,235)	0.0%	Special ER Physician FFS	8,708,157	3,056,795	(5,651,362)	(184.9%)
7,515,835	7,626,559	110,724	1.5%	ER Facility	59,355,547	61,914,546	2,558,999	4.1%
$9,663,854	**$7,626,559**	**($2,037,294)**	**(26.7%)**	**11 - Emergency Expense**	**$72,385,502**	**$65,004,934**	**($7,380,568)**	**(11.4%)**
297,332	0	(297,332)	0.0%	IBNR Pharmacy OP	2,972,556	(204,308)	(3,176,864)	1,554.9%
8,919	0	(8,919)	0.0%	IBNR Settlement (RX) OP	89,173	(6,133)	(95,306)	1,554.0%
0	0	0	0.0%	IBNR Claims Fluctuation (RX) OP	214,018	(16,345)	(230,363)	1,409.4%
613,760	366,471	(247,289)	(67.5%)	Pharmacy FFS	5,104,771	4,156,390	(948,382)	(22.8%)
109,666	11,838,990	11,729,324	99.1%	Pharmacy Non-PBM FFS-Other Anc	1,194,989	65,594,273	64,399,284	98.2%
6,017,999	0	(6,017,999)	0.0%	Pharmacy Non-PBM FFS-OP FAC	57,902,869	21,975,503	(35,927,366)	(163.5%)
241,851	0	(241,851)	0.0%	Pharmacy Non-PBM FFS-PCP	2,174,799	615,362	(1,559,437)	(253.4%)
1,937,082	0	(1,937,082)	0.0%	Pharmacy Non-PBM FFS-SCP	21,643,716	8,807,902	(12,835,814)	(145.7%)
28,778	0	(28,778)	0.0%	Pharmacy Non-PBM FFS-FQHC	125,974	41,158	(84,816)	(206.1%)
5,169	0	(5,169)	0.0%	Pharmacy Non-PBM FFS-HH	83,579	27,987	(55,592)	(198.6%)
(24)	0	24	0.0%	RX Refunds HMS	(87)	(63)	24	(38.0%)
(189,617)	31,562	221,179	700.8%	Pharmacy Rebate	(514,617)	30,631	545,248	1,780.1%
$9,070,915	**$12,237,023**	**$3,166,108**	**25.9%**	**12 - Pharmacy Expense**	**$90,991,740**	**$101,022,356**	**$10,030,616**	**9.9%**
6,499,406	0	(6,499,406)	0.0%	IBNR LTC	29,166,080	4,802,539	(24,363,541)	(507.3%)
194,982	0	(194,982)	0.0%	IBNR Settlement (LTC)	874,984	144,077	(730,907)	(507.3%)
0	0	0	0.0%	IBNR Claims Fluctuation (LTC)	1,813,333	384,202	(1,429,131)	(372.0%)
1,182,627	0	(1,182,627)	0.0%	LTC - ICF/DD	3,497,459	0	(3,497,459)	0.0%
21,758,947	0	(21,758,947)	0.0%	LTC Custodial Care	177,932,773	63,392,176	(114,540,597)	(180.7%)
2,985,958	23,593,045	20,607,088	87.3%	LTC SNF	32,092,680	141,767,863	109,675,184	77.4%
$32,621,920	**$23,593,045**	**($9,028,875)**	**(38.3%)**	**13 - Long Term Care Expense**	**$245,377,309**	**$210,490,858**	**($34,886,451)**	**(16.6%)**
$141,092,851	**$131,981,476**	**($9,111,375)**	**(6.9%)**	**14 - TOTAL FFS MEDICAL EXPENSES**	**$1,126,148,034**	**$1,110,481,737**	**($15,666,297)**	**(1.4%)**
0	(267,602)	(267,602)	100.0%	Clinical Vacancy Department Total	0	(1,828,075)	(1,828,075)	100.0%
107,796	114,505	6,708	5.9%	Quality Analytics Department Total	819,993	1,414,884	594,891	42.0%
1,076,664	1,085,838	9,174	0.8%	Utilization Management Department Total	8,586,250	9,624,920	1,038,670	10.8%

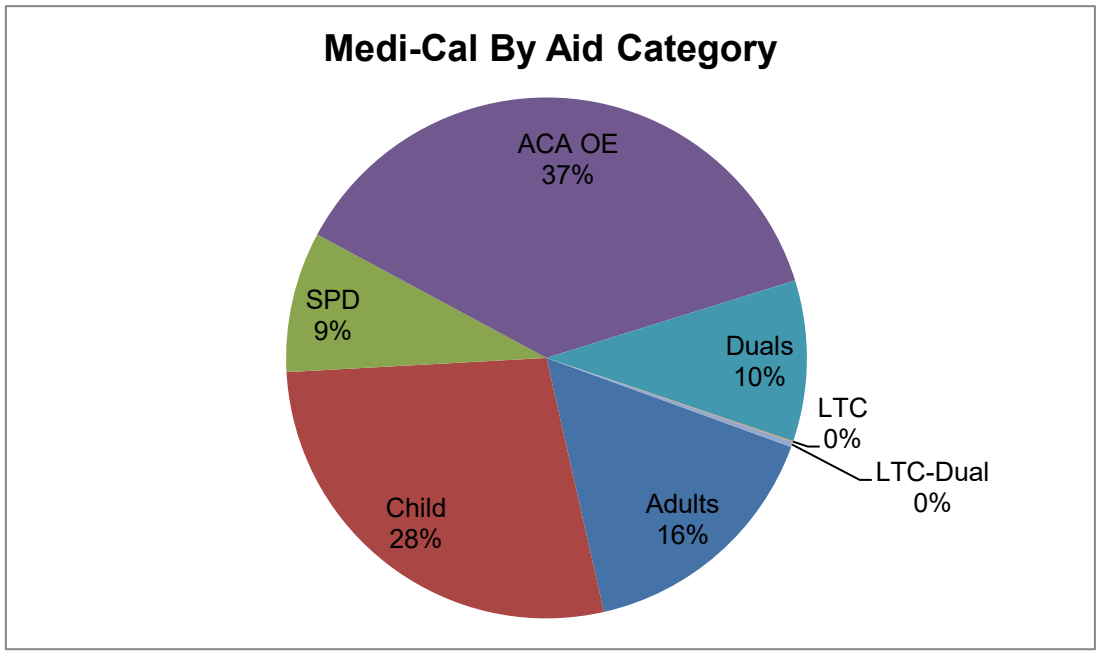
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED APRIL 30, 2024

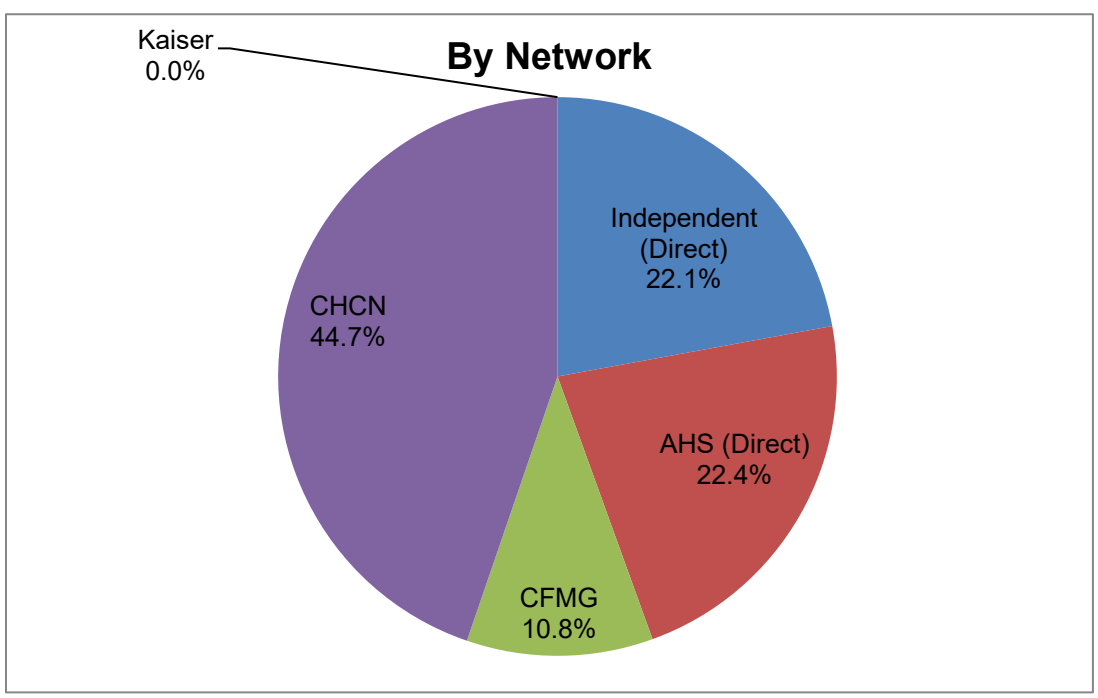
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
686,572	684,045	(2,528)	(0.4%)	Case/Disease Management Department Total	6,148,536	6,328,575	180,039	2.8%
1,124,231	1,536,107	411,876	26.8%	Medical Services Department Total	20,532,329	18,038,688	(2,493,642)	(13.8%)
1,040,893	1,060,796	19,903	1.9%	Quality Management Department Total	8,302,356	11,199,315	2,896,958	25.9%
323,137	325,248	2,111	0.6%	HCS Behavioral Health Department Total	2,782,354	2,965,060	182,706	6.2%
137,286	142,042	4,755	3.3%	Pharmacy Services Department Total	1,407,688	1,461,394	53,706	3.7%
62,980	61,931	(1,049)	(1.7%)	Regulatory Readiness Total	617,212	656,374	39,161	6.0%
$4,559,560	**$4,742,908**	**$183,348**	**3.9%**	**15 - Other Benefits & Services**	**$49,196,719**	**$49,861,134**	**$664,415**	**1.3%**
(1,121,000)	(1,073,839)	47,161	(4.4%)	Reinsurance Recoveries	(12,030,311)	(9,622,067)	2,408,244	(25.0%)
1,401,632	1,431,785	30,154	2.1%	Reinsurance Premium	11,949,022	11,943,644	(5,378)	0.0%
$280,632	**$357,946**	**$77,315**	**21.6%**	**16- Reinsurance Expense**	**($81,289)**	**$2,321,577**	**$2,402,867**	**103.5%**
0	0	0	0.0%	P4P Risk Pool Provider Incenti	3,000,000	3,000,000	0	0.0%
$0	**$0**	**$0**	**0.0%**	**17 - Risk Pool Distribution**	**$3,000,000**	**$3,000,000**	**$0**	**0.0%**
$165,392,082	**$152,976,047**	**($12,416,035)**	**(8.1%)**	**18 - TOTAL MEDICAL EXPENSES**	**$1,409,438,467**	**$1,385,401,741**	**($24,036,726)**	**(1.7%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Apr 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	63,551	16%	13,331	14,435	19	35,766	-
Child	110,566	28%	9,598	13,518	40,692	46,758	-
SPD	34,887	9%	11,348	5,484	1,429	16,626	-
ACA OE	149,154	37%	25,455	53,478	1,555	68,666	-
Duals	39,912	10%	26,211	2,846	7	10,848	-
LTC	223	0%	207	7	-	9	-
LTC-Dual	1,291	0%	1,289	-	-	2	-
Medi-Cal	399,584		87,439	89,768	43,702	178,675	-
Group Care	5,643		2,156	862	-	2,625	-
Total	**405,227**	**100%**	**89,595**	**90,630**	**43,702**	**181,300**	**-**
Medi-Cal %	98.6%		97.6%	99.0%	100.0%	98.6%	0%
Group Care %	1.4%		2.4%	1.0%	0.0%	1.4%	0.0%
	Network Distribution		*22.1%*	*22.4%*	*10.8%*	*44.7%*	*0.0%*
			% Direct:	**44%**		**% Delegated:**	**56%**

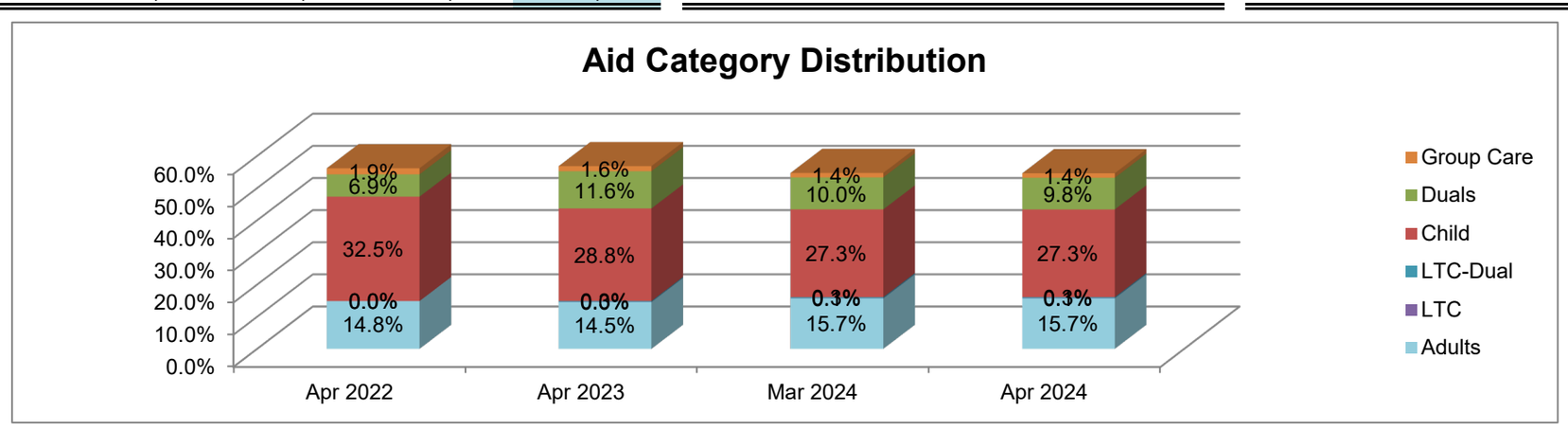




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

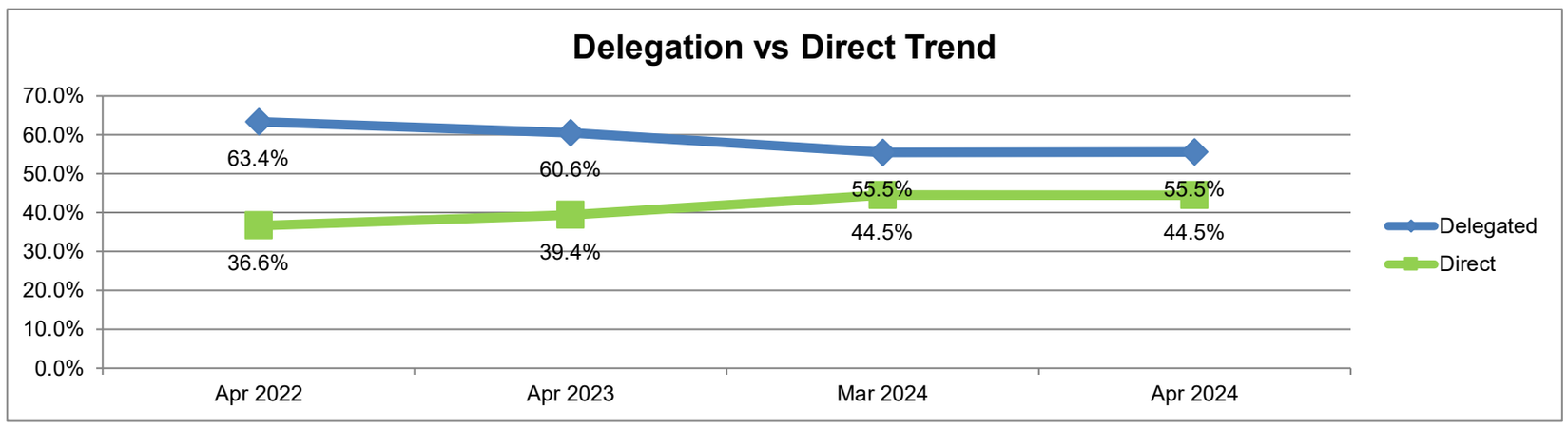
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
Adults	45,826	52,047	63,314	63,551	14.8%	14.5%	15.7%	15.7%	13.6%	22.1%	0.4%
Child	100,215	103,173	110,268	110,566	32.5%	28.8%	27.3%	27.3%	3.0%	7.2%	0.3%
SPD	26,848	31,130	34,972	34,887	8.7%	8.7%	8.7%	8.6%	15.9%	12.1%	-0.2%
ACA OE	108,568	123,606	148,065	149,154	35.2%	34.5%	36.7%	36.8%	13.9%	20.7%	0.7%
Duals	21,456	41,473	40,222	39,912	6.9%	11.6%	10.0%	9.8%	93.3%	-3.8%	-0.8%
LTC	-	145	216	223	0.0%	0.0%	0.1%	0.1%	0.0%	53.8%	3.2%
LTC-Dual	-	983	1,307	1,291	0.0%	0.3%	0.3%	0.3%	0.0%	31.3%	-1.2%
Medi-Cal Total	302,913	352,557	398,364	399,584	98.1%	98.4%	98.6%	98.6%	16.4%	13.3%	0.3%
Group Care	5,828	5,669	5,620	5,643	1.9%	1.6%	1.4%	1.4%	-2.7%	-0.5%	0.4%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**16.0%**	**13.1%**	**0.3%**



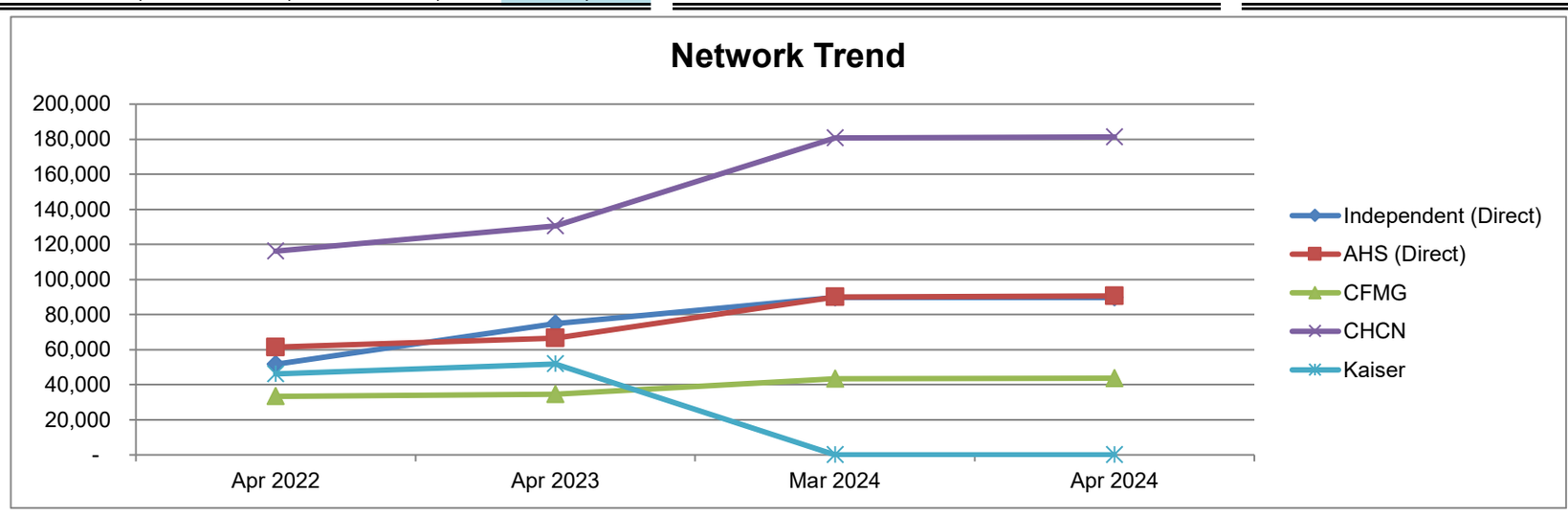
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
Delegated	195,637	216,961	224,105	225,002	63.4%	60.6%	55.5%	55.5%	10.9%	3.7%	0.4%
Direct	113,104	141,265	179,879	180,225	36.6%	39.4%	44.5%	44.5%	24.9%	27.6%	0.2%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**16.0%**	**13.1%**	**0.3%**



Network Trend

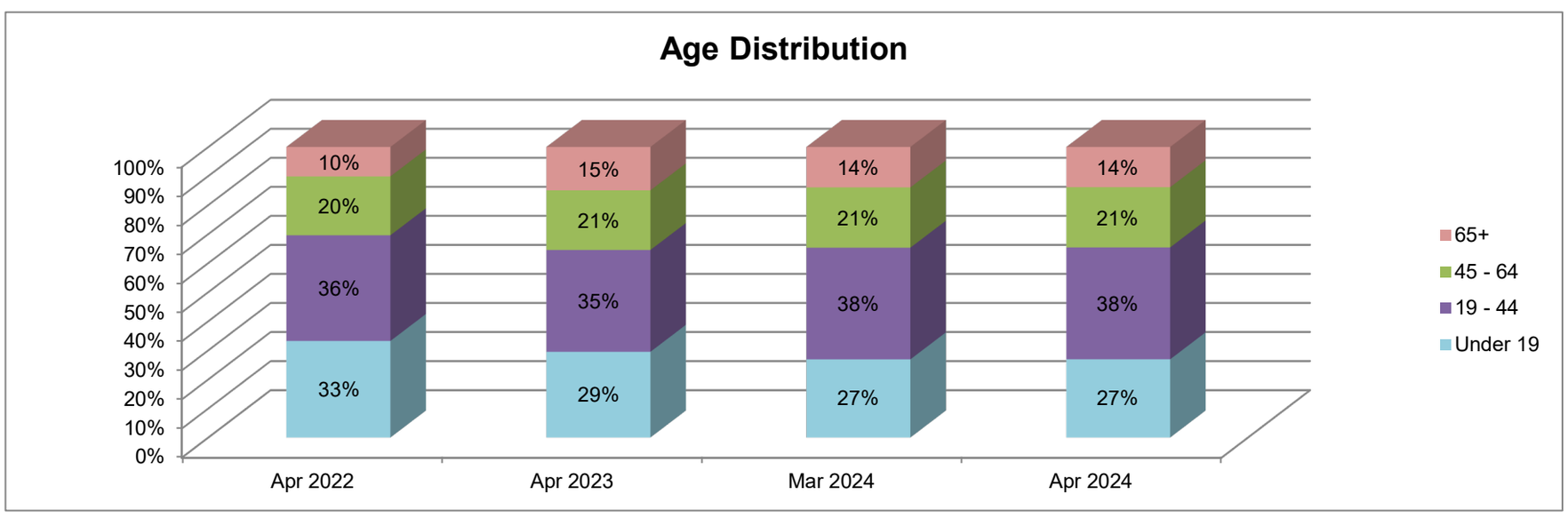
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
Independent (Direct)	51,662	74,713	89,790	89,595	16.7%	20.9%	22.2%	22.1%	44.6%	19.9%	-0.2%
AHS (Direct)	61,442	66,552	90,089	90,630	19.9%	18.6%	22.3%	22.4%	8.3%	36.2%	0.6%
CFMG	33,333	34,644	43,413	43,702	10.8%	9.7%	10.7%	10.8%	3.9%	26.1%	0.7%
CHCN	116,169	130,508	180,692	181,300	37.6%	36.4%	44.7%	44.7%	12.3%	38.9%	0.3%
Kaiser	46,135	51,809	-	-	14.9%	14.5%	0.0%	0.0%	12.3%	-100.0%	0.0%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**16.0%**	**13.1%**	**0.3%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

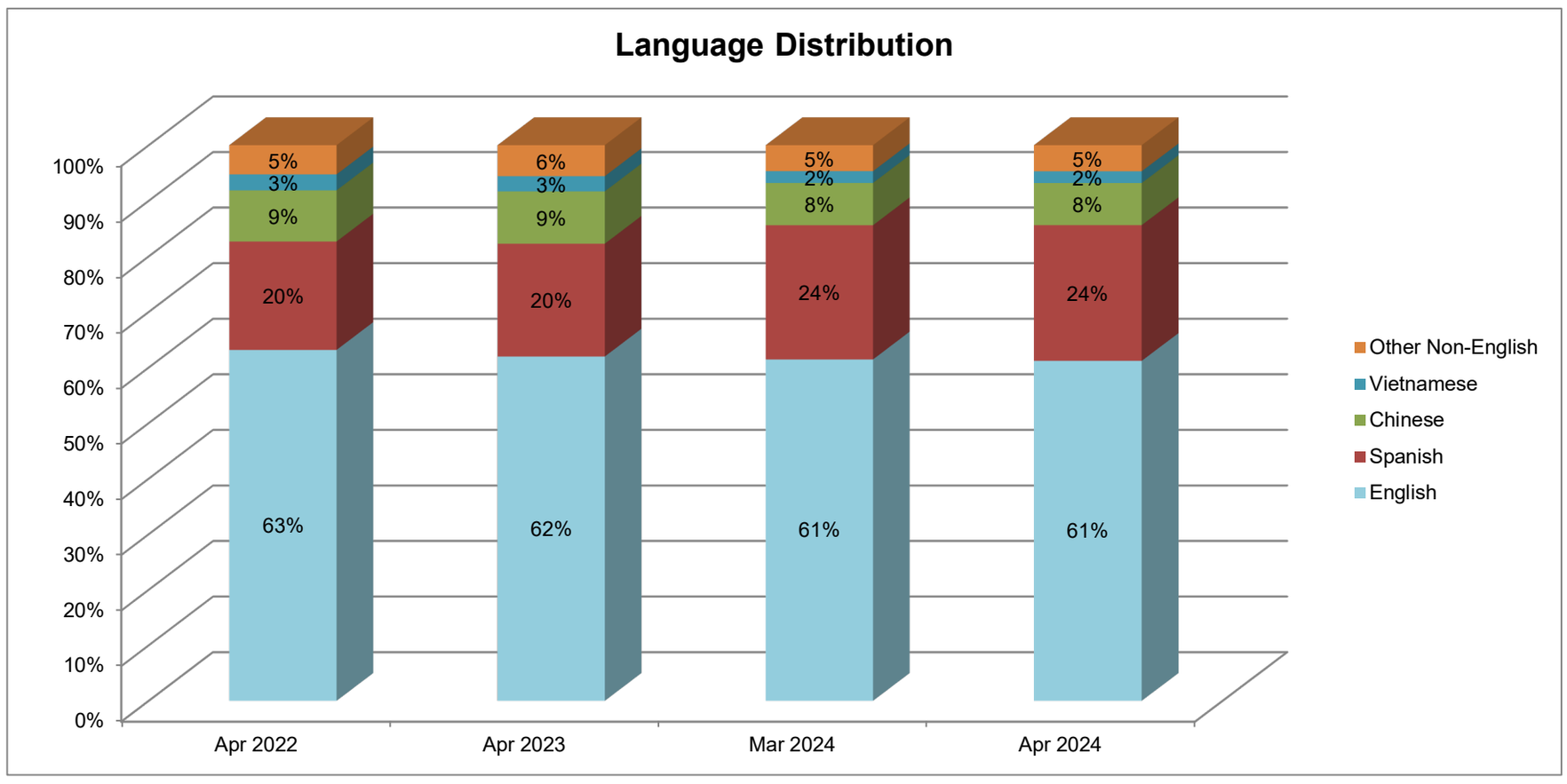
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
Under 19	102,464	105,525	108,522	108,917	33%	29%	27%	27%	3%	3%	0%
19 - 44	112,308	125,496	155,233	156,001	36%	35%	38%	38%	12%	24%	0%
45 - 64	62,659	73,669	83,951	84,128	20%	21%	21%	21%	18%	14%	0%
65+	31,310	53,536	56,278	56,181	10%	15%	14%	14%	71%	5%	0%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



Language Trend

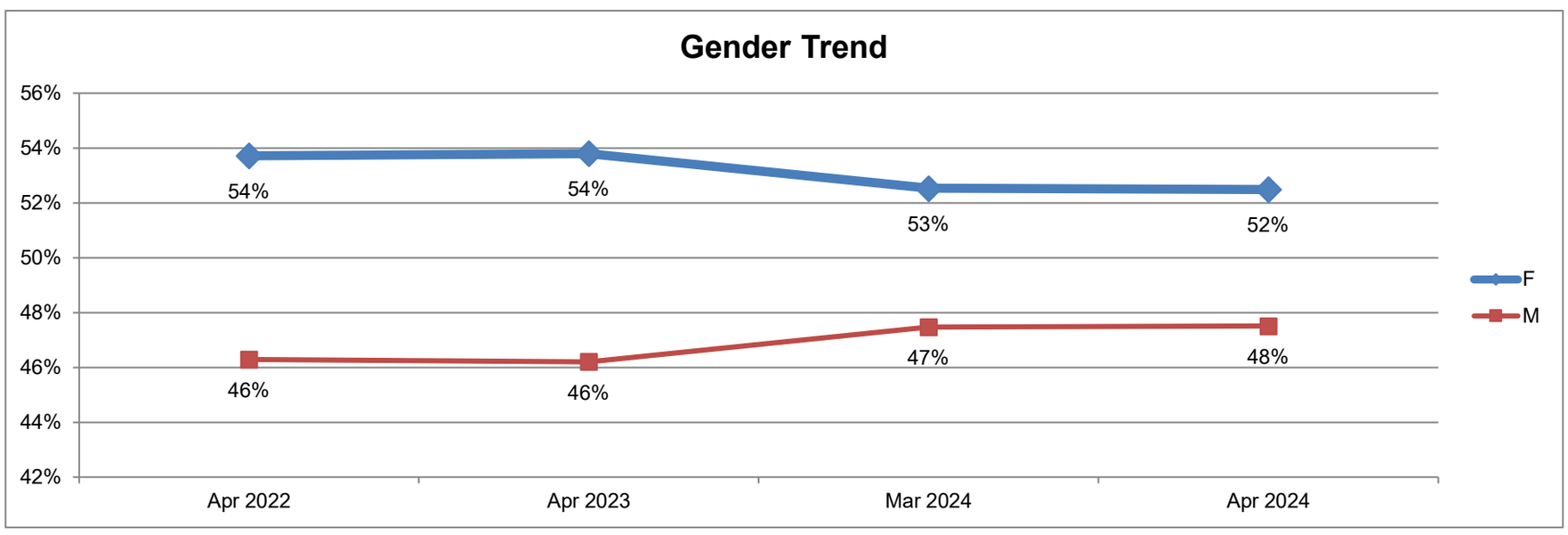
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
English	194,983	221,974	248,207	247,927	63%	62%	61%	61%	14%	12%	0%
Spanish	60,230	72,728	97,569	98,970	20%	20%	24%	24%	21%	36%	1%
Chinese	28,433	33,747	30,760	30,725	9%	9%	8%	8%	19%	-9%	0%
Vietnamese	8,863	9,787	8,536	8,548	3%	3%	2%	2%	10%	-13%	0%
Other Non-English	16,232	19,990	18,912	19,057	5%	6%	5%	5%	23%	-5%	1%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

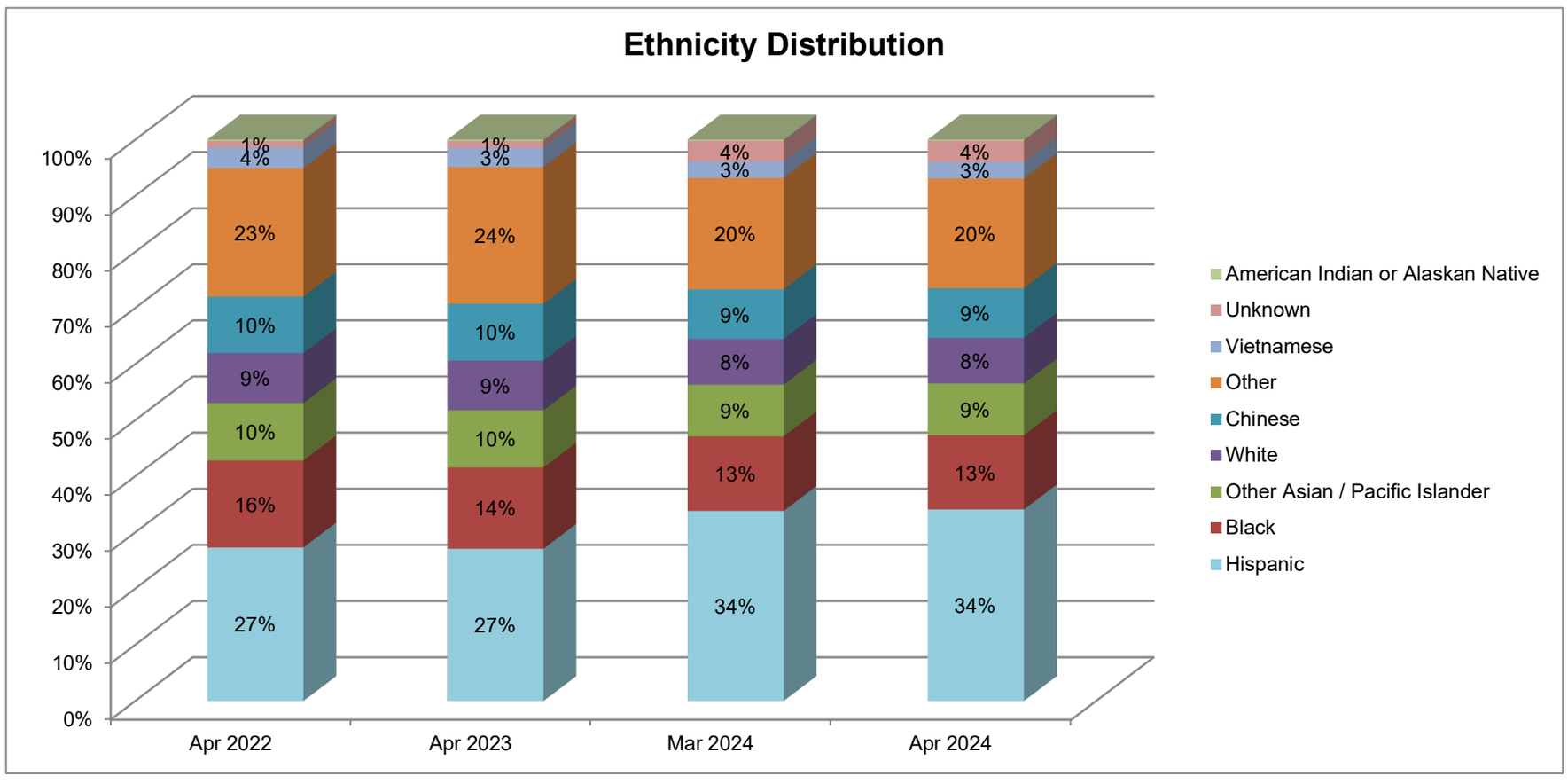
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
F	165,836	192,712	212,211	212,693	54%	54%	53%	52%	16%	10%	0%
M	142,905	165,514	191,773	192,534	46%	46%	47%	48%	16%	16%	0%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
Hispanic	84,250	96,968	136,557	138,080	27%	27%	34%	34%	15%	42%	1%
Black	47,891	51,913	53,627	53,580	16%	14%	13%	13%	8%	3%	0%
Other Asian / Pacific Islander	31,590	36,482	37,287	37,409	10%	10%	9%	9%	15%	3%	0%
White	27,524	31,763	32,857	32,949	9%	9%	8%	8%	15%	4%	0%
Chinese	31,057	36,306	35,796	35,847	10%	10%	9%	9%	17%	-1%	0%
Other	70,736	87,251	80,230	79,277	23%	24%	20%	20%	23%	-9%	-1%
Vietnamese	11,420	12,333	12,036	12,050	4%	3%	3%	3%	8%	-2%	0%
Unknown	3,612	4,471	14,794	15,231	1%	1%	4%	4%	24%	241%	3%
American Indian or Alaskan Native	661	739	800	804	0%	0%	0%	0%	12%	9%	1%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



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

Medi-Cal By City

City	Apr 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	161,674	40%	24,322	42,749	17,473	77,130	-
Hayward	63,447	16%	12,570	16,783	7,413	26,681	-
Fremont	36,430	9%	15,039	6,779	2,029	12,583	-
San Leandro	33,161	8%	8,175	5,708	4,266	15,012	-
Union City	14,623	4%	5,409	2,619	834	5,761	-
Alameda	14,047	4%	3,414	2,541	2,078	6,014	-
Berkeley	15,404	4%	4,282	2,182	1,771	7,169	-
Livermore	12,731	3%	1,921	701	2,233	7,876	-
Newark	9,197	2%	2,693	4,044	485	1,975	-
Castro Valley	9,424	2%	2,452	1,663	1,390	3,919	-
San Lorenzo	7,291	2%	1,451	1,636	829	3,375	-
Pleasanton	7,311	2%	1,794	440	778	4,299	-
Dublin	7,368	2%	1,976	455	881	4,056	-
Emeryville	2,776	1%	616	617	451	1,092	-
Albany	2,545	1%	687	276	563	1,019	-
Piedmont	483	0%	116	195	52	120	-
Sunol	85	0%	24	15	5	41	-
Antioch	32	0%	14	10	4	4	-
Other	1,555	0%	484	355	167	549	-
Total	**399,584**	**100%**	**87,439**	**89,768**	**43,702**	**178,675**	**-**

Group Care By City

City	Apr 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,780	32%	363	333	-	1,084	-
Hayward	624	11%	291	138	-	195	-
Fremont	623	11%	429	62	-	132	-
San Leandro	589	10%	242	83	-	264	-
Union City	299	5%	193	44	-	62	-
Alameda	295	5%	95	22	-	178	-
Berkeley	167	3%	52	15	-	100	-
Livermore	102	2%	34	3	-	65	-
Newark	132	2%	78	31	-	23	-
Castro Valley	191	3%	81	27	-	83	-
San Lorenzo	135	2%	45	20	-	70	-
Pleasanton	63	1%	20	2	-	41	-
Dublin	112	2%	38	6	-	68	-
Emeryville	37	1%	14	5	-	18	-
Albany	18	0%	10	1	-	7	-
Piedmont	11	0%	3	1	-	7	-
Sunol	1	0%	1	-	-	-	-
Antioch	23	0%	6	4	-	13	-
Other	441	8%	161	65	-	215	-
Total	**5,643**	**100%**	**2,156**	**862**	**-**	**2,625**	**-**

Total By City

City	Apr 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	163,454	40%	24,685	43,082	17,473	78,214	-
Hayward	64,071	16%	12,861	16,921	7,413	26,876	-
Fremont	37,053	9%	15,468	6,841	2,029	12,715	-
San Leandro	33,750	8%	8,417	5,791	4,266	15,276	-
Union City	14,922	4%	5,602	2,663	834	5,823	-
Alameda	14,342	4%	3,509	2,563	2,078	6,192	-
Berkeley	15,571	4%	4,334	2,197	1,771	7,269	-
Livermore	12,833	3%	1,955	704	2,233	7,941	-
Newark	9,329	2%	2,771	4,075	485	1,998	-
Castro Valley	9,615	2%	2,533	1,690	1,390	4,002	-
San Lorenzo	7,426	2%	1,496	1,656	829	3,445	-
Pleasanton	7,374	2%	1,814	442	778	4,340	-
Dublin	7,480	2%	2,014	461	881	4,124	-
Emeryville	2,813	1%	630	622	451	1,110	-
Albany	2,563	1%	697	277	563	1,026	-
Piedmont	494	0%	119	196	52	127	-
Sunol	86	0%	25	15	5	41	-
Antioch	55	0%	20	14	4	17	-
Other	1,996	0%	645	420	167	764	-
Total	**405,227**	**100%**	**89,595**	**90,630**	**43,702**	**181,300**	**-**

ALAMEDA Alliance FOR HEALTH

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

FY25 BUDGET PRESENTATION

FY 2025 Preliminary Budget

Presented to the Alameda Alliance Board of Governors

June 14th, 2024

ALAMEDA Alliance FOR HEALTH

Budget Process

- Preliminary budget presented to Finance Committee on June 11th and to the Board of Governors on June 14th.
- Final Budget to be presented in December 2024.
- DHCS has announced that partial Calendar Year 2025 Medi-Cal rates will be distributed in October, with complete rates issued mid to late November.

Summary of Proposed Budget to Board of Governors

Highlights:

- 2025 Projected Net Income of $376 thousand.
- The projected Tangible Net Equity (TNE) excess at 6/30/25 of $245.1 million is 439% of required TNE. The Alliance remains financially strong.
- Year-end enrollment is 5,000 higher than June 2024; Fiscal Year member months are 350,000 higher than prior year. Enrollment peaks at 410,000 in June 2025.
- Premium Revenue is $2.0 billion in FY 2025, an increase of $269.8 million (15.3%) from FY 2024.
- Fee-for-Service and Capitated Medical Expense is $1.9 billion in FY 2025, an increase of $252.2 million (15.3%) from FY 2024.
- Administrative Department Expenses is $11.4 million higher than FY 2024 and represents 5.5% of revenue.
- Clinical Department Expenses is $3.6 million lower than FY 2024 and comprises 2.5% of revenue.
- 2024 Projected Net Loss of $5.5 million.
- Unfavorable Revenue recoupments totaling $87.1 million in FY 2024. The majority of these are for prior years.

Budget Assumptions

Staffing:

- Staffing includes 726 full-time equivalent employees by June 30, 2025.
- There are 101 new positions requested for FY 2025. The new positions are in Operations (48), Healthcare Services (20), Information Technology (8), Analytics (7), Compliance (7), Finance/Vendor Management (6), Integrated Planning (3), and Executive/Legal (2),
- Of the above positions, 30 FTEs are related to D-SNP implementation.
- Temp Hires for anticipated short-term needs total 13 (Admin. 10 and Clinical 3).

Enrollment:

- Approximately 78,000 members transitioned from Anthem, as AAH became the sole Medi-Cal Plan in January 2024.
- Approximately 48,000 Kaiser members disenrolled from the Plan in January 2024.
- Approximately 30,000 undocumented members between 26 and 49 years of age joined the Plan in January 2024.
- Redeterminations are assumed to be complete by June 30, 2024.
- Medi-Cal enrollment is projected to grow slightly over FY 2025.
- Group Care Enrollment is project to remain unchanged at 5,600 members.

Budget Assumptions (cont.)

Revenue:

- 98% of Revenue for Medi-Cal, 2% for Group Care.
- Medi-Cal base rates are assumed to increase by 4.6% on a per member/per month basis, equating to an increase of $90.0 million in premium revenue. This is mainly driven by a full year of the mandated Medi-Cal Targeted Rate Increase.
- Higher Medi-Cal enrollment contributes to $149.8 million in revenue.
- Per-member-per-month Group Care premium increases by 19.6% in July 2024.

Medical Expense:

- 98% of Expense for Medi-Cal, 2% for Group Care.
- Medical loss ratio is 96.0%, an increase of 0.7% over FY24.
- Higher Medi-Cal enrollment volume contributes to $180.7 million in Medical Expense.
- Community Supports expenditures are projected at $35.1 million.

Hospital and Provider Rates:

- FY25 Hospital contracted rates increase by $46.9 million over FY 2024.
- Professional capitation rates increase by $22.5 million, driven by the Targeted Rate Increase program.

Medi-Cal Retroactive Accruals

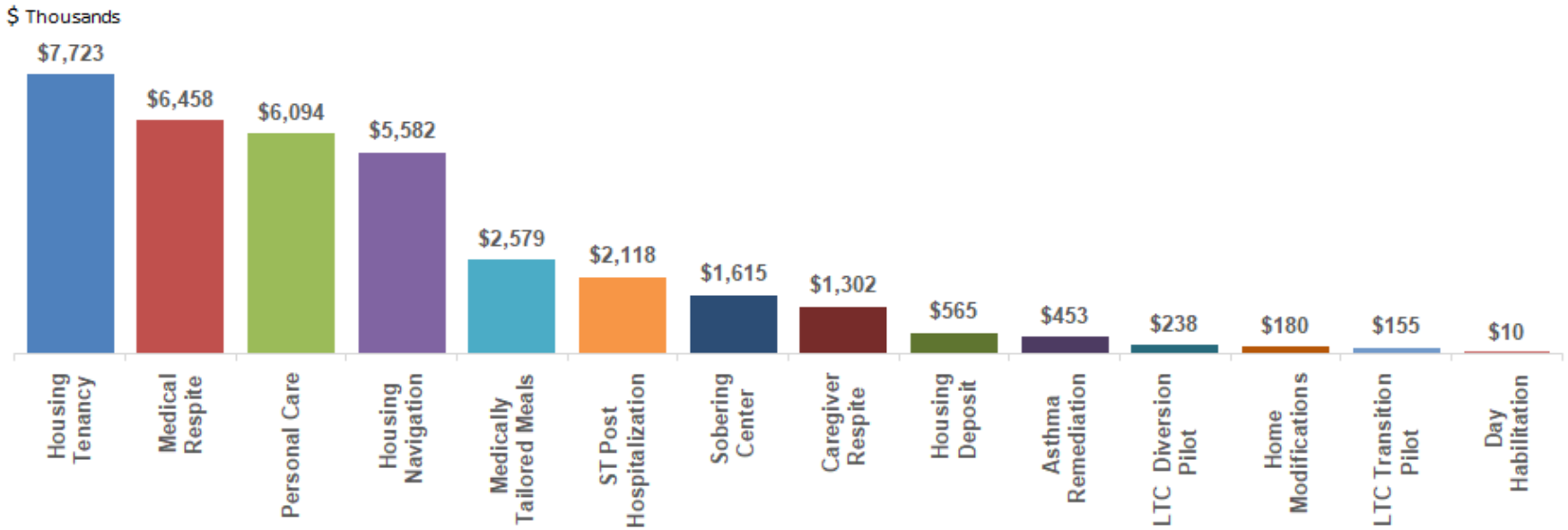
Unfavorable Revenue Accruals in FY 2024 include:

CY 2023 Retroactive Med-Cal Rate Reduction	$59.0 million
CY 2023 Major Organ Transplants Risk Corridor Payback	$10.0 million
Jul ‘19 – Dec ‘20 Bridge Period Risk Corridor Payback	$9.0 million
CY 2022 Major Organ Transplants Risk Corridor Payback	$7.0 million
CY 2022 MCO Tax Expense	$1.2 million
Jul ’21 - Apr ‘24 Date of Death Audit Recoupment	$0.9 million
	$87.1 million

Comparison to FY 2024 Forecast

$ in Thousands	FY 2025 Preliminary Budget				FY 2024 Forecast				Variance F/(U)			
	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total
Enrollment at Year-End	404,574	5,643	0	410,217	399,325	5,643	0	404,968	5,249	0	0	5,249
Member Months	4,825,926	67,716	0	4,893,642	4,476,512	67,517	0	4,544,029	349,414	199	0	349,613
Revenues	$2,567,652	$37,020	$0	$2,604,672	$2,344,406	$30,871	$0	$2,375,277	$223,246	$6,150	$0	$229,395
Medical Expense	1,923,598	30,443	371	1,954,412	1,675,401	26,200	6	1,701,607	(248,197)	(4,243)	(365)	(252,805)
Gross Margin	644,054	6,577	(371)	650,260	669,005	4,671	(6)	673,670	(24,951)	1,906	(365)	(23,410)
Administrative Expense	104,729	1,670	4,826	111,226	97,315	1,925	596	99,836	(7,414)	255	(4,230)	(11,389)
Operating Margin	539,325	4,907	(5,197)	539,034	571,690	2,746	(602)	573,833	(32,365)	2,161	(4,595)	(34,799)
MCO Tax Expense	567,818	0	0	567,818	609,340	0	0	609,340	41,522	0	0	41,522
Other Income / (Expense)	28,770	390	0	29,160	29,490	498	0	29,988	(720)	(108)	0	(828)
Net Income / (Loss)	$277	$5,296	($5,197)	$376	($8,160)	$3,243	($602)	($5,519)	$8,437	$2,053	($4,595)	$5,895
Admin. Expense % of Revenue	5.2%	4.5%		5.5%	5.6%	6.2%		5.6%	0.4%	1.7%		0.2%
Medical Loss Ratio	96.2%	82.2%		96.0%	96.5%	84.9%		96.3%	0.3%	2.6%		0.3%
TNE at Year-End				$317,414				$317,038				$376
TNE Percent of Required at YE				439%				516%				(77%)

Community Supports (CS)



- The Alliance anticipates spending $35 million for Community Supports in FY 2025, compared to $24 million In FY 2024.
- New Community Supports for FY 2025 include Sobering Centers (Jul-24), Short-Term Post Hospitalization (Jan-25), and Day Habilitation (Jan-25).
- CS Revenue included FY 2024 Medi-Cal Base Rates is $7.0 million. FY2025 rates are incomplete.

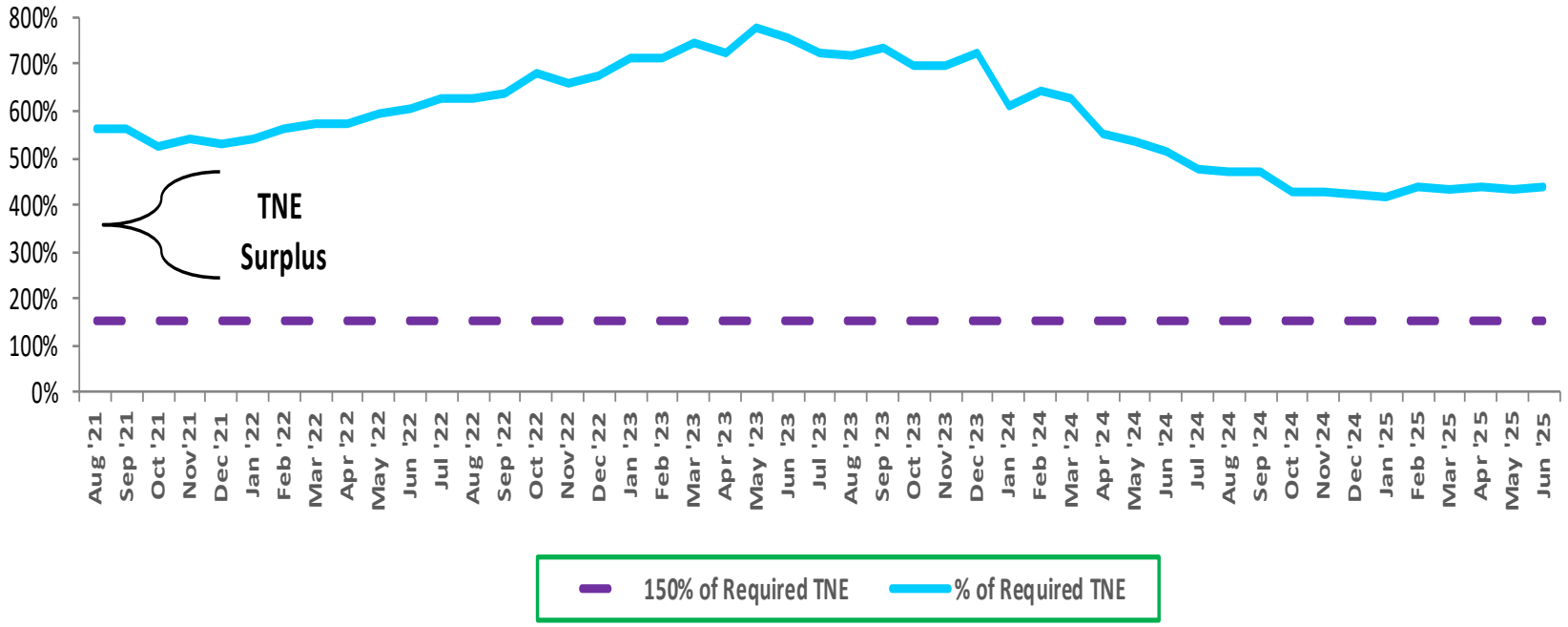
Department Expenses by Line of Business

$ In Thousands

	Administrative Departments				Clinical Departments				
	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total	Total
Employee Expense	$69,162	$937	$3,019	$73,118	$37,836	$512	$371	$38,719	111,837
Member Benefits Admin.	$627	$270	$0	$897	$1,113	$0	$0	$1,113	2,010
Purchased & Prof. Svcs.	$17,050	$218	$1,807	$19,075	$4,991	$1,167	$0	$6,158	25,233
Other	$17,890	$246	$0	$18,136	$4,918	$47	$0	$4,965	23,101
Total	**$104,729**	**$1,670**	**$4,826**	**$111,226**	**$48,858**	**$1,726**	**$371**	**$50,955**	**$162,181**

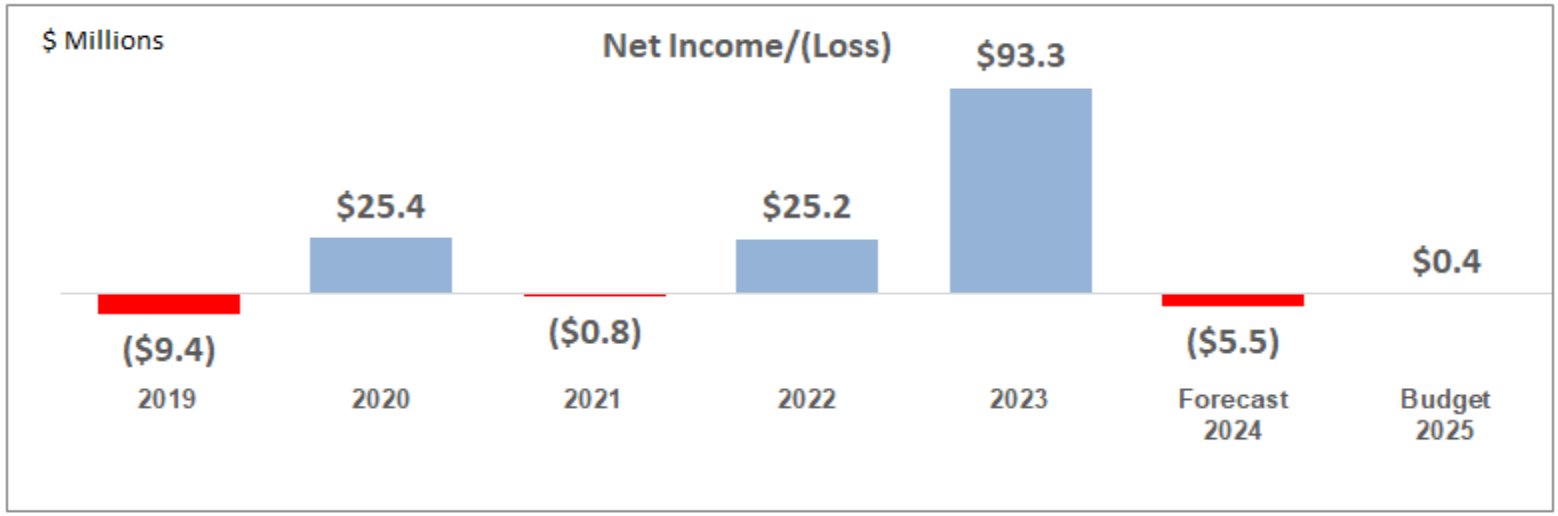
- Administrative Department Expenses are $11.4 million higher than FY 2024. Increases are led by Labor ($12.6 million) and Purchased & Professional Services ($5.3 million), partially offset by Other Services ($5.4 million), and Member Benefits Administration ($1.1 million).
- Clinical Department Expenses are $3.6 million lower than FY24. Increases led by Labor ($8.0 million) and Other ($0.4 million) are more than offset by decreases in Member Benefits Administration ($11.2 million) caused by the sunset of CalAIM programs and Purchased & Professional Services ($0.8 million).

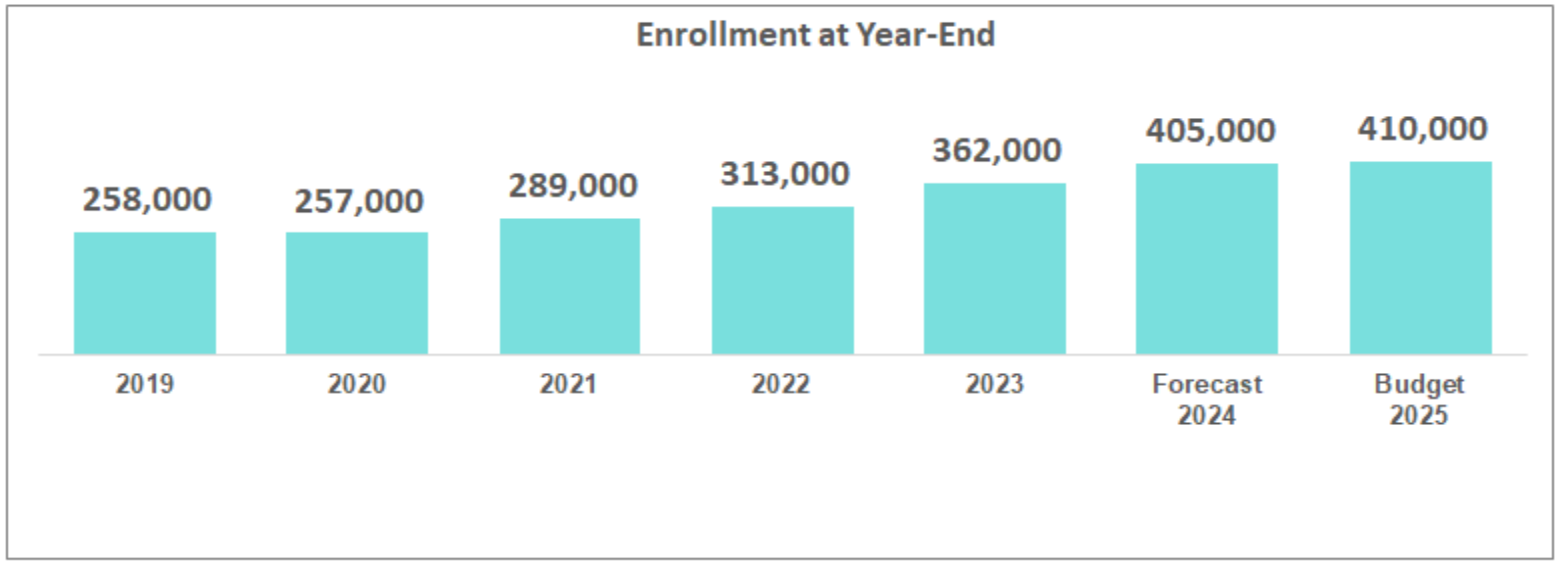
Tangible Net Equity



- The calculation is based on the previous three quarters and projected current quarter FFS expenditures.
- For the Alliance, as the oldest quarter drops off, required TNE increases, due to increased FFS expenditures, mainly resulting from increased enrollment.

Operating Performance: 2019 to 2025





Capital Expenditures

- Full Year budget is $1.7M for capitalized purchases.
- This is an increase of $500K from FY24.
- Totals include $1.7M for IT hardware and $30K for building improvements

Staffing: Full-time Employees at Year-end

Administrative FTEs	FY25 Prelim	FY24 Forecast	Increase/ Decrease
Administrative Vacancy	(65.5)	(51.0)	(14.5)
Operations	9.0	8.0	1.0
Medicare Operations	17.0	0.0	17.0
Executive	2.0	2.0	0.0
Finance	37.0	33.0	4.0
Healthcare Analytics	20.0	17.0	3.0
Claims	53.0	50.0	3.0
Information Technology	15.0	13.0	2.0
IT Infrastructure	9.0	7.0	2.0
Apps Mgmt., IT Quality & Process Imp.	23.0	19.0	4.0
IT Development	18.0	17.0	1.0
IT Data Exchange	11.0	9.0	2.0
IT-Ops and Quality Apps Mgt.	15.0	12.0	3.0
Member Services	110.0	81.0	29.0
Provider Services	45.0	44.0	1.0
Credentialing	11.0	6.0	5.0
Health Plan Operations	1.0	1.0	0.0
Human Resources	12.0	12.0	0.0
Vendor Management	10.0	8.0	2.0
Legal Services	7.0	4.0	3.0
Facilities & Support Services	9.0	9.0	0.0
Marketing & Communication	14.0	13.0	1.0
Privacy and SIU	17.0	16.0	1.0
Regulatory Affairs & Compliance	11.0	11.0	0.0
Risk Mgmt. & Operations Oversite	4.0	0.0	4.0
Grievance and Appeals	27.0	27.0	0.0
Integrated Planning	23.0	3.0	20.0
State Directed & Special Programs	9.0	3.0	6.0
Portfolio Mgmt. & Svc Excellence	0.0	17.0	(17.0)
Workforce Development	10.0	9.0	1.0
Health Equity	4.0	3.0	1.0
Total Administrative FTEs	**487.5**	**403.0**	**84.5**

Clinical FTEs	FY25 Prelim	FY24 Forecast	Increase/ Decrease
Clinical Vacancy	(5.1)	(10.0)	4.9
Quality Analytics	8.0	4.0	4.0
Long-Term services and Support	28.0	0.0	28.0
Utilization Management	68.9	84.9	(16.0)
Case/Disease Management	54.0	55.0	(1.0)
Medical Services	6.0	6.0	0.0
Quality Management	39.0	38.0	1.0
HCS Behavioral Health	27.0	23.0	4.0
Pharmacy Services	9.0	10.0	(1.0)
Regulatory Readiness	4.0	4.0	0.0
Total Clinical FTEs	**238.8**	**214.9**	**23.9**

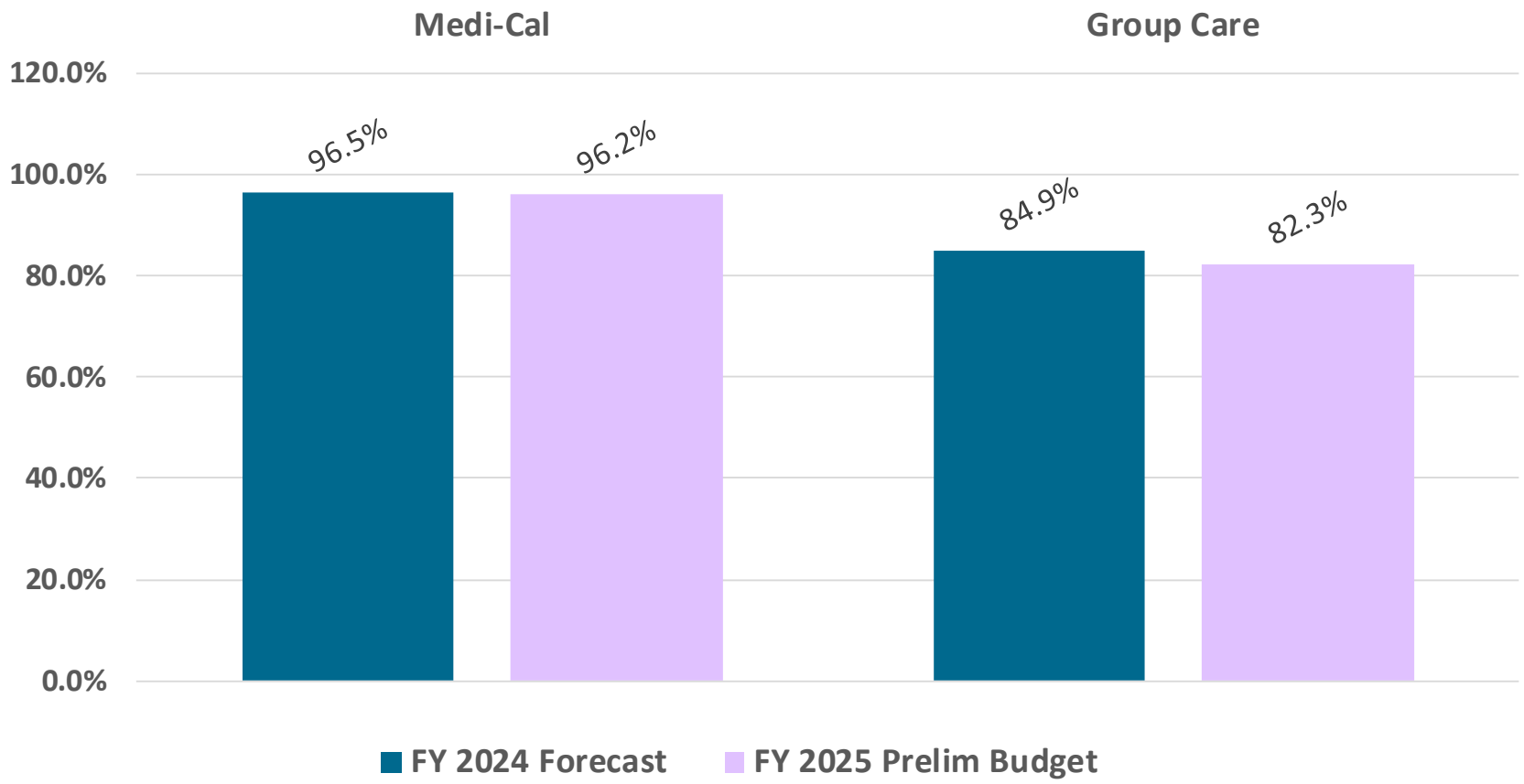
Total FTEs	**726.3**	**617.9**	**108.4**

**FTE = Full-Time Equivalent Personnel working approximately 2,080 hours per year. Includes Temporary Employees.*

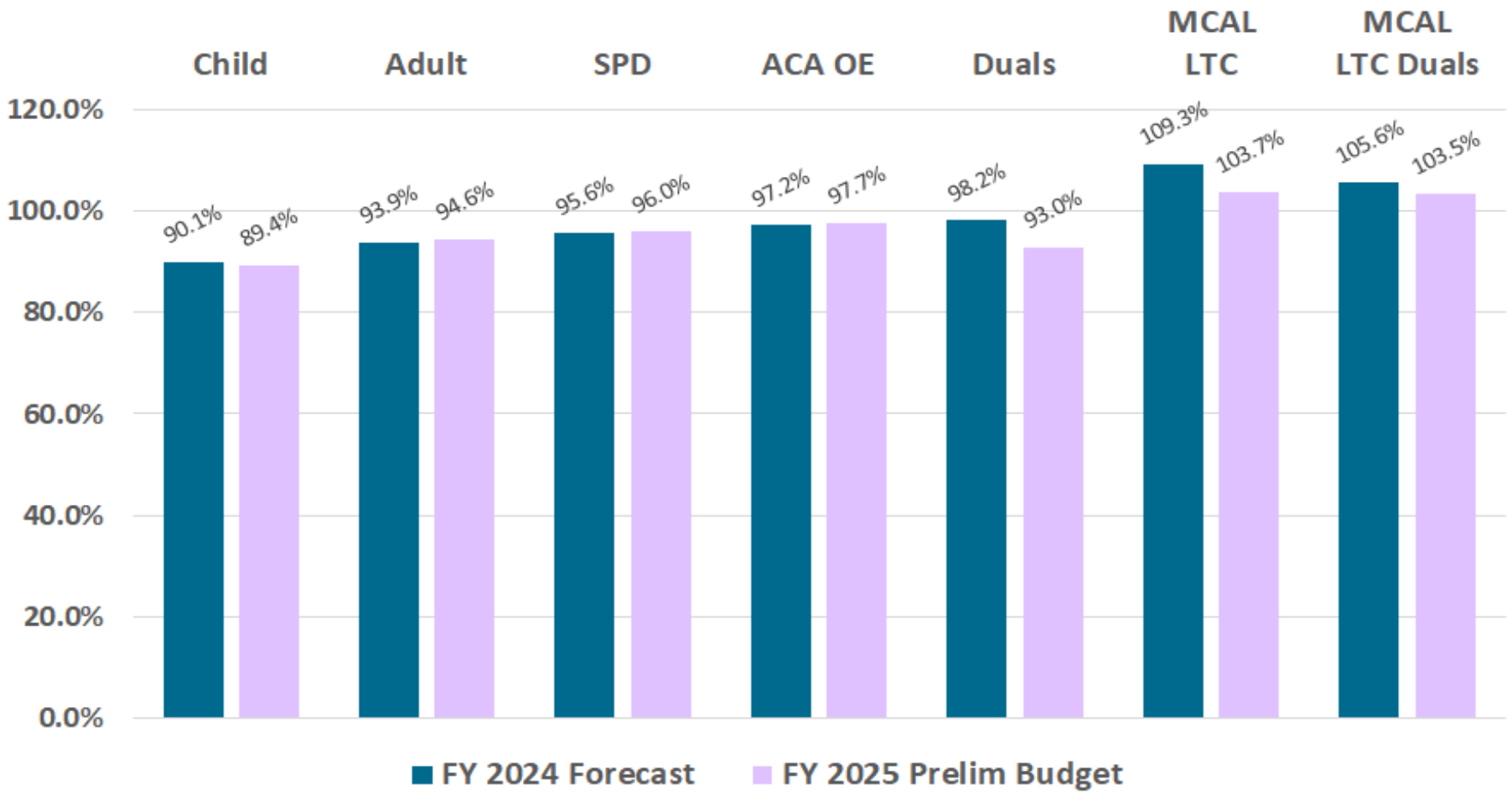
Material Areas of Uncertainty

- AAH has not received Medi-Cal premium rates for CY 2025.
- The revenue forecast is calculated on the current mix of UIS/SIS members. Material changes in the SIS/UIS member mix will impact results.
- We are reserving for a CY 2024 rate reduction, based on DHCS messaging. There is a risk that the reduction may be larger than anticipated.
- Medical Expense includes assumptions regarding the relative acuity of new populations that joined the Plan in January 2024, existing members, and departing members. The relative costs of these cohorts will have significant impact on medical loss ratios.
- Contract changes for hospitals and delegated providers in projections have not been finalized.
- CY 2024 Major Organ Transplants Risk Corridor Liability will continue to be evaluated.
- MCO Tax Expense may be greater than anticipated MCO Tax Revenue.
- Additional Community Supports expense for previously unsubmitted, or denied for incorrectly coded claims may be paid in FY 2024.

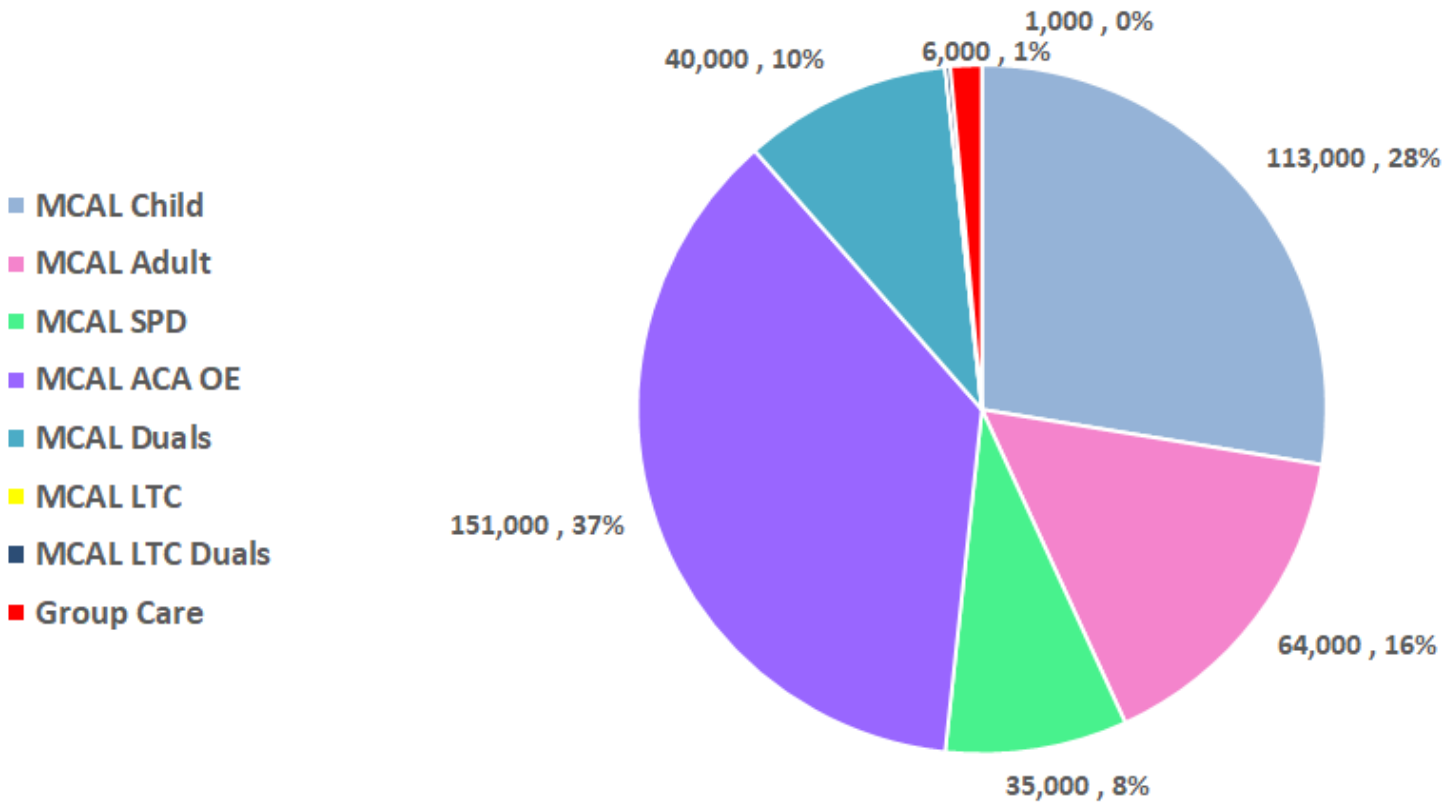
Medical Loss Ratio by Line of Business



Medi-Cal Loss Ratio by Category of Aid



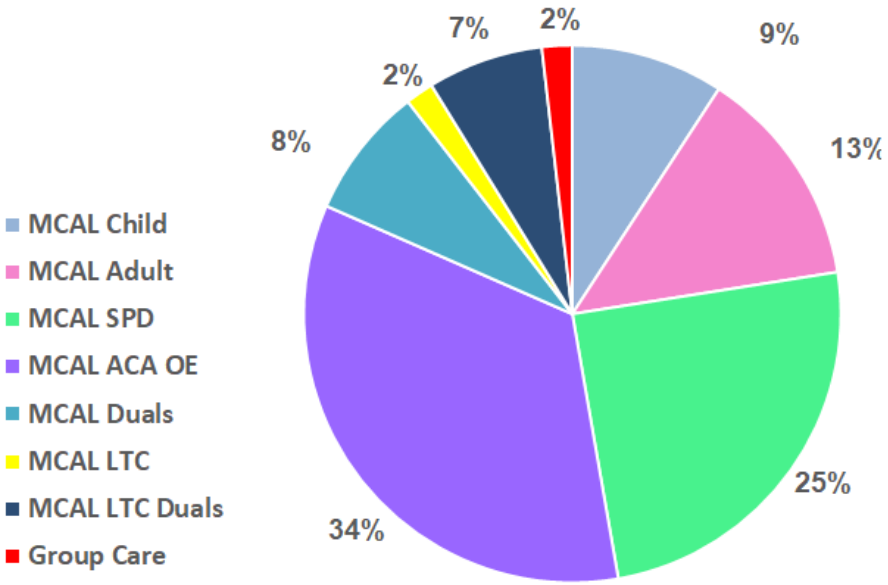
Enrollment by Population at Year-End



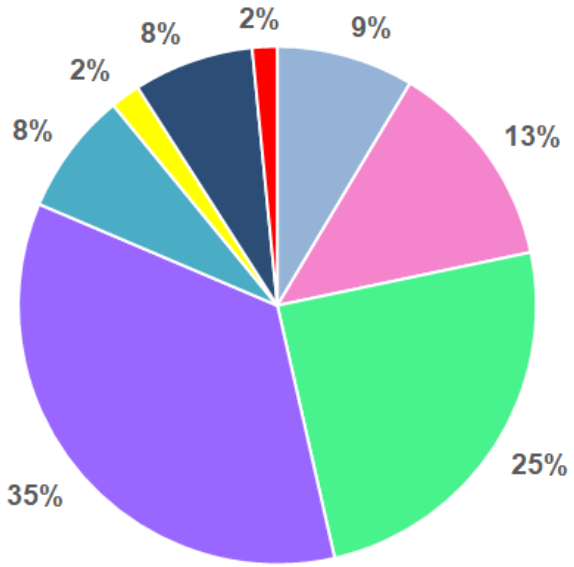
- No significant new populations have been announced by DHCS for 2025.
- June 2025 enrollment of 410,000 represents a 1.3% increase over June 2024.

Revenue and Medical Expense by Population

Premium Revenue



Medical Expense



- $2.6 million of Premium Revenue and $2.4 million of Medical Expense are distributed similarly over AAH's 8 populations.

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Medicare Presentation

Medicare Advantage D-SNP Update
Board of Governors

Ruth Watson, COO
Tome Meyers, ED, Medicare Programs

June 14th, 2024

ALAMEDA Alliance FOR HEALTH

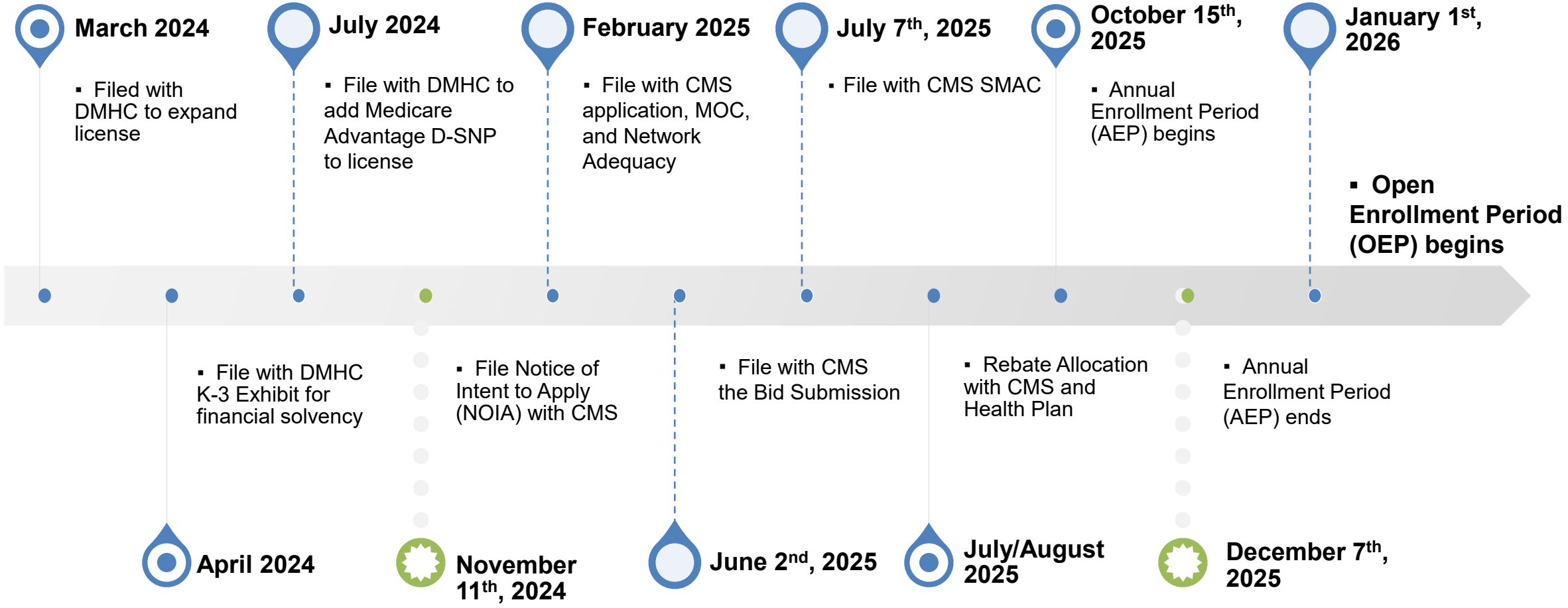
Agenda

- Dual Eligible Special Needs Plans (D-SNPs) in CA
- MA D-SNP Product Timeline
- Key Highlights
- Alameda County Medicare Landscape
- Member & Provider Engagement
- Stars Measures Overview
- Medicare Stars Scoring and Rating Methodology
- Challenges & Risks
- Closing Statements / Next Steps

Dual Eligible Special Needs Plans (D-SNP) in CA

- The Alliance will become an Exclusively Aligned Enrollment (EAE) Medicare Advantage (MA) Dual Eligible Special Needs Plan (D-SNP) effective January 1st, 2026
- DHCS intends that EAE D-SNPs will be implemented statewide by January 1st, 2026
  - D-SNPs in Alameda County will be the Alliance & Kaiser
  - D-SNP members are allowed to keep their plan (member choice)
  - Starting in 2025, unaligned D-SNPs are closed to new members

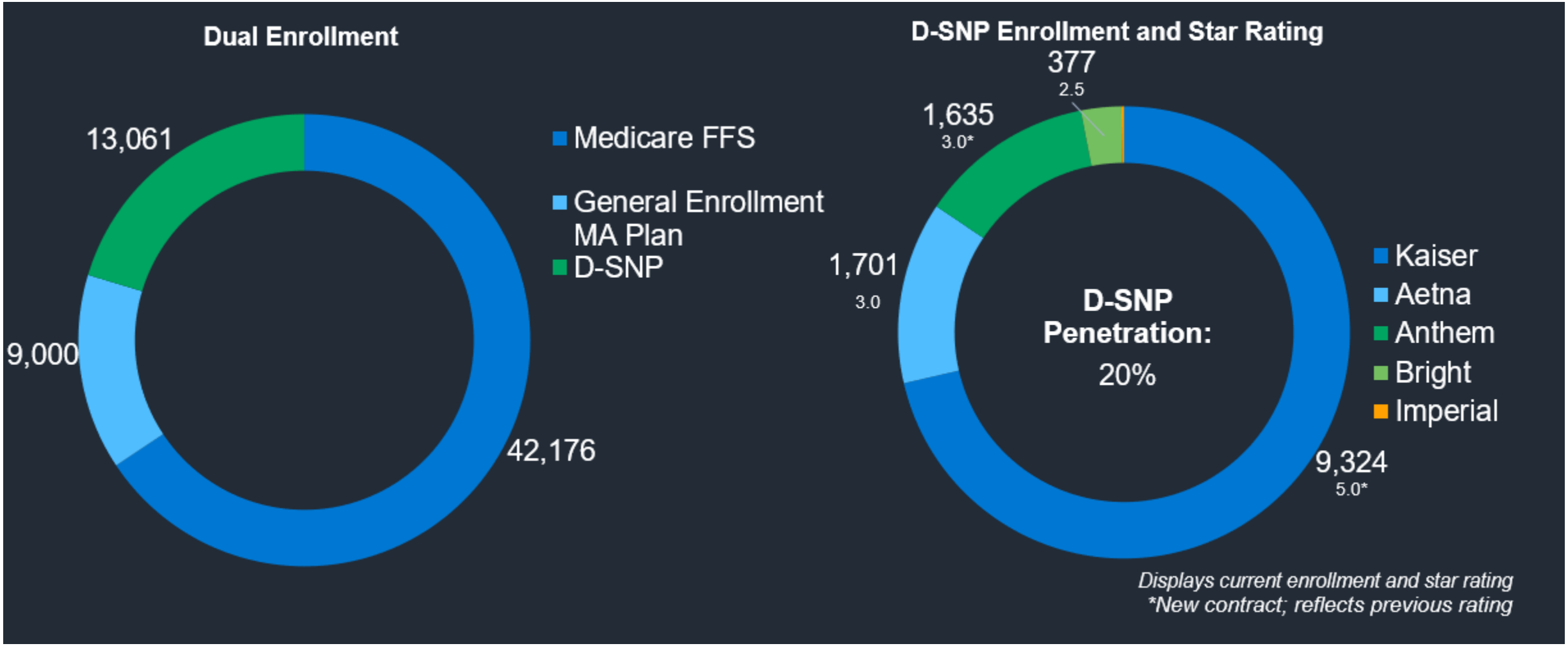
MA D-SNP Product Timeline



Key Highlights

- Provider Medicare Advantage D-SNP overview with CHCN (April 30th) and AHS (May 8th)
- May 17th - received comments from DMHC for all submissions (thus far) related to Medicare License Expansion Filing (20241128)
  - AAH response is due to DMHC by June 16th
- Medicare provider contract & Medicare product amendment (for vendors) is being finalized with a goal to start provider contracting in July 2024
- TruCare optimization and D-SNP core systems upgrades started May 22nd
- In Development: Dental & Vision RFP, Branding RFQ, Current PBM Services, Provider Outreach Services, Model of Care (MOC), IT Strategy, Supplemental Benefits Structure, Stars Playbook & Workplan

Alameda County Medicare Landscape



(Milliman, 2024)

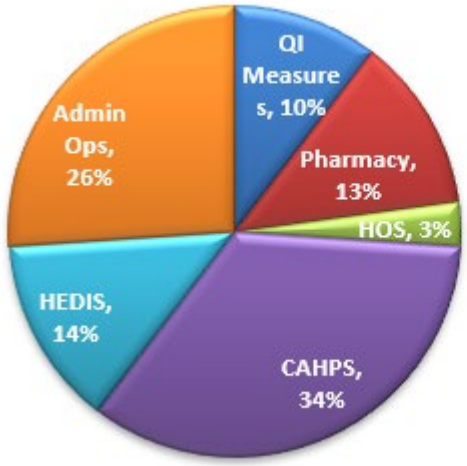
Member & Provider Engagement

- Implementing a concierge-like internal marketing and sales vertical
  - Will not use external agents or FMOs
- Hiring a Manager, Member Experience & Program Management focusing on member retention, process improvement, Stars, and engagement
- Hiring 3 Quality Provider Advisors to work directly with the providers on Stars, risk adjustment, QI, HEDIS, CAPHS, & HOS
- Hiring Director, Stars Strategy & Program Management
- Hiring Medicare Programs Trainer & Curriculum Designer for internal staff and external provider training
- Implementing Provider Advisory Committee and Consumer Governance Board
- Engaging and leveraging Community partners

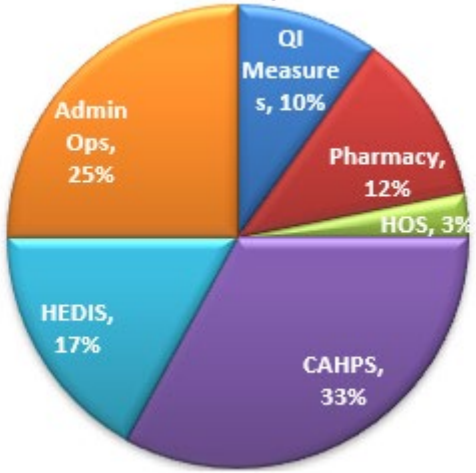
Stars Measures Overview

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers & System (CAHPS) Survey:
  - Annual survey provided to a random sample of plan members to learn about their experience with, and rating of, their health care providers and health plan
- Health Outcomes Survey (HOS):
  - Annual survey provided to a random sample of plan members that measures comparison of member health plan assessments over 2 years
- 40 quality and performance measures for MA-PD (Medicare Advantage Prescription Drug) plans

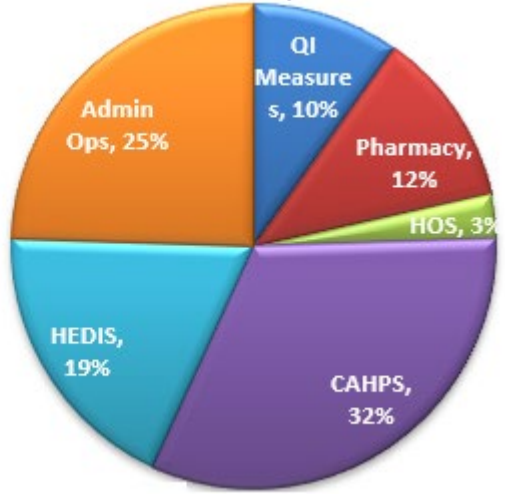
Measurement Year **2023** for Stars Rating Year **2025**



Measurement Year **2024** for Stars Rating Year **2026**



Measurement Year **2025** for Stars Rating Year **2027**



(Rebellis, 2024)

Medicare Stars Scoring & Rating Methodology

- CMS created Part C & D Star Ratings to provide quality and performance information to Medicare beneficiaries
  - Assist Medicare consumers in comparing the quality of Medicare health and drug plans being offered and empowering choice
- Higher the Stars Rating, higher the Quality Bonus Payment (QBP) reimbursement to the plan and higher rebate dollars to offer richer supplemental benefit offerings to D-SNP members

Stars Rating	Quality Bonus Payment	Rebate %
4.5+ Stars	5%	70%
4.0	5%	65%
3.5 Stars	0%	65%
< 3.5%	0%	50%
New/Low Enrollment	3.5%	65%

Challenges and Risks

- Development of IT strategy and road map (implementation of system upgrades for Medicare)
- Keeping current with D-SNP product regulatory changes
- Building the internal knowledge and Medicare operational excellence
- Resource constraints

Closing Remarks / Next Steps

- Partner on how integrated Medicare and Medi-Cal benefits function
- Collaboration activities with providers:
  - Townhalls (with providers)
  - Potential co-branding / marketing
  - Training
  - Member campaigns
- Future discussions on the following:
  - Value Base Payment Models
    - → Pay for Performance (P4P)
  - Provider engagement (SMAC)
  - Coding
    - → General coding (risk adjustment)
    - → Annual coding for chronic disease management

Thank You!

Questions?

ALAMEDA Alliance FOR HEALTH

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Finance

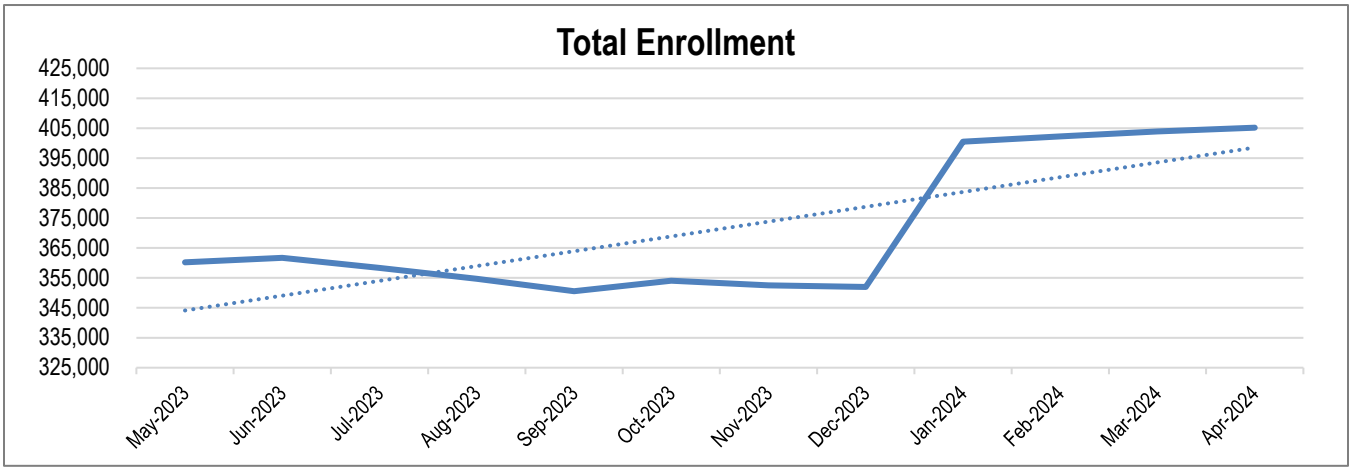
Gil Riojas

To: Alameda Alliance for Health, Finance Committee
From: Gil Riojas, Chief Financial Officer
Date: June 14th, 2024
Subject: Finance Report – April 2024 Financials

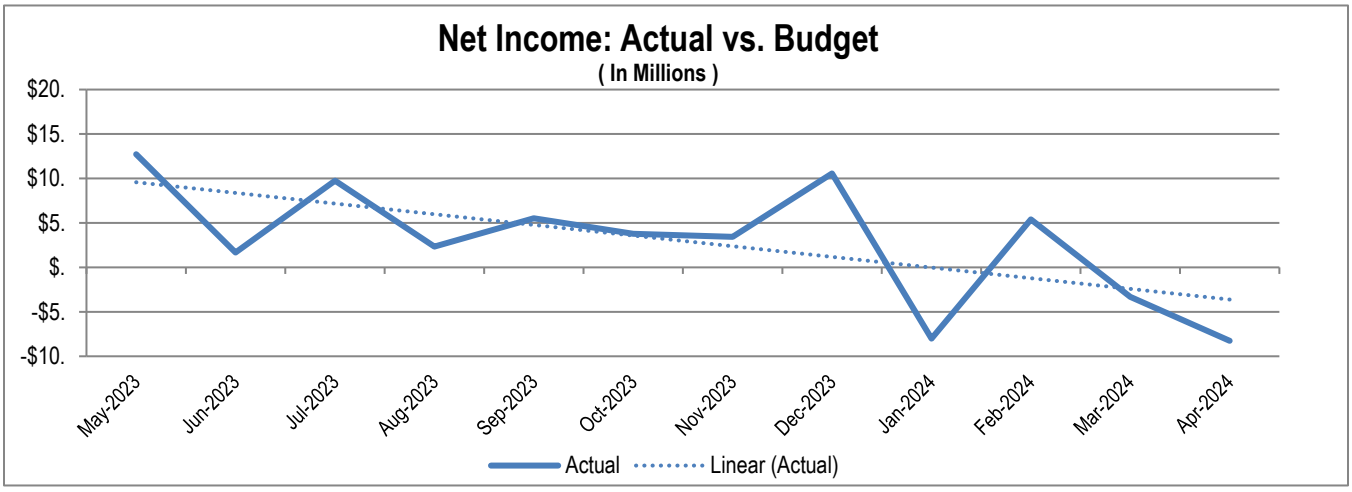
Executive Summary

For the month ended April 30th, 2024, the Alliance continued to experience increases in enrollment, bringing total enrollment to 405K members. A Net Loss of $8.3 million was reported in April. The Plan's Medical Expenses represented 103.6% of revenue. Alliance reserves decreased to 554% of required but remain well above minimum requirements.

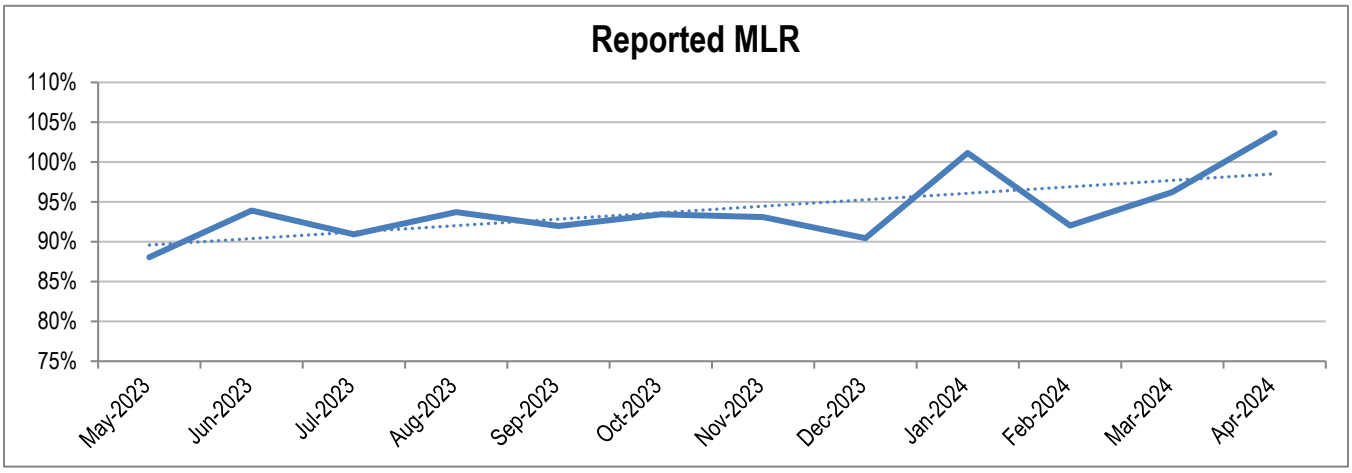
Enrollment – In April, Enrollment increased by 1,233 members.



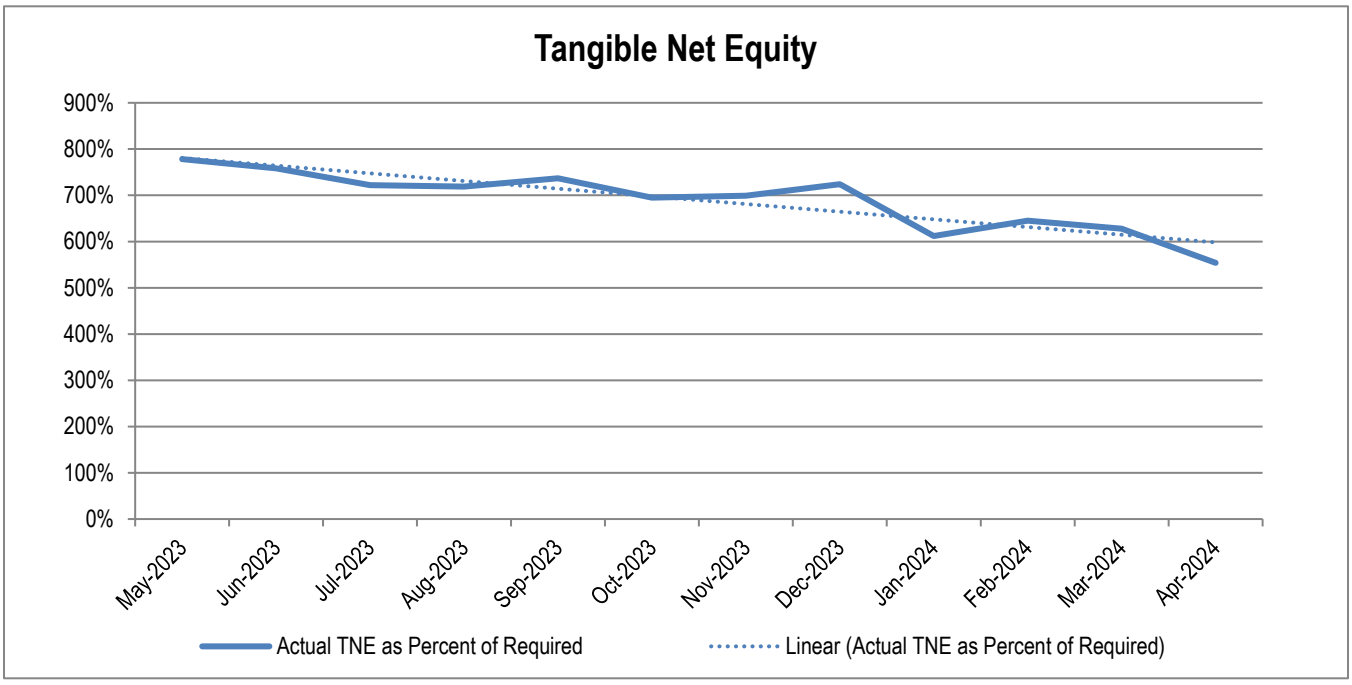
Net Income – For the month ended April 30th, 2024, actual Net Loss was $8.3 million vs. budgeted Net Loss of $876,000. Fiscal year-to-date actual Net Income was $21.2 million vs. Budgeted Net Income of $16.8 million. For the month, Premium Revenue was slightly favorable to Budget.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 103.6% for the month and 94.9% for the fiscal year-to-date. As we've previously discussed and as evident from this month's financial report, MLR percentages exceeding 95% could lead to net losses for the Plan.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $62.4M in reserves, we reported $345.2M. Our overall TNE remains healthy at 554%.



The Alliance continues to benefit from increased non-operating income. For April we reported returns of $2.5M, and year-to-date $25.8M, in the investment portfolio.

ALAMEDA Alliance FOR HEALTH

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

Operations

Ruth Watson

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

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

Date: **June 14th, 2024**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:
    - The Member Services Department received a seven percent (7%) decrease in calls in May 2024, totaling eighteen thousand four hundred six (18,406) compared to nineteen thousand eight hundred six (19,806) in May 2023.
    - The abandonment rate for May 2024 was four percent (4%), compared to twenty-six percent (26%) in May 2023.
    - The Department's service level was ninety-three percent (93%) in May 2024, compared to fifty-seven percent (57%) in May 2023. The average speed to answer (ASA) was nineteen seconds (00:19) compared to two minutes and seventeen seconds (02:17) in May 2023. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
    - The average talk time (ATT) was six minutes and forty-eight seconds (06:48) for May 2024 compared to five minutes and fifty seconds (05:50) for May 2023.
    - One hundred percent (100%) of calls were answered within 10 minutes for May 2024 compared to ninety-seven percent (97%) in May 2023.
    - Outbound calls totaled seven thousand nine hundred and thirty-five (7,935) in May 2024 compared to seven thousand four hundred and eighty (7,480) in May 2023.
    - The top five call reasons for May 2024 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Benefits, 4). Provider Network, 5). ID card requests. The top five call reasons for May 2023 were: 1). Eligibility/Enrollment, 2). Change of PCP, 3). Benefits, 4). Kaiser, 5). ID Card Requests.
    - Utilization for the member automated eligibility IVR system totaled one thousand seven hundred thirty-one (1731) in May 2024 compared to one thousand two hundred ninety-four (1294) in May 2023.
    - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests and in-person) while honoring the organization's policies. The Department responded to one thousand one hundred eighty-two (1182) web-based requests in May 2024 compared to nine hundred twenty (920) in May 2023. The top three web reason requests for May 2024 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information. Seventy-nine (79) members were assisted in-person in May 2024 compared to thirty-nine (39) in May, 2023.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health Unit received a total of one thousand four hundred sixty (1460) calls in May 2024 compared to one thousand five hundred seven (1,507) in May 2023.
    - The abandonment rate was thirteen percent (13%) in May 2024 compared to eight percent (8%) in May 2023.
    - The service level was seventy-dight percent (78%) in May 2024 compared to ninety-one percent (91%) in May 2023.
    - The average speed to answer (ASA) was one minute twelve seconds. (1:12) compared to nineteen seconds (0:19) in May 2023.
    - Calls answered in 10 minutes were ninety-eight percent (98%) compared to one hundred percent (100%) in May 2023.
    - The Average Talk Time (ATT) was eight minutes and thirty-nine seconds (06:39) compared to eight minutes and twenty-nine seconds (08:29) in May 2023. ATT are impacted by the DHCS requirements to complete a screening for all members initiating MH services for the first time.
    - One thousand eighteen (1018) outbound calls were completed in May 2024.
    - Seventy-six (76) outreach campaigns were completed in May 2024, including six (6) BH/ABA screenings.
    - One hundred thirty-seven (137) screenings were completed in May 2024.
    - Twenty-nine (29) referrals were made to the County (ACCESS) in May 2024.
    - Twenty (20) members were referred to Center Point for SUD services in May 2024.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 375,454 claims in May 2024 (an all-time high) compared to 251,858 in May 2023.
    - The Auto Adjudication was 85.6% in May 2024 compared to 82.1% in May 2023.
    - Claims compliance for the 30-day turn-around time was 92.3% in May 2024 compared to 95.4% in May 2023. The 45-day turn-around time was 100% in May 2024 compared to 99.8% in May 2023.

- Monthly Analysis:

    - In the month of May, we received a total of 375,454 claims in the HEALTHsuite system. This represents an increase of 16.3% from April 2024 and is higher, by 123,596 claims, than the number of claims received in May 2023; the higher volume of received claims remains attributed to an increased membership.
    - We received 89.54% of claims via EDI and 10.46% of claims via paper.

- During the month of May, 100% of our claims were processed within 45 working days.
- The Auto Adjudication rate was 85.6% for the month of May.

Provider Services

- 12-Month Trend Summary:

  - The Provider Services department's call volume in May 2024 was 7,469 calls compared to 8,056 calls in May 2023.
  - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
  - The Provider Services department completed 298 calls/visits during May 2024.
  - The Provider Services department answered 5,950 calls for May 2024 and made 1,018 outbound calls.

Credentialing

- 12-Month Trend Summary:

  - At the Peer Review and Credentialing (PRCC) meeting held on May 21 and 31, 2024, there were two hundred and twenty-five (225) initial network providers approved; five (5) primary care providers, nine (9) specialists, one (1) ancillary provider, five (5) midlevel providers, and two hundred and two (202) behavioral health providers. Additionally, forty-eight (48) providers were re-credentialed at this meeting; eight (8) primary care providers, twenty-two (22) specialists, one (1) ancillary provider, and seventeen (17) 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 May 2024, the Provider Dispute Resolution (PDR) team received 2,386 PDRs versus 1,322 in May 2023.
  - The PDR team resolved 2,039 cases in May 2024 compared to 947 cases in May 2023.
  - In May 2024, the PDR team upheld 68% of cases versus 78% in May 2023.
  - The PDR team resolved 99.5% of cases in May 2024 compared to 99.7% in May 2023; the compliance standard is 95% within 45 working days.

- Monthly Analysis:
    - AAH received 2,386 PDRs in May 2024.
    - In the month of May, 2,039 PDRs were resolved. Out of the 2,039 PDRs, 1,388 were upheld and 651 were overturned.
    - The overturn rate for PDRs was 32%, which did not meet our goal of 25% or less.
    - The following is a breakdown of the various causes for the 651 overturned PDRs. There were two primary areas that caused the Department to miss their goal of 25% or less:
        - Member OHC corrections – 129 cases that had been denied incorrectly.
        - No authorization denials – 94 cases reviewed for retro/medical necessity.
    - The combined volumes of the two primary reasons for the overturned PDRs this month prevented us from achieving the goal of 25% or less.
        - System Related Issues 28% (183 cases):
            - 99 cases: General configuration issues, like Not Covered, Modifier. (15%)
            - 46: Retro Eligibility changes (7%)
            - 8 cases: LTC SOC Recoupment (1%)
            - 30 cases: CES (5%)
        - OHC Related Issues 20% (129 cases)
            - 129 cases: OHC Member TPL data, incorrect primary EOB not matching, incorrect manual entry. (20%)
        - Authorization Related Issues 28% (187 cases):
            - 61 cases: Processor errors when auth on file. (9%)
            - 17 cases: System (3%)
            - 15 cases: PTPN (2%)
            - 94 cases: UM/retro review (14%)
        - Additional Documentation Provided 5% (32 cases):
            - 24 cases: Duplicate claim documentation that allows for claims to be adjusted. (4%)
            - 8 cases: Timely Filing (1%)
        - Incorrect Rates 5% (31 cases)
            - 24 cases: System (4%)
            - 7 cases: LOA (1%)
        - Claim Processing Errors 14% (89 cases)
            - 36 cases: Duplicate (6%)
            - 20 Incorrect Rate (3%)
            - 33 cases: Various Processor errors. (5%)
    - 2,029 out of 2,039 cases were resolved within 45 working days resulting in a 99.5% compliance rate.
    - The average turnaround time for resolving PDRs in May was 43 days. There were 3,814 PDRs pending resolution as of 05/31/2024, with no cases older than 45 working days.

Community Relations and Outreach

- 12-Month Trend Summary:
    - In May 2024, the Alliance completed 857 member orientation outreach calls and 150 member orientations by phone.
    - The C&O Department reached 1,158 people (46% identified as Alliance members) during outreach activities, compared to 349 individuals (85% identified as Alliance members) in May 2023.
    - The C&O Department spent $430.00 in donations, fees, and/or sponsorships, compared to $0 in May 2023.
    - The C&O Department reached members in16 cities/unincorporated areas throughout Alameda County, the Bay Area, and the U.S., compared to 11 cities in May 2023.

- Monthly Analysis:
    - In April 2024, the C&O Department completed 857 member orientation outreach calls, 150 member orientations by phone, and 46 Alliance website inquiries.
    - Among the 1,158 people reached, 46% identified as Alliance members.
    - In May 2024, the C&O Department reached members in 16 locations throughout Alameda County, the Bay Area, and the U.S.
    - Please see attached **Addendum A**.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	May 2024
Incoming Calls (R/V)	18,406
Abandoned Rate (R/V)	4%
Answered Calls (R/V)	17,670
Average Speed to Answer (ASA)	00:19
Calls Answered in 30 Seconds (R/V)	93%
Average Talk Time (ATT)	06:48
Calls Answered in 10 minutes	100%
Outbound Calls	7985

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

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

MSBH	MAY 2024
Incoming Calls (R/V)	1460
Abandoned Rate (R/V)	13%
Answered Calls (R/V)	1277
Average Speed to Answer (ASA)	01:12
Calls Answered in 30 Seconds (R/V)	78%
Average Talk Time (ATT)	08:39
Calls Answered in 10 minutes	98%
Outbound Calls	1018
Screenings Completed	137
ACBH Referrals	29
SUD referrals to Center Point	20

Claims Department
April 2024 Final and May 2024 Final

METRICS

Claims Compliance	Apr-24	May-24
90% of clean claims processed within 30 calendar days	92.5%	92.3%
95% of all claims processed within 45 working days	100.0%	100.0%
Claims Volume (Received)	**Apr-24**	**May-24**
Paper claims	33,587	39,268
EDI claims	289,199	336,186
Claim Volume Total	**322,786**	**375,454**
Percentage of Claims Volume by Submission Method	**Apr-24**	**May-24**
% Paper	10.41%	10.46%
% EDI	89.59%	89.54%
Claims Processed	**Apr-24**	**May-24**
HEALTHsuite Paid (original claims)	214,097	280,640
HEALTHsuite Denied (original claims)	76,034	93,493
HEALTHsuite Original Claims Sub-Total	**290,131**	**374,133**
HEALTHsuite Adjustments	15,177	8,263
HEALTHsuite Total	**305,308**	**382,396**
Claims Expense	**Apr-24**	**May-24**
Medical Claims Paid	$115,809,477	$156,841,938
Interest Paid	$136,578	$84,769
Auto Adjudication	**Apr-24**	**May-24**
Claims Auto Adjudicated	252,218	320,197
% Auto Adjudicated	86.9%	85.6%
Average Days from Receipt to Payment	**Apr-24**	**May-24**
HEALTHsuite	13	14
Pended Claim Age	**Apr-24**	**May-24**
0-29 calendar days	38,453	39,193
HEALTHsuite		
30-59 calendar days	572	7,841
HEALTHsuite		
60+ calendar days	3	7
HEALTHsuite		
Overall Denial Rate	**Apr-24**	**May-24**
Claims denied in HEALTHsuite	76,034	93,493
% Denied	24.9%	24.4%

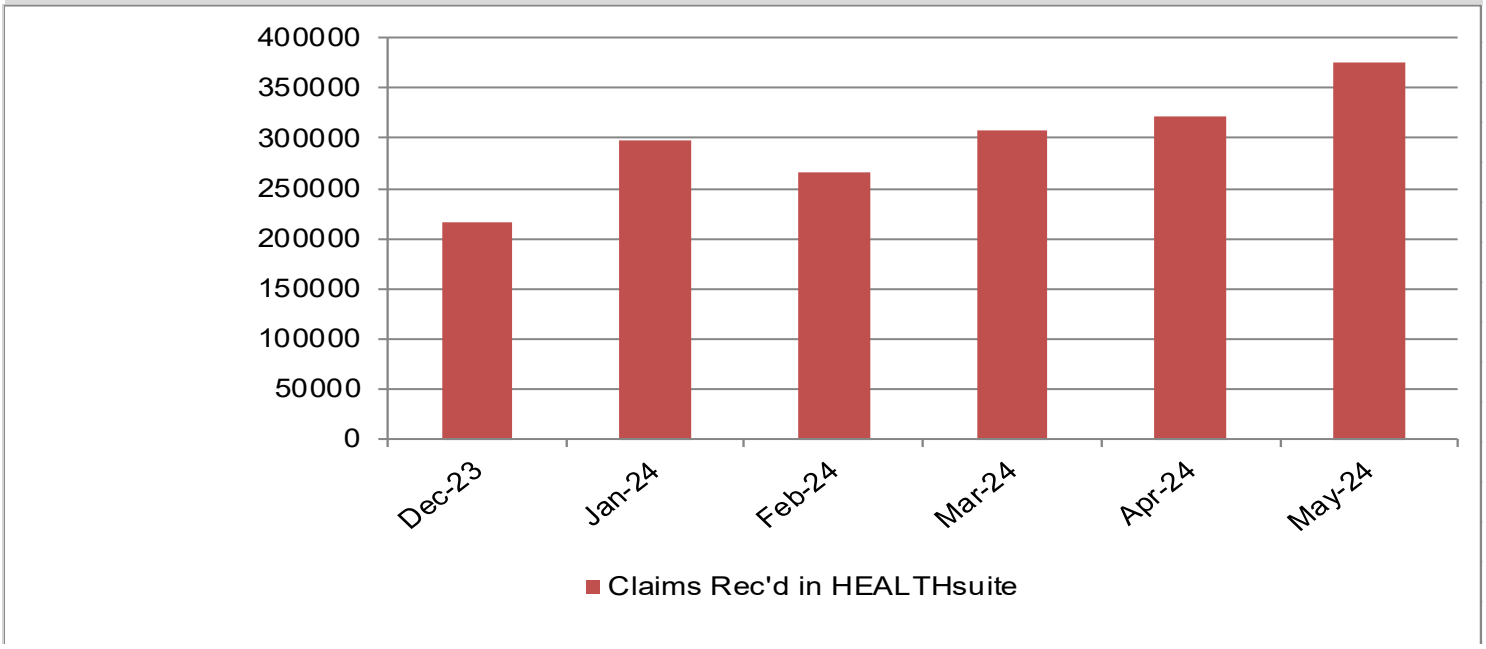
Claims Department
April 2024 Final and May 2024 Final

May-24

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	25%
No Benefits Found For Dates of Service	12%
Non-Covered Benefit For This Plan	10%
Duplicate Claim	10%
Must Submit Paper Claim With Copy of Primary Payor EOB	9%
% Total of all denials	**66%**

Claims Received By Month

Run Date	1/1/2024	2/1/2024	3/1/2024	4/1/2024	5/1/2024	6/1/2024
Claims Received Through	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**
Claims Rec'd in HEALTHsuite	215,246	298,465	266,339	308,453	322,786	375,454



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing May 2024 to May 2023 as follows: 30 Days - 92.3% (2024) vs 95.4% (2023) 45 Days - 100% (2024) vs 99.8% (2023) 90 Days - 99.9% (2024) vs 99.9% (2023)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 375,454 claims in May 2024 vs 251,858 in May 2023	N/A	N/A
EDI - the volume of EDI submissions remains consistent from month to month at ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 374,133 in May 2024 (23 working days) vs 253,475 in May 2023 (23 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in May 2024 was $156,841,938 (5 check runs) vs $99,325,961 in May 2023 (5 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in May 2024 was $84,769 vs $64,040 in May 2023	N/A	< $496,000 per fiscal year or $30,000 per month
Auto Adjudication - the AAH rate in May 2024 was 85.6% vs 82.1% in May 2023	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in May 2024 was 14 days vs 19 days in May 2023	N/A	<= 25 days

Claims Year Over Year Summary

Pended Claim Age - comparing May 2024 to May 2023 as follows: 0-29 calendar days - 39,193 (2024) vs 28,436 (2023) 30-59 calendar days - 7,841 (2024) vs 936 (2023) 60+ calendar days - 7 (2024) vs 225 (2023)	N/A	N/A
Top 5 Denial Reasons - the claim denial reasons remain consistent from month to month so there is no significant changes to report from May 2024 to May 2023	N/A	N/A

Provider Relations Dashboard May 2024

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10695	9359	9033	8064	7469							
Abandoned Calls	4806	4325	3272	2275	1519							
Answered Calls (PR)	5889	5034	5761	5789	5950							
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	413	2551	1970	1595	1093							
Abandoned Calls (R/V)												
Answered Calls (R/V)	413	2551	1970	1595	1093							
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	1140	1358	1298	831	1018							
N/A												
Outbound Calls	1140	1358	1298	831	1018							
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	11835	13268	12301	10490	9580							
Abandoned Calls	4806	4325	3272	2275	1519							
Total Answered Incoming, R/V, Outbound Calls	7442	8993	9029	8215	8061							

Provider Relations Dashboard May 2024

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.5%	5.6%	5.5%	6.1%	6.4%							
Benefits	4.3%	3.6%	2.4%	3.0%	2.5%							
Claims Inquiry	38.5%	41.7%	45.4%	40.1%	43.3%							
Change of PCP	3.3%	3.9%	2.6%	3.6%	2.6%							
Check Tracer	1.1%	1.1%	1.2%	1.0%	1.3%							
Complaint/Grievance (includes PDR's)	4.4%	4.3%	6.1%	5.8%	7.9%							
Contracts/Credentialing	1.1%	1.0%	1.5%	1.4%	0.7%							
Demographic Change	0.0%	0.0%	0.0%	0.0%	0.0%							
Eligibility - Call from Provider	23.0%	20.5%	17.5%	20.9%	18.2%							
Exempt Grievance/ G&A	0.6%	0.1%	0.1%	0.0%	0.0%							
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%							
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%							
Intrepreter Services Request	0.5%	0.6%	0.7%	1.1%	0.6%							
Provider Portal Assistance	3.7%	3.8%	3.2%	3.2%	3.6%							
Pharmacy	0.1%	0.1%	0.1%	0.2%	0.1%							
Prop 56	0.2%	0.4%	0.3%	0.3%	0.4%							
Provider Network Info	0.0%	0.0%	0.1%	0.0%	0.0%							
Transportation Services	0.2%	0.2%	0.1%	0.1%	0.2%							
Transferred Call	0.0%	0.0%	0.0%	0.1%	0.1%							
All Other Calls	13.4%	13.1%	13.1%	13.1%	12.3%							
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%							

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	13	56	38	40	28							
Contracting/Credentialing	9	21	50	26	19							
Drop-ins	27	49	29	30	54							
JOM's	3	2	2	2	2							
New Provider Orientation	104	103	140	101	113							
Quarterly Visits	0	0	0	0	82							
UM Issues	0	0	0	0	0							
Total Field Visits	156	231	259	199	298	0	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS						
Practitioners		BH/ABA 1,919	AHP 528	PCP 369	SPEC 716	PCP/SPEC 13
AAH/AHS/CHCN Breakdown			AAH 2,382	AHS 269	CHCN 536	COMBINATION OF GROUPS 358
Facilities	**424**					

VENDOR SUMMARY **Credentialing Verification Organization, Symplyr CVO**					
	Number	**Average Time to Process in Days**	**Goal - 25 Business Days**	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	220	22	Y	Y	Y
Recred Files in Process	44	6	Y	Y	Y
Expirables Updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**264**				

May 2024 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	5
SPEC	9
ANCILLARY	4
MIDLEVEL/AHP	5
BH/ABA	202
Sub-total	**225**
Recredentialing	
PCP	8
SPEC	22
ANCILLARY	1
MIDLEVEL/AHP	17
Sub-total	**48**
TOTAL	**273**
May 2024 Facility Approvals	
Initial Credentialing	5
Recredentialing	7
Sub-total	**12**
Facility Files in Process	**44**

May 2024 Employee Metrics (5 FTEs)	**Goal**		**Met (Y/N)**
File Processing	Timely processing within 3 days of receipt		Y
Credentialing Accuracy	<3% error rate		Y
DHCS, DMHC, CMS, NCQA Compliant	98%		Y
MBC Monitoring	Timely processing within 3 days of receipt		Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CREDS	CRED DATE
Abenes	Maria	BH-Telehealth	INITIAL	5/21/2024
Abrams	Michael	BH-Telehealth	INITIAL	5/21/2024
Acevedo	Jeremy	BH-Telehealth	INITIAL	5/21/2024
Adler	Karl	BH	INITIAL	5/21/2024
Aguilar Donis	Maria	BH-Telehealth	INITIAL	5/21/2024
Aguirre-Barthell	Yareli	BH-Telehealth	INITIAL	5/31/2024
Aguite	Alfred	BH	INITIAL	5/31/2024
Avery	Priscilla	BH	INITIAL	5/21/2024
Azar	Alees	BH	INITIAL	5/21/2024
Barba	Karla	BH-Telehealth	INITIAL	5/31/2024
Barnett	Christine	BH	INITIAL	5/21/2024
Barreto	Jennifer	ABA-Telehealth	INITIAL	5/21/2024
Battula	Sireesha	Specialist	INITIAL	5/21/2024
Bean	Gary	Primary Care Physician	INITIAL	5/21/2024
Beeson	Craig	BH	INITIAL	5/21/2024
Bixler	Nicole	BH-Telehealth	INITIAL	5/31/2024
Bobo	Kiana	BH	INITIAL	5/21/2024
Bojorquez	Marina	ABA-Telehealth	INITIAL	5/21/2024
Boyd	Alicia	BH	INITIAL	5/31/2024
Breslin	Kayla	BH-Telehealth	INITIAL	5/21/2024
Bridgeman	Brandon	BH-Telehealth	INITIAL	5/21/2024
Brockwell	Matthew	BH	INITIAL	5/21/2024
Callahan	Jennifer	BH-Telehealth	INITIAL	5/21/2024
Carolin	Lynn	BH-Telehealth	INITIAL	5/31/2024
Carrillo	Rosealinda	BH	INITIAL	5/21/2024
Castellanos	Nicholas	ABA	INITIAL	5/21/2024
Chavez	Jessica	BH-Telehealth	INITIAL	5/31/2024
Chavez	Nancy	Doula	INITIAL	5/21/2024
Chiu	Jung Feng	ABA-Telehealth	INITIAL	5/21/2024
Ciano	Catherine	BH	INITIAL	5/21/2024
Claffey	Angela	BH	INITIAL	5/31/2024
Cline	Lizelle	BH-Telehealth	INITIAL	5/21/2024
Coleman	Ashley	ABA-Telehealth	INITIAL	5/21/2024
Coleman	Kayla	ABA-Telehealth	INITIAL	5/21/2024
Conway	Annette	BH-Telehealth	INITIAL	5/21/2024
Cremo	Christina	BH	INITIAL	5/21/2024
Crespo-Belarde	Romana	BH	INITIAL	5/21/2024
Cueva	Janice	Doula	INITIAL	5/21/2024
Cunningham	Amber	BH	INITIAL	5/21/2024
Dakota	Sage	BH	INITIAL	5/21/2024
Dale	Marian	BH-Telehealth	INITIAL	5/21/2024
Dasari	Padma	Primary Care Physician	INITIAL	5/31/2024
DeSilva	Falaya	BH-Telehealth	INITIAL	5/21/2024
DeSilva	Nefertiti	BH	INITIAL	5/31/2024
Di Toro	Bernadette	BH-Telehealth	INITIAL	5/31/2024
Dillingham	Melessa	BH	INITIAL	5/21/2024
Dillon	Leah	BH-Telehealth	INITIAL	5/21/2024
Dinh	Han	BH-Telehealth	INITIAL	5/21/2024
Dom	Mirou	BH-Telehealth	INITIAL	5/21/2024
Dominguez	Laura	BH-Telehealth	INITIAL	5/31/2024
Dominguez Mucciaccio	Priscilla	BH	INITIAL	5/21/2024
Domue	Nadine	BH	INITIAL	5/31/2024
Dunne	Diane	BH-Telehealth	INITIAL	5/21/2024
Duvvuri	Vikas	BH-Telehealth	INITIAL	5/21/2024
Elswick	Benjamin	BH-Telehealth	INITIAL	5/21/2024
Esmaeili-Firidouni	Pardis	Specialist	INITIAL	5/21/2024

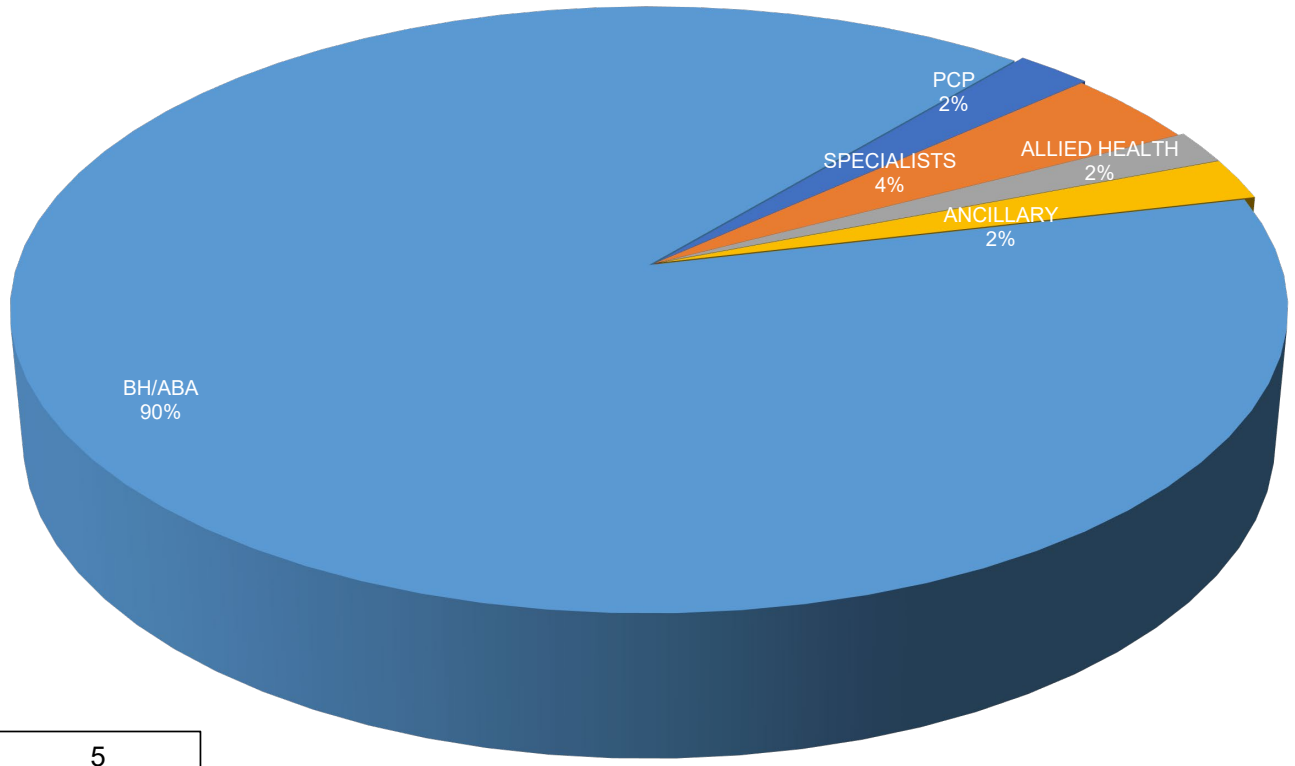
LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CREDS	CRED DATE
Estrada	Alyssa	BH	INITIAL	5/21/2024
Evans	Sydney	ABA-Telehealth	INITIAL	5/21/2024
Ezra	Nancy	BH	INITIAL	5/21/2024
Falakfarsa	Galan	ABA-Telehealth	INITIAL	5/21/2024
Feren	Laura	BH	INITIAL	5/21/2024
Flanagan	Heidi	BH-Telehealth	INITIAL	5/21/2024
Foglia	Anthony	ABA	INITIAL	5/21/2024
Forde	Heather	BH-Telehealth	INITIAL	5/31/2024
Foster	Timothy	BH-Telehealth	INITIAL	5/21/2024
Frazier	Louisa	BH	INITIAL	5/21/2024
Galasi	Katalin	BH-Telehealth	INITIAL	5/21/2024
Ganguly	Anindita	BH	INITIAL	5/21/2024
Gannuscio	Destinee	BH	INITIAL	5/21/2024
Garcia	Lauren	BH-Telehealth	INITIAL	5/21/2024
Garcia	Monica	ABA	INITIAL	5/21/2024
Gasper	Michelle	BH	INITIAL	5/21/2024
Gentry	Yvette	Specialist	INITIAL	5/31/2024
Gibbons	Hope	BH-Telehealth	INITIAL	5/21/2024
Gilbert	Calvin	Allied Health	INITIAL	5/21/2024
Gill	Sharanbir	Specialist	INITIAL	5/21/2024
Gilpin	Melanie	BH-Telehealth	INITIAL	5/31/2024
Glen	Douglas	BH-Telehealth	INITIAL	5/21/2024
Gorton	Ryan	Primary Care Physician	INITIAL	5/31/2024
Gray	Lee-Anne	BH	INITIAL	5/21/2024
Griffin	Ezkiel	BH-Telehealth	INITIAL	5/21/2024
Guntupalli	Sivakumari	ABA-Telehealth	INITIAL	5/21/2024
Guthrey	Christopher	BH	INITIAL	5/21/2024
Halladay	Joie	BH-Telehealth	INITIAL	5/21/2024
Halquist	Ryan	BH	INITIAL	5/21/2024
Harrington	Melanie	BH-Telehealth	INITIAL	5/21/2024
Haven	Debbra	BH	INITIAL	5/31/2024
Higginbottom	Shelby	BH-Telehealth	INITIAL	5/21/2024
Hirchak	David	BH	INITIAL	5/31/2024
Hoffman	Anthony	Specialist	INITIAL	5/21/2024
Holiday	Erika	BH-Telehealth	INITIAL	5/21/2024
Hong	Jan	BH-Telehealth	INITIAL	5/21/2024
Houghton	Madeline	ABA-Telehealth	INITIAL	5/21/2024
Hurff	Aubrey	ABA	INITIAL	5/21/2024
Iankowitz	Michelle	BH	INITIAL	5/21/2024
Iskandar	Lucy	BH-Telehealth	INITIAL	5/21/2024
Jaramillo	Shabnam	ABA-Telehealth	INITIAL	5/21/2024
Jimenez	Yareli	ABA-Telehealth	INITIAL	5/21/2024
Johnson	April	Ancillary	INITIAL	5/31/2024
Johnson	Christine	BH-Telehealth	INITIAL	5/21/2024
Jordan	Lourie	BH-Telehealth	INITIAL	5/21/2024
Joyce	Megan	ABA-Telehealth	INITIAL	5/21/2024
Kancherla	Deepika	Specialist	INITIAL	5/21/2024
Kang	Kagna	ABA-Telehealth	INITIAL	5/21/2024
Kaufman	Laura	BH-Telehealth	INITIAL	5/21/2024
Kellem	Ashley	BH	INITIAL	5/21/2024
Kelly	Irene	Primary Care Physician	INITIAL	5/21/2024
Kerhulas	Ike	BH-Telehealth	INITIAL	5/21/2024
Khaneghahi	Ladan	BH	INITIAL	5/21/2024
Khanjan	Marjan	BH	INITIAL	5/21/2024
Khara	Rabia	BH	INITIAL	5/21/2024
Kiernan	Heidi	BH-Telehealth	INITIAL	5/21/2024
Kilford	Chantel	BH-Telehealth	INITIAL	5/21/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CREDS	CRED DATE
Kim	Megan	BH	INITIAL	5/21/2024
King	Brian	BH	INITIAL	5/21/2024
Konstantinidis	Anthony	BH	INITIAL	5/21/2024
Kopman	Marina	BH	INITIAL	5/21/2024
Kramer	Paul	BH	INITIAL	5/21/2024
Krongold	Karen	BH	INITIAL	5/21/2024
Krupp	Jason	Specialist	INITIAL	5/21/2024
Laing	David	BH	INITIAL	5/31/2024
Laird	Heather	BH-Telehealth	INITIAL	5/21/2024
Lake	James	BH-Telehealth	INITIAL	5/31/2024
Landymore	Erica	BH-Telehealth	INITIAL	5/21/2024
Le	Myan	BH-Telehealth	INITIAL	5/21/2024
Lee	Scott	Specialist	INITIAL	5/21/2024
Lee Escher	Emily	BH-Telehealth	INITIAL	5/21/2024
Leone-Aldrich	Michael	BH	INITIAL	5/21/2024
Leung	Amy	BH	INITIAL	5/21/2024
Locicero	Alice	BH	INITIAL	5/21/2024
Loehr	Jordann	Specialist	INITIAL	5/21/2024
Lollis	Aaron	BH	INITIAL	5/21/2024
Lovdokken	Marie	BH	INITIAL	5/31/2024
Lynch	Kai	BH	INITIAL	5/21/2024
Maddex	Michelle	BH	INITIAL	5/21/2024
Malhotra	Pankaj	Primary Care Physician	INITIAL	5/21/2024
Marez	Andrea	BH	INITIAL	5/21/2024
Martin	Heather	BH-Telehealth	INITIAL	5/21/2024
Martin	Jennifer	BH-Telehealth	INITIAL	5/21/2024
Masjedi Esfahani	Arezoo	BH	INITIAL	5/21/2024
Matthew	Danielle	BH	INITIAL	5/31/2024
McBain	Katie	BH	INITIAL	5/31/2024
McKinley	Brenda	BH-Telehealth	INITIAL	5/21/2024
McLean	Kelli	BH	INITIAL	5/21/2024
Medina Chinas	Yanet Alicia	BH-Telehealth	INITIAL	5/21/2024
Medvedev	Maria	BH	INITIAL	5/21/2024
Milton	Derrick	BH-Telehealth	INITIAL	5/21/2024
Mithani	Ali Hussain	Allied Health	INITIAL	5/21/2024
Mohan	Allison	BH	INITIAL	5/21/2024
Monkhouse	John Eric	BH-Telehealth	INITIAL	5/21/2024
Montgomery	Kelly	BH	INITIAL	5/21/2024
Morris	Heather	BH-Telehealth	INITIAL	5/21/2024
Moskwa	Danika	ABA-Telehealth	INITIAL	5/21/2024
Murrell	Felicia	BH-Telehealth	INITIAL	5/21/2024
Naas	Mark	BH	INITIAL	5/21/2024
Nastasi	Robert	BH-Telehealth	INITIAL	5/21/2024
Navarro-Prescott	Diane	BH	INITIAL	5/21/2024
Nekoorad-Long	Haleh	BH-Telehealth	INITIAL	5/21/2024
Newton	Melissa	ABA-Telehealth	INITIAL	5/21/2024
Ng	Ada	ABA-Telehealth	INITIAL	5/21/2024
Ngo	Michael	ABA-Telehealth	INITIAL	5/21/2024
Nguyen	Thanh-Van	BH	INITIAL	5/31/2024
Norton	Beverly	BH-Telehealth	INITIAL	5/21/2024
Olano	Bozena	ABA-Telehealth	INITIAL	5/21/2024
Ortega	Matthew	BH-Telehealth	INITIAL	5/21/2024
Ortiz	Nicolas	ABA	INITIAL	5/21/2024
Palmer	Richard	BH	INITIAL	5/21/2024
Peixoto	Jessica	ABA	INITIAL	5/31/2024
Pellegrini	Marion	Allied Health	INITIAL	5/21/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CREDS	CRED DATE
Perez	Damaris	ABA	INITIAL	5/21/2024
Perrine	Emily	BH-Telehealth	INITIAL	5/21/2024
Plate	Lauren	Allied Health	INITIAL	5/21/2024
Poon	Mary	BH	INITIAL	5/21/2024
Pospos	Sarah	BH	INITIAL	5/21/2024
Reyes	Jenna	BH-Telehealth	INITIAL	5/21/2024
Robertson	Kristi	BH	INITIAL	5/21/2024
Robinson	Francis	BH-Telehealth	INITIAL	5/31/2024
Rodriguez	Davida	BH	INITIAL	5/21/2024
Rodriguez	Lauren	BH	INITIAL	5/21/2024
Rubin	Kimberlee	BH	INITIAL	5/21/2024
Russell	Margaret	BH	INITIAL	5/21/2024
Samaan	Ron	BH	INITIAL	5/21/2024
Sanders	Christina	ABA-Telehealth	INITIAL	5/21/2024
Schmidt	Dana	BH	INITIAL	5/21/2024
Seary	Alexis	BH	INITIAL	5/31/2024
Sedaghat	Nava	BH	INITIAL	5/31/2024
Sheinin	Boris	BH-Telehealth	INITIAL	5/21/2024
Sinkondo	Martine	ABA-Telehealth	INITIAL	5/21/2024
Sorta	Dennis	BH	INITIAL	5/21/2024
Spencer	Rikki Magdalene	BH	INITIAL	5/21/2024
Spudich	John	BH-Telehealth	INITIAL	5/21/2024
Stevens Sanagustin	Michelle	BH-Telehealth	INITIAL	5/21/2024
Stine	Joshua	BH-Telehealth	INITIAL	5/21/2024
Su	Alan	BH	INITIAL	5/21/2024
Szava	Veronika	BH	INITIAL	5/21/2024
Tapia	Lindsey	ABA-Telehealth	INITIAL	5/21/2024
Thibeault	Paul	BH	INITIAL	5/21/2024
Thiem	Tracy	BH-Telehealth	INITIAL	5/21/2024
Toch	Emily	BH-Telehealth	INITIAL	5/21/2024
Toleikis	Jennifer	BH-Telehealth	INITIAL	5/31/2024
Tsai	Erica	BH-Telehealth	INITIAL	5/21/2024
Tyler	Melinda	BH-Telehealth	INITIAL	5/21/2024
Vaca Navarro	Graciela	Doula	INITIAL	5/21/2024
Vaene Lee	Alanya	BH	INITIAL	5/21/2024
Vaerten	Katelyn	ABA-Telehealth	INITIAL	5/21/2024
Valadez	Agustin	BH	INITIAL	5/21/2024
Valdez Depee	Jessica	BH-Telehealth	INITIAL	5/21/2024
Vang	Cheng	BH	INITIAL	5/21/2024
Vazirian	Mohsen	BH-Telehealth	INITIAL	5/21/2024
Vela	Sarah	Allied Health	INITIAL	5/21/2024
Villanueva	Michael	BH-Telehealth	INITIAL	5/31/2024
Wade	Alexander	BH	INITIAL	5/21/2024
Walker	Carlisha	BH	INITIAL	5/21/2024
Weisz	Igor	BH-Telehealth	INITIAL	5/31/2024
Wellner	Rachia	BH	INITIAL	5/21/2024
Welsh	Erik	BH-Telehealth	INITIAL	5/31/2024
Welsh	Sara	BH	INITIAL	5/21/2024
White	Michael	BH-Telehealth	INITIAL	5/21/2024
Winn	Ayisha	BH	INITIAL	5/21/2024
Wong	Alfred	ABA	INITIAL	5/21/2024
Wood	Lindsay	BH-Telehealth	INITIAL	5/21/2024
Worrall	Sam	BH	INITIAL	5/21/2024
Xiong	Nonish	BH	INITIAL	5/21/2024
Zeichick	Heidi	BH	INITIAL	5/31/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CREDS	CRED DATE
Zeltser	Jason	BH-Telehealth	INITIAL	5/21/2024
Allen	Melissa	Allied Health	RE-CREDS	5/21/2024
Anand	Shwetha	Specialist	RE-CREDS	5/21/2024
Che	Qi	Specialist	RE-CREDS	5/21/2024
Chow	Diane	Specialist	RE-CREDS	5/21/2024
Classen	Jerri	Allied Health	RE-CREDS	5/21/2024
Economou	Vasiliki	Specialist	RE-CREDS	5/21/2024
Elmi	Eman	Specialist	RE-CREDS	5/21/2024
Estoque	Ligaya	Allied Health	RE-CREDS	5/21/2024
Flores	Laravic	Primary Care Physician	RE-CREDS	5/21/2024
Garg	Sachin	Primary Care Physician	RE-CREDS	5/21/2024
Gilani	Hussain	Specialist	RE-CREDS	5/21/2024
Gordon	Danielle	Allied Health	RE-CREDS	5/21/2024
Hamid	Elizabeth	Specialist	RE-CREDS	5/21/2024
Hutton	Melissa	Allied Health	RE-CREDS	5/21/2024
Irani	Adil	Specialist	RE-CREDS	5/21/2024
Jung	Jesse	Specialist	RE-CREDS	5/21/2024
Kellert	Brian	Specialist	RE-CREDS	5/21/2024
Khetrapal	Rabin	Primary Care Physician	RE-CREDS	5/21/2024
Lee	Eileen	Allied Health	RE-CREDS	5/21/2024
Lieu	Macy	Allied Health	RE-CREDS	5/21/2024
Lim	Mira	Specialist	RE-CREDS	5/21/2024
Lin	Jiin-Tarng	Primary Care Physician	RE-CREDS	5/21/2024
Liu	Benny	Specialist	RE-CREDS	5/21/2024
Liu	Jessica	Primary Care Physician	RE-CREDS	5/21/2024
Luna	Lauren	Allied Health	RE-CREDS	5/21/2024
Mahal	Gurjeet	Allied Health	RE-CREDS	5/21/2024
Mahawar	Suresh	Specialist	RE-CREDS	5/21/2024
Meadows	Journey	Allied Health	RE-CREDS	5/21/2024
Miller	Terina	Specialist	RE-CREDS	5/21/2024
Montang	Lisa	Primary Care Physician	RE-CREDS	5/21/2024
Nathan	Sarah	Allied Health	RE-CREDS	5/21/2024
Odabaei	Golaun	Specialist	RE-CREDS	5/21/2024
Pascal	Steven	Specialist	RE-CREDS	5/21/2024
Piatt	Bradford	Specialist	RE-CREDS	5/21/2024
Quan	Tiffany	Allied Health	RE-CREDS	5/21/2024
Richardson	Megan	Allied Health	RE-CREDS	5/21/2024
Riseman	Rebecca	Allied Health	RE-CREDS	5/21/2024
Seibert	Scott	Specialist	RE-CREDS	5/21/2024
Stewart	Kelley	Allied Health	RE-CREDS	5/21/2024
Tannura	Laila	Allied Health	RE-CREDS	5/21/2024
Tsou	Gee Yen	Allied Health	RE-CREDS	5/21/2024
Wang	Aiqun	Ancillary	RE-CREDS	5/21/2024
Wang	Michael	Specialist	RE-CREDS	5/21/2024
Wong	Clifford	Specialist	RE-CREDS	5/21/2024
Wu	Serena	Primary Care Physician	RE-CREDS	5/21/2024
Yalom	Eve	Specialist	RE-CREDS	5/21/2024
Yee	Stephen	Primary Care Physician	RE-CREDS	5/21/2024
Young	Robyn	Specialist	RE-CREDS	5/21/2024

MAY PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	5
Specialists	9
Allied Health	5
Ancillary	4
BH/ABA	202
Total	225

Provider Dispute Resolution
April 2024 and May 2024

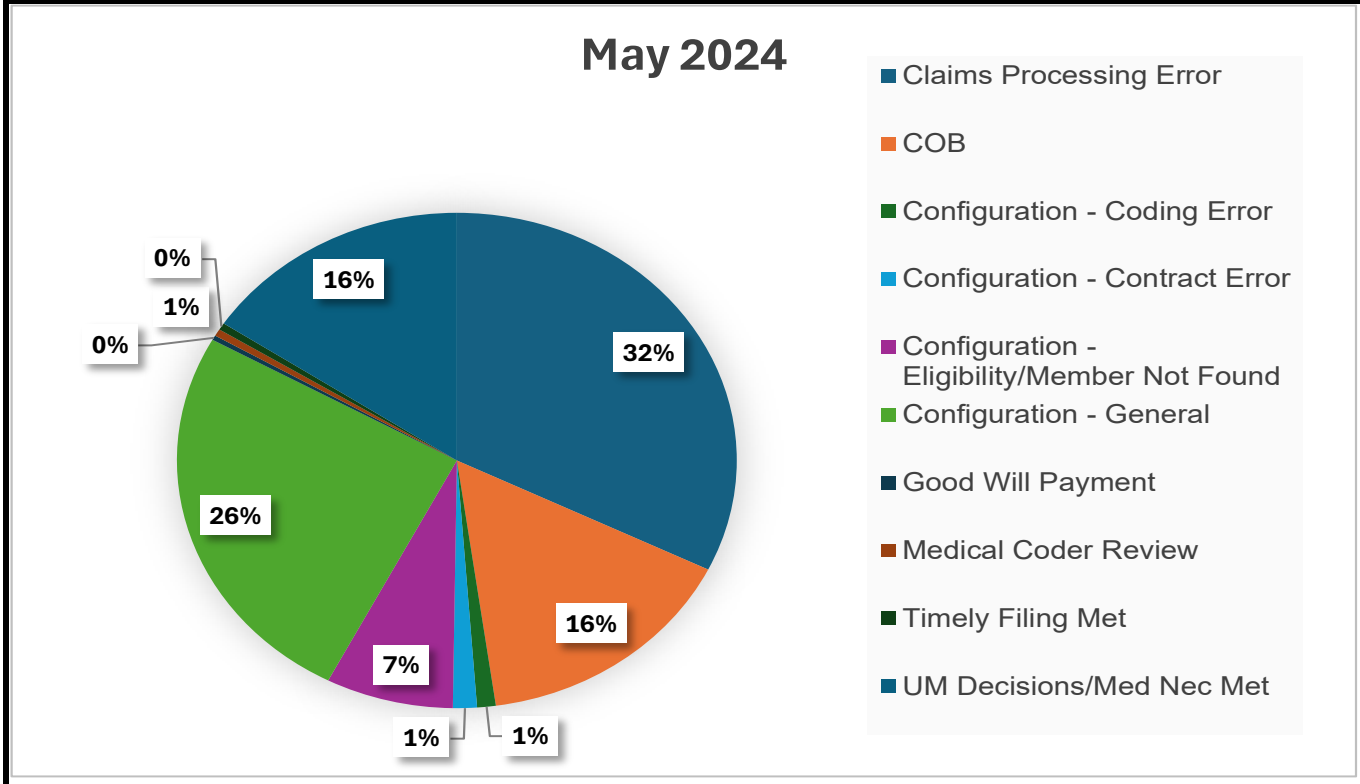
METRICS

PDR Compliance	Apr-24	May-24
# of PDRs Resolved	1,601	2,039
# Resolved Within 45 Working Days	1,596	2,029
% of PDRs Resolved Within 45 Working Days	99.6%	99.5%
PDRs Received	**Apr-24**	**May-24**
# of PDRs Received	1,925	2,386
PDR Volume Total	**1,925**	**2,386**
PDRs Resolved	**Apr-24**	**May-24**
# of PDRs Upheld	1,078	1,388
% of PDRs Upheld	67%	68%
# of PDRs Overturned	523	651
% of PDRs Overturned	33%	32%
Total # of PDRs Resolved	**1,601**	**2,039**
Average Turnaround Time	**Apr-24**	**May-24**
Average # of Days to Resolve PDRs	43	43
Oldest Resolved PDR in Days	89	52
Unresolved PDR Age	**Apr-24**	**May-24**
0-45 Working Days	3,808	3,814
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**3,808**	**3,814**

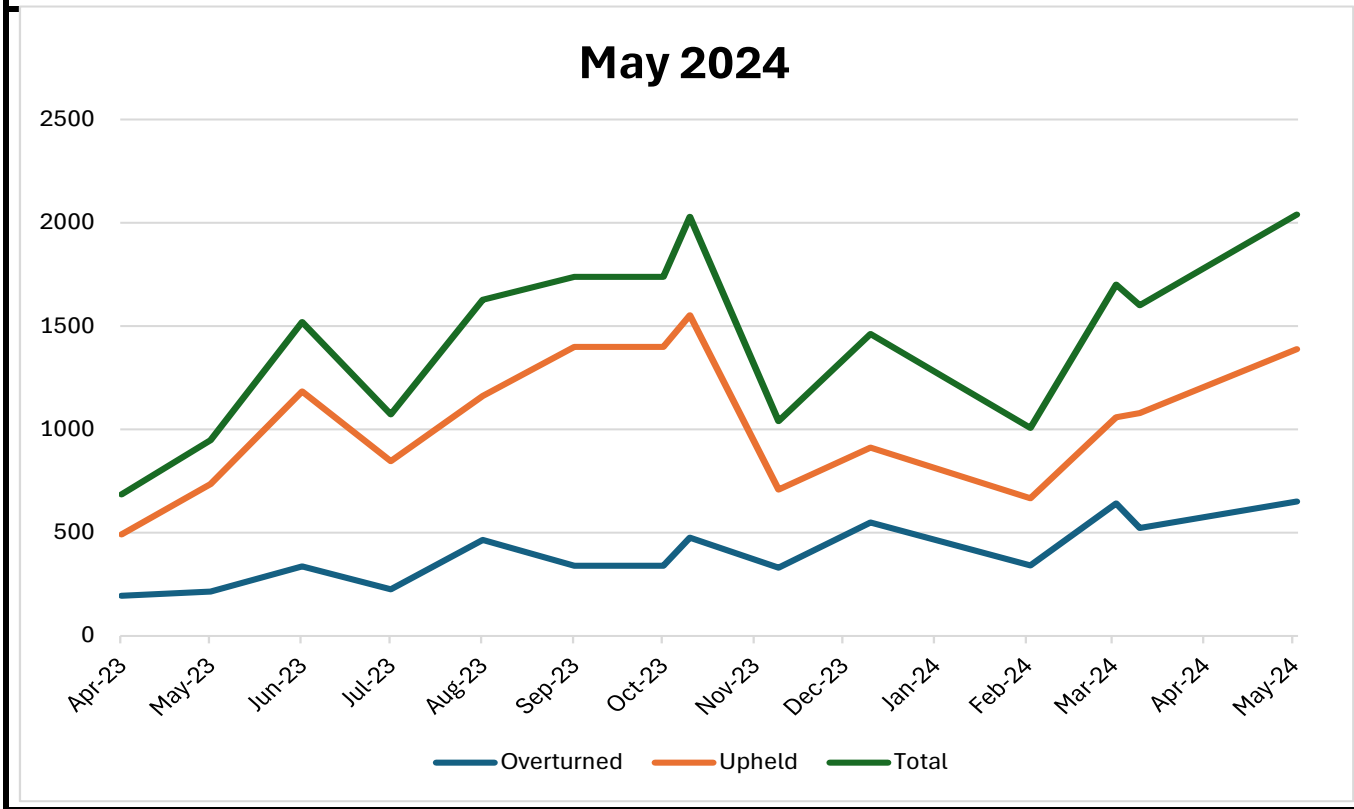
Provider Dispute Resolution
April 2024 and May 2024

May-24

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Resolved - 2,039 in May 2024 vs 947 in May 2023	N/A	N/A
# of PDRs Received - 2,386 in May 2024 vs 1,322 in May 2023	N/A	N/A
# of PDRs Resolved within 45 working days - 2,029 in May 2024 vs 944 in May 2023	N/A	N/A
% of PDRs Resolved within 45 working days - 99.5% in May 2024 vs 99.7% in May 2023	95%	95%
Average # of Days to Resolve PDRs - 43 days in May 2024 vs 39 days in May 2023	N/A	30
Oldest Resolved PDR in Days - 52 days in May 2024 vs 52 days May 2023	N/A	N/A
# of PDRs Upheld - 1,388 in May 2024 vs 735 in May 2023	N/A	N/A
% of PDRs Upheld - 68% in May 2024 vs 78% in May 2023	N/A	> 75%
# of PDRs Overturned - 651 in May 2024 vs 212 in May 2023	N/A	N/A
% of PDRs Overturned - 32% in May 2024 vs 22% in May 2023	N/A	< 25%

Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
PDR Overturn Reasons: Claims processing errors - 16% (2024) vs 54% (2023) Configuration errors - 35% (2024) vs 22% (2023) COB -16% (2024) vs 13% (2023) Clinical Review/UM Decisions/Medical Necessity Met -16% (2024) vs 9% (2023)	N/A	N/A

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2023-2024 | **MAY 2024 OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY
FY 2023-2024 | MAY 2024 OUTREACH REPORT

During May 2024, the Alliance completed **857** member orientation outreach calls among net new members and non-utilizers and conducted **150** member orientations (**18%** member participation rate). In addition, in May 2024, the Outreach team completed **49** Alliance website inquiries, **6** service requests, **1** social media inquiry, **3** community events**, 2** member education events, and **1** community meeting/presentation. The Alliance reached a total of **1,158** people and spent a total of $430 in donations, fees, and/or sponsorships at the 2024 Livermore Downtown Street Fest, Community Healthcare Information Outreach, Asian Health Services Monthly Food Distribution, HEDIS Sprint Meet and Greet, and Housing & Community Services community outreach activities.*

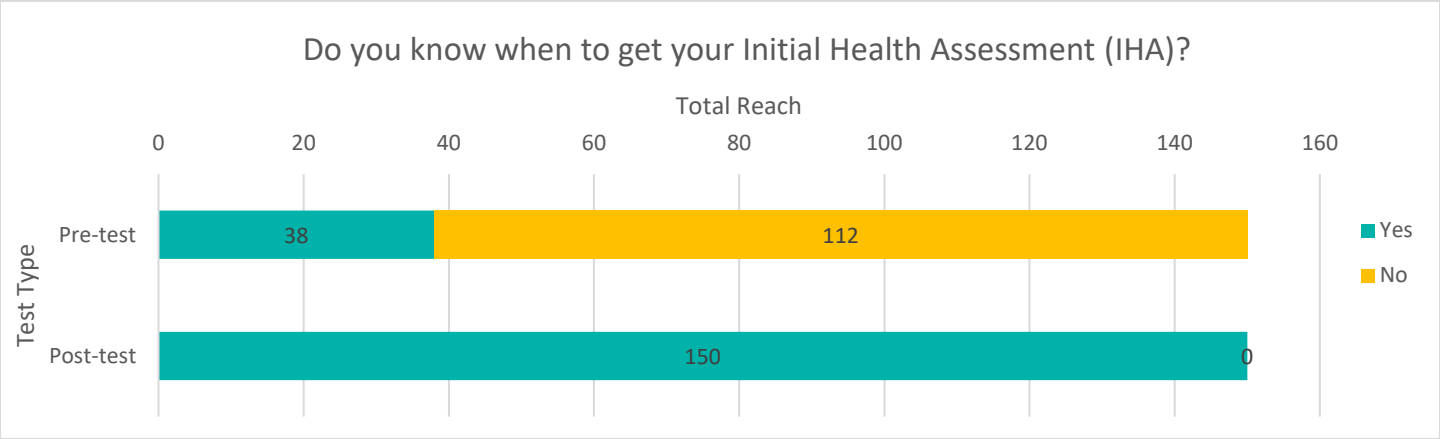
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **32,763** self-identified Alliance members have been reached during outreach activities.

On Monday, March 16, 2020, the Alliance began helping members by telephone only, following the statewide Shelter-in-Place (SIP) guidance to protect the general public from Coronavirus Disease (COVID-19). Subsequently, the Alliance proactively postponed all face-to-face member orientations until further notice.

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of May 31, 2024, the Outreach Team completed **36,338** member orientation outreach calls and conducted **8,522** member orientations (**23.5%** 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 Appointment (IHA) 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 May 1, through May 31, 2024 (22 working days) – **150** members completed an MO by phone.

After completing a MO **100%** of members who completed the post-test survey in May 2024 reported knowing when to get their IHA, compared to only **25.3%** 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 23-24\Q4\2. May 2024**

ALLIANCE IN THE COMMUNITY

FY 2023-2024 | MAY 2024 OUTREACH REPORT

FY 2022-2023 MAY 2023 TOTALS

- 0 COMMUNITY EVENTS
- 1 MEMBER EDUCATION EVENTS
- 124 MEMBER ORIENTATIONS
- 0 MEETINGS/ PRESENTATIONS/
- 0 COMMUNITY TRAINING
- 3 TOTAL INITIATED/ INVITED EVENTS
- **125 TOTAL COMPLETED EVENTS**

11 CITIES

Alameda
Castro Valley
Emeryville
Fremont
Hayward
Livermore
Newark
Oakland
San Leandro
San Lorenzo
Union City

- 0 TOTAL REACHED AT COMMUNITY EVENTS
- 225 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 124 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 TOTAL REACHED AT COMMUNITY TRAINING
- 296 MEMBERS REACHED AT ALL EVENTS
- **349 TOTAL REACHED AT ALL EVENTS**

$0.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2023-2024 MAY 2024 TOTALS

- 3 COMMUNITY EVENTS
- 2 MEMBER EDUCATION EVENTS
- 150 MEMBER ORIENTATIONS
- 1 MEETINGS/ PRESENTATIONS
- 0 COMMUNITY TRAINING
- 9 TOTAL INITIATED/ INVITED EVENTS
- 156 TOTAL COMPLETED **EVENTS**

16 CITIES**

Alameda
Albany
Berkeley
Castro Valley
Dublin
Fremont
Hayward
Livermore
Newark
Oakland
Pleasanton
Sacramento
San Leandro
San Lorenzo
San Ramon
Union City

- 635 TOTAL REACHED AT COMMUNITY EVENTS
- 360 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 150 TOTAL REACHED AT MEMBER ORIENTATIONS
- 13 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 COMMUNITY TRAINING
- 537 MEMBERS REACHED AT ALL EVENTS
- **1158 TOTAL REACHED AT ALL EVENTS**

$430.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

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

COMMUNICATIONS & OUTREACH DEPARTMENT

SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | **May 2024**

The Alliance Communications and Outreach (C&O) Department created the social media and website activity (SM&WA) Report to provide a high-level overview of stakeholder engagement through various digital media platforms. Between **May 1, 2024**, and **May 31, 2024**:

1. Alliance Website:
    - Received **16,000** unique visits
    - Received **13,000** new user visits
    - The top **10** website page visits were:
        i. Homepage
        ii. Provider Page
        iii. Find a Doctor
        iv. Benefits and Services
        v. Careers
        vi. Medi-Cal Members
        vii. Contact Us
        viii. Members
        ix. About Us
        x. Get a New ID Card
2. Facebook Page:
    - Slight Increase in Fans from **631** to **632**
    - Did not receive any reviews in **May 2024**
3. Glassdoor Page:
    - **3** out of a **5-star** overall rating
    - Did not receive any reviews in **May 2024**
4. Instagram Page:
    - Page debuted **June 10, 2021**
    - Increased in followers from **526** to **543**
5. Twitter Page:
    - Slight Increase in Followers from **357** to **358**
6. LinkedIn Page:
    - Increased followers from **5.3k to 5.5k**
    - Received **605-**page clicks
7. Yelp Page:
    - Page visits **65**
    - Appeared in Yelp searches **53** times
    - Did not receive any reviews in **May 2024**
8. Google Page:
    - **5,016** website clicks made from the business profile
    - **1,698** calls made from the business profile
    - Did not receive any reviews in **May 2024**
    - Received **3** chat messages in **May 2024**

GLASSDOOR OVERVIEW

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | May 2024

Alameda Alliance for Health Ratings and Trends

About Glassdoor ratings

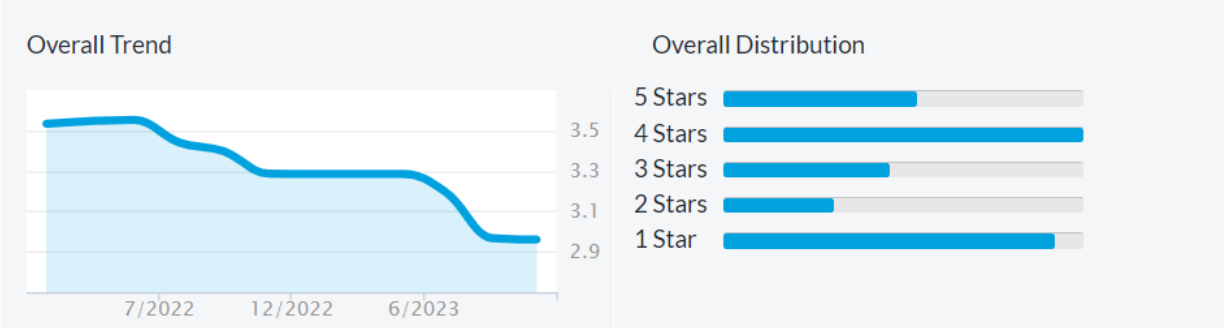
Ratings may vary depending on what filters are applied, but ratings include reviews in all languages. Learn More

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

51% Recommend to a Friend

0% CEO Approval

38% Positive Business Outlook

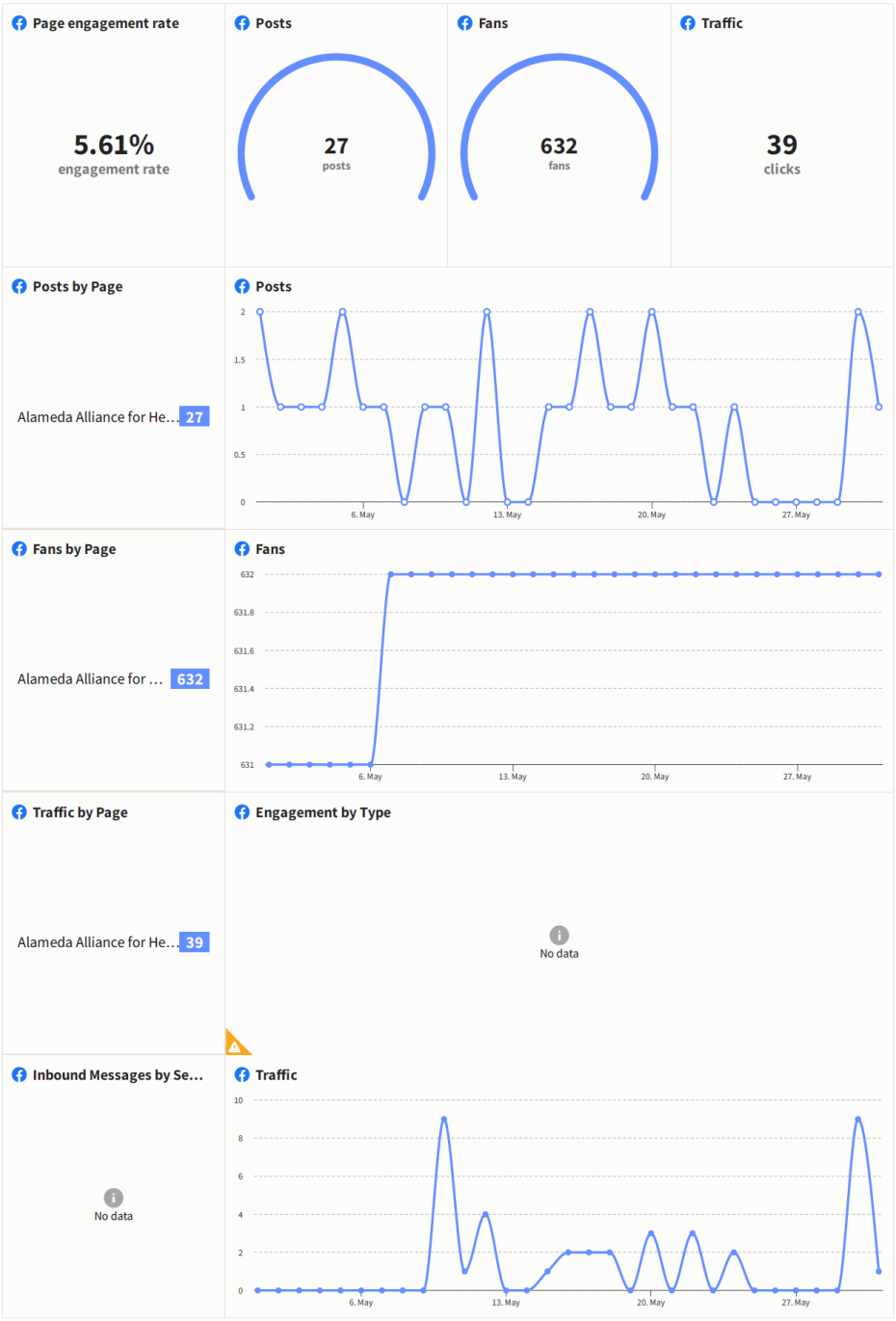


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q4\2. May 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | **May 2024**

FACEBOOK OVERVIEW



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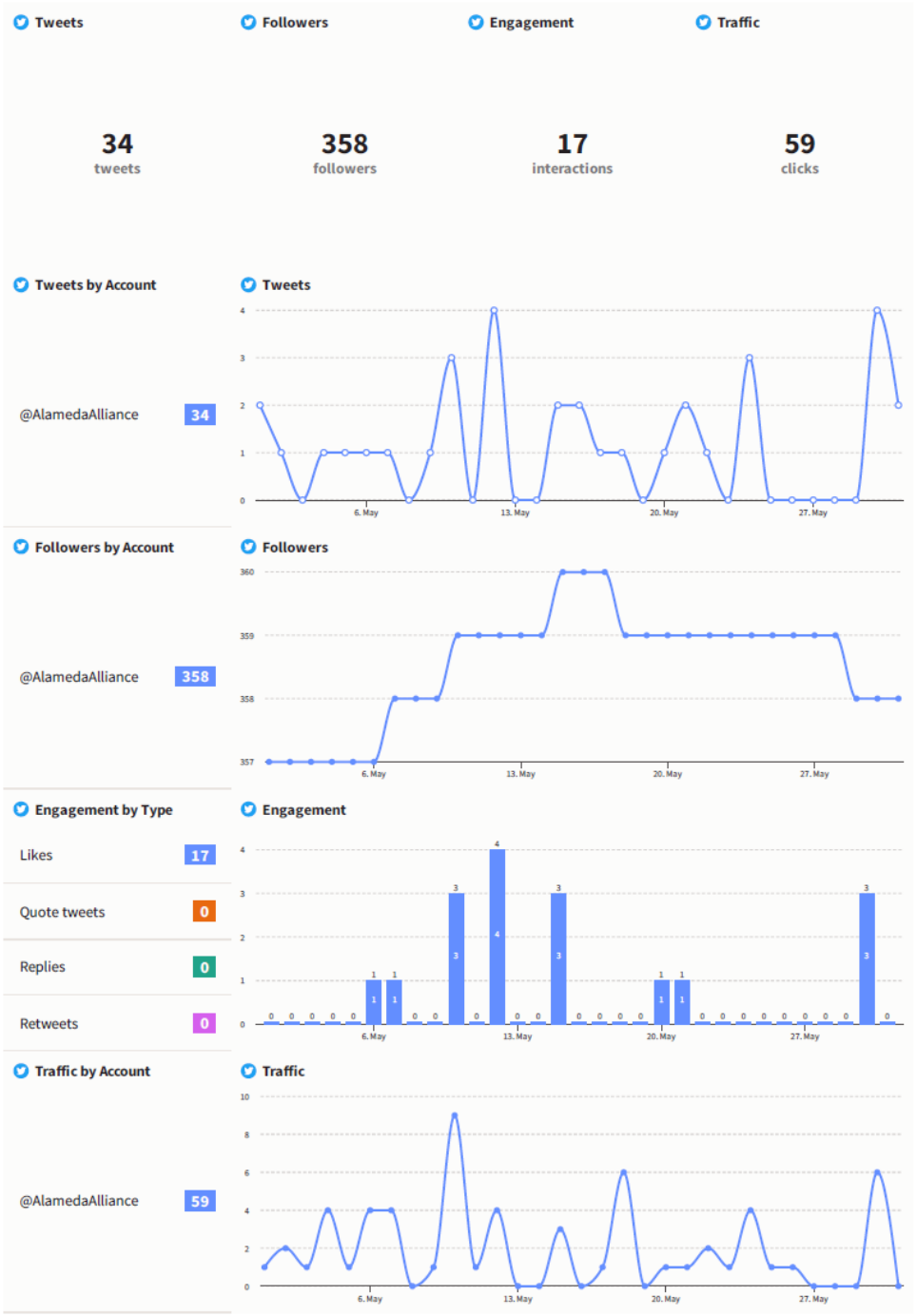
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | **May 2024**

TWITTER OVERVIEW



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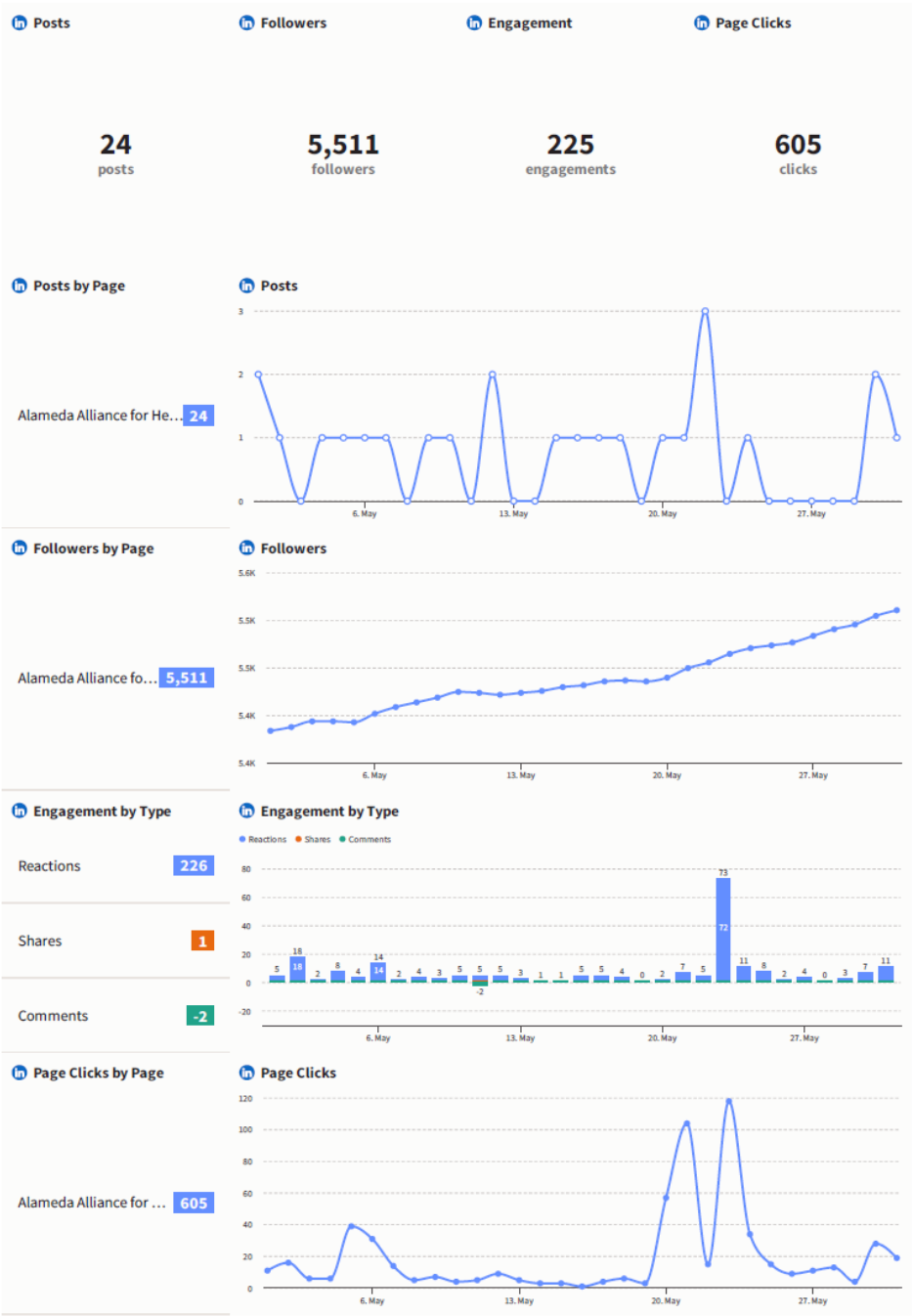
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | May 2024

LINKEDIN OVERVIEW



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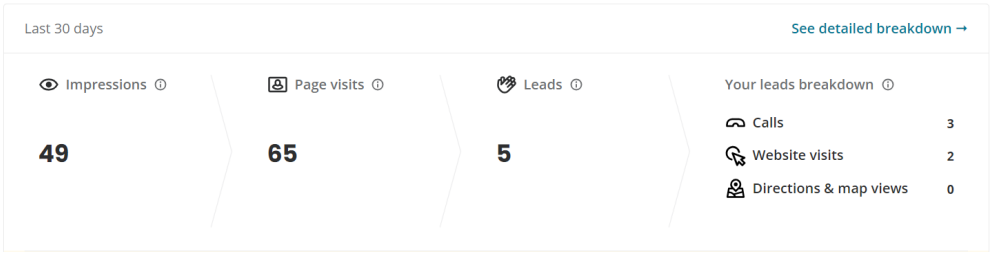
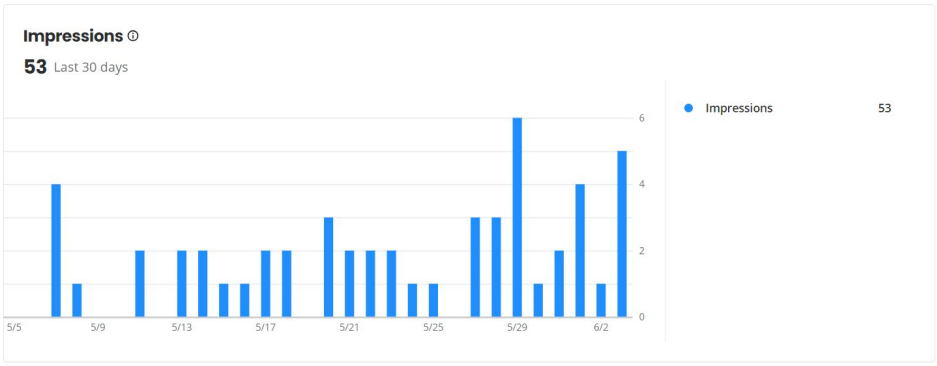
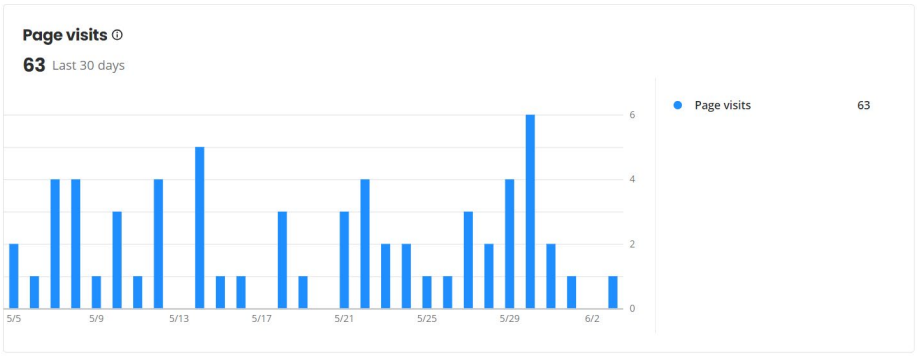
YELP OVERVIEW

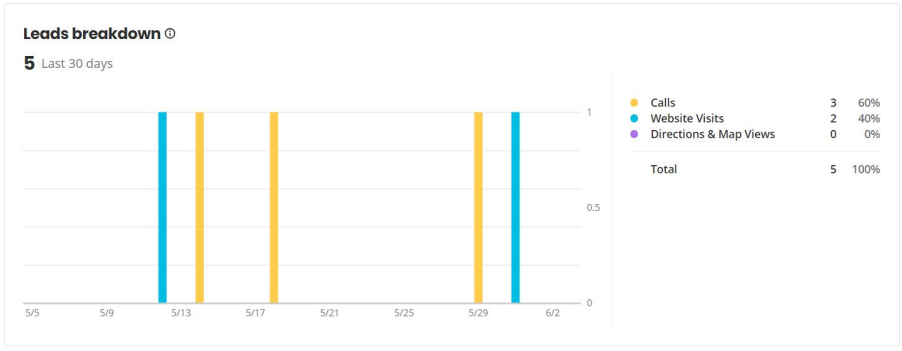
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | May 2024









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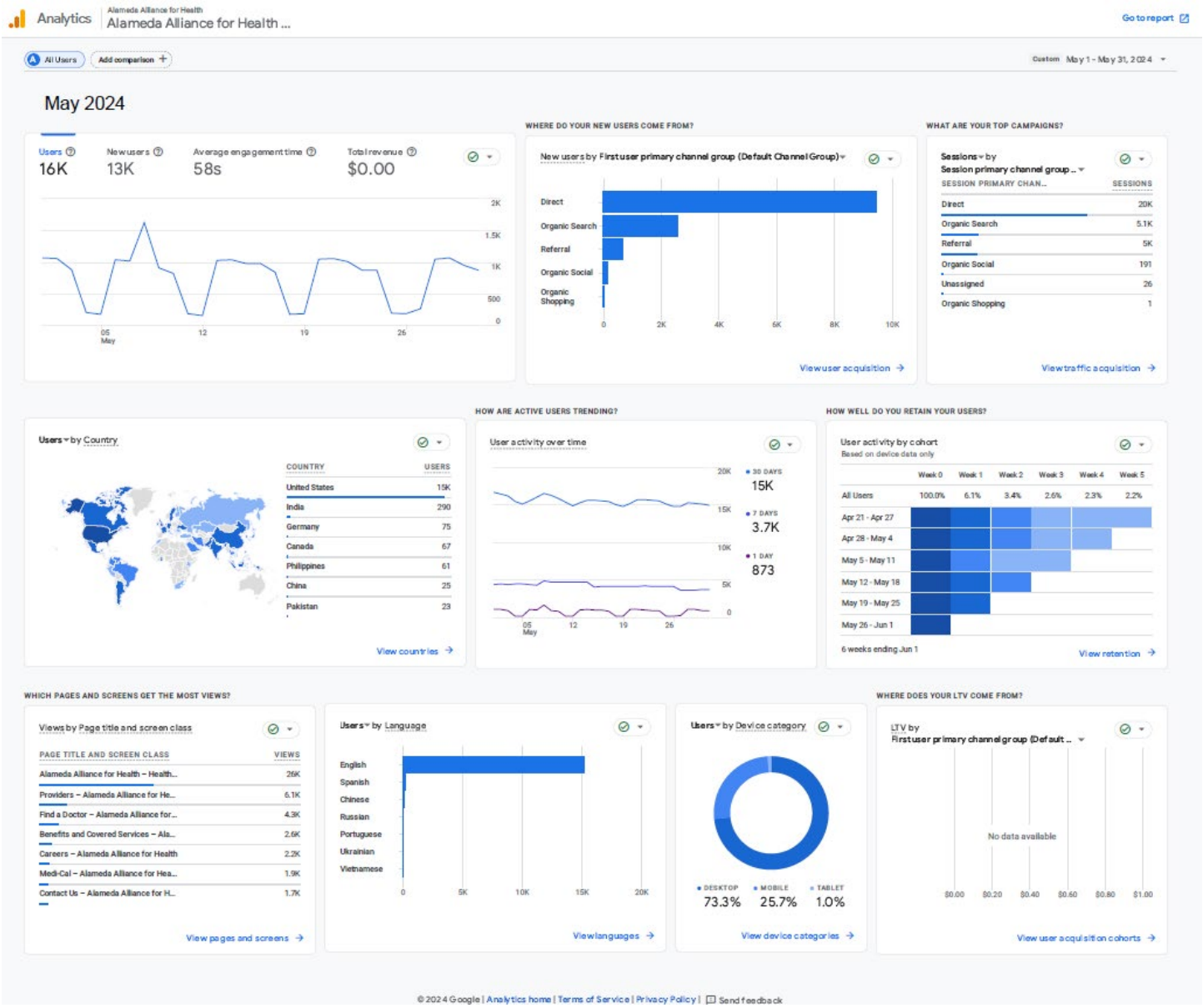
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | **May 2024**

ALLIANCE WEBSITE OVERVIEW:



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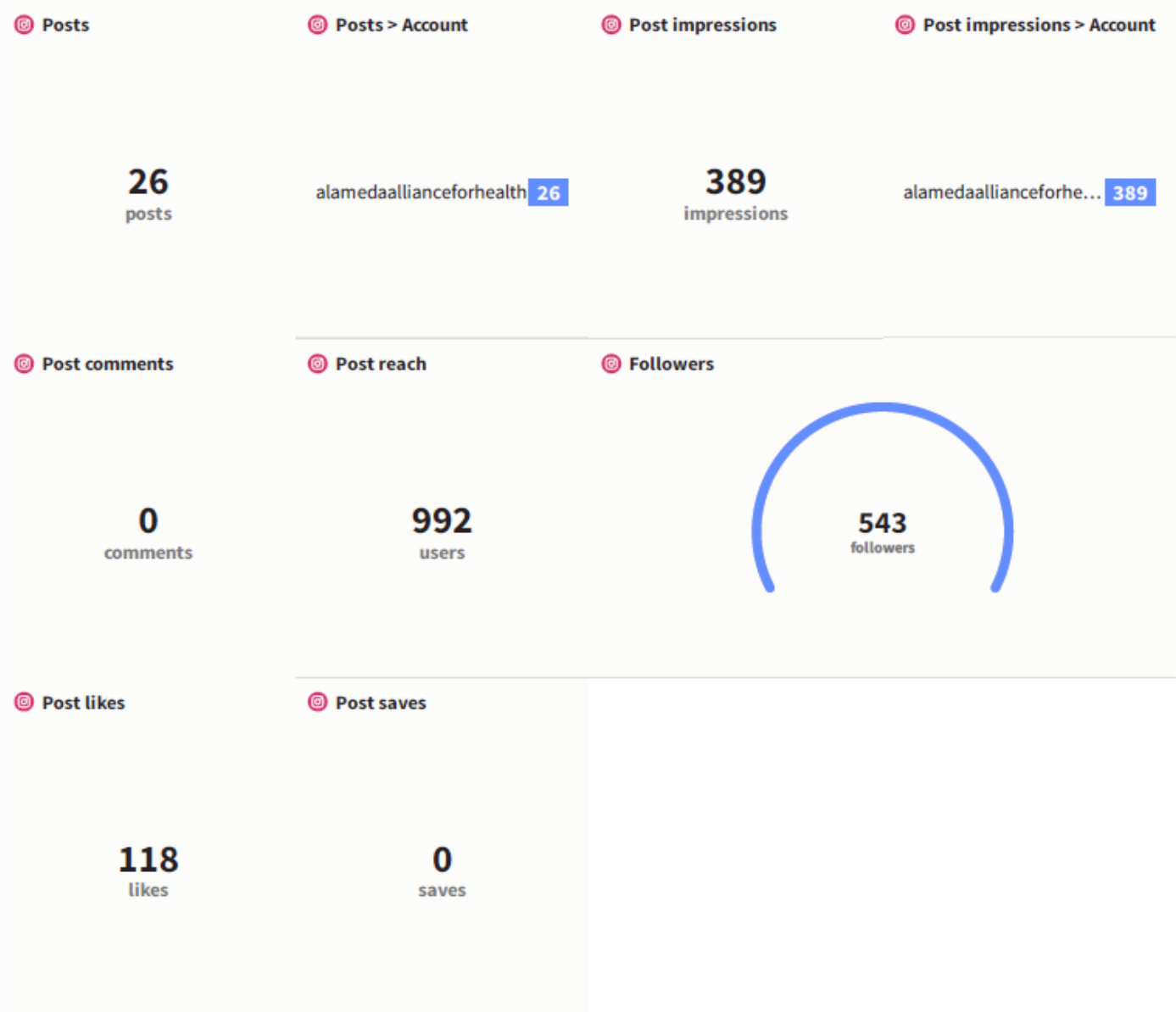
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | **May 2024**

Instagram OVERVIEW:



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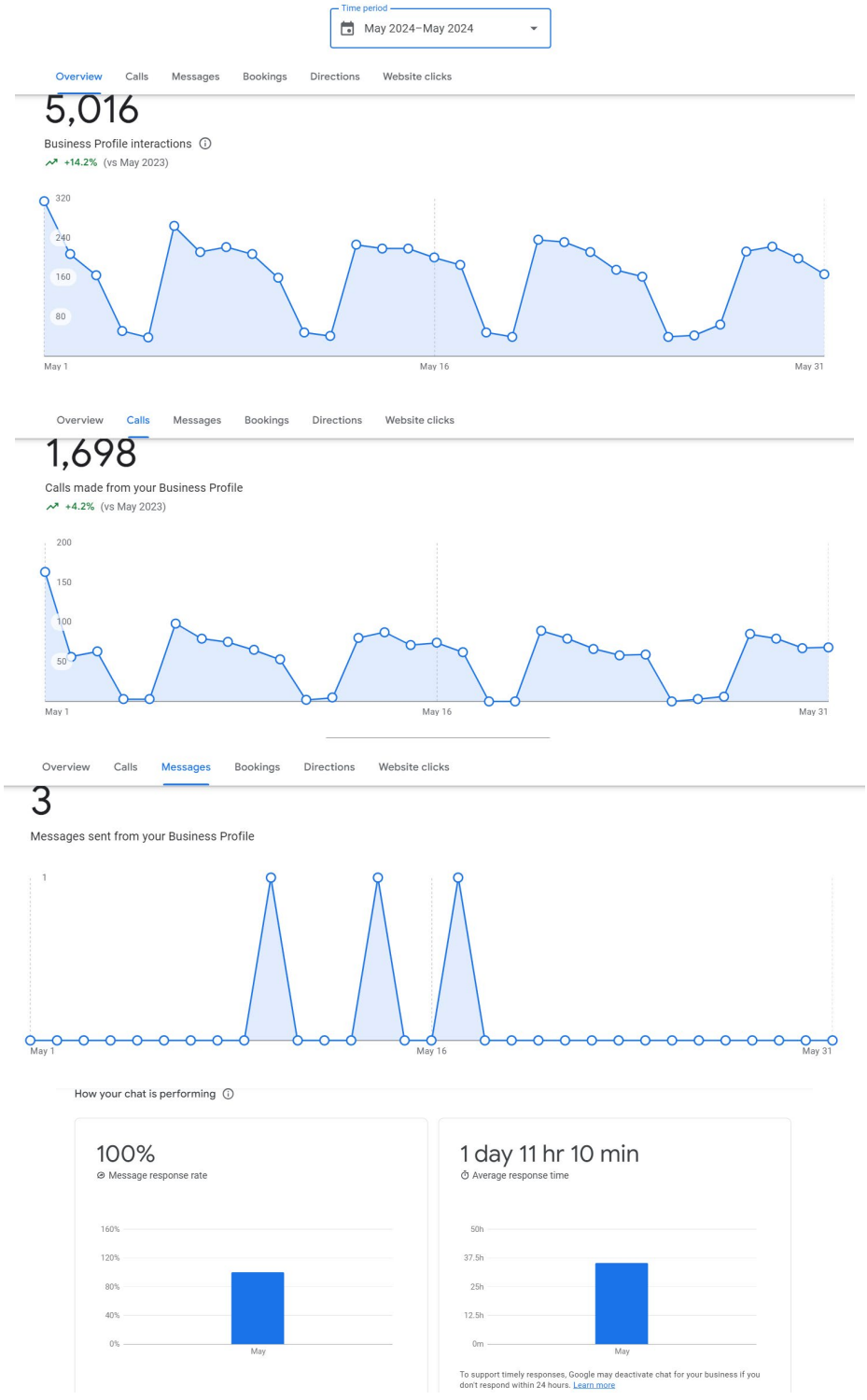
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | **May 2024**

Google OVERVIEW:



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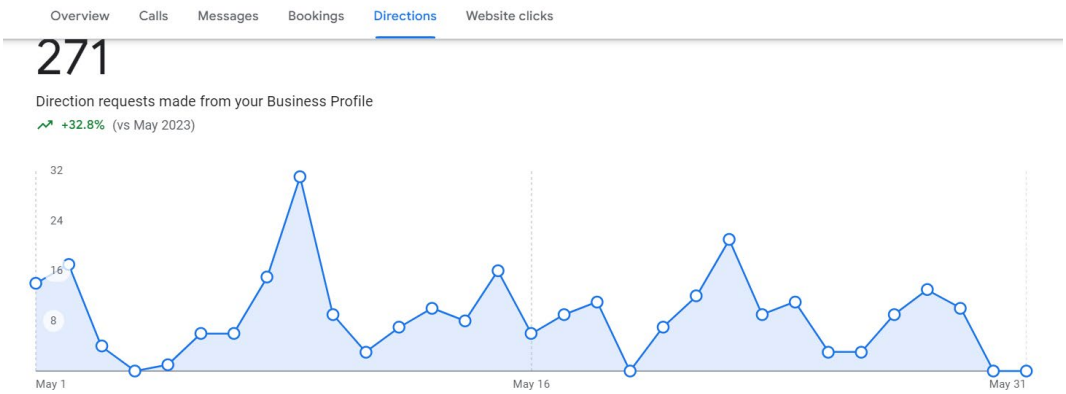

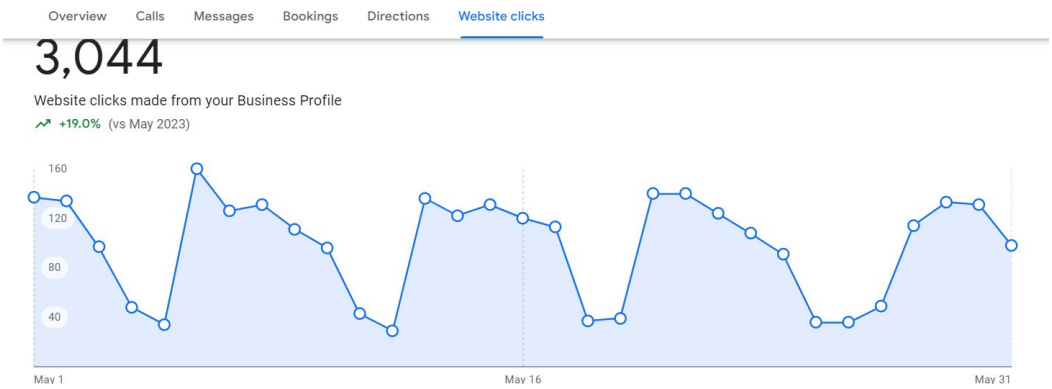

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Integrated Planning

Ruth Watson

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

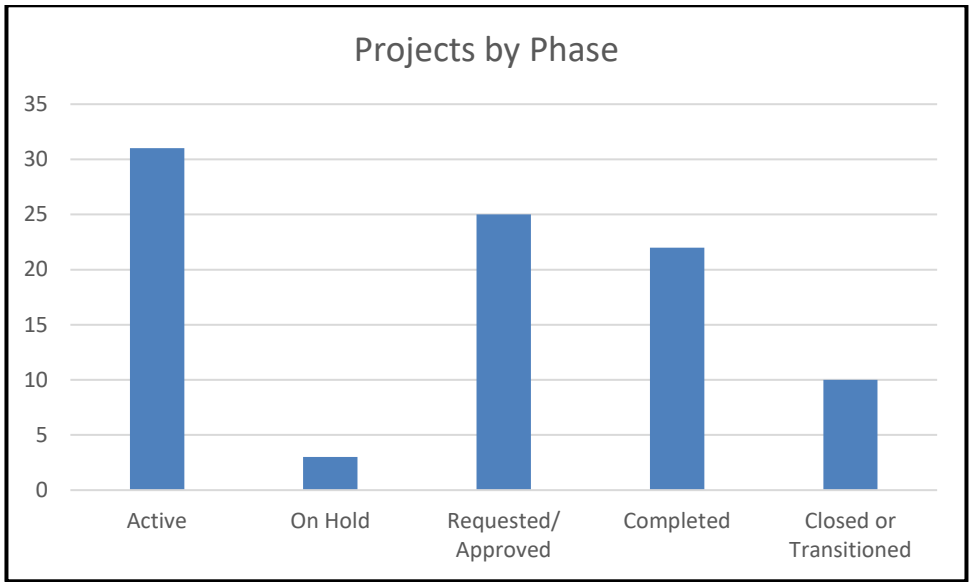
From: **Ruth Watson, Chief Operating Officer**

Date: **June 14, 2024**

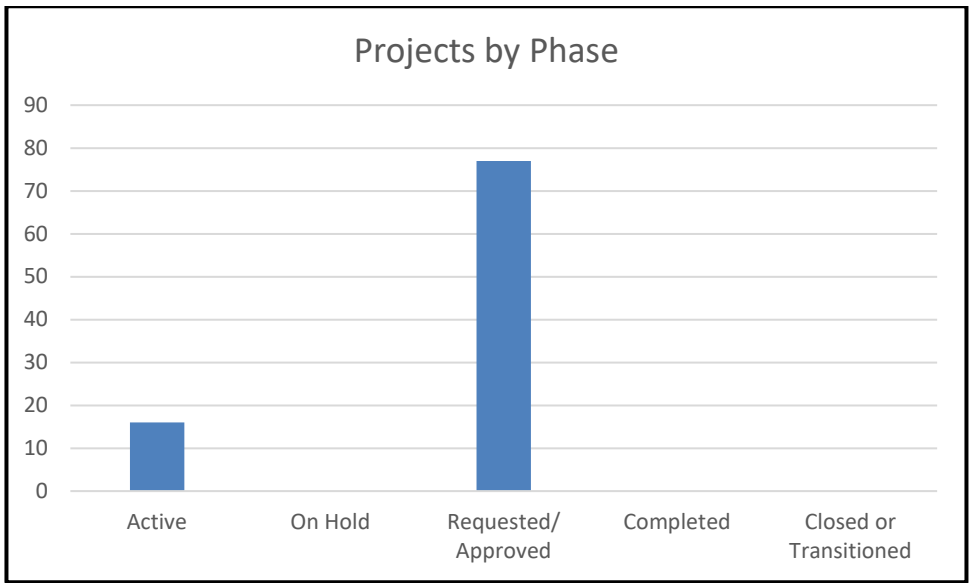
Subject: **Integrated Planning Division Report – May 2024 Activities**

Integrated Planning Division

- Enterprise Portfolio
  - 77 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 31 Active projects (discovery, initiation, planning, execution, warranty)
    - 3 On Hold projects
    - 25 Requested and Approved Projects
    - 22 Complete projects
    - 10 Closed/Transitioned to Department or IT Led



- D-SNP Portfolio
  - 93 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 16 Active projects (discovery, initiation, planning, execution, warranty)
    - 77 Requested and Approved Projects



  - D-SNP Key Initiatives and Dates
    - DMHC Material Modification Submission – MA Service Area Expansion – March 2024
    - DMHC Material Modification Submission – DSNP Product – August 2024
    - CMS Notice of Intent to Apply – November 2024
    - CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025
    - CMS Formulary & Bid Submission (Benefit Determination) – June 2025
    - CMS SMAC Submission – July 7, 2025
    - Rebate Allocation with CMS and Health Plan – July / August 2025
    - Annual Enrollment Period (AEP) – October thru December 2025
    - IT System Readiness – December 15, 2025
    - Open Enrollment Period (OEP) Begins – January 1, 2026

  - D-SNP Activities – May 2024
    - Developing Medicare Provider Contracting Rates Grid
    - Developing Medicare Vendor Analysis and Supplemental Benefit Grid in development
    - Developing Model of Care (MOC) responses for MOC 1, 3, and 4
    - Provider Contract Amendments to support Sequestration, Medical Education, Disproportionate Share Hospital, Risk Adjustment (Coding Accuracy), and Stars is in final stages with outside legal counsel
    - Comment table received from DMHC for all submissions (thus far) related to Medicare License Expansion Filing (20241128). AAH response due to DMHC by June 16th

        - Staffing Updates
            - Posted Two Contract Specialist Positions
        - Director, Stars Strategy & Program Management
        - CEO, COO, & ED, Medicare Programs presented to CHCN on April 30th and AHS on May 30th regarding Medicare Advantage D-SNP 101 and engaged in a dialogue with FQHC leadership on concerns and questions
        - TruCare (EMR) System Kickoff started May 22nd
        - D-SNP Active Projects – 10
        - D-SNP Requested Project – 82

    - Program Decisions
        - Delegate Provider Credentialing – UCSF, Physical Therapy PN, Lucille Packard, Teledoc, PerformRx
        - Delegate most PBM functions to PerformRX
        - Delegate Provider Training to CHCN
        - Delegate Bid Preparation to Milliman
        - Extend current Medi-Cal contract for Medicare within DME to CHME, Transportation to ModivCare, Telehealth to Teladoc, NAL to Optum, and CAHPS to Press Ganey.
        - Delegate Health Risk Assessment (HRA) to a vendor
        - No member delegation

- **<u>CalAIM Initiatives:</u>**
    - Community Supports (CS):
        - Sobering Centers launch has been delayed due to the extending HCSA contract negotiations
            - The negotiations are expected to last through July, which will delay our July 01 expected launch date
            - DHCS will be notified that we are moving the launch to January 01, 2025, and will be included with the final two CS Services we are launching
        - The final two CS services are expected to launch by January 2025:
            - Day Habilitation Programs
            - Short-Term Post-Hospitalization Housing
        - The CS MOC is being edited and will be submitted by the end of this month (June)

    - Justice-Involved (JI) Initiative:
        - CalAIM Re-entry
            - Go-live date for the CalAIM Re-Entry initiative is October 1st, 2024, for all MCPs
                - Correctional facilities will have the ability to select their go-live date within a 24-month phase-in period (10/1/2024 – 9/30/2026)
                    - Santa Rita Jail is targeting to go-live on 7/1/2026 with pre-release services; Juvenile Justice Center's go-live is TBD
                - Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of October 1st, 2024, even if facilities in their county will go-live at a later date
            - Bi-weekly workgroup meetings with Alameda County Sheriff's Office, Probation, Alameda County Behavioral Health, Social Security

Administration, Kaiser Permanente and AAH continue to support collaboration on the strategy for this initiative
    - Workgroup is developing workflows and strategies to support behavioral health linkages, care plans, and the pre-release warm hand-off
- Additional meetings will be held internally to further define the data requirements for AAH to share with external agencies in support of the JI initiatives
- AAH meets monthly with the local Wellpath team (clinical provider within Santa Rita Jail) to continue discussions about data sharing and to learn about discharge planning
    - Wellpath corporate is now hosting monthly meetings with MCPs to define data sharing requirements and workflows
- AAH JI Project team met with UCSF Children's Hospital Oakland team on May 31 to discuss UCSF's role in the intake, transfer, and release of youth from the Juvenile Justic Center
- Alameda County Behavioral Health, Wellpath, and Alameda County Sheriff's office are creating a draft care plan for adults at Santa Rita Jail. They expect to share this draft with AAH in mid-June for our review
    - Youth population will likely have a separate care plan created by Probation. This work is anticipated to begin in June, with partnership between Probation and Alameda County Behavioral Health

- AAH/Roots JI Pilot Project:
    - AAH's pilot for post-release services began in July 2023 in preparation for the 2024 programs related to this population
        - The team continues to track and trend the monthly data received from Roots to support the development of our strategy for the re-entry initiative that commences in 2024
        - Initial data analysis has shown a disparity between the number of males vs. females seeking help upon release (roughly 10% of males vs. near 100% females)
        - Housing assistance is also a top need for this population
        - Discussions about sustainability for the Roots programs funded through this pilot have been initiated. Roots is looking to AAH for guidance around billing for ECM and CHW services provided in the 90-day pre-release period.
            - Roots is proposing an extension to the pilot period. This is under review with senior leadership as of June 4, 2024
        - Monthly check-ins with Roots will continue through the remainder of the pilot

- Community Health Worker (CHW) Benefit – Medi-Cal benefit effective July 1st, 2022, designed to promote the MCP's contractual obligations to meet DHCS broader Population Health Management standards and as adjunctive services as part of the interventions to positively impact health outcomes
    - Provider Recruitment – the Alliance is working or meeting with several organizations in order to grow the CHW network

        - Alameda Health Systems – working with internal teams to create pathways for CHW emergency department services
        - Building Futures – pre-contract phase
        - East Bay Asian Local Development Corporation (EBALDC) – pre-contract phase
        - Family Resource Navigators – pre-contract phase
        - First 5 of California – pre-contract phase
        - Journey Health – contract fully executed
        - Pair Team – awaiting returned agreement from provider
        - Roots – contract amendment to add CHW services in process
        - Save DV – pre-contract phase
        - Youth Alive, West Oakland Collaborative, Alta Bates Medical – conducted CHW presentation with these groups
    - CHW Workgroup Activities:
        - Development of website content with Communications & Outreach; go-live scheduled for June 11th
        - APL 24-006 – DHCS released an updated CHW APL on May 13th; reviewing operational impacts; updated P&P due to DHCS in August

- CYBHI Fee Schedule – Effective January 1st, 2024, the Alliance is partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule
    - Cohort 1 is intended to be a "learning" cohort
    - DHCS continues holding a series of meetings with Cohort participants; these include Onboarding Sessions for the LEAs as well as Technical Office Hours each Thursday of the month
        - The meetings held have been heavily focused on the LEA process
    - The Alliance will utilize Carelon as the Third-Party Administrator (TPA)
    - The Claims submission date has been extended from April 1, 2024 to July 1, 2024
        - It may not be true that all MCPs or LEAs have systems set up, however, LEAs may submit claims for up to 180 days from the date of service
        - Claims may be submitted retroactively back to July 1st, 2024 as long as it is submitted by end of the year

Recruiting and Staffing

- Integrated Planning Open position(s):
    - Backfill for Sr. PM – Position filled. Starting June 10, 2024
    - Business Process Analyst – 1 Position filled – Starting July 1, 2024, 2nd Position - Pending
- Business Analyst – Integrated Planning - Pending
- Backfill Business Analyst – Integrated Planning – 1 Position filled. Starting June 10, 2024, 2nd Position - Pending

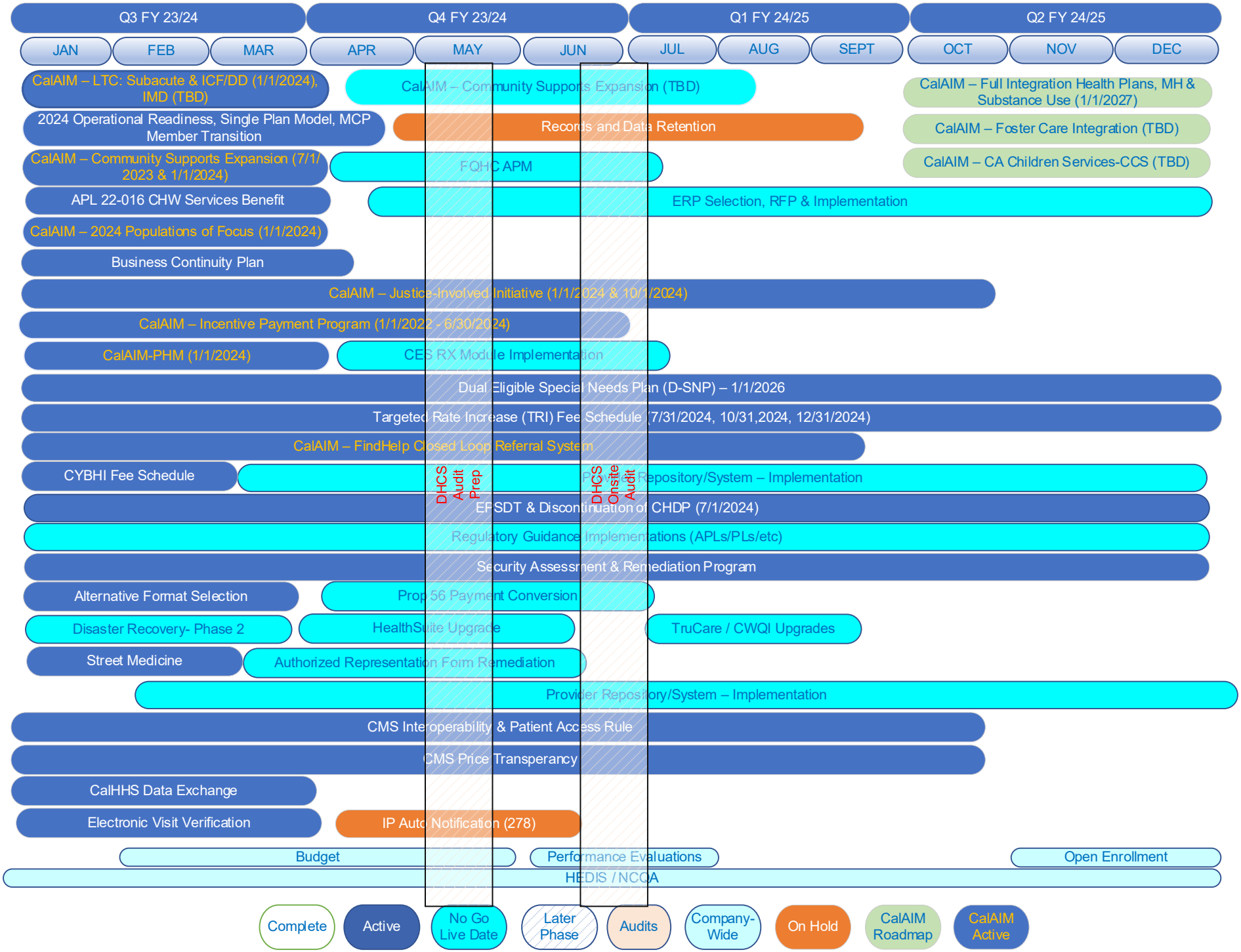
Integrated Planning

Supporting Documents Project Descriptions

Key projects currently in-flight:

- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs.
  - Enhanced Care Management (ECM) – ECM will target eight (8) specific populations of vulnerable and high-risk children and adults
    - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022
    - Two (2) additional PoF became effective on January 1st, 2023
    - One (1) PoF became effective on July 1st, 2023
    - Two (2) PoF became effective on January 1st, 2024
  - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays
    - As of January 1st, 2024, AAH will offer twelve (12) of the fourteen (14) DHCS-designated CS services
      - January 1st, 2022 – Six (6) Community Supports were implemented
      - July 1st, 2023 – Three (3) additional CS services went live
      - January 1st, 2024
        - Two (2) CS services that support the LTC PoFs that were effective January 2023 are being piloted in 7/1-12/31, 2023 and went live in January
        - One (1) additional CS service is also targeted for implementation in July 2024
  - Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
    - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
      - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024
      - MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by October 1st, 2024
      - Correctional facilities will have two years from 10/1/2024-9/30/2026 to go live based on readiness
  - Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 in order to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary

- Community Health Worker Services Benefit – Community Health Worker (CHW) services became a billable Medi-Cal benefit effective July 1st, 2022. CHW services are covered as preventive services on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law for individuals who need such services to prevent disease, disability, and other health conditions or their progression, prolong life; and promote physical and mental health and well-being.
- 2024 Single Plan Model
    - 2024 Managed Care Plan Contract Operational Readiness – new MCP contract developed as part of Procurement RFP; all MCPs must adhere to new contract effective January 1st, 2024
        - Business Continuity Plan required as part of Operational Readiness
        - MOUs with third parties required as part of Operational Readiness
    - MCP Member Transition
        - Anthem members will transition to AAH effective January 1st, 2024
        - Members currently delegated to Kaiser will transition to Kaiser as part of their direct contract with DHCS effective January 1st, 2024
- CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed and a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site. CYBHI requires commercial health plans and the Medi-Cal delivery system, as applicable, to reimburse, at or above the published rates, these school-linked providers, regardless of network provider status, for services furnished to students pursuant to the fee schedule. Effective January 1st, 2024, the Alliance is partnering with the Alameda County Office of Education (ACOE) and several Local Education Agencies (LEAs) who were selected to participate in the CYBHI Fee Schedule Cohort 1


Q3 FY 23/24
Q4 FY 23/24
Q1 FY 24/25
Q2 FY 24/25
JAN
FEB
MAR
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AUG
SEPT
OCT
NOV
DEC
CalAIM – LTC: Subacute & ICF/DD (1/1/2024), IMD (TBD)
CalAIM – Community Supports Expansion (TBD)
CalAIM – Full Integration Health Plans, MH & Substance Use (1/1/2027)
2024 Operational Readiness, Single Plan Model, MCP Member Transition
Records and Data Retention
CalAIM – Foster Care Integration (TBD)
CalAIM – Community Supports Expansion (7/1/2023 & 1/1/2024)
FQHC APM
CalAIM – CA Children Services-CCS (TBD)
APL 22-016 CHW Services Benefit
ERP Selection, RFP & Implementation
CalAIM – 2024 Populations of Focus (1/1/2024)
Business Continuity Plan
CalAIM – Justice-Involved Initiative (1/1/2024 & 10/1/2024)
CalAIM – Incentive Payment Program (1/1/2022 - 6/30/2024)
CalAIM-PHM (1/1/2024)
CES RX Module Implementation
Dual Eligible Special Needs Plan (D-SNP) – 1/1/2026
Targeted Rate Increase (TRI) Fee Schedule (7/31/2024, 10/31,2024, 12/31/2024)
CalAIM – FindHelp Closed Loop Referral System
CYBHI Fee Schedule
DHCS Audit Prep
DHCS Onsite Audit
Repository/System – Implementation
EPSDT & Discontinuation of CHDP (7/1/2024)
Regulatory Guidance Implementations (APLs/PLs/etc)
Security Assessment & Remediation Program
Alternative Format Selection
Prop 56 Payment Conversion
Disaster Recovery- Phase 2
HealthSuite Upgrade
TruCare / CWQI Upgrades
Street Medicine
Authorized Representation Form Remediation
Provider Repository/System – Implementation
CMS Interoperability & Patient Access Rule
CMS Price Transperancy
CalHHS Data Exchange
Electronic Visit Verification
IP Auto Notification (278)
Budget
Performance Evaluations
Open Enrollment
HEDIS / NCQA
Complete
Active
No Go Live Date
Later Phase
Audits
Company-Wide
On Hold
CalAIM Roadmap
CalAIM Active

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

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

Date: **June 14th, 2024**

Subject: **Incentives & Reporting Board Report – May 2024 Activities**

Current Incentive Programs

CalAIM Incentive Payment Program (IPP) – three-year DHCS program to provide funding for the support of ECM and Community Supports (CS) in 1) Delivery System Infrastructure, 2) ECM Provider Capacity Building, 3) CS Provider Capacity Building and CS Take-Up, and 4) Quality and Emerging CalAIM Priorities:

- For Program Year 1 (1/1/2022 - 12/31/2022):
  - Alameda Alliance was allocated $14.8M and earned 100% of the allocated funds; the Plan distributed funding to ten (10) providers and organizations to support the ECM and CS programs
- For Program Year 2 (1/1/2023 - 12/31/2023):
  - Alameda Alliance was allocated $15.1M and earned 60% of the allocated funds based on the Submission 3 report which equaled $4.56M; the Plan distributed funding to twelve (12) providers and organizations to support the ECM and CS programs
  - The Submission 4 report, reflecting the lookback period of 7/1/2023-12/31/2023, was submitted to DHCS on March 1st, 2024
- For Program Year 3 (1/1/2024 - 6/30/2024):
  - The Alliance completed the review of Wave 4 IPP Provider Applications and awarded funding to two (2) entities to support CS programs
- The Submission 5 report, reflecting the lookback period of 1/1/2024 - 6/30/2024, will be due to DHCS on September 2nd, 2024

Student Behavioral Health Incentive Program (SBHIP) – DHCS program commenced January 1st, 2022, and continues through December 31st, 2024

- Partner meetings continued with the Local Education Agencies (LEAs) regarding project plan activities for successful completion of the milestones; additionally, the Alliance has been meeting one-on-one with LEAs to complete the next Bi-Quarterly Report (BQR) submission for the reporting period of January – June 2024, which is due to DHCS on June 30th, 2024
- The Alameda County Office of Education (ACOE) is partnering with the Alliance through SBHIP to build infrastructure to sustain program activities post-SBHIP through regularly scheduled Learning Exchanges and Office Hour sessions
- To date, $7.4M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $6.4M has paid to LEA and SBHIP partners

Housing and Homelessness Incentive Program (HHIP) – DHCS program commenced January 1st, 2022, and ended on December 31st, 2023

- Total earnable dollars by the Alliance under this program was $44M
- The Alliance received a total of $38M based on submission of deliverables and achievement of DHCS-defined metrics
    - $17.9M has been awarded to our HHIP partners to date
- Alameda County Health (formerly HCSA) continues to complete deliverables and milestones outlined in the December 2022 MOU:
    - To date, Alameda County Health (AC Health) has completed deliverables related to:
        - HHIP data reporting
        - Housing Financial Supports Progress Report
        - Street Medicine Data and Program Model as well as Contracting recommendations
        - Housing Community Supports Capacity Building
        - Housing Community Supports Legal Services Pilot grant agreement execution with a legal services provider, hiring of 1.0 FTE staff attorney, and completion of progress report(s)
        - An executed contract with a Data Reporting firm and Project Manager for the 2024 Point-in-Time (PIT) Count
    - As of May 31st, $13.1M in total payments has been paid to AC Health for HHIP milestone completion
- A HHIP funding opportunity was released to SBHIP LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
    - HHIP SBHIP LEA applications were received May 3rd, 2024; of the eleven (11) participating SBHIP LEAs, the Alliance received ten (10) applications representing $1.3M in funding requests
    - All ten (10) LEAs applications were approved for funding and the LEAs were notified of funding decisions on May 31st, 2024
- An application process to increase partnerships within the community to support HHIP program goals of reducing and preventing homelessness utilizing funds earned from the S2 report is underway
    - The application has been developed and is scheduled to be released on June 3rd, 2024

Equity and Practice Transformation (EPT) Payments Program – DHCS is implementing a one-time $700M primary care provider practice transformation program called the Equity and Practice Transformation (EPT) Payments Program. The five-year program is designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment models.

- Of the 14 practices that submitted program applications, Alameda Health System was the only applicant selected by DHCS for this initial cohort

- The MCP Initial Planning Incentive Payment Program milestone documentation was submitted to DHCS on January 4th, 2024, and AAH was notified on March 18th, 2024, that our submitted deliverables were reviewed and approved; the associated payment of $442K was received April 22nd, 2024
- On May 10th, 2024, Governor Newsom released a Revised Budget Proposal for California's fiscal year 2024-2025 that proposed cuts to multiple health and human services programs, including the EPT Directed Payment Program which would reduce the funding from $700M to $140M; if approved, it may impact and reduce payments available to the EPT practices

New Programs in Development

The Provider Recruitment Initiative (PRI) is designed to provide grants to support the Alameda County Safety Net and community-based organizations to hire and retain healthcare professionals who serve the Alameda County Medi-Cal population. The PRI aims to grow the Alliance provider network and support our community partners' ability to supply culturally and linguistically competent care to increase accessibility and to reflect the diversity of Alliance members. Program goals include:

- Expanding the Alameda Alliance Provider network
- Improving member access to Primary Care Providers, Specialists, and Behavioral Health professionals
- Promoting diverse and culturally inclusive care reflective of Alliance members

The Alliance is finalizing program materials, including provider-facing program overview documents, application materials, evaluation criteria, governance structure, and policies and procedures. The program is launching on June 1st, 2024, and was announced via a press release on May 29th, 2024.

Recruiting and Staffing

Incentives & Reporting Open position(s):

- There are currently no open positions

Incentive Program Descriptions

CalAIM Incentive Payment Program (IPP) – The CalAIM ECM and CS programs will require significant new investments in care management capabilities, ECM and CS infrastructure, information technology (IT) and data exchange, and workforce capacity across MCPs, city and county agencies, providers, and other community-based organizations. CalAIM incentive payments are intended to:

- Build appropriate and sustainable ECM and Community Supports capacity
- Drive MCP investment in necessary delivery system infrastructure
- Incentivize MCP take-up of Community Supports
- Bridge current silos across physical and behavioral health care service delivery
- Reduce health disparities and promote health equity
- Achieve improvements in quality performance

Student Behavioral Health Incentive Program (SBHIP) – program launched in January 2022 to support new investments in behavioral health services, infrastructure, information technology and data exchange, and workforce capacity for school-based and school-affiliated behavioral health providers. Incentive payments will be paid to Medi-Cal managed care plans (MCPs) to build infrastructure, partnerships, and capacity, statewide, for school behavioral health services

Housing and Homelessness Incentive Program (HHIP) – program launched in January 2022 and is part of the Home and Community-Based (HCBS) Spending Plan

- Enables MCPs to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health
- MCPs must collaborate with local homeless Continuums of Care (CoCs) and submit a Local Homelessness Plan (LHP) to be eligible for HHIP funding

Equity and Practice Transformation (EPT) Payments Program – new program released by DHCS in August 2023 and is a one-time $700M primary care provider practice transformation program designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment models

- EPT is for primary care practices, including Family Medicine, Internal Medicine, Pediatrics, Primary Care 0B/GYN, and/or Behavioral Health in an integrated primary care setting
- Medi-Cal Managed Care Plan (MCP) Initial Provider Planning Incentive Payments
    - $25 million over one (1) year to incentivize MCPs to identify and work with small to medium-sized independent practices as they develop practice transformation plans and applications to the larger EPT Provider Directed Payment Program

- EPT Provider Directed Payment Program
    - $650 million over five (5) years to support delivery system transformation, specifically targeting primary care practices that provide primary care pediatrics, family medicine, internal medicine, primary care OB/GYN services, or behavioral health services that are integrated into a primary care setting to Medi-Cal members; $200 million of the $650 million will be dedicated to practices for value-based care
    - The Statewide Learning Collaborative
        - $25 million over five (5) years to support participants in the Provider Directed Payment Program in implementation of practice transformation activities, sharing and spreading of best practices, practice coaching activities, and achievement of stated quality and equity goals

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

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

Date: **June 14th, 2024**

Subject: **Housing and Community Services Program Report – Fiscal Year 2023-2024 Status**

Housing & Community Services Department Overview: The Housing and Community Services Program (HCSP) is responsible for leading, developing, and implementing a comprehensive housing & homelessness strategy for Alameda Alliance for Health (Alliance). HCSP will evaluate the current processes for members' access to the healthcare system, identify the barriers to achieving housing outcomes for members, and create a strategic plan to establish partnerships with various community stakeholders. HCSP aims to mitigate health disparities and improve health outcomes of Alliance members by bridging the gap between health and housing systems of care to support members' overall health, wellness, and positive outcomes on a member's social determinants of health.

Infrastructure Development

Projects in Progress:

- Designing a Housing Inventory worksheet to learn about expanded community housing providers
- Developing curriculum for Housing Learning Symposium
- Developing curriculum for Community Health Worker (CHW) Learning Cohort
- ROI project for Housing Community Supports
- Housing Department internal restructuring – in progress

Staffing:

- Manager, Community Health Worker Program – position approved; job description being developed
- Housing Coordinator/Navigator – positions approved; job description being developed
- Developed CHW onboarding and recruitment materials
- Developed Housing Coordinator/Navigator onboarding schedules and materials

Budget:

- Department budget has been approved internally and awaiting Board approval

Community Networks & Partnerships Development:

- Alameda Alliance and Continuum of Care (CoC) collaboration:
    - Racial Equity Committee – active voting member status
    - Outreach Access & Coordination Committee – active participant status
    - HMIS Committee – active co-chair status

    - Leadership Board – active voting member status
    - Healthcare for the Homeless, Oakland Monthly Regional Housing meeting - HCSP attended on May 1st
- Community Education on CalAIM Community Supports:
    - Age Friendly Council on Housing – HCSP conducted a housing presentation on May 8th
    - West Oakland Community Connection – HCSP conducted a presentation on Housing and Community Health Worker benefits on May 16th
    - Youth Alive Presentation – HCSP conducted a presentation on Housing & Community Health Worker benefits on May 24th
    - DHCS Closed Loop Referral Focus Group- HCSP attended on May 14th
    - Alameda County Director of Health Housing and Homeless Services - met with Director on May 31st to continue strong relationship building with Alameda County
- Participation in the following Community Networks:
    - CSH Housing Policy Advisory Council – workgroup problem-solving
    - Bring California Home Policy & Education Council – workgroup
    - Addressing Older Adult Homelessness in Alameda County – training
    - CalAIM for Individuals and Families Experiencing Homelessness – training

Interdepartmental Collaboration:

- Incentives and Reporting/HCSP – project updates:
    - Completion of Housing and Homelessness Incentive Program (HHIP) and Housing Application process content to reflect the Housing Bridge the Gap model and support HHIP program goals of reducing and preventing homelessness
    - HHIP & Housing Legal Pilot collaboration – HCSP is establishing workflows and content for the pilot
- Quality Department:
    - HCSP & CHW to assist members who transitioned from Anthem in January 2024

Operations

Supporting Documents

Compliance

Richard Golfin III

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

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

Date: **June 14th, 2024**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey:
    - The DHCS 2024 Routine Full Medical Survey is scheduled to begin June 17th, 2024. The Plan has submitted upwards of 1,000 pages of supplemental pre-audit materials to auditors in preparation for its two-week survey. The Plan anticipates pre-audit requests will continue to be received until the morning of June 17th, 2024. The entrance conference will begin promptly at 9:00am on Day 1.
- 2024 HSAG Network Adequacy Validation Audit (NAV)
    - On March 15th, 2024, Health Services Advisory Group, Inc. (HSAG) informed the Plan that it will conduct a Network Adequacy Validation (NAV) Audit. HSAG is a third-party contractor of DHCS, an External Quality Review Organization conducting the audit on behalf of DHCS. The NAV Audit will evaluate the Plan's data, systems and methods used to calculate results for each network adequacy indicator outlined by the State. Impacted departments include Analytics, IT, QI, Provider Services and Compliance. HSAG has made 51 separate requests, with additional requests made to a key delegate. A virtual walkthrough and interviews are scheduled for July 15th, 2024, and July 17th, 2024.

Compliance Activity Updates

- DMHC Material Modification – 2024 RFP Readiness Submission:
    - The Plan received additional comments from the Department of Managed Healthcare on May 2nd, 2024. The Plan provided responses to comments on May 21, 2024, and are awaiting closure from DMHC. The Plan anticipates closure of the filing by early July 2024.

- 2024 Privacy Memo - HIPAA Guidelines for Working Remote

    - In coordination with the Privacy and Security Joint Task Force (PSJTF), the Privacy Office has released the 2024 HIPAA Guidelines for Working Remote. This memo has been released annually since 2021 and provides specific guidance to Staff on best practices for protecting member Protected Health Information (PHI) and Personally Identifiable Information (PII).

- Annual Privacy & Security World Tour Training

    - Each Spring, the Privacy Office creates and delivers an in-person (virtual) training to all Departments across the enterprise. This year's training focuses on what, when, and how to report potential incidents to the Compliance Division. This year's training also provides a brief overview on the use of Artificial Intelligence and Large Language Models while working at the Alliance. The annual process of training all departments is 87% complete. The anticipated completion date is June 30th, 2024.

- DMHC Medicare Licensure Expansion Filing:

    - On March 1st, 2024, the Plan submitted Material Modification (E-Filing No. 20241128) to expand its Knox-Keene license to include the Medicare Line of Business by January 1, 2026. The DMHC issued an Order of Postponement on March 28th, 2024. The DMHC's May 17th, 2024, comments sought clarification on supplemental benefits, staffing needed to support Medicare, and the methodology used to develop enrollment and financial projections. The Plan reviewed the comments internally and will provide its responses to the DMHC by June 14th.

- Protiviti Enterprise Risk Management (ERM) Assessment Implementation:

    - Outside consultants have finalized completion of 19-stakeholder interviews, focusing on potential areas of risk as a part of the assessment process. The next step is for Protiviti to provide ERM Training to the Plan, currently planned for July 2024, after the 2024 Annual Medical Services Survey.

- 2022 Behavioral Health Insourcing: Material Modification
    - On March 23rd, 2023, the Plan received a conditional order of approval from the Department of Managed Health Care (DMHC). The DMHC's conditional approval was subject to the Plan's full performance of eight (8) undertakings. One Undertaking remains outstanding, listed below.

Undertaking Compliance Chart			
Undertaking No.	**Deliverable**	**Next Milestone**	**Progress**
No. 6	Submit electronically an Amendment filing to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") (42 USC § 300 gg-26) and its regulations (45 CFR § 146.136) and Section 1374.76 of the Act.	June 30th, 2024	The DMHC responded with additional comments to the Plan's updated Non-Quantitative Treatment Limitations (NQTL) Tables submitted on April 30th, 2024. With support from outside counsel, the Plan will provide responses by June 30th, 2024, and anticipates closing this filing within the next 90 days.

2024 DHCS Routine Full Medical Survey Plan Readiness & Initial Observations

As Presented to the June 2024 Compliance Advisory Committee

As Prepared By:
Alameda Alliance Compliance Division
June 14th, 2024

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2024 Survey Overview

Routine Full Medical Survey (Focused Medical Review)

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2024 Survey Overview & Key Dates

- **Audit Sections (“Categories”):**
  - Category 1: Utilization Management
  - Category 2: Case Management & Coordination of Care
  - Category 3: Access & Availability
  - Category 4: Member’s Rights
  - Category 5: Quality Improvement
  - Category 6: Administrative and Organizational Capacity

Audit Period	June 1, 2023 through May 31, 2024
Onsite Dates	June 17, 2024 through June 28, 2024
Entrance Conference	June 17, 2024 at 9am

2024 Survey File Selections

CATEGORY	# OF FILES
1.2 UM PA	36*
1.3 PA Appeals	20
1.5 UM CHCN	32*
2.1 CCS	20
2.1 IHA	20
2.2 CCM	10
2.3 BHT	15
2.4 CoC	15
3.6 ER_FP Claims	40 (20 ER/20 FP)
3.8 NEMT/NMT	45 (25 NEMT/20 NMT)

CATEGORY	# OF FILES
4.1 Grievances (Standard, Expedited, Exempt, Inquiries)	91 (61 Standard/10 Expedited/10 Exempt/10 Inquiries)
4.3 HIPAA	17*
5.1 PQI	9
5.3 Provider Training	15
6.2 FWA	15*
SSS	20

^More than 420 files submitted

Pre-Survey Plan Observations

Executive Summary of Key Observations

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2024 Claims Observations

- Claims Case File Observations:
  - A small volume of ER claims selected were denied incorrectly due to a system issue. Claims is working with IT to remediate the systemic issue. Impacted claims, for the audit period have been corrected.

- *Risk for Repeat Finding:* None. 2023 Findings were related to Prop 56 payment and payment involving non-contracted mid-level providers.

2024 UM Observations

- Observable Themes:
  - Continuity of Care
  - Prior Authorizations
  - Early Periodic Screening and Diagnostic and Treatment (EPSDT)
  - CCS
  - Transportation
  - Care Coordination across Departments and Agencies
  - Clinical Production Lines (BH, LTSS, UM, CM)

- *Risk for Repeat Finding:* None. There were no findings under Plan UM during 2023 Audit.

2024 Delegate Observations

- CHCN UM Case File Observations: 28 Cases
  - Out-of-Network reviews – opportunities for evaluating Continuity of Care, verifying timely access before redirection to in-network providers, quite a few cases related to services at Stanford
  - Pediatric reviews – opportunities for coordination around EPSDT (including coordination with CCS and RCEB); many requests related to PT/OT/ST
  - Overall authorization processing requirements:
    - 1 case missed turn-around time (post-acute care at a skilled nursing facility)
    - Some NOA letters missing language assistance and non-discrimination enclosures
    - Some cases missing NOA letter translation into member's preferred language
- *Risk for Repeat Finding:* The observations with CHCN's NOAs could be considered a repeat finding from the 2023 DHCS audit.

2024 FWA Observations

- Three of the cases involved ModivCare
  - All allegations that rides were billed with no associated medical care claims
  - One case has been closed after recoupment confirmed
  - Remaining two cases will be closed once recoupment is complete
  - Potential Risk: ModivCare continuing to bill for services not provided
- Three cases were referred by the DOJ
  - Cases involve potential provider fraud in relation to COVID testing
  - Investigation ongoing with DOJ

2024 FWA Observations

- One case referred by DHCS
  - Home Health services not rendered
- One case involved stolen identity
  - Confirmed case - involved member benefits
  - Both parties enrolled in Medi-Cal (only one is an AAH member)
  - Case will be closed once recoupment is complete

- *Risk for Repeat Finding:* No repeat findings from the 2023 DHCS Audit.

2024 Grievance Observations

- Potential risk for exempt grievances cases that were resolved by Member Services with a referral to CM or BH for care coordination. Could be flagged as misclassified standard grievances.

- *Risk for Repeat Finding: Potential repeat finding.* 2023 Finding 4.1.6 Grievance Identification: The Plan did not process and resolve all member expressions of dissatisfaction as grievances.

2024 Privacy Observations

- Four (4) potential privacy incidents were not categorized correctly in HealthSuite. These cases were not referred to the Privacy Office timely. (This caused an internal reporting delay greater than 24 hours which would have impacted reporting to DHCS.)

- *Risk for Repeat Finding:* There were no findings under HIPAA/Privacy during the 2023 Audit, however, there is a risk of finding for these incidents missing the 24-hour timeline.

2024 IHA Observations

- A number of records are missing preventative health screenings.
- Some records show IHA completed with a specialist, while it is possible that the elements of IHA can be completed by specialists, generally, an IHA is completed by PCP.
- The team educated providers on the elements and requirements of IHA through webinars, 1:1 PCP meetings, provider guide, JOM and QI Committees. Additionally, we work on preventative health screenings through the MCAS measures.
- *Risk for Repeat Finding:* 2023 Finding 2.1.1: The Plan did not ensure the provision of a complete IHA for new members. The missing preventative health screenings may be a risk for repeat CAP.

2024 Survey Preparations

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2024 Preparations

- The Compliance Division held mock audit interview sessions with the subject matter experts (SMEs) in preparation for the 2024 DHCS Audit.
  - There were a total of sixteen (16) mock audit interview sessions held from April 22nd – May 3rd, 2024.
  - Compliance also held mock audit interview sessions with ModivCare and CHCN (selected by DHCS).
  - The interview sessions included questions for all sections of the Full Medical Survey.

- Outcomes & Insights
  - SMEs were prepared for their interview sessions.
  - They were comfortable answering the questions and passing off to another SME when applicable.
  - Clarifying questions were asked when needed.
  - Mock Audit questions shared.
  - Compliance continues to meet and work with the SMEs on any additional questions that they have to further assist with preparation for the onsite interviews.

LHPC Plan Feedback

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Feedback from Sister Plan's

- Org chart- ensuring all medical necessity decisions were made appropriately by licensed staff (LVN or higher)
- Who tracks the validity of licenses?
- Retro reviews
- Hierarchy of criteria
- Second opinions
- How do you ensure you are meeting TATs? How do you ensure the NOA letters are dated and postmarked within 2 business days of decision?
- How do you ensure the correct templates are attached to NOAs?
- Ensuring proper letter translation
- Delegate data (denials etc.)
- CMO transition-ensuring all areas were adequately covered during the transition
- NEMT:
  - Delegates and their NEMT/NMT responsibilities
  - How are members notified of 15-minute arrival time requirement
  - Monitoring of services

Feedback from Sister Plan's (Cont'd)

- MOT denials
- Internal denials- any significant findings
- Any major changes in UM to address CalAIM findings- LTC
- IRR
- Over/under utilization—how does the plan address it?
- Services that do not require a PA
- External UM reviews
- How does the plan educate providers on updated Um guidelines?
- Specialty Referral tracking- any trends in the data?
- How does UMC interact with QIHEC
- UM integration with quality
- Auto Auth

Questions?

The Plan will provide updates and observations following the June 2024 Survey interviews. The statements and observations made in this presentation are not final and are not conclusive of what actually may be observed or not observed by auditors in the preliminary and final audit reports. Statements made in this presentation do not represent actual audit findings.

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Compliance

Supporting Documents

COMPLIANCE DASHBOARD SUMMARY										
	Resource	Type							TOTAL	% Completed
			2018	2019	2020	2021	2022	2023		
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	15	136	
		Total Self-Identified Issues	12	0	0	2	0	2	16	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**17**	**152**	
		Total In Progress	0	0	0	0	0	0	0	
		Total Completed	50	28	7	35	15	17	152	**100%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**17**	**152**	
	DMHC	Total State Audit Findings			5	6	8		19	
		Total Self-Identified Issues			3	0	0		3	
		Total Findings			**8**	**6**	**8**		**22**	
		Total In Progress			0	0	1		1	
		Total Completed			8	6	7		21	**95%**
		Total Findings	**NA**	**NA**	**8**	**6**	**8**	**NA**	**22**	
	DMHC Financial Services	Total State Audit Findings		5			4		9	
		Total Self-Identified Issues		0			0		0	
		Total Findings		**5**			**4**		**9**	
		Total In Progress		0			0		0	
		Total Completed		5			4		9	**100%**
		Total Findings	**NA**	**5**	**NA**	**NA**	**4**	**NA**	**9**	
STATE AUDIT FINDINGS		In Progress	0	0	0	0	1	0	1	
		Completed	38	33	12	39	26	15	163	**99%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**15**	**164**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	0	
		Completed	12	0	3	2	0	2	19	**100%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**19**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**17**	**183**	

COMPLIANCE DASHBOARD SUMMARY			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	164	90%
	Total Self-Identified Issues	19	10%
	Total Findings	**183**	
	Total In Progress	1	1%
	Total Completed	182	99%
	Total Findings	**183**	
STATE AUDIT FINDINGS	In Progress	1	1%
	Completed	163	99%
	Total Findings	**164**	
SELF-IDENTIFIED FINDINGS	In Progress	0	0%
	Completed	19	100%
	Total Findings	**19**	

2023 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	15	88%
	Total Self-Identified Issues	2	12%
	Total Findings	**17**	
	Total In Progress	0	0%
	Total Completed	17	100%
	Total Findings	**17**	

2022 DMHC BHI Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	2	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**2**	
	Total In Progress	1	50%
	Total Completed	1	50%
	Total Findings	**2**	

2022 DMHC RBO Audit: Delegate			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**3**	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	**3**	

2022 DMHC RBO Audit: Delegate			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**3**	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	**3**	

2022 DMHC Financial Serviceds Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	4	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**4**	
	Total In Progress	0	0%
	Total Completed	4	100%
	Total Findings	**4**	

2022 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	15	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**15**	
	Total In Progress	0	0%
	Total Completed	15	100%
	Total Findings	**15**	

2021 DMHC Joint Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	6	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**6**	
	Total In Progress	0	0%
	Total Completed	6	100%
	Total Findings	**6**	

2021 DHCS Joint Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	33	94%
	Total Self-Identified Issues	2	6%
	Total Findings	**35**	
	Total In Progress	0	0%
	Total Completed	35	100%
	Total Findings	**35**	

2020 DHCS Focused Audit Summary			
	Type	TOTAL	%
OVERALL FINDINGS	Total State Audit Findings	7	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**7**	
	Total In Progress	0	0%
	Total Completed	7	100%
	Total Findings	**7**	

2020 DMHC Medical Services Audit Summary			
	Type	TOTAL	%
OVERALL FINDINGS	Total State Audit Findings	5	63%
	Total Self-Identified Issues	3	38%
	Total Findings	**8**	
	Total In Progress	0	0%
	Total Completed	8	100%
	Total Findings	**8**	

2019 DMHC Financial Services Audit Summary			
	Type	TOTAL	%
OVERALL FINDINGS	Total State Audit Findings	5	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**5**	
	Total In Progress	0	0%
	Total Completed	5	100%
	Total Findings	**5**	

2019 DHCS Medical Services Audit Summary			
	Type	TOTAL	%
OVERALL FINDINGS	Total State Audit Findings	28	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**28**	
	Total In Progress	0	0%
	Total Completed	28	100%
	Total Findings	**28**	

2018 DHCS Medical Services Audit Summary			
	Type	TOTAL	%
OVERALL FINDINGS	Total State Audit Findings	38	76%
	Total Self-Identified Issues	12	24%
	Total Findings	**50**	
	Total In Progress	0	0%
	Total Completed	50	100%
	Total Findings	**50**	

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
Yellow = Plan Observations (Included in the Preliminary Report)
Orange = Plan Observations (Not Included in the Preliminary Report)
R = Repeat Findings

2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
1	UM	(1.5.1) Notice of Action (NOA) Letters The Plan did not ensure a delegate sent NOA letters to providers and members.	The Plan received the delegate's Root Cause Analysis (RCA) and CAP on 04/14/2023. After review and evaluation of the delegate's document the Plan issued a formal CAP on 05/31/2023 and received the delegate's CAP response on 06/27/2023. The initial corrective actions completed by the delegate includes updating their IT script and ensuring the identified missing NOA letters were sent out to the member and that outreach was completed to confirm that services approved or had denial modification authorizations were utilized by members. The delegate also developed workflows to detect and mitigate failures. The CAP includes the delegate's implementation of a remediation plan. The remediation plan includes updates in their workflow, training, and an internal monthly audit- with results submitted to The Alliance for review. The Plan reviewed and evaluated the delegate's CAP implementation and progress during the interim and provided guidance. The CAP was approved and closed on 09/25/2023. (Completed) The delegate is expected to continue its internal monthly audit for the NOA letters and fax confirmation. The Plan will continue to monitor the audit results for compliance. Please see document 1.5.1_AAH Response for full details. (On Track) Additionally, the Plan will review the UM delegates' P&P's to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation and these will be evaluated annually at minimum. (On Track) 1a. Monitoring of the delegate's monthly internal audit is ongoing. (On Track) 2. Review the UM delegates' policies and procedures to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation. (On Track) Update 3/8/2024 P&P review complete and P&P deemed adequate. Review of the delegate's P&P regarding NOAs is ongoing and The Alliance will continue to meet with the delegate to have P&P appropriately updated. **Update 4/5/2024** The delegates have submitted all requested policies for review. The policies have been reviewed and the delegates have made all necessary revisions.	**3/31/2024**	Completed	Compliance UM	State	DHCS	2023

ALAMEDA ALLIANCE FOR HEALTH
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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
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2	QI	(2.1.1) Provision of an Initial Health Assessment (IHA) The Plan did not ensure the provision of a complete IHA for new members.	1. Update IHA policy QI-124 (On Track) **Update 4/5/2024:** Policy updated and approved at Compliance Committee on 3/19/2024 1a. Update IHA policy 124 to include requirement regarding outreach attempts (On Track) **Update 4/5/2024**: Policy updated and approved at Compliance Committee on 3/19/2024 2. Provider education and feedback through Joint Operational Meetings (On going) Update 4/5/2024: Presented at JOMs with delegates in December 2023 2a. Deliver provider education webinars with information about IHA requirements (On Track) **Update 4/5/2024**: Webinars with delegates scheduled through May 2024 2b. Develop a "Measure Highlights" tool for providers. This tool will encompass outreach requirements, IHA elements, USPSTF screenings, and claim codes used to account for IHA completion 3. Expand code set to include additional codes for capturing IHA-related activities (On Track) Update 3/8/2024: Codes updated and included in policy QI-124. 3a. Communicate and provide code sets to providers (On Track) **Update 4/5/2024:** Codes updated and included in policy QI-124 4. Monitor IHA rates (Ongoing) **Update 4/5/2024**: Non-compliance providers and missing elements identified, CAPs issued. 5. Enhance the volume of medical records subjected to review for completeness, including review of USPSTF requirements. (On Track)	**3/31/2024**	Completed	Quality	State	DHCS	2023

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3	BHT	(2.3.1) Behavioral Health Treatment (BHT) Plan Elements The Plan did not ensure members' BHT treatment plans contained all the required elements.	1. The Behavioral Heath team developed the attached Treatment Plan Guidelines for our ABA Providers (please see attachment). This document outlines the treatment plan elements that are listed in APL 23-010. All treatment plans and prior-authorization requests for ABA services are reviewed by Board Certified Behavior Analysts (BCBA).The guidelines were emailed to all providers and will also be available on-line for providers to access. In addition to the document, the ABA clinicians worked with the Provider communication team to send out updates/reminders to providers regarding the treatment plan guidelines. Our team is also available to meet with providers and educate them on how to apply the guidelines to their treatment plan templates. (Completed) 1a. Pending Project: We are currently developing an on-line treatment plan template/form that will be utilized by our ABA providers when completing the initia assessment and subsequent progress reports. This form includes the treatment plan elements required in APL 23-010 and providers will be required to complete this form when submitting the initial assessment/FBA and subsequent progress reports. This will ensure that all ABA providers use the same template and include the required elements in their reports/assessments. (On Track) In the interim while the project is pending, if information is missing from the Treatment Plan, the Plan will inform the provider and ask that they add the information and re-submit. Update 4/5/2024: Policy BH-004 is scheduled to be approved at April Compliance Committee.**Update 5/10/2024:** Policy BH-004 was approved at Compliance Committee on 4/10/2024. 1b. The Plan intends to conduct audits on our Treatment Review documentation to ensure that all required elements are covered in the review process in compliance with the requirements in the APL. The expected implementation date of this audit is Q1 of 2024. **Update 5/10/2024**: Q1 2024 treatment plan audits are in progress pending completion at end of March. The next audit period (Q2) will go through June. 1c. The Provider/PCP Manual is also pending updates that will include a FAQ for PCPs, provider education regarding the prior authorization process, and the referra process. This is currently under review-pending completion**Update 5/10/2024:** Provider Manual revised and submited to DHCS Plan Communications Department, who is reviewing proposed revisions and once completed will be made available via the provider portal	**5/10/2024**	**Completed**	Behavioral Health	State	DHCS	2023
4	Access and Availability	(3.1.1) First Prenatal Visit The Plan's policies and procedures for a first prenatal visit for a pregnant member is not compliant with the standard of two weeks upon request.	The Plan has edited Timely Access Standard table, policy QI-107 and QI-114 to reflect the first prenatal visit standard within 2 weeks of the request. (Completed)	Q4 2023	Completed	Quality	State	DHCS	2023
5	Family Planning and State Supported Services	(3.6.1) Non-contracted Provider Payments The Plan did not pay non-contracted providers at the appropriate Medi-Cal fee-for-service rate.	A Change Request was entered to change non-contract mid-level providers reimbursements to 100% of the Medi-Cal rate moving forward. (Completed)	11/16/2023	Completed	Claims	State	DHCS	2023
6	Family Planning and State Supported Services	(3.6.2) Proposition 56 Family Planning Payments The Plan did not distribute add-on payments for institutional family planning service claims as required by APL 22-011.	1. P&P has been revised to ensure that Family Planning services paid on institutiona claims are paid As part of Prop 56 payments. 1a. The Plan's Analytics Team is in the midst of preparing the payment details for the retro payment on the FP institutional data and looking to complete by 11/30/2023 timeline. (On Track) 2. The Analytics dept has calculated the retroactive payments due to facilities as a result of finding 3.6.2, APL 22-011 and APL 23-008. (On Track) 2a. Payments will be distributed to providers prior to or latest by Nov 30, 2023. (On Track) 2b. Facility providers with qualifying Family Planning services as per APL 23-008 will be included as part of our monthly Prop 56 payment processing going forward starting Dec 2023. (On Track)	1/15/2024	Completed	Claims	State	DHCS	2023

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7	NMT & NEMT	(3.8.1) R Physician Certificate Statement (PCS) Forms The Plan did not ensure PCS forms were on file for members receiving NEMT services.	1.The Plan made the decision to no longer allow courtesy NEMT trips for members without a PCS form on file and the decision to insource PCS form acquisition to the Plan's Case Management Department beginning 3/1/23. Working alongside the Plan's transportation subcontractor, the Plan created new workflows to ensure the transportation subcontractor was not scheduling NEMT trips for members unless there was a confirmed valid PCS form on file, or the Plan provided a verbal authorization due to a trip being of an urgent nature. The Plan hired two transportation coordinators to focus on PCS acquisition leveraging the Plan's preexisting relationships with the provider network and access to EHR's. Through the end of 2022 and beginning of 2023, the Plan's transportation subcontractor trained its call center agents on the new workflow. On 2/14/23, the Plan trained its transportation coordinators on PCS acquisition. On 2/21/23, the Plan trained its entire case management team, that participates in phone shifts for the Plan's case management phone line, on the parameters for verbal authorizations for NEMT trips of an urgent nature. The Plan continues to report on the success of the new workflows at the Plan's UM Committee. (On Track) 1a.The Plan is working with its analytics team to create a report using PCS data elements to match up against subcontractor's report of all NEMT trips taken each month. This report will assist in finding any gaps in PCS compliance. The Plan estimates this report to go live 12/1/2023. (On Track)	12/15/2023	Completed	Case Management	State	DHCS	2023
8	NMT & NEMT	(3.8.2) Transportation Providers' Medi-Cal Enrollment Status The Plan did not ensure all transportation providers were enrolled in the Medi-Cal program.	The Plan has updated the P&P VMG-005 from reviewing the Transportation Providers (TP) on a quarterly review to a monthly review. Attached for reference is the updated P&P. The Plan began reviewing the TP monthly for the utilization from April 2023 to current. (Completed and Ongoing)	4/1/2023	Completed	Vendor Management	State	DHCS	2023
9	Member Rights	(4.1.1) R Grievance Acknowledgement and Resolution Letter Timeframes The Plan did not send acknowledgement and resolution letters within the required timeframes.	A grievance processing timeline was created to outline the grievance 30 calendar day process, day by day. The timeline outlines that by day 5, acknowledgement letters will be sent out. We will continue to monitor the daily aging report to ensure that acknowledgement letters are sent in a timely manner. The timeline also outlines that on Day 20, "If response is not received, after at least two follow-up attempts, task to a Medical Director in Quality Suite." Complying with this process will ensure that the Medical Director has sufficient time to reach out to the provider or facility to assist in obtaining a response. The Grievance and Appeals staff were trained on the new timeline on 8/1/2023, copies of the timeline were distributed to the department. (Completed and Ongoing)	8/1/2023	Completed	G&A	State	DHCS	2023

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
10	Member Rights	(4.1.2) R Grievance Letters in Threshold Languages The Plan did not send acknowledgement, resolution delay, and resolution letters in threshold languages.	The Plan's Grievance and Appeals Department has created a reporting mechanism in our daily aging reports to monitor what cases are still pending translation and when was the request for translation sent out, this was implemented on 4/12/2023 We have then assigned one specific team member to be responsible for following up on translation letters to ensure that they are getting the attention that they nee to be completed in a timely manner. The Grievance Processing Timeline will be updated to include when a request for translation needs to be sent out and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted on 10/10/2023. (Completed and ongoing)	10/10/2023	Completed	G&A	State	DHCS	2023
11	Member Rights	(4.1.3) R Written Notification of Grievance Resolution Delays The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days and did not resolve grievances by the estimated resolution date in the delay letters.	The Plan's Grievance and Appeals Department will be updating our system, Quality Suite, to better capture data on if and/or when a delay letter is sent out. Once the system is updated, we will be able to create a reporting mechanism in our daily aging reports to monitor for when a case needs a delay letter and if the letter was sent out. The Grievance Processing Timeline will also be updated to include the process for sending out a delay letter and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted. (Completed and Ongoing)	12/1/2023	Completed	G&A	State	DHCS	2023
12	Member Rights	(4.1.4) Grievance Delay Timeframes The Plan inappropriately utilized a 14 calendar day delay timeframe for grievance resolutions.	In review of our current policy and procedures, and workflows; they were in line with the APL requirements. There was miscommunication in the staff training to us 14 calendar days instead of an estimated resolution date in the delay letters. There was a refresher training for the Grievance and Appeals staff held on 4/18/2023, the staff was provided the requirement and were reminded to provide an estimated resolution date in the delay letters if a resolution is not reached within 30 calendar days. (Completed)	4/18/2023	Completed	G&A	State	DHCS	2023
13	Member Rights	(4.1.5) Exempt Grievance Resolution The Plan did not resolve exempt grievances by close of the next business day.	In conjunction with the Grievance Department, the Member Services Grievance Guide was revised on 10/9/2023. (Completed) Training was provided to all Member Services staff on these revisions by 11/1/2023. (Completed)	11/1/2023	Completed	Member Services	State	DHCS	2023
14	Member Rights	(4.1.6) Grievance Identification The Plan did not process and resolve all member expressions of dissatisfaction as grievances.	Member Services has implemented a process to identify expressions of dissatisfaction that were not classified appropriately. (Completed) A Member Services Supervisor works with the agent to ensure the case is classified accurately and resolved in a timely manner. (Completed)	3/15/2023	Completed	Member Services	State	DHCS	2023
15	State Supported Services	(SSS.1) Minimum Proposition 56 Payments The Plan did not distribute minimum payments for a State Supported Services claim as described in APL 1 013.	The claims system configuration team has corrected the fee schedule for the provider and adjusted the impacted claims to pay the correct rate. (Completed)	4/26/2023	Completed	Claims	State	DHCS	2023
16	CM	(2.2) PCP and members are not consistently notified of Case Management case closures	Configuration made in TruCare to ensure consistent notification	4/26/2023	Completed	Case Management	Self	DHCS	2023
17	Fraud and Abuse	(6.2) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness Training provided to staff and new tools being used consistently	4/26/2023	Completed	Compliance	Self	DHCS	2023

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2022 DMHC Behavioral Health Investigation - *Audit Review Period* 4/1/2020 - 4/30/2022 *Audit Onsite Dates - September 7, 2022 - September 8, 2022*							INTERNAL AUDITS	
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**Agency**
1	UM	The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855)	The Alliance reviews and/or updates all policy and procedures at least annually, to ensure our policy and procedures content is reflective of current regulatory requirements. All UM policy and procedures including any updates and the UM Program Description, are reviewed in the Utilization Management Committee (UMC), subsequently reviewed, and approved at our Board Delegated Quality Improvement Health Equity Committee (QIHEC) which reports directly to the Alliance Board of Governors. In response and in compliance with SB 855, The Alliance has updated UM-063 - Gender Affirmation Surgery and Transgender Services and the Alliance UM Program Description. Both bodies of work are aligned with current WPATH Standards of Care. The Alliance is contracted with WPATH to provide training on WPATH Standards of Care - all UM decision makers (including RNs and physicians) are required to complete WPATH training to ensure the most current WPATH standards required by SB 855 are used for medical necessity decision-making. 100% of current UM reviewers will complete WPATH Training by Q2 2024 & 100% of newly hired UM reviewers will complete WPATH Training within 90-days of their start date The Alliance also conducts annual Inter-Rater Reliability Studies (IRR) with all UM decision makers to ensure that documented criteria is being applied consistently and accurately by decision makers. Additional training and testing is conducted when a passing score is not met. Annual IRR: 100% of UM reviewers will complete the Annual IRR Studies by Q3 2024	In Progress	Closed 9/27/2022 Q2 2024 Q3 2024	UM Behavioral Health	State	DMHC
2	Quality Assurance	The Plan does not ensure its delegate consistently documents quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.	As of 4/1/2023, The Alliance has terminated its contract with the delegate. Since termination, The Alliance has insourced all mental and behavioral health services and processes all quality of care issues identified. The Alliance follows its internal policy and procedures and workflows to ensure that all quality of care problems are identified, reviewed and further, that effective action is taken to improve care whe deficiencies are identified, and that follow-up is planned where indicated.	4/1/2023	Completed	UM Quality Assurance Behavioral Health Compliance	State	DMHC
#	**Category**	**Barriers to Care**	**Plan Response**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**Agency**
1	Pharmacy Services	The Plan has limited ability to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy and lacks policies and procedures for these treatments.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	UM Behavioral Health Pharmacy Provider Contracting	State	DMHC
2	Cultural Competency and Health Equity	Neither the Plan nor its delegate conduct assessments pertaining to cultural competency and health equit specific to the Plan's enrollee population.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	Quality Assurance Behavioral Health	State	DMHC
3	Enrollee Experience	Enrollees experience difficulties obtaining appointments.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	Quality Assurance Behavioral Health	State	DMHC

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2022 DMHC RBO Audit: Delegate - *Audit Review Period* 1/1/2022 - 3/31/2022							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Claims Payment Accuracy	The Department's examination disclosed that the RBO failed to reimburse one paid claim correctly due to a systematic error. The claims system failed to classify the provider as a contracted provider. The claim was paid incorrectly at the non-contracted rate, which was less than the contracted rate. The RBO represented to the Department that this deficiency was due to a contract amendment, effective February 1, 2021, that was not updated in their claims system. This deficiency was noted in paid claims sample number P-18.	Delegate updated claims system to accurately reflect all providers listed on the provider roster as contracted with the effective date of 2/1/2021 to align with the contract amendment. A claims sweep was completed with a lookback to 2/1/2021. All claims previously paid noncontracted were reprocessed as contract and have been paid with any accrued interest and/or penalties associate with each claim reprocessed on 10/12/2022. Evidence of the complete claims audit sweep associated with members was sent to The Alliance on 1/19/2023 via secure email. Draft policy was created to ensure provider contracts and rosters are appropriately loaded within delegate's claims system. Draft policy will be presented to the delegate's Compliance Committee on 3/29/2023 for review and approval. Update 4/14/2023: The delegate's Compliance Committee rescheduled to 4/26/2023. The updated policy will be approved at that time. Update 5/12/2023: The delegate approved the policy at their Compliance Committee	5/12/2023	Completed	Claims Compliance		State	DMHC	2022
2	Claims Payment Accuracy	The Department's examination disclosed that the RBO failed to reimburse two high dollar claims correctly due to a systematic error. The contracted provider was not paid per contract for laboratory procedures. The RBO stated the laboratory procedures were based on an old boiler plate and should not have been included in the contract. The contract was amended on 9/1/2022. This deficiency was noted in high dollar claims sample numbers HD-18 and HD-24	There were no Alliance members impacted by this deficiency. Effective 10/12/2022 all claims were reprocessed and paid.	10/12/2022	Completed	Claims Compliance		State	DMHC	2022
3	Incorrect Claim Denials	The Department's examination disclosed that the RBO failed to reimburse one denied claim correctly due to a systematic error. The RBO incorrectly denied claims for podiatric and chiropractic services at federally qualified health centers and rural health clinics. The denial reason instructed the provider to bill "Medi-Cal EDS" when it should have been paid. This deficiency was noted in denied claims sample number D-29.	There were no Alliance members impacted by this deficiency. Effective 10/12/2022 all claims were reprocessed and paid.	10/12/2022	Completed	Claims Compliance		State	DMHC	2022

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Claims Payment Accuracy	The Department's examination disclosed that one of 30 high dollar claims were not reimbursed correctly. The claims billed with Current Procedural Terminology (CPT) codes 93005 were underpaid. This deficiency was noted in high dollar claim sample number 28.	The RBO is reprocessing all claims with code 93005 underpaid from January 2021 to present and will upload corrected explanations of benefits upon completion. Corrected explanations of benefits showing additional payment (plus interest and penalty where applicable) as well as the requested report and policies will be submitted to DMHC on or before 1/30/2023.	1/30/2023	Completed	Claims Compliance		State	DMHC	2022
2	Misdirected Claims	The Department's examination disclosed that five out of 40 denied claims were not forwarded. This deficiency was noted in the following denied claims sample numbers: 3, 6, 20, 34, and 37. This deficiency was also noted in the high dollar claim sample numbers: 3, 5, 9, 10, and 25.	There is a system limitation (i.e. mapping issue) where some of the claims (837I encounters) are not being forwarded through our claims processing system. Because of this issue, 837I claims are not being forwarded to health plans. 837I misdirected claims are denied as health plan responsibility and providers are notified via weekly explanations of benefits. The mapping issue was discovered Q1 2022 and tests began at that time with health plans and clearinghouses. 837P files continue to be submitted successfully. The delegate is working with IT to upgrade the server so that updates provided by our software vendors can be implemented for the mapping issue to be resolved. The expected compliance date will be on or before 2/28/2023. 1/26/2023: server updates completed, system updates happening this week. 1/27/2023: system consultant met with the software vendor and their development team to identify and resolve issues so that system updates can happen successfully. 1/30/2023: all system updates completed successfully on test environment	1/30/2023	Completed	Claims Compliance		State	DMHC	2022
3	Reimbursement of Claims Overpayments	The Department's examination disclosed that the RBO failed to send a written request for overpayment reimbursement to the provider. This deficiency was noted in the following late claim sample numbers: 16, 32, and 35.	Examiner error. When the claims examiner reprocessed these claims, the overpayment was reversed instead of a refund request letter being sent to the provider. Compliance met September 27, 2022 when the claims examiner was reminded in a verbal meeting of the above rule as well as the Delegate's internal policy on overpayments. Also, there is a report run prior to the weekly check run to ensure compliance. Because the overpayment was reversed in the adjusted claims, a refund request was not sent for the original claims.	1/30/2023	Completed	Claims Compliance		State	DMHC	2022

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2022 DMHC FINANCIAL SERVICES : *Audit Review Period 1/1/2022 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Provider Dispute Resolutions	The Department's examination disclosed that the Plan failed to timely acknowledge receipt of 12 out of 71 provider disputes reviewed.	1. Policies and procedures, including internal claims audit procedures, implemented to ensure provider disputes are acknowledged timely. Update 2/13/2023: Policy updated and will be approved at Committee 3/25/2023 2. Staff training completed January 2023 and created a audit workflow effective 01/01/2023. 3. Claims Operations Support Manager and PDR Supervisor. PDR Supervisor will monitor all incoming PDR mail. A daily audit will be conducted before the 15th due date to assure all cases are acknowledged timely.	2/24/2023	Completed	Claims		State	DMHC	2022
2	Claims	The Department's examination disclosed that, due to systemic issues, claims were not reimbursed accurately, including interest and penalties.	CORRECTIVE ACTION TAKEN DURING EXAMINATION The Plan submitted evidence on October 28, 2022, that the Plan reprocessed and paid claims previously paid incorrectly. This correction and remediation resulted in the additional payment of $5,742.29, plus interest of $7,675.43, on 742 claims. In addition, the Plan submitted evidence on October 28, 2022, that the Plan reprocessed and paid claims previously denied incorrectly. This correction and remediation resulted in the additional payment of $64,718.77, plus interest of $6,002.98, on 750 claims. The Plan corrected the deficiencies noted above and completed the required remediation during the course of the examination; therefore, no additional response is required.	10/28/2022	Completed	Claims		State	DMHC	2022
3	Changes in Plan Personnel	R The Department's examination disclosed that the Plan did not timely file changes in plan personnel.	1. The Plan revised its Desktop Procedure to define the Key Personnel as "Persons holding official positions that are responsible for the conduct of the Plan including but not limited to all Senior Leadership, all members of the BOG and other principal officers." The Desktop Procedure further clarifies the activities that will constitute an official personnel change event for Senior Leadership versus Board of Governors members. Finally, the Desktop Procedure was revised reflect that Key Personnel Change filings must be submitted within five (5) calendar days. 2. We have taken steps to improve the communication with the internal stakeholders to ensure personnel change events are routed to the Regulatory Affairs and Compliance team in a timely manner. The Board Clerk is responsible to immediately notify the Compliance Department of any Board Member changes. To ensure no updates are missed, each month the Compliance Specialist will email the Board Clerk and the Human Resources Department to confirm whether the BOG or SLT has experienced any personnel changes. The Compliance Specialist also maintains a log of Key Personnel Changes. Furthermore, once a personnel change event is anticipated, the Compliance Specialist immediately begins an electronic file and begins preparation of the necessary documents for submission.	1/13/2023	Completed	Compliance		State	DMHC	2022
4	Fidelity Bond	The Department's examination disclosed that the Plan's fidelity bond did not have a provision for 30 days' notice to the Department prior to cancellation.	Immediately after receiving the DMHC's audit request, The Alliance finance staff requested its insurance broker to work with the insurer in adding the requested provision. Before the DMHC's audit exit conference, such requested provision was provided to the DMHC auditor, and the auditor expressed that the supplied document was satisfactory. The Alliance has also created a new Policy & Procedure effective 1/11/2023.	1/11/2023	Completed	Finance		State	DMHC	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
1	G&A	(1.3.1) The Plan did not send acknowledgement letters for standard appeals within the required timeframe of five calendar days.	1. The Daily Clerk Report is received daily by Grievance & Appeals Clerks and Leadership. The report will be reviewed by the Grievance & Appeals Leadership team to ensure acknowledgment letters are mailed timely. 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement letters.	10/1/2022	Completed	G&A		State	DHCS	2022
2	G&A	(1.3.2) The Plan did not comply with existing APLs to notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days in addition to the initial 120 days allowed to request a SFH.	1. Your Rights enclosure was updated to reflect enrollees have 240 days to request a State Fair Hearing 2. Policy & Procedure G&A-007 State Hearings has been updated to reflect the member has 240 calendar days to request a State Hearing. The policy will go to committee for review and approval in December. Update 03/10/2022: Plan submitted draft policy G&A-007 State Fair Hearings that reflects current timeframe to request a SFH (240 calendar days) per the PHE. Policy pending internal committee approval. Plan will need to monitor end of PHE in order to revise policy to reflect normal regulatory requirement of 120 calendar days. PHE was extended through 1/11/23.Update 4/14/2023: The updated policy was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022
3	Provider Relations	**R** (1.5.1) The Plan did not ensure that its subcontractors submitted complete ownership and control disclosure information.	1. The Alliance has made updates to its Provider Services Standard Operating Procedure (SOP) – Ownership and Control Disclosure Reviews for Delegates. This includes an additional layer of review from the Alliance Compliance Department when ownership and control forms are received from delegates. The SOP and tracking sheet has been updated. 2. The findings specifically mentioned two (2) forms: • The delegate who provided the Alliance with the email confirming that the form they submitted to the Alliance is the same form that it files with DHCS. According to the delegate, DHCS confirmed acknowledgement of the form with no additional feedback. • Another delegate who does not have a sole owner and provided a list of their leadership team with the FEIN for each of the clinics. The Alliance will notify the impacted delegates of the findings to receive forms that meet requirements by DHCS. 3. The Alliance will collect the new forms starting Q1 2023Update 03/10/2023: Delegate has submitted an updated form and delegate is currently working toward completion of the form for submission to the Plan. Provider Services and Compliance will review to validate all fields are complete once all forms are received. Update 4/15/2023: The other delegate's form received on 3/2/2023, and two levels of review completed 3/10/2023.	3/10/2023	Completed	Provider Relations		State	DHCS	2022

ALAMEDA ALLIANCE FOR HEALTH
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4	QI	(2.1.1) The Plan did not document attempts to contact members and schedule the IHA.	1. The plan will continue to inform members of the IHA through the EOC, welcome letters to all new members, and videos. - In addition, all members are eligible for a new member orientation (including a financial incentive). - Information regarding the IHA will be included in the member newsletter. The Alliance will initiate a new phone campaign where all new members will receive a phone call encouraging the member to receive an IHA. This phone log will be appropriately documented. The Alliance will create a call script for new member phone calls. 2. The plan will create a report to identify new plan members Update 5/12/2023: Fulfillment Report created to track mailing of member Orientation reports that contain reminder to schedule IHA to new members. Member Orientation Service Request tracking report tracks outreach attempts to members to complete new member orientation, which includes communication about scheduling IHAs 3. The plan will create workflows for informing members of the IHA Update 5/12/2023: Clinical QI Program Coordinator will review IVR reports to determine all new members have received an outreach call. 4. The plan will update the IHA P&P to reflect the updated workflows Update 3/10/2023: Draft policy QI-124 completed, IVR outreach is pending DHCS approval of script. Upon DHCS approval we will continue to develop the process for IVR outreach and develop desktop procedures. Update 4/15/2023: The updated P&P was approved at Compliance Committee 3/21/2023 5. The plan will create a phone call campaign, create a script, and work with the state for approval Update 3/10/2023: Awaiting DHCS approval of script. Update 6/9/2023: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreac attempts via providers, by reviewing documentation as part of FSRs.	9/8/2023	Completed	QI		State	DHCS	2022
5	CM	**R** (2.5.1) The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.	1. The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with the MHP to review redline changes to the MOU. The MHP is currently under review of the redline changes and will notify the Alliance when they can move forward with signing the MOU. The MHP MOU vetting process includes County Board of Supervisor (BOS) approval. Therefore, the Alliance is hoping to execute the MOU by the end of 2022.	12/31/2023	Completed	Provider Relations		State	DHCS	2022
6	Provider Relations	**R** (3.1.1) The Plan did not monitor the network providers' compliance with requirements for when appointments were extended.	1. The Provider Manual was edited to update the requirements, providers were advised in the Quarterly Provider Packet, and The Alliance Provider Representatives advised providers during PCP visits. Additionally, fax blasts were sent to providers regarding the updated requirements, and the Provider Education document was updated to reflect the requirements. 2. Edit P&P and Quality of Access Workflow to ensure all cases are reviewed by a QI Nurse. If a case is determined to be related to access, QI / A&A staff will review data for ED / Inpatient Stays as a result of delay in appointment. If the member does have an ED / IP Claim, the QI RN will then work the case up as a PQI / Quality of Care. This will be reviewed by the Medical Director and follow the PQI process. Finally, all QOA cases with available MRs will be reviewed to ensure the appropriate provider documentation. Update 03/10/2023: Policy QI-114 has been updated and is awaiting approval at committee Update 4/14/2023: P&P Q1-114 was approved at Compliance Committee 3/21/2023	3/21/2023	Completed	Provider Relations QI		State	DHCS	2022

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7	Claims	(3.6.1) The Plan improperly denied emergency services claims.	1. Case #7 – The claim was paid on 8/11/2021. The vendor was notified of the finding on 5/19/2022 and asked to review their internal process to ensure that codes on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. 2. Case #20 –The vender was notified of the issue on 5/19/2022 and asked to review their internal process to ensure that dates on clams are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. In addition, an edit was enhanced to ensure that the date range order is correct. 3. The claim was paid on 1/5/2022 correctly. The Claims Processor was shown the claim finding for review along with the correct workflow document that shows the correct process to help ensure moving forward this does not occur again. This workflow was also reviewed by the Claim Processor team and training occurred.	10/11/2022	Completed	Claims		State	DHCS	2022
8	Access and Availability	**R** (3.8.1) The Plan did not use PCS forms for NEMT services.	1. The Plan will educate providers on PCS requirements. Update 3/10/2023: Provider Alert PCS Form Reminder and Form was sent out to Providers in a fax blast on Tuesday, 12/27/22. 2. Refine PCS workflows to meet all regulatory requirements. Update 3/10/2023: Workflow updated. 3. The Plan will conduct staff trainings on process workflow changes.Update 4/15/2023: Training completed 1/31/2023. 4. The Plan will ensure that the transportation subcontractor trains their staff on the PCS process workflow changes. The transportation subcontractor will provide training materials and sign in sheetsUpdate 4/15/2023: Training completed 1/31/2023. 5. The Plan will develop reports on PCS form outcomes using both transportation subcontractor information and the Plan's process to obtain PCS forms.Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 6. The Plan will monitor process workflows from the transportation subcontractor and the Plan to obtain missing PCS forms Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 7. The Plan will analyze trends in provider practices and provide feedback to providers regarding PCS form requirements. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022, where trends analyzed. 8. The plan will evaluate whether to continue having the transportation subcontractor manage the PCS forms or take the direct management of PCS forms back into the Plan.Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. Will continue to analyze quarterly. 9. The Plan will provide a quarterly report to UM CommitteeUpdate 4/15/2023: Reports developed and presented at UM Committee Q4 2022.	4/1/2023	Completed	UM		State	DHCS	2022
9	Member Rights	**R** (4.1.1) The Plan did not send acknowledgement and resolution letters within the required timeframes.	1. The G & A Department Leadership and Quality Assurance Specialist will reference the daily reports to ensure the acknowledgment and resolution letters are sent timely 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement and resolution letters. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/20222	Completed	G&A		State	DHCS	2022

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10	Member Rights	**R** (4.1.2) The Plan did not send acknowledgement and resolution letters in threshold languages.	1. Updated our system of record to capture the dates the resolution letter was submitted for translation and the date it was mailed to the member. 2. The Plan provided training to the Grievance & Appeals staff on the updates made to the system of record. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	9/20/2022	Completed	G&A		State	DHCS	2022
11	Member Rights	(4.1.3) The Plan was not compliant with grievance extension letter timeframes; in some cases, it did not send extension letters for grievances that were not resolved within 30 calendar days and in other cases it did not resolve grievances by the estimated completion date specified in the extension letter	1. The Plan provided training to the Grievance & Appeals staff on the system updates to capture extension letters. 2. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month. 3. Updated Policy & Procedure G&A- 003: Grievance and Appeals, Receipt, Review and Resolution. The policy will be sent to Committee for approval. Update 03/10/2023: Draft policy updated and awaiting approval at committee. Update 4/15/2023: P&P G&A-003 was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022
12	Member Rights	**R** (4.1.4) The Plan did not thoroughly investigate and resolve grievances prior to sending resolution letters	1. The Alliance will review resolution letters prior to mailing to the member. 2. The Alliance provided training to the Grievance & Appeals staff to ensure the resolution letter clearly addresses all of the member's concerns 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/2022	Completed	G&A		State	DHCS	2022
13	Member Rights	**R** (4.3.1) The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes.	The Plan has created an interdepartmental team to work in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify HIPAA and FWA incidents and the method for immediate reporting to compliance. Update 03/10/2023: Training created and provided to The Alliance staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022
14	Member Rights	(4.3.2) The Plan did not notify the DHCS Program Contract Manager and DHCS ISO of suspected security incidents or unauthorized disclosure of PHI or PI.	Due to human error, reporting to the three (3) entities at DHCS; DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer was not completed for all possible HIPAA incidents. Reporting Policy CMP-013 has been updated to reflect the current reporting email address for possible HIPAA incidents to DHCS incidents@dhcs.ca.gov. This change was reviewed and approved by the Compliance Committee on 11/23/2021.	11/23/2021	Completed	Compliance		State	DHCS	2022
15	Fraud and Abuse	**R** (6.2.1) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness. Update 03/10/2023: Training created and provided to The Alliance staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022

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

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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	UM	(1.2.1) The Plan did not have appropriate processes to ensure that limitations on speech therapy services would not be imposed. In addition to using Medi-Cal guidelines, the Plan used MCG as its evidence-based criteria to make decisions. MCG criteria dictates the amount of visits that can be approved based on a diagnosis and therefore imposes limits.	1. The Plan developed workflow outlining standard review process for speech therapy Prior Authorization (PA) requests, ensuring that no limitations on speech therapy would be imposed on members under age 21. 2. The Plan will conduct a current staff training on standard process, and include it in new staff training. Update 10/8/2021: Training complete 9/29/2021 3. The Plan will revise 10748 Daily Auth Denial report to incorporate service type to capture PA requests for Speech Therapy. Update 11/12/2021: The report request has been submitted, estimated completion is 11/15/2021. Update 12/10/2021: Report has been created and is being completed weekly. 4. The Plan will monitor PA requests for Speech Therapy on a quarterly basis. Update 11/12/2021: The report request has been submitted, estimated completion is 11/15/2021. Update 12/10/2021: Requests for Speech Therapy are being monitored quarterly. 5. The Plan will report results quarterly to UMC. Update 12/10/2021: The first report will be given to the UMC in January 2022. Update 09/09/2022: Speech therapy is now being tracked on a quarterly basis and was reported out at the Q1 2022 UM Committee	Medium	Q1 2022	Completed	UM		State	DHCS	2021
2	UM	(1.2.2) The Plan did not ensure that a qualified health care professional reviewed dental anesthesia prior authorization requests which includes a review of clinical data. The Plan did not ensure the use of appropriate criteria/guidelines when reviewing dental anesthesia requests.	1. The Plan developed workflow outlining standard review process for dental anesthesia Prior Authorization (PA) requests. 2. The Plan will develop mitigation plan until auto auth programming is removed. Update 10/8/2021: Mitigation plan developed and put into place 9/29/2021 3. The Plan will conduct a staff training on the mitigation plan to identify and use standard UM review process for dental anesthesia (DA) and include it in new staff training. Update 10/8/2021 Training complete 9/29/2021 4. The Plan's UM and IT teams will collaborate to remove DA requests from Auto Authorization programming in TruCare (TC). Update 12/10/2021: DA requests have been removed from Auto Authorization programming in TruCare as of 10/1/2021 5. The Plan will develop a Tracking Report to capture and report on PA requests for Dental Anesthesia. Update 12/10/2021: The quarterly report (03127) Dental General Anesthesia Report will be utilized for monitoring 6. The Plan will monitor PA requests for Dental Anesthesia quarterly. Update 10/14/2022: PA requests for Dental Anesthesia are now being monitored quarterly 7. The Plan will report results quarterly to UMC. Update 10/14/2022: PA requests for Dental Anesthesia are now being tracked on a quarterly basis and was reported out at the Q1 2022 UM Committee	High	Q1 2022	Completed	UM		State	DHCS	2021
3	UM	(1.5.1) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The Delegate inappropriately denied medical prior authorization requests.	1.The Plan will inform Delegate 1 of DHCS findings about inappropriately denied medical prior authorization requests. Update 11/12/2021: On 10/8/2021 a letter was sent to the delegate to advise of the audit findings. 2.The Plan will re-educate delegates on requirements for standard UM processes, including application of appropriate criteria guidelines. Update 11/12/2021: On 10/12/2021 a meeting was held with Delegate 1 leadership do educate on requirements for the standard UM process. 3.The Plan will audit Delegate 1's denied cases for appropriateness of denial elements using annual audit tool. Update 2/11/2022: The annual Delegate 1 delegation audit began 12/17/2021 and includes an audit of denied cases for appropriateness of denial elements. 4.The Plan will review denied cases at monthly Delegate 1 meeting for education. Update 2/11/2022: Denied cases are now being reviewed at the monthly Delegate 1 meeting for education. Update 5/13/2022: The Q1 2022 audit has commenced as of 5/5/2022. Update 08/09/2022: The Delegate 1 audit is in progress and is expected to be completed by 8/12/2022 Update 09/06/2022: The audit for Q2 2022 is in progress, preliminary findings have been submitted to Delegate 1. The audit for Q3 2022 is beginning. There will be four total quarters of reviews completed in order to close out this finding. 4/3/2023: Four quarters of the audit have been completed. Results under review. Update 6/9/2023: A Trend Report for 2022 Quarterly Focused Audit findings regarding medical necessity denials was issued to Delegate 1 along with the Final Report for their Annual Audit on 4/11/23. Delegate 1 CAP response due 6/16/2023. **Update 9/8/2023:** The 2022 CAP is ongoing. Delegate 1's CAP included updates to UM workflows, staff training, and internal audits. The CAP is in progress. Workflows, trainings, and internal audits have been completed and are under review by Alliance SMEs.	Medium	Q4 2023	Completed	UM		State	DHCS	2021

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4	UM	(1.5.2) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The delegate did not ensure that requests to see out of network providers were reviewed and decisions were made by a qualified health care professional. It did not include the decision-maker's name in the NOA.	1.The Plan will inform Delegate of DHCS findings about qualified health care professional did not always make decisions to deny or only authorized an amount, duration, or scope that was less than requested, and the lack of name and contact information on the NOA of the decision-maker. Update 11/12/2021: On 10/8/2021 a letter was sent to delegate to advise of the audit findings. 2.The Plan will re-educate delegates on standard UM requirement that only qualified health care professionals make decisions to deny or authorize an amount, duration, or scope that is less than requested, including out of network requests, and on the requirement to have the decision-makers' name and contact information on the NOA. Update 11/12/2021: The Alliance met with the delegate on 10/28/2021 to provide re-education. 3.The Plan will audit delegate's cases during the annual audit to ensure that only qualified health care professionals make decisions on denials and authorizations of the amount, duration, and scope less than requested, and contact information for the decision maker. Update 02/11/2022: The annual delegation audit started on 12/20/2021 and is in progress. The audit is expected to be completed on 4/1/2022. Update 09/09/2022: The delegate audit is in progress. And is expected to be completed by 9/23/2022	Medium	12/20/2021	Completed	UM Compliance		State	DHCS	2021
5	UM	**R** (1.5.3) The Plan did not ensure complete ownership and control disclosure information were collected from its delegates.	1.The Plan has updated its documentation, Provider Services Standard Operating Procedure – Ownership and Control Disclosure Reviews for Delegates, to include collecting required disclosures from the managing employees, or board of directors and senior management team in cases where the entity is a non-profit with no majority ownership and/or owned by physician shareholders.	Low	9/14/2021	Completed	Provider Network Vendor Management		State	DHCS	2021
6	UM	(1.5.4) The Plan did not ensure the written agreements with its delegates included the requirement to allow specified departments, agencies, and officials to audit, inspect, and evaluate the Plan's facilities, records, and systems related to good and services provided to Medi-Cal members.	1.The Plan is adding the Comptroller General in the Behavioral Health contract, Amendment 7. Update 11/12/2021: The Comptroller General was added to the contract, Amendment 7, as of 10/13/2021 2.The Plan is currently working with its delegate on a new contract and delegation agreement which will include the provision and requirement to allow governmental and specified agencies and officials to audit records and systems. Update 1/14/2022: The draft agreement has been completed and is expected to be fully executed in January 2022. Update 2/11/2022: Full execution of the draft agreement is still in progress. Update 09/09/2022: Full execution of the draft agreement is expected by the end of September 2022 3.The Plan will conduct a review of all of its delegated agreements and update the agreements to ensure that all of the language requirements are included. Update 1/14/2022: The agreement has been reviewed and updated. Update 2/11/2022: The Plan conducts annual oversight of its Delegates via an Annual Delegation Audit, as described in CMP-019 – Delegation Oversight. The Plan has updated its Compliance Audit tool to ensure the audit includes a review of the Delegation Agreement to confirm it contains the required language.	Medium	12/31/2022	Completed	Provider Network Vendor Management Compliance		State	DHCS	2021
7	UM	(1.5.5) The Plan did not have policies and procedures for imposing financial sanctions on its delegate and delegated entities.	1.The Plan has created a new Policy, CMP-030 Sanction and Escalation. This Policy describes the standards by which the Plan may impose sanctions against Delegated Entities (DE), providers and vendors for non-compliance or failure to comply with Corrective Actions Plan (CAP) deficiencies, or for breach of any material term, covenant or condition of an agreement and/or for failure to comply with applicable federal or state statutes, regulations, and rules. Update 12/10/2021: Policy CMP-030 was approved at Compliance Committee on 11/23/2021	Low	12/1/2021	Completed	Compliance		State	DHCS	2021
8	Case Management	**R** (2.1.1) The Plan did not conduct HRAs within the required timeframes for newly enrolled SPD members in 2019 and 2020.	1. The Plan revised the HRA process to track all incoming HRAs via a Log, documenting date of receipt. 2. The Plan revised current process for HRAs received past due to be entered into the system of record TruCare (TC) during the month of receipt. 2.a. The Plan updated workflows. 3. The Plan re-trained staff on the HRA process. 4. The Plan will monitor the Log weekly to ensure adherence to the new process. Update 10/8/2021: The log has been created and is being monitored weekly 5. The Plan will report outcomes up to UMC quarterly. Update 2/11/2022: As of the December UM Committee meeting, outcomes are now being reported at the UMC.	Low	12/31/2021	Completed	Case Management		State	DHCS	2021

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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
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9	Case Management	(2.1.2) The Plan did not ensure coordination of care in certain cases where EPSDT services were medically necessary.	1.The Plan will develop training on EPSDT PA requests to identify and refer members who need coordination of their care. Update 11/12/2021: Training developed 2.The Plan will provide training to UM and CM staff. Update 11/12/2021: Training completed for UM and CM staff 3.The Plan will create a reporting system to capture referrals to CM and the provision of care coordination. Update 11/12/2021: Reporting system to capture referrals has been created, change in reporting will be reflected mid-December 4.The Plan will report outcomes at UMC on a quarterly basis. Update 5/13/2022: Outcomes reported at January and March 2022 UMC Meetings.	Medium	5/13/2022	Completed	Case Management		State	DHCS	2021
10	Case Management	(2.2.1) The Plan did not ensure the completion of Individualized Care Plans for members enrolled in Complex Case Management.	1. The Plan revised its CCM ICP workflow and added the requirement that all staff complete ICPs for all members in CCM. 2. The Plan re-trained staff to complete ICPs for all members in CCM. 3. The Plan will revise its CM Aging Report to capture completion of ICPs for daily management and reporting outcomes. Update 10/8/2021: Aging report has been updated to capture completion of ICPs 4. The Plan will develop a monitoring workflow. Update 10/8/2021: The monitoring workflow has been completed 5. The Plan will routinely monitor completion of the ICPs. Update 10/8/2021: The log has been created and is being monitored weekly 6. The Plan will report outcomes at UMC quarterly. Update 09/09/2022: Monitoring of the ICPs is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
11	Case Management	(2.2.2) The Plan did not ensure development of care plans in collaboration with the PCP.	1. The Plan re-trained staff on policy regarding developing care plans in collaboration with PCP. 2. The Plan will revise its CM Aging Report to capture the date the letter regarding Care Plans was sent to the PCP.10/8/2021: The CM Aging Report has been updated to capture the date the letter regarding Care Plans was sent to the PCP 3. The Plan will monitor, on an ongoing basis, the CM Aging Report to ensure CP letters are being sent to PCPs. Update 10/8/2021: Monitoring has begun, automation of this report is in progress 4. The Plan will report outcomes to UMC quarterly. Update 09/09/2022: Monitoring of the development of care plans with the PCP is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
12	Case Management	(2.2.3) The Plan did not conduct periodic evaluations to ensure the provision of complex case management based on the member's medical needs. The Plan did not implement procedures for monitoring time frame standards or maintaining monthly contact with members.	1. The Plan developed a workflow to maintain regular contact with members and ensure that the continuation of CCM is based on medical needs by using the Complex Criteria Checklist. 2. The Plan conducted staff training. 3. The Plan will revise its CM Aging Report to capture provision of CCM and maintaining monthly contact with member. 10/8/2021: The CM Aging Report has been revised to capture the provision of CCM and maintaining monthly contact with member 4. The Plan will monitor, on an ongoing basis, the CM Aging Report. 10/8/2021: Monitoring has begun, automation of this report is in progress 5. The Plan will report outcomes quarterly to UMC. Update 09/09/2022: Monitoring of the CM Aging Report is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021

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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
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13	Case Management	(2.2.4) The Plan did not ensure that interdisciplinary team assessments were included in the updating of members' care plans. The Plan did not ensure timely documentation of the interdisciplinary team meeting notes.	1. The Plan created an additional column in the Complex Case Log to monitor timely entry of IDT Round note into system of record. 2. The Plan will develop a workflow for staff to include the IDT note in the updated care plans. Update 10/8/2021: The workflow has been updated to include the IDT note in the updated care plans. 3. The Plan will develop a monitoring workflow. Monitoring will be done on a bi-weekly basis. Update 9/9/2022: Monitoring is now being completed on a bi-weekly basis 4. The Plan conducted a staff training on the process. 5. The Plan will use Complex Case Log to monitor adherence to procedure. Update 11/12/2021: The Plan is now using the Complex Case Log to monitor adherence 6. The Plan will report outcomes quarterly to UMC. Update 09/09/2022: Monitoring of the IDT assessments is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	UM		State	DHCS	2021
14	Case Management	(2.5.1) The Plan's MOU with the County MHP did not meet all the requirements specified in APL 18-015.	1. The Plan will conduct annual meetings with the County to ensure that the MOU is being updated (when appropriate). Update 1/14/2022: Due to staffing availability, the meeting with the County to review the MOU was not able to take place in December, and will be scheduled for early 2022. Update 2/11/2022: The first meeting with the county took place on 1/31/2022. 1.a. The Plan will develop meeting minutes to demonstrate topic of discussions. The Plan will submit meeting minutes to DHCS. Update 2/11/2022: Meeting minutes completed for first meeting on 1/31/2022. 2. The Plan's internal departments will work together to ensure clinical and quality components that are not present be updated in the MOU to reflect the requirements in APL-018. Update 2/11/2022: MOU has been updated to ensure clinical and quality components reflected.	Low	1/31/2022	Completed	Case Management Provider Network		State	DHCS	2021
15	Case Management	(2.5.2) The Plan's MOU with the County MHP did not specify policies, procedures, and reports to address quality improvements requirements specified in APL 18-015. The Plan did not conduct semi-annual calendar year reviews of referral and care coordination processes, generate semi-annual reports, or develop performance measures and quality improvement initiatives during the audit period.	1. The Plan will establish a cross-functional workgroup to develop specific P&Ps and QI performance metrics, in addition to referral and care coordination reports. Update 12/10/2021: The cross-functional workgroup was established and held it's first meeting on 10/20/2021. County JOMs will begin January 2022.	High	12/10/2021	Completed	Case Management Provider Network		State	DHCS	2021
16	Access	(3.1.1) The Plan did not enforce and monitor providers' compliance with the requirement to document when timeframes for appointments were extended.	1. The Plan revised P&P QI-107 to include appointment extension language and will be submitted to committee for approval. Update 11/12/2021: The P&P has been revised and is awaiting approval at committee on 11/23/2021. Update 12/10/2021: The policy was approved at Compliance Committee on 11/23/2021. 2. The Plan revised Timely Access Standards Provider Communication Sheet and will be submitted to committee for approval. Update 11/12/2021: The Timely Access Standards Provider Communication Sheet has been revised and is awaiting approval at committee on 11/18/2021. Update 12/10/2021: The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021.	Low	11/23/2021	Completed	QI		State	DHCS	2021
17	Access	(3.1.2) The Plan did not continuously review, evaluate and improve access to and availability of the first prenatal appointment.	1.The Plan revised P&P QI-107 to indicate current Access Standards for First Prenatal Appointment from 2 weeks from date of request to 10 days for PCP OB/GYN and 15 days from request for OB/GYN Specialty Care. P&P will be submitted to committee for approval. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: QI-107 was approved at the Compliance Committee on 11/23/2021. 2.The Plan revised Timely Access Standards Provider Communications Sheet. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021. 3.The Plan will be implementing a tracking and trending report of First Prenatal PQIs. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: The Tracking and Trending report of First Prenatal PQIs has been implemented	Medium	11/23/2021	Completed	QI		State	DHCS	2021

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18	Access	(3.4.1) The Plan did not ensure standing referral determinations and processing were made within the required timeframes.	1. The Plan will develop a standing referral workflow. 11/12/2021: Standing referral workflow has been developed 2. The Plan will update The Alliance system of record for UM and CM, TruCare (TC) to add user define field in order to identify standing referral status to ensure correct TAT, which would include a reportable field for monthly reporting. Update 12/10/2021: TruCare has been updated to add the user defined field. 3. The Plan will revise TruCare (TC) to capture timeframes for processing Standing Referrals. Update 12/10/2021: The reporting TAT has been scheduled to begin in December, with the first report, containing December data, due in January. 4. The Plan will revise Authorization Aging report for day to day management and to report on timeframes for Standing Referrals. Update 01/14/2022: Revision of aging report complete 5. The Plan will conduct staff training on standard work for Standing Referrals. Update 01/14/2022: Staff training on standing referrals completed 11/16/2021 6. The Plan will monitor Standing Referral timeframes with the daily Authorization Aging report. 7. The Plan will report results quarterly to UMC. Update 09/09/2022: Standing referrals are now being tracked and reported on during UM Committee quarterly	High	3/25/2022	Completed	UM Case Management	Completed	State	DHCS	2021
19	Access	(3.6.1) The Plan improperly denied emergency services claims and family planning claims.	1.The Plan updated its monitoring report criteria to include a denial code (code:0630) which would allow us to identify claims prior to finalizing adjudication.	Low	3/26/2021	Completed	Claims IT (Config)		State	DHCS	2021
20	Access	(3.6.2) The Plan did not pay interest for family planning claims not completely reimbursed within 45 working days of receipt.	1. The Plan reviewed the issue thru Claims Processor & Specialist training to ensure staff understands the issue that resulted in no interest. The trainings were completed in May 2021.	Low	5/1/2021	Completed	Claims		State	DHCS	2021
21	Access	(3.8.1) The Plan did not ensure its transportation broker's NEMT providers were enrolled in the Medi-Cal program.	1. The Plan notified its transportation broker that remaining unenrolled NEMT providers need to complete PAVE application by 12/01/2021. Update 12/10/2021: The notification letter was sent to the transportation broker on 12/1/2021, 2. The Plan will audit transportation broker providers to ensure drivers are enrolled in the Medi-Cal program. This was last completed August 27, 2021. Monitoring will be conducted on an annual basis.	Low	12/31/2022	Completed	Vendor Management		State	DHCS	2021
22	Access	(3.8.2) The Plan did not require PCS forms for NEMT services.	1. The Plan will require transportation broker to provide ongoing reports on rates of obtaining PCS forms from providers: Update 11/12/2021: UM Team working with Vendor Management and the transportation broker to obtain needed reports. Update 12/10/2021: The report was received from transportation broker on 10/28/2021. 2. The Plan will analyze trends in provider practices on a quarterly basis. Update 12/10/2021: The first report will be given at UMC in January 2022. Update 2/11/2022: Awaiting reports from the transportation broker 3. The Plan will educate providers on PCS requirements and provide data on their performance: Update 2/11/2022: Awaiting reports from the transportation broker 3.a. Provider newsletter. Update 2/11/2022: Awaiting reports from the transportation broker 3.b. Individual office contacts 4. The Plan will finalize process workflow to obtain missing PCS forms. Update 11/12/2021: UM Team working with Vendor Management and the transportation broker to obtain needed reports. Update 12/10/2021: The workflow has been finalized based on the reports received from the transportation broker 5. The Plan will conduct staff trainings on process workflow. Update 12/10/2021: Training was completed 11/8/2021. 6. The Plan will provide a quarterly report to UMC. Update 01/14/2021: Reporting will begin at UMC in Q1 2022. Update 2/11/2022: Awaiting reports from the transportation broker Update 09/09/2022: NEMT services are now being tracked and reported quarterly at the UM Committee.	Medium	12/31/2022	Completed	Vendor Management UM		State	DHCS	2021
23	Member Rights	(4.1.1) The Plan did not ensure that the medical director fully resolved QOC grievances prior to sending resolution letters.	1. The Plan updated G&A-003 Grievance and Appeals Receipt, Review and Resolution to include the process for the medical director's review and resolution of all levels of quality of care grievances prior to sending a resolution letter to members. The policy will be reviewed at the Health Care Quality Committee on November 18, 2021 and the Compliance Committee Meeting on November 23, 2021. Update 12/10/2021: G&A-003 was approved at the Compliance Committee meeting on 11/23/2021 2. The Plan will provide training to the medical directors to review G&A-003 Grievance and Appeals Receipt, Review and Resolution by November 30, 2021. Update 3/11/2022: Training was completed 1/12/2022	Medium	1/12/2022	Completed	G&A		State	DHCS	2021
24	Member Rights	(4.1.2) The Plan did not consistently implement its procedure for processing grievances. The Plan considered member's grievances resolved and classified as exempt without conducting investigation.	1. The Plan is updating its policy and procedures for processing Exempt Grievances to reflect its current process. The policy MBR-0024 will be reviewed at the Compliance Committee Meeting on November 23, 2021. Update 12/10/2021: MBR-024 was approved at Compliance Committee on 11/23/2021 2. The Plan will provide staff training by November 30, 2021. Update 1/14/2022: Training was completed 11/19/2021	Low	11/30/2021	Completed	Member Services		State	DHCS	2021

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25	Member Rights	(4.1.3) The Plan did not send acknowledgement and resolution letters within the required timeframes. The Plan did not promptly notify the members that expedited grievances would not be resolved within the required timeframe.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-003 Grievance and Appeals Receipt, Review and Resolution and G&A-005 Expedited Review of Urgent Grievances. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent within the required timeframes, and to also notify members when expedited grievances would not be resolved within the required timeframe.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
26	Member Rights	(4.1.4) The Plan did not send acknowledgement and resolution letters in threshold languages.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description and CLS-003 Language Assistance Services. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent to members in their threshold languages.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
27	Member Rights	**R** (4.1.5) The Plan did not consistently resolve grievances prior to sending resolution letters.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description. The staff attested that they understood the requirements and will ensure that grievances are fully resolved prior to sending resolution letters.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
28	Member Rights	(4.3.1) The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery, did not provide an updated investigation report within 72 hours, and did not submit a complete report of the investigation within 10 working days.	1. To address staffing needs, the Plan has streamlined its Compliance Department and now has a dedicated staff member who focuses on Privacy. This FTE was hired on February 22, 2021. 2. The Plan reviewed and updated CMP-013 HIPAA Privacy Reporting to reflect the 24hr, 72hr and 10-day reporting requirements. This policy is scheduled to be reviewed and approved at the Compliance Committee on November 23, 2021. Update 12/10/2021: CMP-013 was approved at Compliance Committee on 11/23/2021	Low	11/30/2021	Completed	Compliance		State	DHCS	2021
29	Compliance	**R** (6.2.1) The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within ten working days.	1. The Plan has a dedicated staff member in the Special Investigations Unit (SIU) to focus on Fraud, Waste and Abuse FWA cases. This FTE was hired on 6/25/2021. 2. The plan updated CMP-002 to reflect reporting requirements. This policy is scheduled to be re-approved at the Compliance Committee on Nov 23, 2021. Update 12/10/2021: CMP-002 was approved at the 11/23/2021 Compliance Committee	Low	12/1/2021	Completed	Compliance		State	DHCS	2021
30	Compliance	(6.2.2) The Plan did not report recoveries of overpayments to DHCS annually.	After internal review, the Plan found that an update to CMP-002 was not necessary as the reporting of overpayments is addressed in CLM-008: Overpayment Recovery. The Plan has validated that reports were submitted appropriately to the Department.	Low	2/11/2022	Completed	Compliance		State	DHCS	2021
31	Claims	(SSS.1) The Plan did not distribute payments for state supported services claims within 90 calendar days as described in APL 19-013.	1. The Plan made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate.	Low	2/17/2021	Completed	Claims		State	DHCS	2021
32	Claims	(SSS.2) The Plan did not pay interest for state supported services claims processed beyond the 90-calendar day timeframe specified in APL 19-013.	1. The Plan made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate. The claim system was also updated to pay interest at the normal timeline of claims adjudicated after 45 work days from the received date.	Low	2/17/2021	Completed	Claims		State	DHCS	2021
33	Claims	(SSS.3) The Plan improperly denied state supported services claims.	1. As of 8/7/2020 the Plan reconfigured the system to no longer re-suspend the delegate's Non-Emergency Out of Area processed claims. In addition, the Claims workflow has been updated to accommodate the system change.	Low	8/7/2020	Completed	Claims		State	DHCS	2021
34	Compliance	The Plan should have a policy and workflow for tracking discrimination grievances	1. The Plan has created the Special Cases Incident Log for tracking discrimination grievances 2. The Plan will update the policy and create a workflow regarding tracking of discrimination grievances. Update 12/1/2021: The policy has been created and was approved at the Compliance Committee on 11/23/2021	Medium	12/1/2021	Completed	Compliance		Self Identified	AAH	2021
35	Quality Management	The Plan should ensure that PQIs are appropriately classified (as QOS / QOA / QOC)	1. Sr. Dir. Of Quality and the QI Supervisor conduct quarterly audits of QOA and QOS case files 2. QOC files are reviewed and leveled by Quality Medical Director weekly	Low	2/28/2021	Completed	QM		Self Identified	AAH	2021

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

2020 DHCS STATE AUDIT FINDINGS - *Audit Review Period: 10/01/2018 - 9/30/2020*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Claims	The Plan denied payment to a contracted hospital for continued treatment of Plan members with chronic medical conditions. The Plan did not provide for all medically necessary covered services for members	1. The Plan and the hospital renegotiated its hospital agreement with an effective date of February 1, 2021. The Alliance and the hospital agreed to a step down approach where The Alliance will authorize care at the appropriate level and work in conjunction with the hospital toward an appropriate discharge. The rate paid by Plan will be equal to the medical surgical rate. Please see Section 3.6 Utilization Management of The Alliance and hospital Contract Amendment. 2. The Plan and the hospital have a meeting set up for 4/6/2021 at 3:30 PM. The goal of this meeting is to finalize the cases in arbitration and any other outstanding claims. Update 5/14/21 The legal team is continuing to review which claims to pay. Update 6/11/21 The Alliance is working with the provider on evaluating and assessing the claims from the audit. Senior level discussions are in process between the hospital and the Alliance. Update 10/8/2021 The Plan paid the hospital for all claims in Arbitration on the 7/22/2021 check run. The hospital had some additional claims they wanted reviewed and we met on 7/27/2021 to review them. The Plan agreed to pay these claims, as well, and they were paid out on the 8/25/2021 and 9/1/2021 check runs. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	9/1/2021	Completed	UM / Claims		State	DHCS	2020	Completed
2	UM	The Plan did not apply written criteria for each concurrent review of continued long term acute care (LTAC) services throughout members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021: Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
3	UM	The Plan did not document that qualified physicians reviewed all denials of continued long term acute care (LTAC) services throughout members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021: Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The results of the next quarterly audit will be reported at the December UM Committee. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress

ALAMEDA ALLIANCE FOR HEALTH
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4	UM	The Plan did not notify members and the hospital of continued denial of long term acute care (LTAC) services through NOA letters and "Your Rights" attachments for each concurrent review throughout the members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021 Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
5	UM	The Plan provided unclear information about the Plan's decision for denial of long term acute care (LTAC) services in the only NOA letters that were issued to members and the Hospital. Letters contained inaccurate information about denied dates and requesting providers.	1. The automated section of the NOA letter generated by the Plan's system of record, TruCare, was incorrectly configured and displayed inaccurate information about the requesting LTAC provider and the dates of denial. The Plan's system of record, TruCare, was re-configured to display the correct dates and correct requesting provider in the automated portion of the NOA letters. 2. The Plan's In-Patient Utilization Management Leadership will continue to audit the NOA letters to ensure that they contain accurate information and meet the regulatory requirements. Update 5/15/2021: Identified deficiencies have been added to the audit tool and audits of inpatient NOA letters are currently taking place. 3. The Plan will report the results of NOA letter audit at Utilization Management Committee on a quarterly basis, starting Q3 2021. Update 7/9/2021: Manual tracking continues, report will be provided starting in Q3 2021 Update 10/8/2021: Manual tracking continues, awaiting completion of automated report. First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress

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2020 DHCS STATE AUDIT FINDINGS - *Audit Review Period: 10/01/2018 - 9/30/2020*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
6	Delegation	The Plan did not ensure the Delegate met standards set forth by the Plan and DHCS. The Delegate did not ensure that concurrent review denials were reviewed and made by a qualified physician. It did not send NOA letters with "Your Rights" information for denial of services that occurred after initial denial. It did not include the decisions maker's name in the initial and only NOA sent to providers.	1. The Plan's revised policy UM-003 Concurrent Review and Discharge Planning Process and the revised process expectations were shared with Delegate on 3/26/2021. 2. The Plan will require the Delegate to do the following: a. Adopt the Plan's policies, to reflect that the concurrent review denials are reviewed and made by a qualified physician, that the clinical case is reviewed using the regulatory requirements on a regular cadence after the initial denial, that NOA letters with "Your Rights" information are sent after every subsequent review, and that the decision-maker's name is on each NOA. Update 6/11/2021 The Alliance's Health Care Services is working with the delegate to update the policies. b. Provide evidence of policy and procedure approval. Update 7/9/2021: Delegate has provided evidence that the revised policy was approved on 6/23/2021 c. Train its staff on the new Concurrent review process. Update 7/9/2021: Delegate states they are developing the training for their staff and are on track to provide the documents to The Alliance. Update 9/10/2021: Staff training completed, training documents provided. d. Provide evidence of the training, including the training materials and the attendance records. Update 9/10/2021: Delegate provided attestations to show training completed 6/23/2021 3. The Plan will audit the Delegate on a quarterly basis to ensure that the process is implemented, starting at the end of Q3 2021, and report the results of the audit at the Plan's UM Committee on a quarterly basis. Update 10/8/2021: Q3 2021 audit completed 9/29/2021, and initial audit results provided to the Delegate; final audit report will be issued to the Delegate by 10/13/2021. Update 11/12/2021: The next quarterly audit is scheduled for 12/17/2021. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022 4. At annual Delegate oversight audits, concurrent reviews and letters will be examined to ensure compliance. Update 11/12/2021: The next annual Delegation Oversight Audit is scheduled for February 2022. Concurrent reviews and letters will be reviewed at that time. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 5/13/2022: The delegate does not have any cases that meet the criteria for audit for Q1 2022. DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 07/08/2022: The Alliance is currently in the process of quarterly delegate audit. Update 09/09/2022: The quarterly delegate audit is in progress and is expected to be completed by October 2022. Update 10/14/2022: The quarterly delegate audit has been completed, there were no findings. This audit will be closed and the findings noted by DHCS will continue to be reviewed during the annual audit.	9/23/2022	Completed	UM		State	DHCS	2020	In Progress

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2020 DHCS STATE AUDIT FINDINGS - *Audit Review Period: 10/01/2018 - 9/30/2020*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
7	Delegation	The Plan did not ensure the Delegate met standards set forth by the Plan and DHCS. The Delegate denied medically necessary services.	1. The Plan's revised policy UM-003 Concurrent Review and Discharge Planning Process and the revised process expectations were shared with Delegate on 3/26/2021. 2. The Plan will require the Delegate to do the following: a. Adopt the Plan's policies, to reflect that the concurrent review denials are reviewed and made by a qualified physician, that the clinical case is reviewed using the regulatory requirements on a regular cadence after the initial denial, that NOA letters with "Your Rights" information are sent after every subsequent review, and that the decision-maker's name is on each NOA. Update 6/11/2021 The Alliance's Health Care Services is working with the delegate to update the policies. b. Provide evidence of policy and procedure approval. Update 7/9/2021: Delegate has provided evidence that the revised policy was approved on 6/23/2021 c. Train its staff on the new Concurrent review process. Update 7/9/2021: Delegate states they are developing the training for their staff and are on track to provide the documents to The Alliance. Update 9/10/2021: Staff training completed, training documents provided. d. Provide evidence of the training, including the training materials and the attendance records. Update 9/10/2021: Delegate provided attestations to show training completed 6/23/2021 3. The Plan will audit the Delegate on a quarterly basis to ensure that the process is implemented, starting at the end of Q3 2021, and report the results of the audit at the Plan's UM Committee on a quarterly basis. Update 10/8/2021: Q3 2021 audit completed 9/29/2021, and initial audit results provided to the Delegate; final audit report will be issued to the Delegate by 10/13/2021. Update 11/12/2021: The next quarterly audit is scheduled for 12/17/2021. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022 4. At annual Delegate oversight audits, concurrent reviews and letters will be examined to ensure compliance. Update 11/12/2021: The next annual Delegation Oversight Audit is scheduled for February 2022. Concurrent reviews and letters will be reviewed at that time. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022. Update 5/13/2022: The delegate does not have any cases that meet the criteria for audit for Q1 2022. DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 07/08/2022: The Alliance is currently in the process of quarterly delegate audit. Update 09/09/2022: The quarterly delegate audit is in progress and is expected to be completed by October 2022. Update 10/14/2022: The quarterly delegate audit has been completed, there were no findings. This audit will be closed and the findings noted by DHCS will continue to be reviewed during the annual audit.	9/23/2022	Completed	UM		State	DHCS	2020	In Progress

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2020 DMHC STATE AUDIT FINDINGS - *Audit Review Period: 1/01/2019 - 9/30/2019*					INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
1	Grievances & Appeals	The Plan failed to accurately and consistently identify grievances received by telephone. Coverage Dispute issues were processed as an exempt grievance and not a standard grievance as required.	The G&A current procedures appropriately process coverage disputes as a standard grievance. Member Services will provide a refresher staff training of the procedures by 3/31/2020 to ensure coverage disputes are processed appropriately. Update as of 4/10/2020 Refresher training for benefits coverage disputes was completed on 3/12/2020.	3/12/2020	Completed	Member Services/ G&A	✓	State	DMHC	2020	Completed
2	Grievances & Appeals	The Plan does not consistently provide immediate notification to complainants of their right to contact the Department regarding expedited appeals.	G&A staff training was conducted to review regulations on 1/30/2020. G&A application was updated to include a new log type for expedited DMHC rights notification that was implemented on 2/6/2020.	2/6/2020	Completed	G&A	✓	State	DMHC	2020	Completed
3	UM	The Plan does not include the statement required by Section 1363.5(c) when disclosing medical necessity criteria for UM decisions.	Cover sheet being created in the TruCare system for all requests by providers for clinical criteria used to adjudicate requests. Creation of tracking log, workflow and training to be completed by 3/31/2020. Update as of 4/10/2020: Tracking log workflow and training completed as of 3/12/2020.	3/12/2020	Completed	UM	✓	State	DMHC	2020	Completed
4	Access to Emergency Services	The Plan does not provide all non-contracting hospitals in the state with Plan contact information needed to request authorization of post-stabilization care. DMHC expects the onus to be on the Plan to reach out to the hospitals and notices should be mailed at least annually.	The Plan is working with the Hospital Association to assist in sending out the notices to non-contracted hospitals. Update as of 6/12/2020: Notices were mailed to non-contracted hospital providers on May 26.	5/31/2020	Completed	Provider Relations	✓	State	DMHC	2020	Completed
5	Access & Availability	The Plan failed to adequately review and address access issues as part of its quality assurance (QA) program.	The QI Team and Member Services team perform an annual training to ensure that the appropriate process is followed. The Alliance is working on additional training to ensure the appropriate referral of PQIs. All access-related exempt grievances are compiled in a track and trend report and referred to Quality Improvement via the Access and Availability Sub-Committee	4/30/2020	Completed	Quality Management	✓	State	DMHC	2020	Completed
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Compliance Internal Audit**	**State/Self Identified**	**Agency**	**Year**	**Status**
1	Quality Assurance	The Plan failed to ensure that all potential quality of care issues were identified and processed in accordance with its Quality Assurance (QA) Program. Cases were found to misclassified and include documentation issues.	1. RN Staff In-Service on PQI definition, classification, review, processing and documentation conducted by Quality Sr. Director on 2/7/2020. 2. Deleted "Not a PQI" from classification drop down selections. 3. All new PQI submissions are reviewed and classified (as QOS/QOA/QOC) by Quality Director. 4. RN PQI Classification IRR conducted by Quality Director on 2/25/2020. 5.Department wide IRR Conducted by Medical Director on 2/27/2020 6.Quality Director to process all QOAs and QOSs 7. Medical Director is auditing random sample of QOA and QOS cases processed by nurse management staff as of 4/6/2020. 8. Quality Director to conduct weekly auditing of RN documentation of all QOCs as of 3/5/2020. 9. Medical Director continues to level and audit all QOC cases 10. Ongoing weekly team meeting continues to ensure case discussion and review Update as of 4/30/2020: QI team has completed all steps listed above.	4/30/2020	Completed	Quality Improvement	✓	Self Identified	AAH	2020	Completed
2	UM	The Plan does not consistently provide enrollees with a clear and concise reason for denials based in whole or in part on medical necessity.	Quality checklist for review of NOA letters for all requirements prior to being sent out to be developed, then train staff, by 3/31. Quality checks of all NOAs by management before sending out continues. Weekly review by external consultants continue with MDs to improve decision notices. Update as of 4/10/2020: NOA checklist training and implementation done as of 4/2/2020. Weekly review by external consultants continues.	4/2/2020	Completed	UM	✓	Self Identified	AAH	2020	Completed
3	UM	In letters to providers denying or modifying requested services on the basis of medical necessity, the Plan does not include a direct telephone number or extension of the professional responsible for the decision. The peer to peer process to improve its oversight and tracking process.	Phone numbers in all UM template letters being checked for accuracy and corrected in TruCare as needed. Standardized tracking workflow of Peer to Peer communication is being developed, trained and implemented by 3/31/2020. Update as of 4/10/2020: Training and tracking implemented as of 3/12/2020.	3/12/2020	Completed	UM	✓	Self Identified	AAH	2020	Completed

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2019 DMHC AUDIT FINDINGS - *Audit Review Period: 10/1/2017-9/30/2019*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Payment Accuracy	Three out of 50 late paid claims (a compliance rate of 94 percent). This deficiency was caused by the Plan using the incorrect date to calculate interest on improperly denied and reprocessed claims. Three out of 30 high dollar claims. The deficiency was caused by the Plan not paying interest on a claim improperly denied for missing authorization when the independent practice association (IPA) authorized services but did not forward the authorization to the Plan, and underpaying claims due to processor error.	Late Claims – processing errors identified in this finding are attributable to human error by one specific individual. The incorrect handling was addressed verbally with the employee at the time of the audit. Refresher training on CLM-001 Claims Processing, CLM-003 Emergency Services Claims Processing and Claims Change Alert Clean Claim Interest Workflow was completed on March 13, 2020 to ensure that all staff who handles adjustments are using the appropriate received date for adjusted claims. Update 5/1/2020: At the Department's request, the Plan created a report to identify claims where the incorrect received date was used on an adjusted claim. The report was provided to the Department on 4/21/2020. The identified claims have been adjusted and the report has been updated to add the check date, check # and the amount of interest and penalties paid. Current policies and procedures do not require changes and meet compliance requirements. High Dollar Claims – processing errors identified in this finding are attributable to human error. Refresher training on CLM-001 Claims Processing and Claims Change Alert - Clean Claim Interest Workflow was completed on 3/13/2020 to ensure that all staff who handles adjustments are using the appropriate received date for adjusted claims.	4/29/2020	Completed	Claims	✓	State	DMHC	2019	Completed
2	Incorrect Claim Denials	Claims were improperly denied and should have been paid in three out of 50 denied claims (a compliance rate of 94 percent). The deficiency was caused by the Plan not re-processing retro enrollment, incorrectly denying a claim as duplicate and a system configuration issue that incorrectly denied claims as not the financial responsibility of the Plan.	Retro Eligibility Denial – The Plan's Claims management is working with its Information Technology/Analytics Department to create a retroactive eligibility report to identify claims that were denied correctly at the time of processing, but may be impacted due to the retroactive reinstatement of eligibility. Once the report is completed, the Plan will make sure to adjudicate any claims found to be improperly denied since 5/29/2018, and provide evidence that the claims were adjudicated appropriately. Update 5/1/2020: Report was put into production on 5/1/2020 and will be run weekly. Claims is working with IT to identify impacted claims from 5/29/2018-9/30/2019 and will adjust impacted claims and provide the final spreadsheet to the Department by 5/15/2020. Division Of Financial Responsibility (DOFR) Denial - this issue was identified as a configuration error for one specific service, and corrected in October 2019 prior to the audit. Update 5/1/2020: At the Department's request, the Plan created a report to identify claims where the service had been denied incorrectly. The report was provided to the Department on 4/21/2020. The identified claims are being adjusted and should be complete by 5/15/2020. The report will then be updated to add the check date, check # and the amount of interest paid. Duplicate Denial - duplicate claims refresher training on HS-004 Duplicate Claims was completed on 3/13/2020 for all staff that handles adjustments. Due to the unique cause of this non-system related error, a remediation report cannot be run.	~~4/15/2020~~ 5/15/2020	Completed	Claims	✓	State	DMHC	2019	Completed
3	Clear & Accurate Denial Explanation	Plan provided an incorrect denial explanation in three out of 50 denied claims (a compliance rate of 94 percent).	The Plan reviewed the deficient cases and found that the three denial errors identified in the audit were related to Division of Financial Responsibility (DOFR) issues. The Plan will review the services where there are DOFR conflicts, come to agreement with the delegates, and make any required configuration changes to the system. Update 5/1/2020: System changes for the delegate were completed and put into production on 4/16/2020. The claims were originally denied correctly as the responsibility of another delegate but contained an additional incorrect message that they were forwarded to delegate. These claims do not need to be re-adjudicated and re-denied again. Due to the Coronavirus Pandemic, meetings with delegate have been put on hold. The Plan has updated the system to correct the configuration with out of area office visits that was identified during the audit. At the Department's request, the Plan created a report to identify claims where these services had been denied incorrectly. The report was provided to the Department on 4/21/2020. The identified claims are being adjusted and should be complete by 5/15/2020. The report will then be updated to add the check date, check # and the amount of interest paid.	~~6/30/2020~~ 5/15/2020	Completed	Claims	✓	State	DMHC	2019	Completed

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2019 DMHC AUDIT FINDINGS - *Audit Review Period: 10/1/2017-9/30/2019*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
4	Change in Plan Personnel	Plan shall within five days, file an amendment when there are changes in personnel of the plan. Plan did not file the Board of Governors changes for three members.	The Plan has updated its internal procedures to ensure key personnel requirements are met. The Plan implemented a monthly quality check capturing any changes with the Plan's Board of Governor member seats. The Plan's Compliance team staff completed updated training for key personnel filing procedures on March 30, 2020. As of 3/31/2020, the Plan has also completed updates to the filings for three Board members as requested: Member 1: DMHC Filing #20201241 Member 2: DMHC Filing #20200184/#20201243 Member 3: DMHC Filing #20200644	4/1/2020	Completed	Compliance	✓	State	DMHC	2019	Completed
5	Control over Mailroom Claims Processing	Plan does not have sufficient control over its mailroom claims processing as the mailroom staff does not stamp the date of receipt on paper claims. In addition, the Plan's mailroom staff does not count the number of claims sent to vendors for further processing, impeding the Plan's ability to reconcile the number of claims received and processed.	The Plan has an established process for receiving claims in its onsite mailroom for capturing receipt dates. The Plan performs quality checks for reconciliations of claims count scanned and received to ensure all claims are captured for processing. The Plan has daily logs of professional and facility claims received and scanned. The logs have the original claim count, the claim count successfully scanned, the rejected claim count and the merged claim count. The Plan utilizes the daily log counts to perform reconciliation when the files are received and loaded. Included with the CAP response is the weekly reconciliation sample report and sample logs of claims as evidence of this quality internal control process for counting the number of claims.	4/1/2020	Completed	Support Services/ Claims	✓	State	DMHC	2019	Completed

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#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required PA for an initial visit with a mental health provider to determine if the member had mild-to-moderate mental health issues, which the contract does not allow.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and agree with the changes for member self-referral process. Discussing with DHCS prior to final CAP submission.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
2	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required a two-step prior authorization (PA) process for BHT services, which is allowed, but did not send written notification when it denied services at the first step. The delegate did not consistently apply criteria for approving BHT.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and still have open items not documented. Plan will be meeting with the delegate to discuss criteria and procedures for further documentation needed. Update as of 2/7/2020: Met with the delegate to review their criteria and approval process. Requested policy language changes to meet the regulatory requirements. Policy was approved by Committee on 1/27/20. Updated CAP response submitted to DHCS on 2/7/2020.	No	2/7/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
3	UM Delegation	(1.1.3) The Plan did not review ownership and control disclosure information for their Utilization Management (UM) delegates	The Plan will ensure that its delegated providers complete the Ownership and Control disclosure forms. The Plan will create a tracking log and document any follow up attempts made with the delegate to ensure accuracy. Update as of 12/2/2019: PR has created a tracking log and is working on a desktop procedure.	Yes	1/1/2020	Completed	Provider Services	✓	State	DHCS	2019	Completed
4	UM Delegation	The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan will conduct staff retraining of delegation reporting procedures to ensure all are tracked and monitored for receipt and review. Update as of 12/5/2019: Staff training was conducted on 12/3/2019.	Yes	12/1/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
5	UM Delegation	The Plan's oversight of its delegate did not identify unclear NOA letters, and incorrect appeal and SFH information	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has developed on a new process regarding NOA letters, appeal rights and SFH Information. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and agreed with changes of procedure checklist and training materials.	No	1/15/2020	Completed	Utilization Management		State	DHCS	2019	Completed
6	Referral Tracking process	The Plan did not track all approved PAs; the specialty referral tracking process did not include modified PAs and in-network approved services.	The UM Department is working with analytics to expand the routine referral tracking report to include all approved authorizations. Update as of 12/5/19: Clarity is being sought from DHCS on the scope of specialty referral tracking. Update as of 1/8/20: An updated referral tracking report is being developed to include all decision types and specialty services that require authorization. Update as of 2/7/20. Updated report sample generated and submitted to DHCS. Working with Analytics to create routine report that captures all needed data elements. Update as of 3/5/2020 UM met with Analytics to create the routine report capturing all needed elements. Report is in development. Update as of 5/8/20 Specialty Tracking Report has been created by Analytics, including all required elements, and will now be routinely reported quarterly through UMC and HCQC. Reported at HCQC on 5/21/20. Update as of 6/12/20: Report sent to HCQC on 5/21/20 and reviewed at UMC at 5/29/20.	Yes	5/21/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
7	Prior Authorizations	A review of PA data showed non-qualified Plan staff denied retrospective cases for administrative reasons other than non-eligibility for membership. The Plan denied retrospective service requests without review by a medical director if the provider submitted the request more than 30 days after the service delivery date, or if requests did not meet Plan-imposed conditions. The Plan's contract did not specify submission timeframes or other conditions that, if not met, allowed eliminating medical necessity review of retrospective requests for covered services.	Policy and procedure UM-001 Utilization Management will be updated to comply with the contractual requirements. Workflows will be updated to have all retrospective requests reviewed by a medical director. Workflows have been updated to have all retrospective requests reviewed by a medical director. Update as of 12/5/2019: Clarity is being sought from DHCS on allowing a time limit of 30 days. Update as of 1/8/2020: Plan received clarity from DHCS and is updating internal procedures. Update as of 2/7/2020: P&Ps updated to reflect that only an MD can deny retro PA requests. P&Ps approved at HCQC on 1/16/2020.	Yes	1/16/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
8	Prior Authorizations	(1.2.2) The Plan did not ensure it used appropriate processes to review and approve medically necessary covered services when it did not ensure that qualified medical personnel rendered medical decisions. Dependent practitioners reviewed, assessed and approved requests for continued hospital stays	The process for ensuring LVNs perform only within their scope of practice was updated and implemented on 10/2/2019. Additional changes to the UM systems to better track the change in process are being developed. Update as of 12/5/2019: Changes to the UM systems to better track the RN oversight role with the LVNs completed. Other Managed Medi-Cal plans have LVNs performing UM. Clarity is being sought from DHCS on the use of LVNs in UM. Policies and procedures and job descriptions are being reviewed to be aligned with the updated oversight process. Update as of 1/8/2020: Plan received clarity from DHCS and updated procedures for RN oversight.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
9	Prior Authorizations (UM and Rx)	The Plan's notice of action (NOA) letters did not follow specifications in Health and Safety Code Section 1367.01. Provider letters in medical cases did not include the decision makers' direct phone number or contained the incorrect number. Letters did not explain the reasons for the denial. Pharmacy NOAs were not concise.	Accurate phone numbers for the decision makers are on the NOA, monitoring will be conducted through internal audits. UM NOA template letters were updated and implemented on 11/4/2019, internal auditing will be conducted monthly to ensure that the letters are clear and concise and explain the reasons for denial. Pharmacy NOA template letters were updated and implemented in April 2019, internal auditing will be conducted at least monthly to ensure that the letters are clear and concise and explain the reasons for denial. The pharmacy team also meets with the PBM on a weekly basis to optimize PA review process, NOA letter language and reasons for denial.	Yes	11/4/2019	Completed	Utilization Management /Pharmacy		State	DHCS	2019	Completed

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#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
10	Prior Authorizations	The Plan did not ensure that all contracting practitioners were aware of the procedures for orthotic items; the Plan provided inaccurate information about authorization requirements for orthotic items	The Alliance's Authorization Grid will be updated to include the accurate information about authorization requirements for orthotics. The updated grid will be uploaded on the website. Update as of 12/5/2019: A meeting will be scheduled the week of 12/9 to discuss changes. Update as of 1/8/2020: Meeting was conducted and PA grid will be updated to reflect corrections. Update as of 2/7/2020. PA grid is being updated for all services requiring PA, so that MDs do not receive repeat communication about changes to the PA grid. Orthotics will be included in the comprehensive update. Update as of 3/5/2020 Prior Auth requirement for Orthotics was added to the PA grid on the Provider Portal	No	3/2/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
11	Appeals	The Plan's appeal notification letters did not comply with contractual regulations. NAR letters were not clear or concise, and contained inaccurate information	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
12	Case Management & Care Coordination - HRAs	The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members. The Plan did not ensure that HRAs were completed within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk, and within 105 calendar days of enrollment for those identified as lower risk.	HRA tracking had been implemented in early 2019, and continues at present. HRAs are sent out within the required timeframes. Robo calls are made to low risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls are made by CM staff on high risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log is kept to ensure that the required timelines are met.	No	9/16/2019	Completed	Case Management		State	DHCS	2019	Completed
13	Case Management & Care Coordination - Initial Health Assessment (IHA)	The Plan did not ensure that all providers documented all required components of an IHA. Preventive services identified as USPSTF "A" and "B" recommended services were not provided, or status of these recommended services was not documented	The QI Department revised its provider medical record request letter to include: all categories that support IHA completion; a hyperlink and/or copy of the SHA/IHEBA form; and sample documentation of a compliant SHA/IHEBA. Providers were re-educated on the SHA/IHEBA requirements.	No	9/30/2019	Completed	Quality		State	DHCS	2019	Completed
14	Complex Case Management (CCM)	2.2.1 The Plan did not implement its monitoring of the CCM program to address member needs. The Plan did not close its CCM cases after 90 days, or present them at Case Rounds as stated in its policy	Existing aging reports are being utilized by the Case Management Department in CCM Rounds to ensure that members' cases are either reviewed and closed, or extended past 90 days.	Yes	10/14/2019	Completed	Case Management	✓	State	DHCS	2019	Completed
15	Access & Availability	3.1.1 The Plan did not maintain an accurate provider directory.	The Plan will continue to verify 10 providers per week and has added the following two processes to continuously maintain an accurate provider directory: 1. Provider Data Comparison to manually review provider data received from our delegates started September 2019 and 2. Provider Data Validation Yearly Project to review directly contracted providers who appear in the Provider Directory. In addition, the Provider Relations Department includes a Provider Demographic form in all provider quarterly packets and work with providers to obtain the completed forms during provider visits.	Yes	11/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
16	Emerg Family Planning Claims/SSS	The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-For-Service rate. The Plan's claim system misclassified non-contracted family services as non-billable. The Plan is required to pay all covered family planning services regardless if these services are contracted with the Plan.	This finding is specific to one provider based on the list of services identified in the contract. No other provider was impacted by this issue. The claims system has been re-configured to reimburse services as follows: * services listed in the provider contract will be reimbursed at the contracted rate * covered Medi-Cal services not listed in the contract will be reimbursed at 100% of the prevailing Medi-Cal rate	No	9/5/2019	Completed	Claims	✓	State	DHCS	2019	Completed
17	Emerge Family Planning Claims	The Plan did not inform members of the correct minor consent provision for family planning services in its Evidence of Coverage (EOC).	The Plan has updated its 2020 EOC to include the appropriate minor consent provisions. The EOC was submitted to DHCS for review and approval on 10/7/2019.	No	10/7/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
18	Access to Pharm Services	The Plan did not monitor the provision of drugs prescribed in emergency situations.	The Pharmacy Department is working with the PBM to create routine monitoring reports of drugs prescribed in emergency situations. Update as of 1/8/20: Internal meeting was conducted to ensure requirements are clear and next steps for updating policy and monitoring reports. Update as of 2/11/2020: Draft P&P and monitoring log have been created and are under review. Update as of 4/10/2020: The P&P and monitoring log were approved at the most recent P&T Committee meeting.	Yes	3/17/2020	Completed	Pharmacy	✓	State	DHCS	2019	Completed
19	Grievances	4.1.1 The Plan did not document review and final resolution of clinical grievances by a qualified health care professional	The G&A workflow for Quality of Care review was updated and implemented on 4/15/2019 to include the CMOs review and final resolution.	Yes	4/15/2019	Completed	G&A	✓	State	DHCS	2019	Completed
20	Grievances	4.1.2 The Plan's grievance system did not capture all complaints and expressions of dissatisfaction reported by members.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training was conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
21	Grievances	The Plan's grievance system did not capture all complaints and expressions of dissatisfaction filed through Plan providers.	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. Clinics will be trained by the delegate to ensure that the Alliance is capturing all complaints. Update as of 1/8/2020: Medical group provided training sign in sheet. The delegate is working on next steps of educating providers. Update as of 2/7/2020: the delegate provided an attestation to complete its provider training by the end of Q1 2020. Update as of 4/10/2020: Meeting medical group week of 4/6 to discuss implementation. Update as of 4/20/2020: Process for forwarding complaints received by medical group has been implemented as of 4/20/2020.	Yes	~~3/31/2020~~ 5/1/2020	Completed	G&A/Provider Services/ Compliance	✓	State	DHCS	2019	Completed
22	Grievances	4.1.4 The Plan sent member resolution letters without completely resolving all complaints.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training was conducted on 11/14/2019.	Yes	11/22/2019	Completed	G&A		State	DHCS	2019	Completed

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2019 DHCS AUDIT FINDINGS - *Audit Review Period: 6/1/2018-5/31/2019*						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
23	Quality Program	The QIPD did not list the individuals' qualifications, which was inconsistent with Plan policy.	The 2019 Annual Quality Improvement Program Description (QIPD) was revised to include the leadership positions and their qualifications (Licensure, Education, Work Exp) The program description was presented and approved in the July 18, 2019 Health Care Service oversight committee.	No	7/18/2019	Completed	Quality	✓	State	DHCS	2019	Completed
24	Provider Training	The Plan did not ensure provider training was conducted within 10 working days	During the last review period of June 2017 through May 2018, the Plan acknowledged deficiencies in the NPO process to be corrected by the end of December 2018. Since January 2019, the plan is meeting its goal of conducting training with the 10 day working timeframe 100% of the time.	Yes	1/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
25	Fraud, Waste, and Abuse (FWA)	The Plan did not conduct preliminary investigations of all suspected cases of fraud and abuse.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. Staff training of the revised procedure will be completed by 12/01/2019. Update as of 12/5/2019: Staff training will be conducted on 12/11/2019 to review the updated procedure. Update as of 1/8/2020: Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
26	Fraud, Waste, and Abuse (FWA)	The Plan did not investigate all suspected fraud and abuse incidents promptly. The Plan did not conduct a preliminary or follow-up investigation of 4 of 12 suspected fraud and abuse cases until two to six months after it became aware of the incidents.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. All cases will be resolved and closed within 90 days of receipt. Staff training of the revised procedure will be completed by 12/01/2019. Update as of 12/5/2019: Staff training will be conducted on 12/11/2019 to review the updated procedure. Update as of 1/8/2020: Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
27	Fraud, Waste, and Abuse (FWA)	The Plan's compliance officer did not develop and implement fraud, waste, and abuse policies and procedures	The Plan's designated compliance officer will develop and attest to all new and updated policies and procedures prior to committee review.	No	12/13/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
28	State Supportive Services Claims	The Plan did not forward all misdirected claims within 10 working days.	The post-adjudication script that adds the forwarding action was corrected and deployed.	No	7/11/2019	Completed	IT/ Claims	✓	State	DHCS	2019	Completed

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2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
1	Utilization Management (UM) Program	1.1.1 The Plan did not continuously update and improve its UM program during the audit period.	The Plan's policy and procedure UM-001 includes the annual review process of the UM program. The 2018 UM program was approved by Committee timely this year on 3/20/2018. The Plan will continue to update its UM program annually and track for a timely approval by Committee.	3/31/2018	Completed	Utilization Management	✓	State	DHCS	2018	Completed
2	Prior Authorizations	1.2.1 The Plan did not conduct IRR testing to evaluate the consistency of UM criteria application during the audit period.	The Plan has implemented an IRR testing policy and procedure to ensure clinical staff is evaluated on an annual basis to ensure consistency in decision making and criteria application. - UM/Appeals IRR conducted on 5/25/2018 - Pharmacy IRR conducted on 12/17/2018 Update as of 1/31/2019: IRR testing for Health Care Services (Pharmacy & UM) has been completed as of 1/31/2019.	12/17/2018	Completed	Utilization Management/ Pharmacy	✓	State	DHCS	2018	Completed
3	Prior Authorizations	1.2.2 The Plan did not use appropriate processes to determine medical necessity for PA requests. The Plan's UM staff used outdated criteria and criteria that did not meet the case details.	The Plan has updated its policy and procedure to ensure the Plan's criteria is reviewed at least annually. IRR testing of clinical staff is completed annually to ensure consistency in decision making and criteria application. - UM/Appeals IRR conducted on 5/25/2018 - Pharmacy IRR conducted on 12/17/2018 Update as of 1/31/2019: IRR testing for Health Care Services (Pharmacy & UM) has been completed as of 1/31/2019.	12/17/2018	Completed	Utilization Management	✓	State	DHCS	2018	Completed
4	Prior Authorizations	1.2.3 The Plan denied retrospective service requests for medical services without documentation of a qualified health care professional's review for medical necessity.	The Plan updated its policy and procedure for the retrospective authorization request process to include details of the review process. The P&P and workflow will be reviewed and approved on 1/17/2019. Staff training will then be conducted on 1/22/2019. Update as of 1/31/2019: Updated P&P and workflow retro authorization request processes were approved at HCQC on 1/17/2019. Staff training was conducted on 1/29/2019.	1/22/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
5	Prior Authorizations	1.2.4 The Plan did not respond to pharmacy requests within 24 hours or one business day.	The Plan monitors pharmacy authorization request timeframes by a daily aging report. Staff training of the turnaround timeframe requirements was provided on 10/02/2018. Update as of 1/07/2019: The Plan has determined that timeframe requirements were not consistently met due to a lack of coverage on weekends and holidays. The Plan has updated its Pharmacy Benefit Management contract to include coverage for weekends and holidays as of 12/1/2018. Staff training of the updated procedures will be completed by 1/22/2019. Update as of 1/31/2019: Staff training was completed on 1/23/2019.	1/22/2019	Completed	Pharmacy	✓	State	DHCS	2018	Completed
6	Prior Authorizations	1.2.5 The Plan's NOA letters were not clear and concise, or at sixth grade reading level.	Update as of 3/5/2019: Continuing internal audits revealed issues with how TruCare generates letters, leading to potentially confusing language for members. A team is working on a plan to mitigate the issues. Once the TruCare issues are resolved, staff will be retrained on the mitigation procedures. In the meantime, audits continue to ensure that the language is clear and concise and a process for final review before sending out is being developed. The updated timeline for completion is 4/30/2019. Update as of 4/10/2019: Denial rationale language has been updated. Staff training was completed on 3/29/2019.	4/30/2019	Completed	Utilization Management/ Pharmacy		State	DHCS	2018	Completed
7	Prior Authorizations	1.2.6 The Plan provided incorrect appeal, grievance, and state fair hearing information in translated pharmacy member notifications. The translated "Your Rights" attachments did not follow the required format.	The Plan will update its pharmacy member notifications to ensure the translated versions are in the required format with updated member rights information by 1/25/2019. Update as of 2/4/2019: Updated translated versions of the "Your Rights" attachments have been provided to the Pharmacy Benefits Manager. Update as of 2/19/2019: Updated translated versions of the "Your Rights" attachments have been placed into production by the Pharmacy Benefits Manager.	1/25/2019	Completed	Pharmacy	✓	State	DHCS	2018	Completed
8	Prior Authorizations	1.2.7 The Plan provided conflicting information to providers about podiatry benefits, which required PA; it therefore did not communicate to providers the services that required PA.	The Plan will be updating its Prior Authorization Grid and Provider Training Presentation to include clear communication of the prior authorization process including clarification of the podiatry benefit.Update as of 1/07/2019: The Plan will be updating its prior authorization grid and provider training materials by 1/25/2019. Update as of 1/31/2019: The PA Grid and Provider Training Presentation have been updated. The PA Grid and updated Provider Manual have been posted to the Plan website.	1/25/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
9	Referral Tracking process	1.3.1 The Plan did not track authorized PAs to completion and inform providers of the referral tracking process.	The Plan has updated its referral tracking policy and procedure. Routine reporting has been developed to track authorization PAs to completion. The Plan's provider manual has been updated to include information on the Plan's referral tracking process for providers. Update as of 1/07/2019: The Plan will be uploading the provider manual to the website by 1/25/19. Update as of 1/31/2019: The updated Provider Manual has been posted to the Plan website.	1/25/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
10	Appeal	1.4.1 The Plan did not ensure health care professionals with appropriate clinical expertise in treating the member's condition resolved pharmacy appeals. The Plan allowed the Pharmacy Director to resolve appeals for medication requests instead of requiring a clinical professional with expertise in treating the member's condition.	The Plan updated its appeal procedures to reflect MD review for final decision for pharmacy appeals on 09/26/2018 and conducted staff training on 10/30/2018.	10/30/2018	Completed	Health Care Services	✓	State	DHCS	2018	Completed

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#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
11	Appeal	1.4.2 The Plan did not translate acknowledgement and resolution appeal letters into the required threshold languages.	The Plan's appeal policies and procedures in place are compliant with the translation requirements. Staff training refresher of translation of letters was conducted on 10/30/2018.	10/30/2018	Completed	Grievance & Appeals	✓	State	DHCS	2018	Completed
12	Appeal	1.4.3 The Plan did not update its provider manual to include the new timeframes for filing a state fair hearing that became effective July 1, 2017.	The Plan updated its provider manual on 12/25/2018 to include the correct new SFH filing timeframes. Update as of 1/07/2019: The Manual is scheduled to be uploaded on our website on 1/25/2019. Update as of 1/31/2019: The updated Provider Manual has been posted to the Plan website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
13	Delegation Oversight	1.5.1 The Plan did not collect and review ownership and control disclosure information for their UM delegates.	The Plan's subcontractor policy & procedure addresses the ownership and control disclosure information requirements. Update as of 1/07/2019: The Plan has requested ownership and control disclosure information of its UM delegates as of 1/4/2019. Update as of 1/30/2019: All forms from the Plan's UM delegates have been received as of 1/31/2019 with the exception of the Plan Pharmacy Benefits Manager (PBM). Update as of 3/6/2019: All forms from the Plan's UM delegates have been received.	3/15/2019	Completed	Provider Relations	✓	State	DHCS	2018	Completed
14	Delegation Oversight	1.5.2 The Plan did not require corrective action for all identified deficiencies as a part of their annual oversight audits.	The Plan updated its corrective action plan policy and procedure on 11/8/2018 to ensure all identified deficiencies are a part of annual audits such as policy and procedure deficiencies. UM annual delegation audits conducted for 2018 reflect the policy and procedure deficiencies in the corrective action.	11/8/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
15	Delegation Oversight	1.5.3 The Plan did not continuously monitor and evaluate the functions of its UM delegates. The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan has updated its monitoring of UM delegates to ensure all contractual and regulatory reports are being tracked for review. The Plan's delegation reporting tracking log has been updated to document all UM delegation reporting.Update as of 1/7/2019: The Plan will update the desktop procedure and conduct staff training on the monitoring process by 1/22/2019. Update as of 1/31/2019: The Plan completed staff training on 12/20/2018.	1/22/2019	Completed	Compliance	✓	State	DHCS	2018	Completed
16	Initial Health Assessment (IHA)	2.4.1 The Plan did not ensure that new members receive an IHA within 120 days from enrollment. The Plan's IHA completion records were inaccurate.	The Plan updated its procedures to monitor IHA completion and validate the procedure codes. Medical record auditing procedures will be conducted to monitor IHA completion and conduct validity testing.Update as of 1/07/2019: The Plan completed the audit and is completing the summary report for Committee by 1/17/2019.	1/17/2019	Completed	Quality Management	✓	State	DHCS	2018	Completed
17	Complex Case Management (CCM)	2.5.1 The Plan did not implement its policy and did not consistently monitor its CCM program.	The Plan monitors its daily aging report to ensure compliance with its CCM program.	12/1/2018	Completed	Health Services	✓	State	DHCS	2018	Completed
18	Complex Case Management (CCM)	2.5.2 The Plan did not ensure PCP participation in the provision of CCM services to each eligible member.	The Plan's updated CCM policy and procedure includes a process for PCP participation. The PCP Input Form was implemented for use on 5/31/2018.	5/31/2018	Completed	Health Services	✓	State	DHCS	2018	Completed
19	Access & Availability	3.1.1 The Plan did not initiate and implement steps to monitor wait times for providers to answer members' telephone calls.	The Plan will be updating its policy and procedure to include the telephone wait times standards for answering and returning calls. The Plan will monitor wait times for providers and answering member telephone calls through a quarterly survey. Update as of 1/31/2019: The Plan has updated its P&P to include all wait time standards. The Plan conducted a survey in January 2019 to assess and monitor wait times as required.	1/31/2019	Completed	Quality Management	✓	State	DHCS	2018	Completed
20	Access & Availability	3.1.2 The Plan did not maintain an accurate and complete provider directory.	The Plan implemented an audit process of the provider directory. The Plan expanded its annual audit for its Pharmacy Benefit Manager (PBM) to include monitoring its provider data included in the directory.Update as of 1/30/2019: Provider Directory Data P&P and desktop procedure for internal auditing have been updated.	2/28/2019	Completed	Provider Services/ Pharmacy	✓	State	DHCS	2018	Completed
21	Emergency & Family Planning Claims	3.5.1 The Plan denied emergency room (ER) service and family planning (FP) claims containing procedures that normally require prior authorization outside of an ER or FP setting.	The Plan updated its system configuration to ensure ER and FP claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
22	Emergency & Family Planning Claims	3.5.2 The Plan did not pay the greater of $15 or 15 percent interest annually for emergency service claims not reimbursed within 45 working days of receipt.	The Plan updated its system to ensure interest is paid based on the greater of the $15 or 15 percent interest annually for emergency services not reimbursed timely. Update as of 1/07/2019: The Plan will run a pre-payment monitoring report prior to each check run to ensure interest is paid based on the greater of the $15 or 15% per annum for emergency services claims not adjudicated timely. Update as of 1/31/2019: The Plan's pre-payment monitoring report process is now in place prior to each check run to ensure interest is paid accurately for emergency services claims when interest is required. All claims identified on the weekly report are manually adjusted as needed prior to payment to providers.	1/25/2019	Completed	Claims	✓	State	DHCS	2018	Completed

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#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
23	Emergency & Family Planning Claims	3.5.3 The Plan improperly denied family planning claims for out of network, non-contracted providers. These claims were denied based on edits in the Plan's claims system and subsequent review by claims analysts.	The Plan provided staff training on 6/11/2018 to ensure FP claims edits for out of network claims are reviewed and not inappropriately denied. Monitoring reports have been implemented to review any claims denied incorrectly. Any claims identified as denied incorrectly are adjusted the following week manually.	12/31/2018	Completed	Claims	✓	State	DHCS	2018	Completed
24	Emergency & Family Planning Claims	3.5.4 The Plan did not disclose the specific rationale used in determining why claims are rejected.	Update as of 3/6/2019: The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by May 31, 2019. Update 4/8/2019: The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
25	Emergency Pharmacy Provisions	3.6.1 The Plan did not ensure the provision of sufficient amounts of drugs prescribed in emergency situations.	The Plan updated its policy and procedure to ensure emergency provisions of drugs are prescribed in emergency situations. The monitoring report was updated to include all supply claims to ensure members have access to medically necessary drugs.	12/11/2018	Completed	Pharmacy	✓	State	DHCS	2018	Completed
26	Grievances	4.1.1 The Plan's process omitted medical director review of QOC grievances prior to sending resolution letters.	The Plan updated its grievance procedures and letters to include MD review for quality of care grievances.Update as of 1/7/2019: Implementation will be completed by 3/31/2019 once RN staff are on board and trained on the updated process. Update as of 3/5/2019: Health Care Services has successfully recruited one nurse, and is in the process of filling the remaining vacancy. Update as of 4/10/2019: Training is to be completed by 4/11/2019. The checklist for standard and expedited grievances has been updated. Update as of 5/8/2019: The review process for QOC grievances was implemented on 4/15/2019.	4/15/2019	Completed	Health Care Services	✓	State	DHCS	2018	Completed
27	Grievances	4.1.2 The Plan sent member resolution letters without completely resolving all complaints.	The Plan updated its grievance procedure to include a process for resolving all complaints and resolutions resolved outside the 30 day timeframe. Staff training was conducted on 7/17/2018.	7/17/2018	Completed	Grievance & Appeals		State	DHCS	2018	Completed
28	Grievances	4.1.3 The Plan did not update its provider manual to include the new timeframes for filing grievances that became effective July 1, 2017.	The Plan updated its Provider Manual on 12/25/2018 to include the correct new grievance filing timeframes. Update as of 1/07/19: The Manual is scheduled to be uploaded on our website on 1/25/2019. Update as of 1/25/2019: The Plan has posted the updated Provider Manual to its website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
29	Grievances	4.1.4 The Plan's grievance system did not capture and process all complaints and expressions of dissatisfaction	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. New provider orientation materials and the provider manual will include education materials of the Plan's grievance process for new and existing providers. Update as of 1/7/2019: The Plan will be uploading the provider manual to the website by 1/25/19. Update as of 1/25/2019: The Plan has posted the updated Provider Manual to its website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
30	HIPAA	4.3.1 The Plan did not report the discovery of PHI breaches to the DHCS Information Security Officer.	The Plan updated its procedures to ensure reporting of PHI incidents are reported to all DHCS contacts including the DHCS Information Security Officer. Staff training on updated procedures was conducted on 8/22/2018 and 10/3/2018.	10/3/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
31	HIPAA	4.3.2 The Plan did not report all suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery.	The Plan updated its procedures and tracking log to ensure monitoring of reporting to DHCS occurs timely. Staff training on updated procedures was conducted on 8/22/2018 and 10/3/2018.	10/3/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
32	Provider Training	5.2.1 The Plan did not ensure provider training was conducted within 10 working days.	The Plan monitors its tracking log to ensure provider training is conducted within 10 working days. Staff training of the required timeframe was conducted on 12/17/2018.	12/31/2018	Completed	Provider Services	✓	State	DHCS	2018	Completed
33	Provider Training	5.2.2 The Plan did not specify in its written agreement provider training responsibilities for two delegated entities.	The Plan updated its contract with the two delegated entities to ensure provider training requirements.Update 12/31/2018: The Plan has updated its contract with one of the delegates to include delegation of provider training requirements. The other delegate's contract is in progress to be finalized. Estimated time for contract to be completed is 2/28/2019.Update as of 3/4/2019: The remaining delegate has agreed to the provider training responsibilities; the final contract will be signed once the delegate agrees to terms for non-related items. Update as of 8/5/2019: Both delegates involved in the finding delegation agreements were updated. Another delegate's contract still needs to be finalized.	6/30/2019	Completed	Provider Services	✓	State	DHCS	2018	Completed
34	Provider Training	5.2.3 The Plan did not ensure training materials provided by two delegated entities included information on Plan policies, procedures, services, and member rights and responsibilities.	The Plan's delegated entities have updated their training materials to include the required information. Update 12/31/2018: The Plan is currently working with the delegate to incorporate this information. Target date for materials to be updated is 1/31/19. Update as of 1/30/2019: Both delegates have revised their training materials to include member rights and responsibilities, grievances and services.	1/31/2019	Completed	Provider Services	✓	State	DHCS	2018	Completed

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#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
35	Fraud, Waste, and Abuse (FWA)	6.3.1 The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10-working days.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to ensure timely reporting of incidents to DHCS. Staff training on updated procedures was conducted on 7/17/2018. The Plan updated its monitoring tracking log to monitor the reporting timeframe requirement.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
36	Fraud, Waste, and Abuse (FWA)	6.3.2 The Plan did not conduct prompt and complete investigations of all suspected fraud and abuse incidents.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to investigate all suspected incidents and update DHCS until the case closure. Standardized investigation form for documentation was implemented as of 7/17/2018. Staff training on updated procedures was conducted on 7/17/2018.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
37	State Supportive Services	SSS.1 The Plan denied state supported services (SSS) claims containing procedures that normally require prior authorization outside of a SSS setting. These claims were denied based on edits in the Plan's claims system and review by claims analysts; the Plan's process did not include exceptions for FP or ER services.	The Plan updated its system configuration to ensure SSS claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
38	State Supportive Services	SSS.2 The Plan did not disclose the specific rationale used in determining why claims are rejected.	The Plan's Remittance Advice (RA) includes the specific rationale for claims denials. Denial codes can be applied at the Header level, line level or both. The Plan's claims processing system edits each claims and assigns all denial or informational codes that are applicable to the claim. Update as of 1/31/2019: The Plan will provide training to providers to ensure comprehension concerning the remittance advice set-up. Update as of 3/6/19: The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by 5/31/2019. Update 4/8/2019: The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
1	Prior Authorizations	Authorizations were auto-approved for hospital.	Effective 9/17/2018, the Plan started to review and impose standard UM authorization guidelines for hospital authorizations.	9/17/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
2	Appeal	The Plan's expedited appeals checklist does not include a reminder to call the member when the case is de-escalated from urgent to routine.	The expedited appeals checklist has been updated. Staff training will be conducted by 10/1/2018. Checklist includes requirements of De-expedited: Decision to de-expedite must be made within 24 hours. Send ack letter within 3 calendar days notifying of priority change and right to contact DMHC. Follow standard appeal process. If 24 hour TAT is not met, proceed with expedited appeal.	10/1/2018	Completed	Grievance & Appeals	✓	Self Identified	AAH	2018	Completed
3	Delegation Oversight	Some authorization cases included many errors with subcontractor's notices of actions. Plan oversight of authorizations and notices is in process.	Reestablished bi weekly meetings with subcontractors and conducted monthly focused file audit which included NOAs, conducted clinical case rounds for overturned appeals. The plan will continue to monitor during annual audit review process. The Plan will be terminating services subcontractor and consuming this function to review authorization effective 4/1/2019.	12/1/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
4	Care Coordination	The Plan did not annually review the County MOU for CCS services.	Update 9/27/2019: MOUs have transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including CCS. Update as of 12/2/2019: The MOUs have been transitioned to the Provider Services team. The MOU was executed with an effective date of 8/1/2019	8/1/2019	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
5	Care Coordination	The Plan did not annually review the County MOU for Early intervention/development disabilities.	Update 9/27/2019: MOUs have been transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including EI/DD services. Update as of 12/2/2019: The Plan is currently working on developing a full county MOU to include services for early intervention and development disabilities services Update 7/10/2020: The MOU was sent to the County for review on6/16/2020. Update 10/9/2020: The County has accepted the Alliance's edits and the MOU is currently under review for final approval with the County.Update 11/10/2020: The County has cancelled the November 3rd meeting. This agenda item will be carried over to the December 15th docket.**Update 5/14/2021**: The MOU was approved by the county board on 4/6/2021.	~~2/28/20~~ TBD	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
6	Initial Health Assessment (IHA)	The Plan did not have a process for validating the procedure codes used for IHA completion.	P&P will be updated to include the detail of the process for annual validation and codes. The validated for this year will occur prior to 11/1/2018. Update 11/6/2018: Codes were validated and updated by QM department.	11/1/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
7	Initial Health Assessment (IHA)	The Plan does not have a system in place for monitoring member's missed appointments.	Missed appointments are identified during the Medical Record Review that is part of a FSR. The criteria for missed primary care appointments and outreach efforts, which is part of DHCS's tool. The FSR review nurse evaluates this information and if a deficiency is identified the provider is educated on the importance of outreaching to the member and that documentation of the outreach attempts is required.	11/26/2019	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
8	Access & Availability	The Plan did not monitor appointment wait times.	Policy and procedure is in place for monitoring appointment wait time standards. Standardized process for monitoring and corrective action plan in place as of 9/20/2018.	9/20/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
9	Grievances	Some exempt grievance cases were not resolved within the next business day timeframe (applied to 1 3 cases).	Policies and procedures in place are compliant with the exempt grievance resolution timeframe requirements. Staff training refresher of resolving all exempt grievances by close of next business day was conducted on 10/12/2018.	10/12/2018	Completed	Member Services	✓	Self Identified	AAH	2018	Completed

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
10	Quality Improvement	Reporting of the HCQC was not consistently reported to the Board.	The Chief Medical Officer will provide HCQC summary updates to the Board starting in November. The meeting minutes will be included in the Board materials.	11/9/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
11	Utilization Management	The Plan did not routinely review overturned UM denials for trends & to develop plans for intervention where needed.	The Plan will pull reporting of UM denial trends that will be presented at the UM committee. The first UM committee for presenting the overturn UM denial trends at UM committee will be on 9/28/2018. These findings will be presented to the HCQC and subsequently to the Board of Governors.	9/28/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
12	Utilization Management	The Plan did not have a clear process for peer-to-peer clinician discussions concerning denied services.	Steps Plan took or will take to correct deficiency: 1.Plan develop a desktop procedure on peer to peer discussion by 9/14/2018. 2. Plan to train physicians and pharmacists of desktop procedure and when and how to document peer-to-peer clinician discussions by 9/26/2018. 3.Plan has started a weekly meeting with physicians and pharmacist for peer to peer discussions as of 7/17/2018.	9/26/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed

ALAMEDA Alliance FOR HEALTH

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

Health Care Services

Dr. Donna Carey, MD

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

From: **Dr. Donna Carey, Chief Medical Officer (Interim)**

Date: **June 14th, 2024**

Subject: **Health Care Services Report**

Overall Authorization Volumes *(inpatient, outpatient, and long-term care):*

There was a month-over-month increase in total authorization volume from March to April 2024, with the largest month-over-month increase in outpatient authorization volumes.

Total Authorization Volume (Medical Services)			
Authorization Type	**March 2024**	**April 2024**	**May 2024**
Inpatient	2,169	2,246	2,188
Outpatient	4,020	4,464	4,278
Long-Term Care	836	1,018	915
Total	**7,025**	**7,728**	**7,381**

***Source**: #02569_AuthTAT_Summary*

The following sections provide additional detail on utilization management trends in each department.

Utilization Management: Outpatient

- Anthem CoC volume is consistently running at 10-15% of all incoming authorizations at any given time.

- For process improvement, OP UM completed an analysis of our radiology requests over the last 15 months and identified services that were being approved at 90% or more and moved them to an automated authorization process. Further assessment will be done by our Physicians to evaluate if certain radiology services may ultimately be removed from our prior authorization process. Improvements to our reporting are being made to further evaluate at a code level other services where we may be able to automate the decision process or remove from PA.

- Annual evaluation of our PA coding on prior authorization has begun. Impact analysis of updated coding is being done in the following areas: acupuncture, allergy, EEG, sleep study, blood products and radiology.

- Reporting is being analyzed to identify members who DHCS has categorized as special populations to ensure enhanced CoC benefits are managed properly for our

new members. Provider relations contracting team continuing to engage in contract negotiations with identified OON providers to bring them into AAH.

- Reporting requirements for DHCS are continuing through 12/31/2024 as part of the DHCS monitoring and oversight process.

- OP processed a total of 4,278 authorizations in the month of May. The top 5 categories remain radiology, OP Rehab, TQ, Home Health and Outpatient facility.

Total Outpatient Authorization Volume			
Authorization Status	**March 2024**	**April 2024**	**May 2024**
Approvals	3,785	4,295	4,130
Partial Approvals	24	9	9
Denials	211	160	139
Total	**4,020**	**4,464**	**4,278**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**March 2024**	**April 2024**	**May 2024**
Overall Denial Rate	**3.7%**	**3.0%**	**3.0%**
Denial Rate Excluding Partial Denials	**3.4%**	**2.8%**	**2.8%**
Partial Denial Rate	**0.4%**	**0.2%**	**0.2%**

***Source**: #03690_Executive_Dashboard*

Turn Around Time Compliance			
Line of Business	**March 2024**	**April 2024**	**May 2024**
Overall	**99%**	**100%**	**100%**
Medi-Cal	**99%**	**100%**	**100%**
IHSS	**99%**	**100%**	**100%**
Benchmark	*95%*	*95%*	*95%*

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- The Inpatient UM team processed a total of 2,351 authorizations and 3,135 corresponding reviews in the month of May. This is a slight increase from the volume reported in April 2024, markedly higher than December 2023 before the integration of the Anthem and Adult Expansion members IP UM team auth volume includes inpatient authorizations as well as outpatient authorizations related to discharge planning and care coordination needs including but not limited to SNF skilled and short term custodial, LTACH, Acute Rehab, home health, DME, hospice, wound care.

- IP Auth TAT compliance was 99% in March and 97% in April, and 98% in May. Despite the increase in auth volume, IP UM Team still exceeded the benchmark TAT of 95% for both our Medical and Commercial Lines of Business.

- IP UM is receiving ADT feed for Authorization automation from Alameda Health System's, Alta Bates Summit Medical Center, Eden Hospital, Washington Hospital, and St Rose. IP UM team has, in working with IT, automated the auth request process for these hospitals. This has reduced the administrative burden on the hospital provider side while facilitating real time communication on member admissions.

- IP UM team continues to identify members eligible for care management services who are currently admitted to a hospital, conducts inpatient discharge risk assessment, provides the name of Care Manager for inclusion in the discharge summary, and refers to Case Management department for follow up. Starting in 2024, TCS also includes simplified requirements for low-risk members, and the IP team has operationalized the enhanced TCS requirements.

- IP UM continues weekly hospital rounds with tertiary care centers UCSF and Stanford, as well as contracted hospital providers; Alameda Health System, Sutter, Kindred LTACH, Kentfield LTACH, and Washington, to discuss UM issues, address discharge barriers, and offer support in terms of ECM, Community Supports services, and other opportunities for supporting throughput and appropriate discharge.

Total Inpatient Authorization Volume			
Authorization Status	**March 2024**	**April 2024**	**May 2024**
Approvals	2,094	2,178	2,144
Partial Approvals	0	0	0
Denials	75	68	44
Total	**2,169**	**2,246**	**2,188**

***Source**: #02569_AuthTAT_Summary*

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**February 2024**	**March 2024**	**April 2024**
Authorized LOS	**5.7**	**5.9**	**5.5**
Admits/1,000	**54.1**	**51.8**	**50.1**
Days/1,000	**310.7**	**304.5**	**275.2**

***Source**: #01034_AuthUtilizationStatistics*

Inpatient Authorization Denial Rates			
Denial Rate Type	**February 2024**	**March 2024**	**April 2024**
Full Denials Rate	**0.7%**	**1.6%**	**1.1%**
Partial Denials	**1.5%**	**1.2%**	**1.1%**
All Types of Denials Rate	**2.1%**	**2.9%**	**2.2%**

***Source**: #01292_AllAuthDenialsRates*

Turn Around Time Compliance			
Line of Business	**March 2024**	**April 2024**	**May 2024**
Overall	**99%**	**97%**	**98%**
Medi-Cal	**99%**	**97%**	**97%**
IHSS	**100%**	**97%**	**100%**
Benchmark	*95%*	*95%*	*95%*

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Long-Term Care

- New Long Term Care Manger started 05/06/24

- LTC census during May 2024 was 2,888 members. This is an increase of 0.31% from April 2024.

- Month to Month the admissions, days and readmissions are decreasing. From February to April the admissions decreased by 45.65%, the days increased by 32.56% and the readmissions decreased by 26.67%. Some of this could be due to a lag in claims, but we are seeing a decrease overall.

Totals	February 2024	March 2024	April 2024
Admissions	138	128	75
Days	1,301	810	399
Readmissions	30	29	22

***Source**: #14236_LTC_Dashboard*

- COC is ending for DME for members in long-term care. LTC team is coordinating with CHME and reaching out to facilities/providers that have been using out-of-network venders. CHME is assisting with obtaining new orders to ensure no disruption in services for members.

- Continuing to meet with Regional Center of East Bay, monthly meetings have been scheduled to have a “rounds” discussion to touch base on the members and their possible needs while in the ICF/DD facilities.

- LTC Staff continue to participate in SNF collaboratives around the county to ensure that our facility partners are updated with the processes and program enhancements.

- Having virtual rounds with AHS and Eden LTC facilities to coordinate on complex cases; Social Workers continue visiting LTC facilities in person, on monthly and quarterly basis depending on census

- Continue referrals to TCS and other internal/external programs to provide wraparound supports to members preparing to discharge from an LTC custodial facility.

- Authorization volume had a slight decrease in May by 10.12% compared to April 2024.

- Authorization processing turn-around time (TAT) continues to **exceed** benchmark.

Total LTC Authorization Volume			
Authorization Status	**March 2024**	**April 2024**	**May 2024**
Approvals	827	986	891
Partial Approvals	0	0	0
Denials	9	32	24
Total	**836**	**1,018**	**915**

***Source**: #02569_AuthTAT_Summary*

Turn Around Time Compliance			
Line of Business	**March 2024**	**April 2024**	**May 2024**
Medi-Cal	**96%**	**98%**	**97%**
Benchmark	*95%*	*95%*	*95%*

***Source**: #02569_AuthTAT_Summary*

Behavioral Health

- Behavioral health processed 471 authorizations, 476 care coordination referrals, and 175 mental health screenings.

- On April 16, 2024, the IT department fixed the letter automation for approved authorizations in the Provider Portal and increased efficiency in meeting the organizational goal for notification TAT for the first time in 2024.

Total BH Authorization Volume			
	24-Mar	**24-Apr**	**24-May**
Approvals	465	486	469
Partial Approvals	0	0	1
Denials	1	0	1
Total	466	486	471

***Source: 14939_BH_AuthTAT**

Mental Health Turnaround Times

MH TAT			
**Goal ≥95%*	**24-Mar**	**24-Apr**	**24-May**
Determination TAT%	99%	98%	97%
Notification TAT%	75%	89%	95%

Behavioral Health Treatment Turnaround Times

BHT TAT			
**Goal ≥95%*	**24-Mar**	**24-Apr**	**24-May**
Determination TAT%	97%	99%	99%
Notification TAT%	100%	100%	100%

Behavioral Health Denial Rates

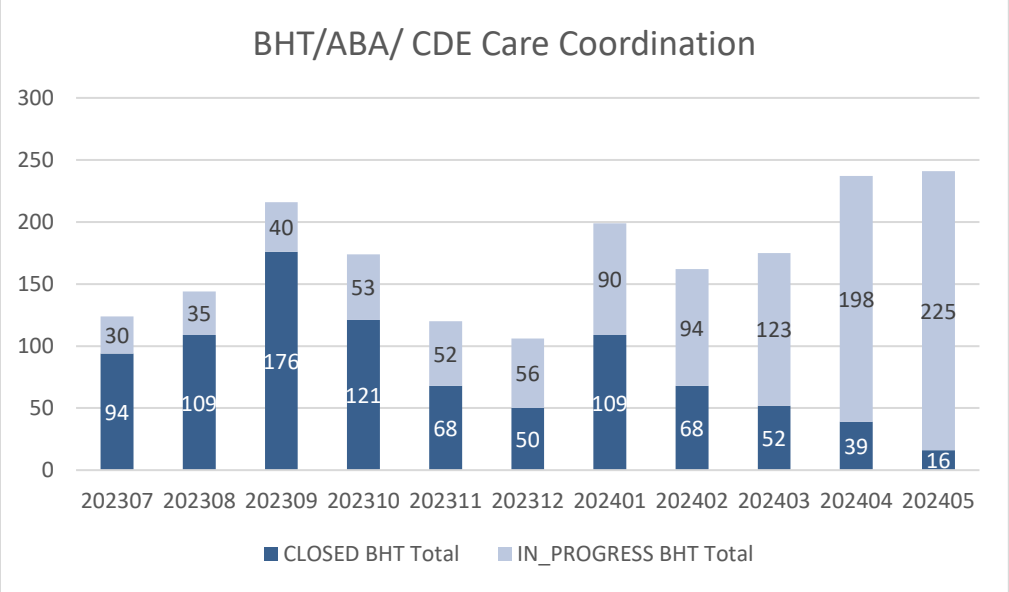
**Goal ≤ 5%*	BH Denial Rates	
24-Mar	**24-Apr**	**24-May**
0.01%	0	0.01%

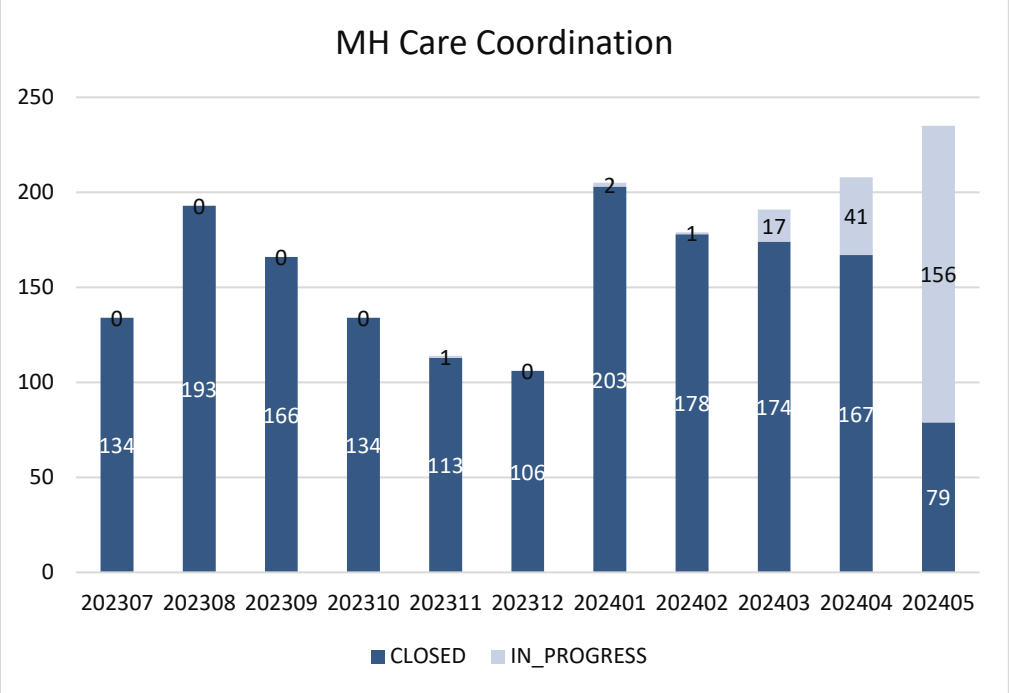
***Source: 14939_BH_AuthTAT**

BH Care Coordination

Total # Medi-Cal Screening Tools			
	24-Mar	**24-Apr**	**24-May**
Youth Screenings	44	46	57
Adults Screenings	97	119	118

***Source: PBI_14460 – MLS BH TruCare Assessment**





***Source: 14665_BH_Cases**

Pharmacy

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

- Top 10 Requested Drugs Submitted for Authorizations:

HCPCS Code	Drug Name	Authorizations
J2930	INJ METHYLPRDNISLN SODIM TO 125 MG	190
J9035	INJECTION BEVACIZUMAB 10 MG	149
J1453	INJECTION FOSAPREPITANT 1 MG	72
J0585	BOTULINUM TOXIN TYPE A PER UNIT	66
J0178	INJECTION AFLIBERCEPT 1 MG	64
J0897	INJECTION DENOSUMAB 1 MG	56
J7030	INFUS NORMAL SALINE SOL 1000 CC	50
J1100	INJ DEXMETHOSON SODIM PHOSHATE 1 MG	39
J9271	INJECTION PEMBROLIZUMAB 1 MG	36
J1950	INJ LEUPROLIDE ACETATE PER 3.75 MG	31

Authorization Overview

Line of Business	February 2024	March 2024	April 2024
IHSS	7	7	14
Medi-Cal	472	424	420

Turnaround Time and Determinations By Line of Business

LOB	Determination	February 2024	March 2024	April 2024
Medi-Cal	Approved	330	311	291
	Denied/Partials	11	5	9
	TAT	99.7%	100%	99.6%
IHSS	Approved	2	6	11
	Denied/Partials	1	0	1
	TAT	100%	100%	100%

- Updates to the physician administered drug prior authorization list will go live 6/3/2024. Pharmacy has collaborated with Provider Services and C&O to inform our valued providers and members.

- Starting 7/1/2024, the Alliance will no longer manage Continuous Glucose Monitors (CGM) for Medi-Cal Members with Type 2 Diabetes. The benefit and prior authorizations will be managed by Medi-Cal Rx. CGM for Type 2 Diabetes has been a covered benefit through Medi-Cal Rx since 10/2023.

Case and Disease Management

- The CM team has been working diligently to assist all members with Transitional Care Services (TCS) as they transition from one level of care to another. The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including (but not limited to) scheduling and ensuring follow up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners, members/caregivers/support teams, etc).

- CM is collaborating with UM and LTC to work on members with long lengths of (hospital) stays in hopes of successful and safe discharges and referrals as appropriate. (Referrals include Community Supports, ECM and other community resources, as needed.)

- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues to educate the provider network, including hospital discharge planners, and dialysis centers about PCS form requirements.

- As of January 1, 2024, Disease Management programming is offered for Asthma, Diabetes, Cardiovascular Disease and Depression diseases in accordance with the Population Health Management Policy Guide.

Case Type	Cases Opened in April 2024	Total Open Cases as of April 2024	Cases Opened in May 2024	Total Open Cases as of May 2024
Care Coordination	642	1,473	775	1,447
Complex Case Management	6	44	4	22
Transitions of Care (TCS)	1,202	2,156	1,212	2,331

***Source**: #03342 TruCare Caseload*

CalAIM

Enhanced Case Management

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

- The Alliance is continuing to meet with Roots regarding the Justice Involved (JI) Pilot. The Alliance is gaining a better understanding of how members previously incarcerated are assisted post-release, including member interest in any level of case management service.

- The ECM team meets with each ECM provider twice a month: once to discuss specific cases and once to discuss operational issues. This has created greater rapport with our providers and has led to assisting ECM providers with working through challenging issues such as appropriate billing.

- The ECM team is working closely with current ECM providers to expand serving additional ECM Populations of Focus as appropriate. This expansion is preparation for additional provider expansion for Jan 1, 2025.

- AAH continues to collaborate with Alameda County (AC) Health (formerly known as Health Care Services Agency (HCSA)) to discuss Street Medicine alignment. All 4 of the Street Medicine teams have finalized their contracts for ECM. As the number of authorizations continues to increase for Street Medicine, the ECM team will continue to work closely with the Street Team providers to make sure encounters are submitted smoothly.

ECM Outreach in February 2024	Total Open Cases as of February 2024	ECM Outreach in March 2024	Total Open Cases as of March 2024	ECM Outreach in April 2024	Total Open Cases as of April 2024
2,094	2,451	2,386	2,634	1,206	2856

***Source**: #13360 ECM Dashboard*

Community Supports (CS)

- AAH CS team is working on notifying members that are receiving services from non-contracted providers, that they need to start transitioning to in-network providers as their Continuity of Care comes to an end.

- The AAH CS team is working collaboratively with AC Health to assist with catching up on Housing CS services for the FY '23-'24. This includes correcting authorization dates and continuing authorizations for members who have received services from HCSA since 7/1/23.

- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance offers the following community supports:
    - Housing Navigation
    - Housing Deposits
    - Tenancy Sustaining Services
    - Medical Respite
    - Medically Tailored/Supportive Meals
    - Asthma Remediation
    - (Caregiver) Respite Services
    - Personal Care & Homemaker Services
    - Environmental Accessibility Adaptations (Home Modifications)
    - Nursing Facility Transition/Diversion to Assisted Living Facilities
    - Community Transition Services/Nursing Facility Transition to a Home
    - Sobering Centers (Coming Jan 2025)
    - Short term Post Hospitalization Housing (coming Jan 2025)
    - Day Habilitation (coming Jan 2025)

- AAH CS staff continue to meet regularly with each CS provider to work through logistical issues as they arise, including referral management, claims payment and member throughput.

- To meet the regulatory requirements of a closed loop referral process, AAH continues to work with FindHelp as the support platform. AAH continues with onboarding Community Supports providers and the CS team is working closely with each CS provider to bring them onto the platform.

- The CS leadership team is updating the Model of Care to submit to DHCS to bring the last 3 Community Supports services live on 1/1/25:
    - Sobering Centers
    - Short-Term Post-Hospitalization Housing
    - Day Habilitation Program

Community Supports	Services Authorized in February 2024	Services Authorized in March 2024	Services Authorized in April 2024
Housing Navigation	1,112	1,166	1,165
Housing Deposits	206	213	232
Housing Tenancy	1,671	1,618	1,418
Asthma Remediation	77	90	100
Meals	1,152	1,263	1,300
Medical Respite	103	112	119
Transition to Home	6	6	12
Nursing Facility Diversion	27	24	25
Home Modifications	5	3	3
Homemaker Services	232	284	275
Caregiver Respite	6	5	8

***Source**: #13581 Community Support Auths Dashboard*

Grievances & Appeals

- All cases were resolved within the goal of 95% of regulatory timeframes.
- Total grievances resolved in May were 9.13 complaints per 1,000 members.
- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of May 2024; we met our goal at 16% overturn rate.

May 2024 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,045	30 Calendar Days	95% compliance within standard	2,045	100.0%	4.69
Expedited Grievance	0	72 Hours	95% compliance within standard	0	N/A	0.00
Exempt Grievance	2,113	Next Business Day	95% compliance within standard	2,113	100.0%	4.46
Standard Appeal	55	30 Calendar Days	95% compliance within standard	55	100.0%	0.13
Expedited Appeal	2	72 Hours	95% compliance within standard	2	100.0%	0.00
Total Cases:	7,794		95% compliance within standard	7,792	99.9%	9.13

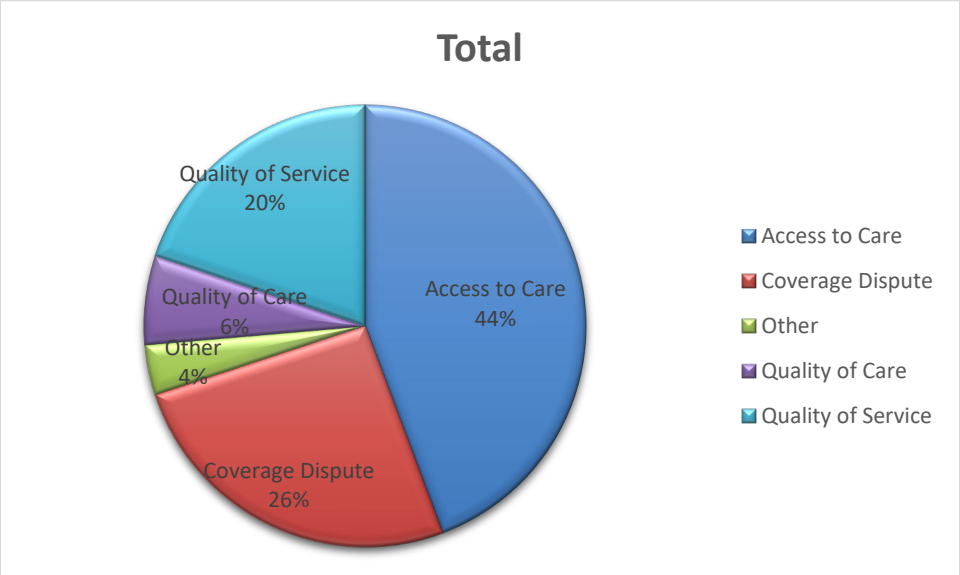
*Calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1000.

Grievances

- 906 of 2,045 (44%) cases were related to Access to Care, the top 3 grievance categories are:
  - (425) Timely Access
  - (179) Technology/Telephone
  - (123) Provider Availability

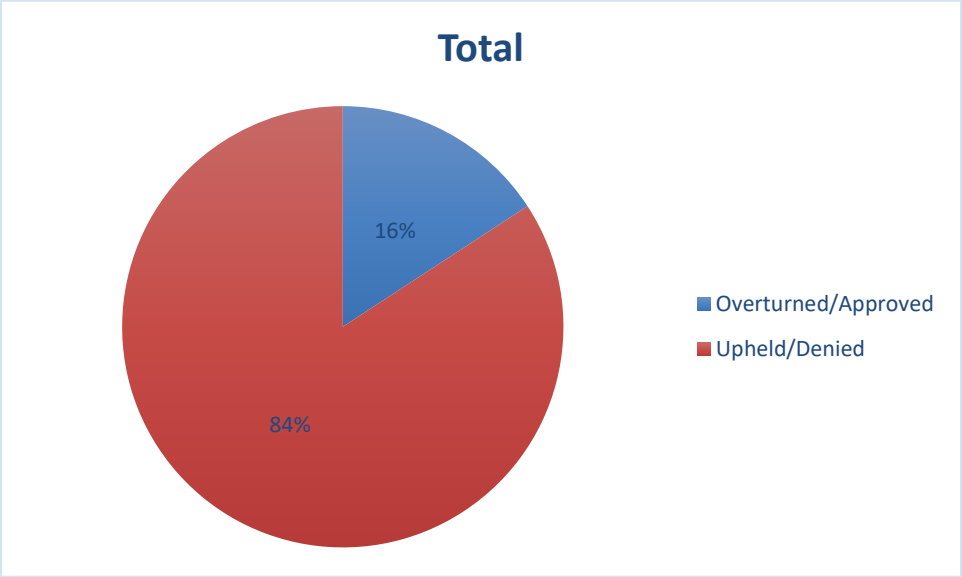
- 525 of 2,045 (26%) cases were related to Coverage Dispute, the top 3 grievance categories are:
  - (216) Provider Direct Member Billing
  - (178) Provider Balance Billing
  - (74) Benefit

- 406 of 2,045 (20%) cases were related to Quality of Service, the top 3 categories are:
  - (85) Plan Customer Service
  - (44) Transportation
  - (70) Provider/Staff Attitude



Appeals:

- 9 out of 57 (16%) cases were overturned for the month of May 2024:
  - (7) Out of network
  - (2) Disputes Involving Medical Necessity



Quality

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

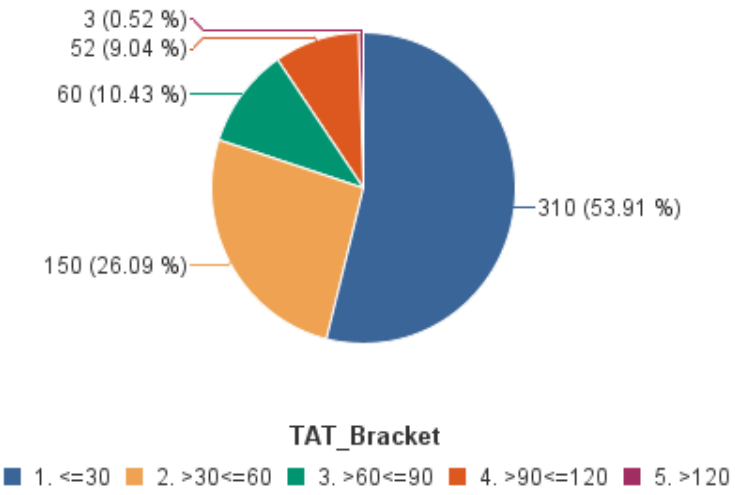
- As part of an effort to streamline the PQI review process, Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics team after they are triaged by the QI Clinical team. Quality of Care and Service issues continue to be reviewed by the QI Clinical staff.

- 0.13% of cases in April and 0.52% in May were still open past the 120-day TAT. Therefore, turnaround times for case review and closure remain well within the benchmark of 95% per PQI P&P QI-104 for this lookback period.

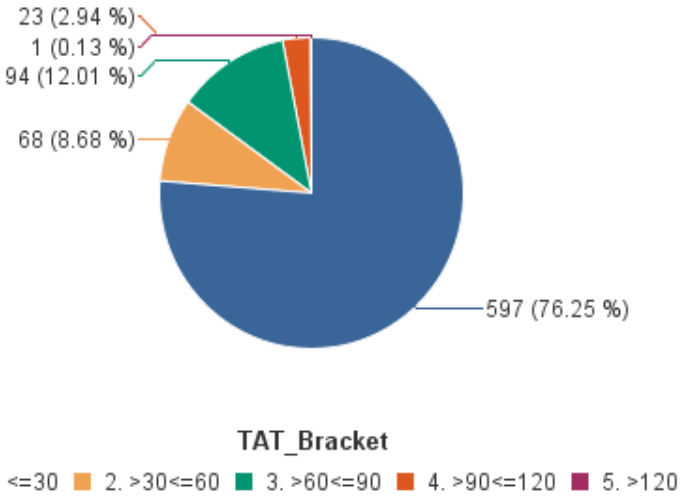
- When cases are open for >120 days, the reason continues to be primarily due to delay in receipt of medical records and/or provider responses. As part of the escalation process of obtaining medical records and/or responses, efforts are made to identify barriers with specific providers to find ways to better collaborate to achieve resolution.

- As membership has increased since the beginning of the year, QI saw a gradual increase in PQI referrals through April, the majority of which were Quality of Service and Access issues. May totals have decreased by approximately 200 cases. TATs are closely monitored to ensure timely closure of cases within the standard 95%.

PQI Aging Report as of 05/31/2024 N= 575



PQI Aging Report as of 04/30/2024 N= 783



Health Equity

Lao Paul Vang

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

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

Date: **June 14th, 2024**

Subject: **Health Equity Report**

Staffing Update –

- **The Health Equity Department has hired a Director of Health Equity to start July 8th.**

Internal Collaboration:

- **Meetings and check-ins with Division Chiefs Update** –
    - The Alliance division chiefs meet 1x1 monthly to update on Health Equity (HE) and Diversity, Equity, and Inclusion (DEI) activities.
- **Population Health Management (PHM), Quality Improvement (QI), and Utilization Management (UM) Update** –
    - The committee discussed the following topics:
        - LGBTQ Center - Outreach Collaboration
        - PHM Strategy - Staff DEI Training

External Collaboration

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update**
    - Discussed the DEI training development process for MCPs, including selection of providers for the pilot training process as required by APL23-025 to ensure success and completion of this process.
- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**
    - DHCS CHEO and MCPs CHEOs met to collaborate on Health Equity and DEI initiatives.
    - The meeting was largely focused on APL23-025, as well as some EPT discussions.
- **County Data on Health Equity**

- Maternal mortality disproportionately affects African American women compared to other groups. More than 50% higherBlack women are 2x more likely to experience complications, die in pregnancy, or die in childbirth. Infant mortality among the African American/Black population is twice the Alameda County rate. African American/Black babies are 3-4x more likely to be born too early, too small or die before their first birthday.
    - **PARTNERSHIPS**: Work with the County to build partnerships with doulas and African American/Black birthing centers, like EmbraceHer (BElovedBirth Black Centering).
    - **GOAL**: To reduce infant and maternal mortality. To build collaborative partnerships within the community that serve the African American/Black female population and to contribute to healthy birth outcomes.
        - Alameda Alliance for Health (PHM) is set to meet with EmbraceHer in July or August. (contact: Jyesha Wren)

- Life expectancy for American Indian/Alaska Native people was 7.3 years lower than for the general population of Alameda County in 2020-2021. American Indian/Alaska Native people are more likely to lack health insurance than the general population of Alameda County (9% of Native Americans/American Indians lack health insurance, compared to 4% of Alameda County). In 2019, the second leading cause of death for Native Americans/American Indians was suicide between the ages of 10-34. In 2021, Native Americans/American Indian males and females had the highest suicide rates in the United States. However, white people in Alameda County are more likely to die of suicide, with African Americans/Blacks showing a trend of increased suicides since 2014-2015.
    - **PARTNERSHIPS**: Collaborating with Alameda County's Office of Violence Prevention (2024-2025 CHIP conference follow up: first meeting, *Peaceful Communities & Families*, on June 13th at 3:30PM).
    - **GOAL**: Our goal is to build collaborative partnerships & to assist with access to care and mental health services that serve the Native American/American Indian & LGBTQIA+ community.

- Cancer is the leading cause of death, and heart disease is the second-leading cause of death for those 45 to 84 years old in Alameda County. These rates are higher in households experiencing poverty. Native American/American Indians are dying at a median rate of 20 years younger (64 years old) than the average Asian at 84 years old due to heart disease. African Americans/Blacks are dying at a higher rate of cancer than any

other ethnic group.

- **PARTNERSHIPS**: Collaborating with Alameda County Public Health Dept (2024-2025 CHIP conference follow up: first meeting, *Access to Care*, on June 11th at 3:30PM).
- **GOAL**: Our goal is to reduce chronic disease and assist this older population with accessing healthcare services, especially preventative care. To build collaborative partnerships within the community to bring awareness and education.

- Discriminatory practices of redlining, racial steering, and affordability affect minorities' likelihood of successful and healthy homeownership and housing opportunities. Housing problems and poor health outcomes are linked. The inability to have stable housing exposes households and communities to a variety of health risk factors like stress, high blood pressure, and depression. In Alameda County, African Americans/Blacks (54.3%), Whites (20.3%), and Latinos (15.4%) make up the majority of service users for homeless services. Nevertheless, African Americans/Blacks (39%) and Latinos (46%) are least likely to attain homeownership compared to Whites (65%) and Asians (63%).
  - **PARTNERSHIPS**: Collaborating with Alameda County Public Health Dept (2024-2025 CHIP conference follow up: first meeting, *Economic Security*, on June 18th at 3:30PM).
  - **GOAL**: Our goal is to reduce homelessness, prevent displacement and increase healthier outcomes for members; to build collaborative partnerships within the community and county to bring awareness, opportunities, and education.

Advancing Health Equity Initiative (AHEI)

- **Leadership Enrichment Sessions**

  - The final two Leadership Enrichment Sessions were conducted with the Senior Leadership Team in May.

- **Alliance Strategic Roadmap Update**

  - The first Committee meeting session was conducted in May.
  - Session 1 consisted of –
    - Introductions
    - Committee Rules & Commitment
    - Findings Report

  - The second session is scheduled for early June.

- **DEI Training Curriculum (APL 23–025) Updates**

DEI Curriculum Development

- The project moved forward to 'storyboarding' for all modules and all versions of the modules (employee, provider, and vendors).
- Meeting invites were sent to community members to discuss curriculum content specifics and meet APL requirements pertaining to the members served (speaking with representatives from LGBTQ+, Native American, etc., segments of the population).
- Working with the Vendor Management team to review the identified vendors' DEI/Health Equity training curriculum (5 vendor reviews conducted to date) and to 'brand' the attestation form to be utilized by Alliance vendors.

DEI Training Curriculum Timeline

- Mid-July 2024 - First draft.
- Mid-August - Final draft.
- Mid-September - Submission to DHCS for approval.
- Mid-November - Select a provider for the pilot training process.
- January 2025 – Launch pilot training process.
- April – June, completion of pilot training and launch all training to all providers and downstream subcontractors.

- **Communications Update**

  - The HE Department is working with Communications and Outreach to brand the attestation form.
  - A communication from the CEO introducing the DEI Training Curriculum is also being prepared for staff and stakeholders.

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

- **DEIB Committee Update**

  - In May, the DEIB Committee discussed arrangements for the committee's upcoming get–together. To date, no exact date has been set.
  - The Committee also discussed Delta Dental, hoping that the Alliance would add another dental option so the staff could choose the plan they want.
  - Other items discussed were Employee of the Month, Catastrophe Insurance, the PTO Borrow Program, and the Policy for Events.

- **VIA Committee Update**

  - The VIA Committee was canceled in May due to the Alliance Spring

Social.

- **Alliance Spring Social**

    - At this event, the proposed headcount given to vendors was 200-250, and we remained within those limits.

    - A select few staff requested more vegetarian and vegan options; we will do our best to engage a vendor with more vegan/vegetarian options to fulfill that need.

    - In our last VIA meeting, we had a post-event report, and nametags were suggested. We implemented this suggestion at the Spring Social and received great feedback.

    - In collaboration with Facilities, we ordered more tents for sun relief for our next event(s). Currently, we are utilizing Yemaya's personal inventory.

    - A mental health & wellness activity was implemented in recognition of Mental Health Awareness Month. (As we continue to plan & build on each social gathering, suggestions like more entertainment and interactive activities will be considered.)

    - We received feedback from all vendors who are from our communities, woman-owned or minority-owned. They were very appreciative of the opportunity and would love to come back and serve AAH. Some vendors reported that they were very grateful that AAH paid them on time because, with their previous experience working with different high-profile corporate organizations, AAH is the first organization to pay on time.

    - Shoutouts & Big Thank–Yous to help make this event possible for our staff:

        - Facilities & Support Services
        - Vendor Management,
        - Finance
        - Latrice Allen,
        - Laura Grossman Hicks in collaboration with Michelle Lewis & Dr. Bhatt for their Mental Health & Wellness activity,
        - Health Equity Department,
        - our CEO and
        - VIA Committee.

The following food was available.

Yummi BBQ:
Sweet & Spicy Shortribs
Orange Chicken
Teriyaki Chicken
(all come with rice)

Lorraine's Café:
Chicken & Mac n' Cheese
Chicken & Fries
Chicken & Pancakes
**(Veggie option could be created: fries and pancakes or mac n cheese with fries or pancakes)*

Tacos Sinaloa:
Chicken, Shrimp or Steak Tacos
**(Veggie option: Rice & Bean Tacos)*

FroGo Food Truck:
Frozen Yogurt truck that is *allergen-free (no lactose, no gluten, no egg, no nuts, or soy)*
Chocolate, vanilla, pineapple dole whip, and strawberry flavors

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: **June 14th, 2024**

Subject: **Information Technology Report**

Call Center System Availability

- AAH phone systems and call center applications performed at 97.81% availability during the month of May 2024 despite supporting 97% of staff working remotely.

Encounter Data

- In the month of May 2024, the Alliance submitted 203 encounter files to the Department of Health Care Services (DHCS) with a total of 403,654 encounters.

Enrollment

- The Medi-Cal Enrollment file for the month of March 2024 was received and loaded to HEALTHsuite.

HealthSuite

- The Alliance received 374,133 claims in the month of May 2024.

- A total of 374,133 claims were finalized during the month out of which 320,197 claims auto adjudicated. This sets the auto-adjudication rate for this period to 85.6%.

TruCare

- A total of 21,604 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.99%.

IT Security Program

- IT Security 3.0 initiative is one of the Alliance's top priorities for fiscal year 2024. Our goal is to continue to elevate and further improve our security posture, ensure that our network perimeter is secure from threats and vulnerabilities, and to improve and strengthen our security policies and procedures.

    - **Key initiatives include:**

        - Implement actionable items from the Azure Governance best-practices and recommendations document.
        - Remediating issues from security assessments. (e.g., Cyber, Microsoft Office 365, & Azure Cloud).
        - Continue to create, update, and implement policies and procedures to operationalize and maintain security level after remediation.

- The Annual Security Penetration testing report has been delivered by our vendor and the project team is currently prioritizing the critical items from the report which will be addressed immediately.

- Successfully deployed server patches to 95% of our server environment. This includes security vulnerability patches.

IT Disaster Recovery (Phase 2)

- One of the Alliance primary objectives for fiscal year 2024 is to complete the second phase of the implementation of an enterprise IT Disaster Recovery program that will focus on tier 2/3 applications and systems. This is to ensure that our core business areas have the ability to restore and continue operations when there is a disaster.

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

- Project team is currently collecting procedural documentations, server inventory lists, and diagrams and submitting them to the disaster recovery technical writer for review and clean-up.

- Procurement of additional replication licenses has been processed.

Data Retention Project (Phase 1)

- One of the Alliance major goals for fiscal year 2024 is to complete the first phase of the implementation of an enterprise Data Retention program that will focus on structured data.

- This program will guarantee the practice of storing and managing data and records for a designated period, to ensure that data is discoverable, cataloged, classified and easily accessible.

- The project team is currently in the midst of a product “Proof of concept” which is set to be completed by mid-May 2024.

- Product selection and contract processing for both services and licenses will soon follow to proceed with the implementation phase of the project.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of May 2024”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of May 2024”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal and Group Care Member enrollment in the month of May 2024

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
May	405,347	7,666	8,004	5,641	149	152

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 May 2024

Auto-Assignments	Member Count
Auto-assignments MC	3,212
Auto-assignments Expansion	2,925
Auto-assignments GC	105
PCP Changes (PCP Change Tool) Total	4,630

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of May 2024”.
- There were 21,604 authorizations processed within the TruCare application.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of May 2024*

Transaction Type	Inbound automated Auths	Errored	Total Auths Loaded in TruCare
Paper Fax to Scan (DocuStream)	2,849	2,286	1,603
Provider Portal Requests (Zipari)	5,154	997	5,076
EDI (CHCN)	5,665	1,682	5,531
Provider Portal to AAH Online (Long Term Care)	29	16	27
ADT	1,240	6,89	714
Behavioral Health COC Update - Online	53	37	49
Behavioral initial evaluation - Online	74	41	69
HCSA (Health Care Service Agencies)	N/A	N/A	N/A
Manual Entry (all other not automated or faxed vs portal use)	N/A	N/A	3,154
Total			16,223

Key: EDI – Electronic Data Interchange

Web Portal Consumer Platform

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

Table 3-1 Web Portal Usage for the Month of May 2024

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	7,317	5,434	363,471	705
MCAL	111,331	4,310	10,523	1,587
IHSS	3,654	78	108	46
Total	122,345	9,822	374,102	2,338

Table 3-2 Top Pages Viewed for the Month of May 2024

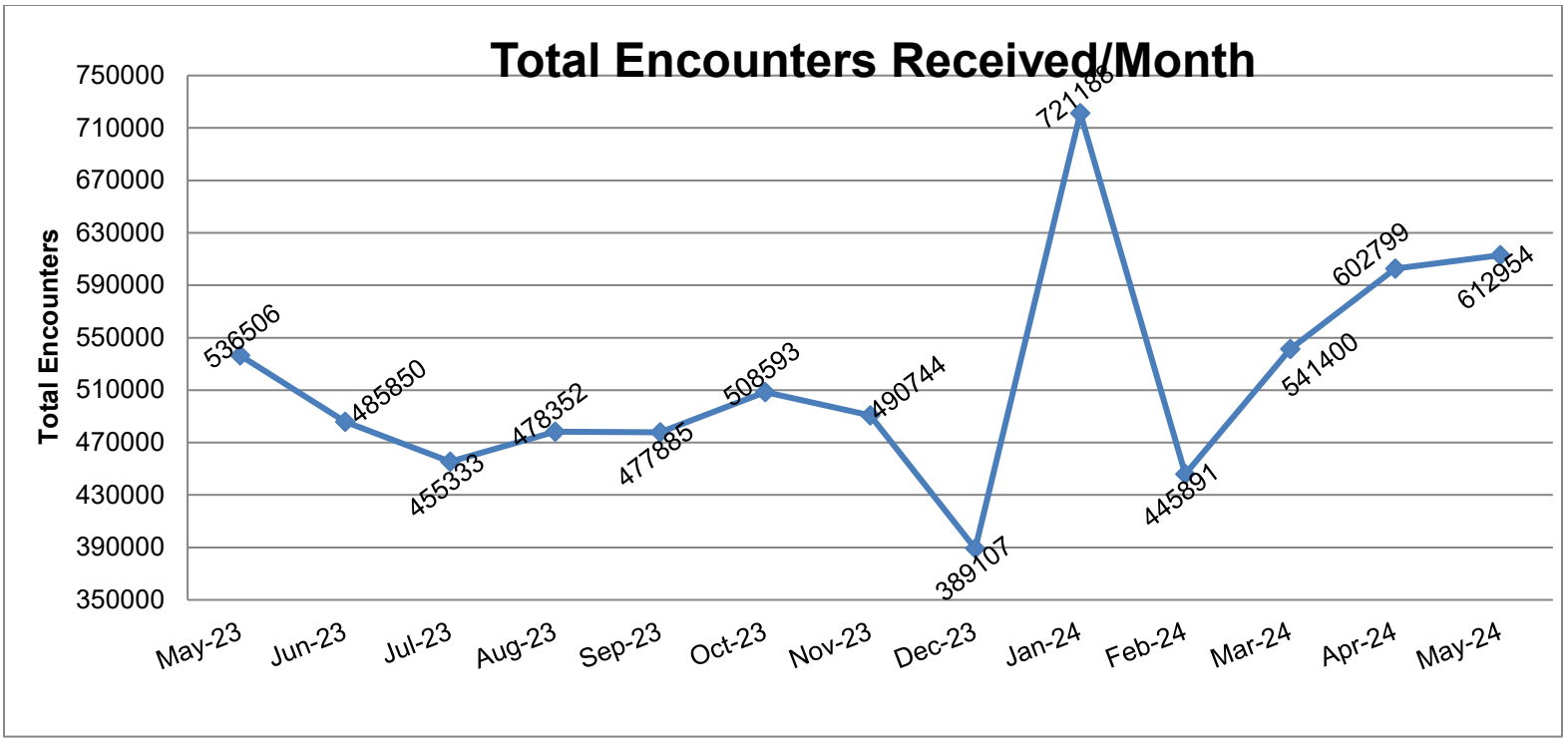
Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1,393,725
Provider - Claims	Claim Status	231,000
Provider - eligibility/claim	Claim Status	28,295
Provider - authorizations	Auth Submit	17,714
Provider - authorizations	Auth Search	8,752
Member Config	Provider Directory	8,118
Member My Care	Member Eligibility	5,489
Provider - Claims	Submit professional claims	5,301
Directory Config	Provider Directory	5,245
Member Help Resources	Find a Doctor or Hospital	3,867
Provider - eligibility/claim	Member Roster	3,619
Member Help Resources	ID Card	2,819
Member Help Resources	Select or Change Your PCP	2,316
Member Home	MC ID Card	1,513
Member My Care	My Claims Services	1,398
Provider - Provider Directory	Provider Directory 2019	1,294
Member My Care	Authorization	956
Provider - reports	Reports	930
Provider - Home	Forms	516
Member My Care	My Pharmacy Medication Benefits	515
Provider - Home	Behavior Health Forms SSO	498
Member Help Resources	FAQs	455
Member Help Resources	Forms Resources	453
Member My Care	Member Benefits Materials	374
Member Help Resources	Authorizations Referrals	369
Provider - Provider Directory	Manual	315
Member Help Resources	Contact Us	263
Provider - Provider Directory	Instruction Guide	254

Encounter Data From Trading Partners 2024

- **AHS**: May weekly files (8,412 records) were received on time.
- **BAC**: May monthly files (70 records) were received on time.
- **Beacon**: May weekly files (0 records)
    - No longer receiving encounter files.
- **CHCN**: May weekly files (122,445 records) were received on time.
- **CHME**: May monthly files (7,107 records) were received on time.
- **CFMG**: May weekly files (15,934 records) were received on time.
- **Docustream**: May monthly files (1,589 records) were received on time.
- **EBI**: May monthly files (184 records) were received on time.
- **FULLCIR**: May monthly files (8,478 records) were received on time.
- **HCSA**: May monthly files (5,535 records) were received on time.
- **IOA**: May monthly files (1,163 records) were received on time.
- **Kaiser**: May bi-weekly files (886 records) were received on time.
- **LAFAM**: May monthly files (116 records) were received on time.
- **LogistiCare**: May weekly files (27,531 records) were received on time.
- **March Vision**: May monthly files (8,546 records) were received on time.
- **MED**: May monthly files (722 records) were received on time.
- **OMATOCHI**: May monthly files (0 records) were not received on time.
- **PAIRTEAM**: May monthly files (7,582 records) were received on time.
- **Quest Diagnostics**: May weekly files (18,001 records) were received on time.
- **SENECA**: May monthly files (113 records) were received on time.
- **TITANIUM**: May monthly files (3,086 records) were received on time.
- **Magellan**: May monthly files (455,622 records) were received on time.

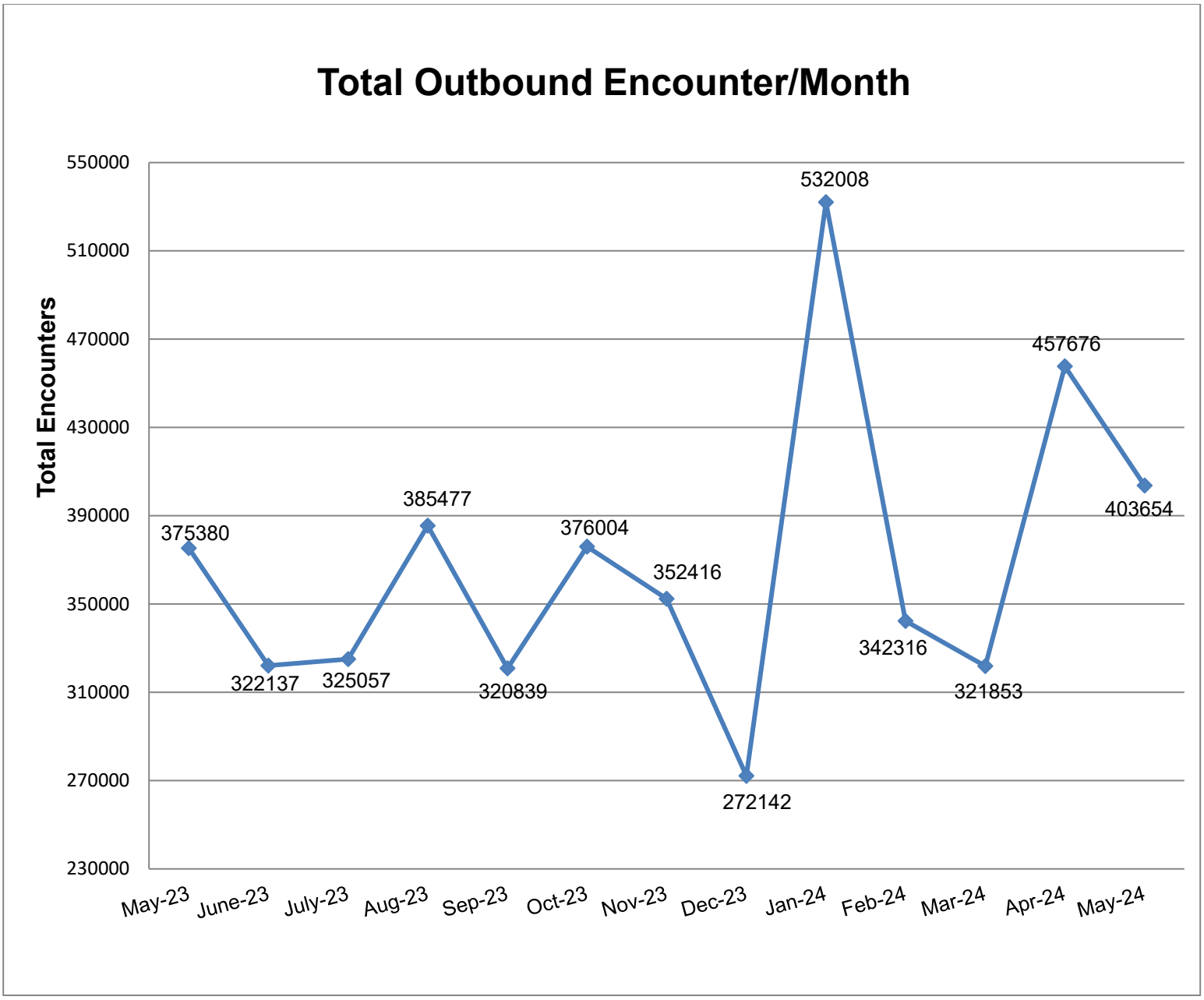
Trading Partner Encounter Inbound Submission History

Trading Partners	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Health Suite	251858	267437	224540	244907	247423	241298	247537	215246	298465	266339	308453	322786	375454
AHS	5380	6250	4363	4380	5479	5371	5243	6284	4570	7736	7005	6573	8412
BAC	40	37	39	38	38	57	73	55	59	57	55	64	70
Beacon	5822	4559	620										
CHCN	117764	90418	102081	85836	77060	111275	87839	58566	96124	103674	122217	170653	122445
CHME	4987	5692	5706	5704	6212	7609	6445	5694	5843	5560	6022	7969	7107
Claimsnet	12526	9986	12379	8946	12302	12167	11670	18995	12043	10557	12651	16394	15934
Docustream	575	607	567	744	562	400	705	476	930	814	698	302	1589
EBI	15	910	1664	814	867	718	823	811	1047	2903	1625	1700	184
FULLCIR						888	598	177	828	1586	213	2261	8478
HCSA	72	5573	3824	3466	2490	1913	2403	2087	2223	2097	2822	7118	5535
IOA	325	974	424	673	1086	967	1073	1250	1453	1233	1054	1925	1163
Kaiser	91196	53820	56673	76278	79751	81985	87005	26208	77407	3725	9966	2286	886
LAFAM						24				60	39	105	116
LogistiCare	28628	20859	22235	27129	22456	25509	20781	32181	182822	20774	35600	32632	27531
March Vision	3647	5101	4468	4563	4933	4427	4428	4562	9693		6183	3633	8546
MED			9	11	144	194	523	532	535	742	683	633	722
OMATOCHI												29	
PAIRTEAM												5344	7582
Quest	13671	13627	15741	14859	17008	13712	13077	15834	27022	17658	22306	18000	18001
SENECA				4	74	79	56	52	124	222	112	159	113
TITANIUM							465	97		154	3696	2233	3086
Total	536506	485850	455333	478352	477885	508593	490744	389107	721188	445891	541400	602799	612954



Outbound Encounter Submission

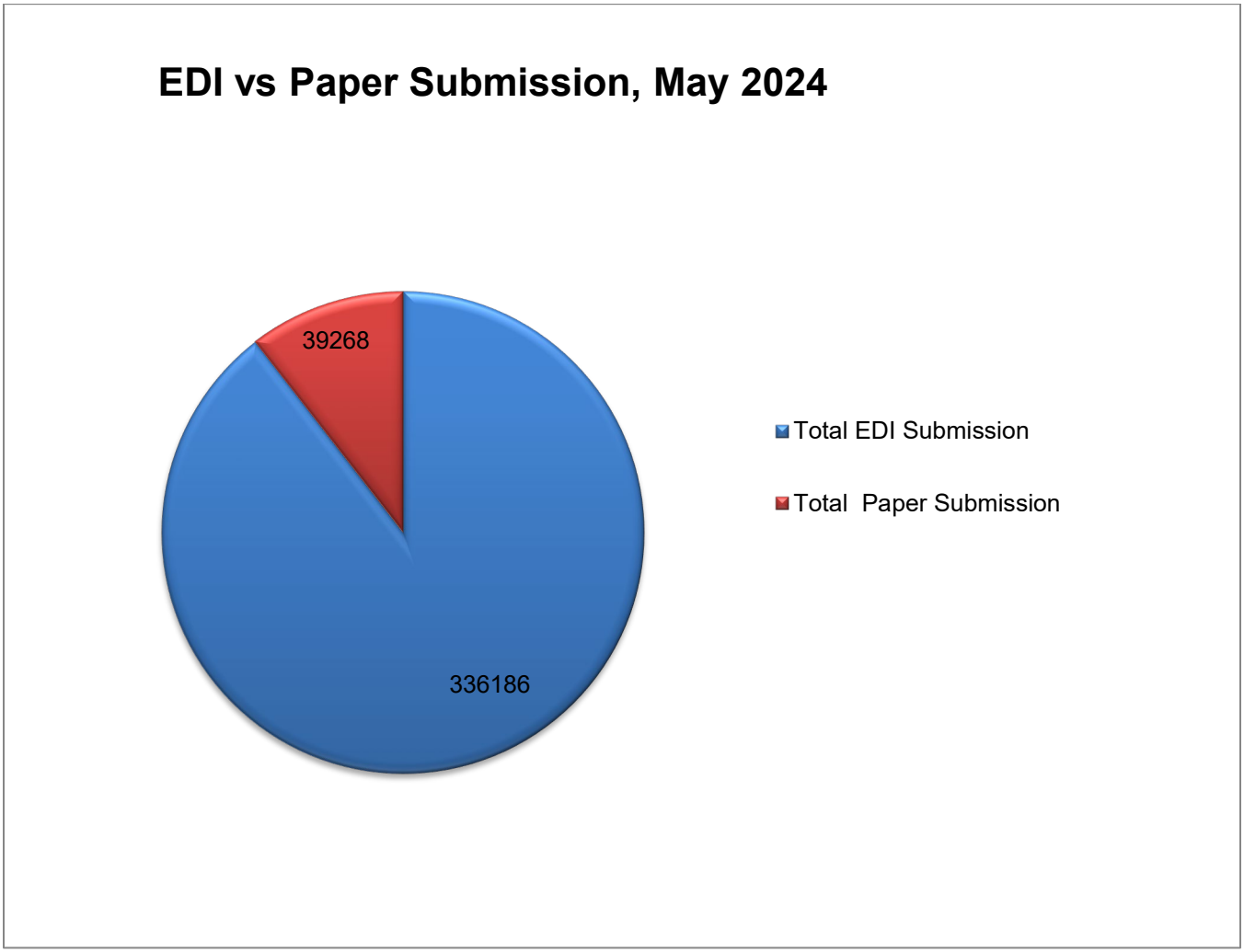
Trading Partners	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Health Suite	151866	126674	147199	170751	127465	163149	134823	136233	172386	177658	147776	250835	198595
AHS	5236	5070	5318	4251	4253	6355	5147	4936	5667	7497	6968	6524	7002
BAC	40	37	39	37	38	52	67	53	55	55	47	59	66
Beacon	2879	2233	318										
CHCN	79256	65595	56593	74313	55365	62962	73866	39846	67063	74336	80498	104625	107577
CHME	4864	5577	5595	5546	6063	7475	6321	5588	5703	5470	5889	7558	6749
Claimsnet	10891	7445	8849	6386	7075	7452	8031	11581	10145	7730	6757	13467	11561
Docustream	411	378	347	529	441	270	573	404	387	600	377	267	839
EBI	15	872	1574	804	855	710	794	802	987	1347	1002	1589	60
FULLCIR						806	516	124	653	540	116	1636	5401
HCSA	55	1781	3778	3405	2349	1876	2342	1991	2142	2013	2769	4710	5363
IOA	276	751	410	654	984	65	934	1228	1378	1156	1000	1868	1029
Kaiser	72893	68887	55988	75591	78162	81165	85807	26113	76335	3542	9650	1905	1292
LAFAM						2					16	92	103
LogistiCare	28455	20787	21686	26670	22142	24497	25951	31546	157548	40529	34931	32247	27487
March Vision	2366	3408	2720	2737	2992	2863	2661	2752	2700	2616	3736	2407	5719
MED			9	11	126	145	438	428	446	624	528	518	579
OMATOCHI												56	
PAIRTEAM												4279	4422
Quest	15877	12642	14634	13788	12456	16082	3655	8394	28299	16589	16333	20983	16912
SENECA				4	73	78	52	48	114	14	199	140	109
TITANIUM							438	75			3261	1911	2789
Total	375380	322137	325057	385477	320839	376004	352416	272142	532008	342316	321853	457676	403654


Total Outbound Encounter/Month
Total Encounters
550000
510000
470000
430000
390000
350000
310000
270000
230000
375380
322137
325057
385477
320839
376004
352416
272142
532008
342316
321853
457676
403654
May-23
June-23
July-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24

HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
24-May	336186	39268	375454

Key: EDI – Electronic Data Interchange

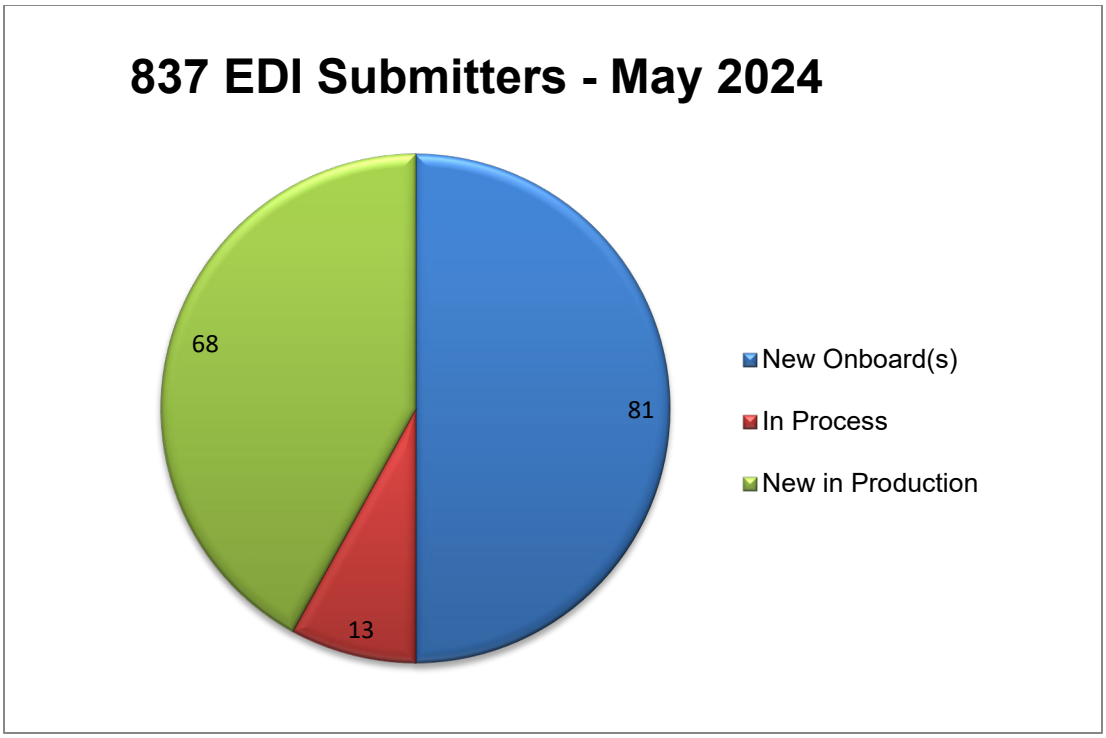


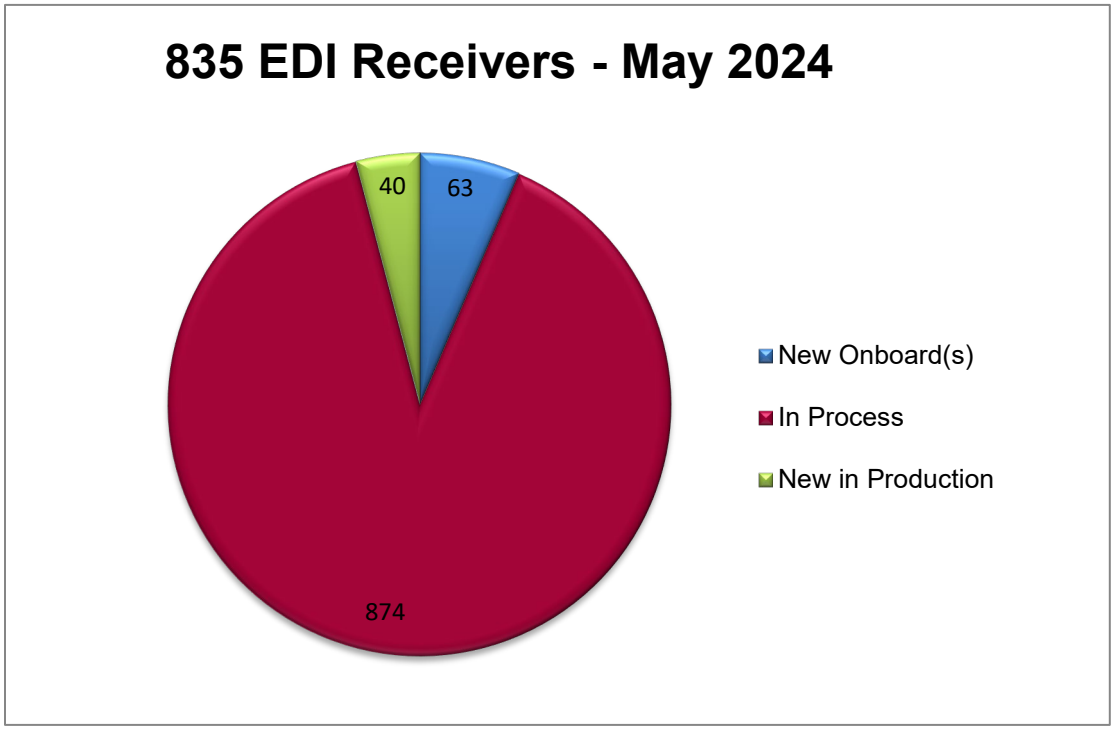
Onboarding EDI Providers – Updates

- May 2024 EDI Claims:
  - A total of 2345 new EDI submitters have been added since October 2015, with 68 added in May 2024.
  - The total number of EDI submitters is 3085 providers.

- May 2024 EDI Remittances (ERA):
  - A total of 1036 new ERA receivers have been added since October 2015, with 40 added in May 2024.
  - The total number of ERA receivers is 1052 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
Jun-23	79	7	72	2472	58	544	41	763
Jul-23	48	2	46	2518	62	583	23	786
Aug-23	44	1	43	2561	41	602	22	808
Sep-23	70	0	70	2631	46	621	27	835
Oct-23	36	2	34	2665	21	640	2	837
Nov-23	47	2	45	2710	45	679	6	843
Dec-23	25	2	23	2733	63	716	26	869
Jan-24	63	2	61	2794	76	751	41	910
Feb-24	37	17	20	2814	59	783	27	937
Mar-24	111	25	86	2900	60	822	21	958
Apr-24	120	3	117	3017	83	851	54	1012
May-24	81	13	68	3085	63	874	40	1052


837 EDI Submitters - May 2024
68
81
13
New Onboard(s)
In Process
New in Production


835 EDI Receivers - May 2024
40
63
874
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 **May** 2024.

File Type	May-24
837 I Files	33
837 P Files	170
Total Files	203

Lag-time Metrics/Key Performance Indicators (KPI)

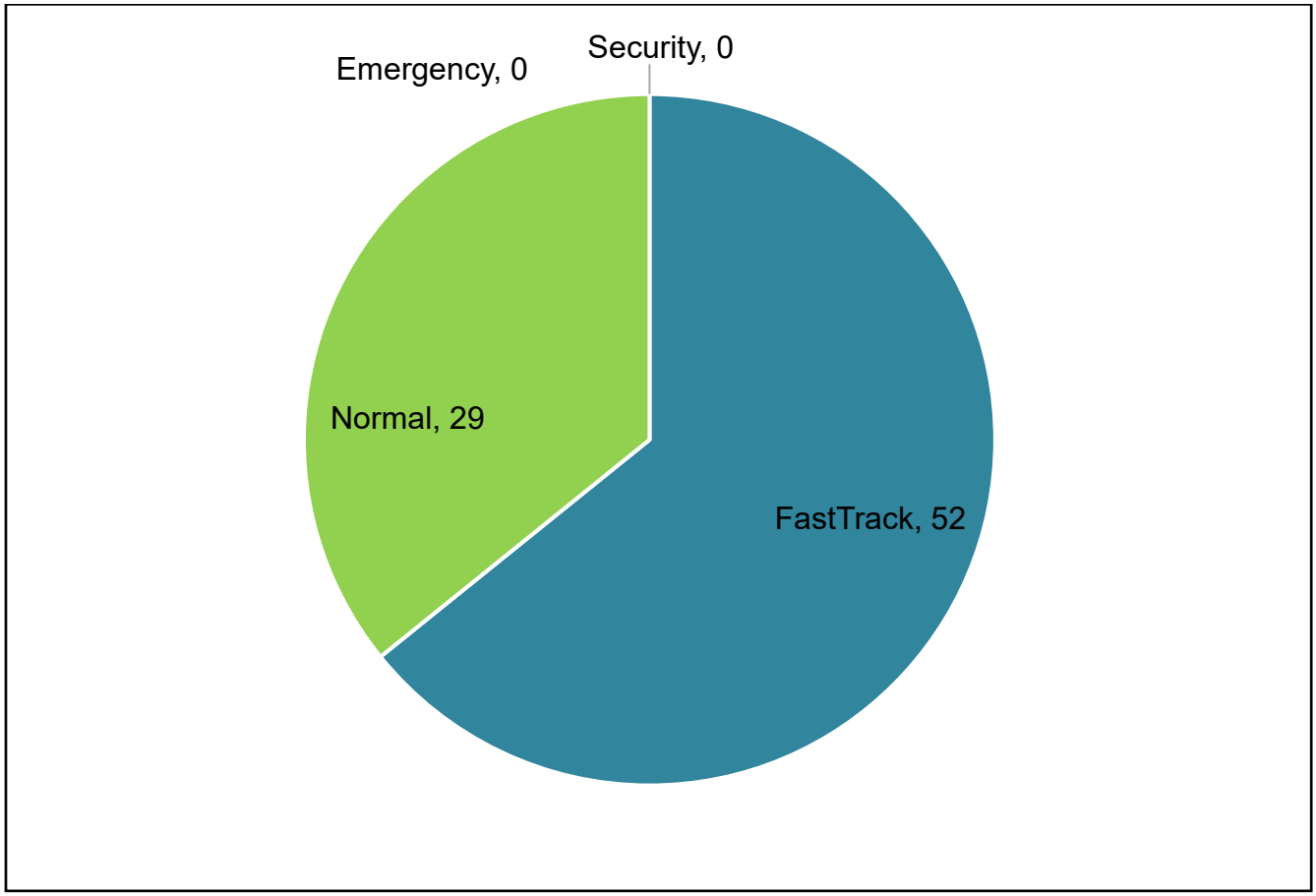
AAH Encounters: Outbound 837	May-24	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	94%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	99%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	93%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	99%	80%

*Note, the Number of Encounters comes from: Total at bottom of this chart: **Outbound Encounter Submission**

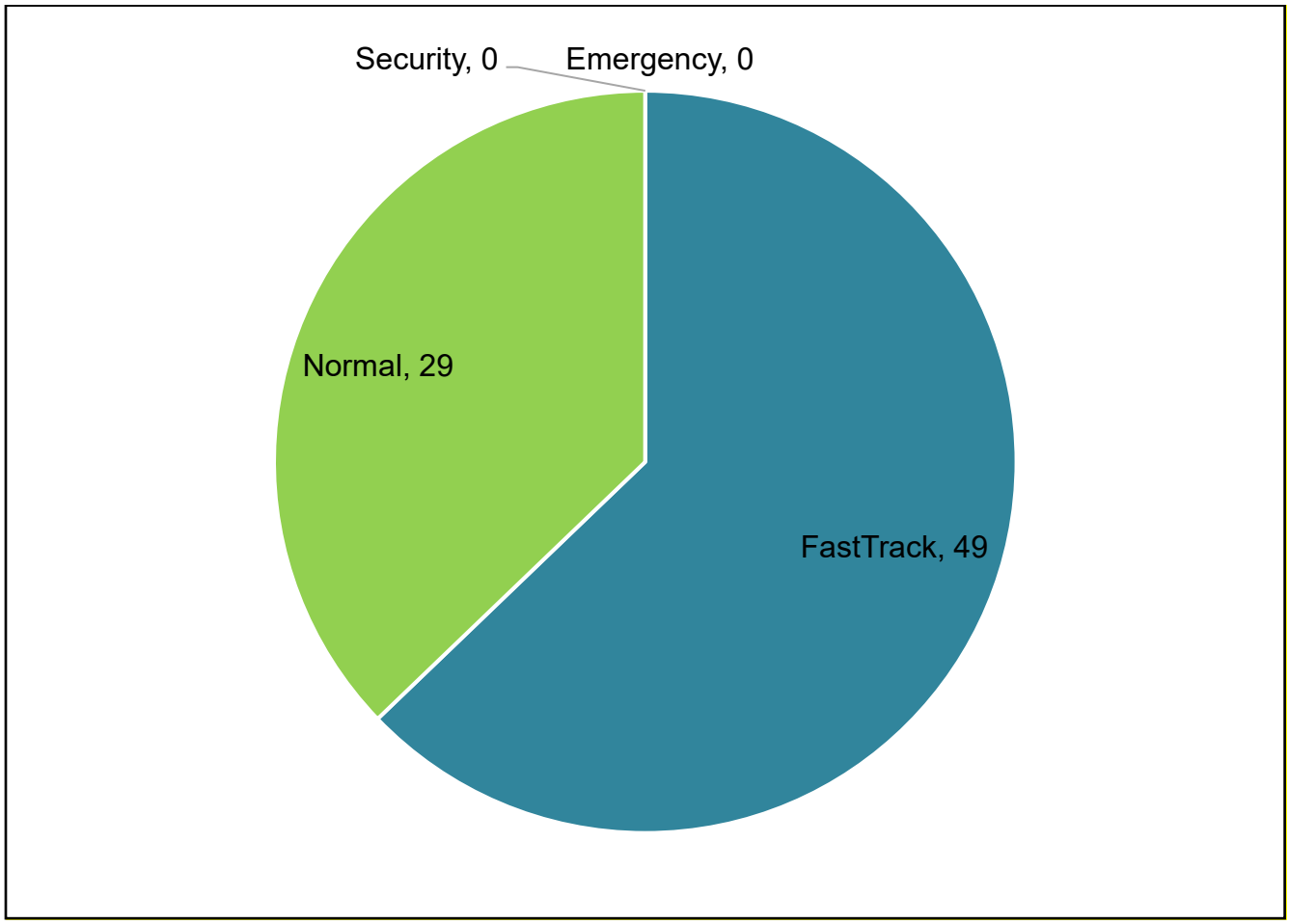
Change Management Key Performance Indicator (KPI)

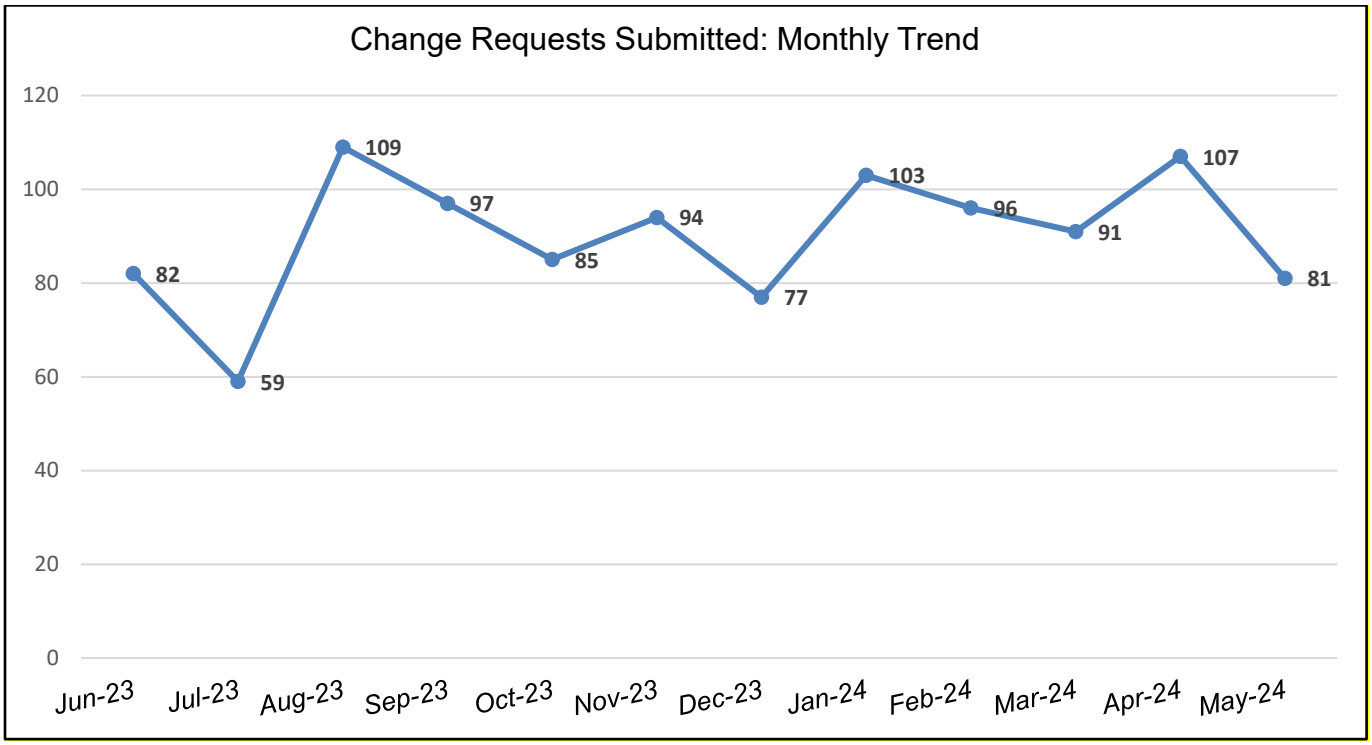
- Change Request Overall Summary in the month of May 2024 KPI:
  - 81 Changes Submitted.
  - 78 Changes Completed and Closed.
  - 171 Active Change Requests in pipeline.
  - 5 Change Requests Cancelled or Rejected.

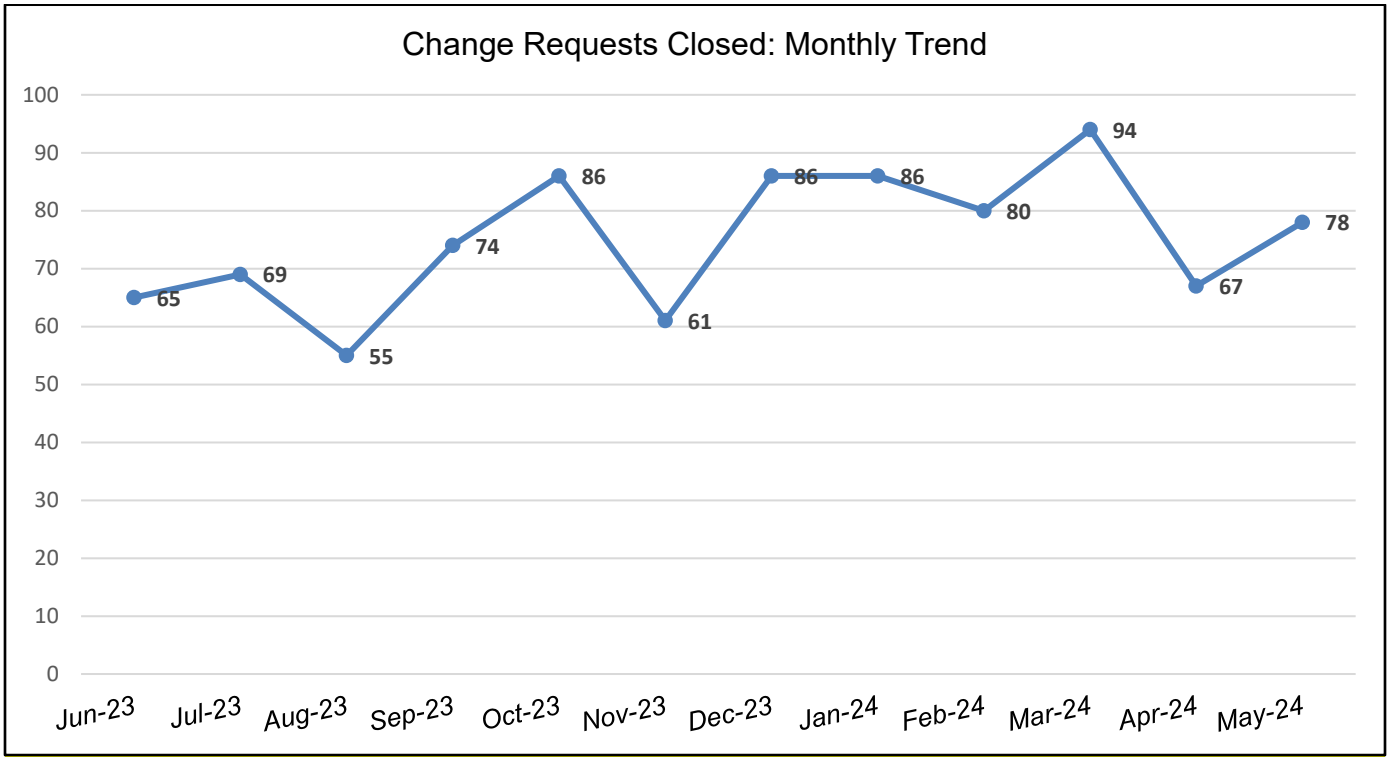
- 81 Change Requests Submitted/Logged in the month of May 2024



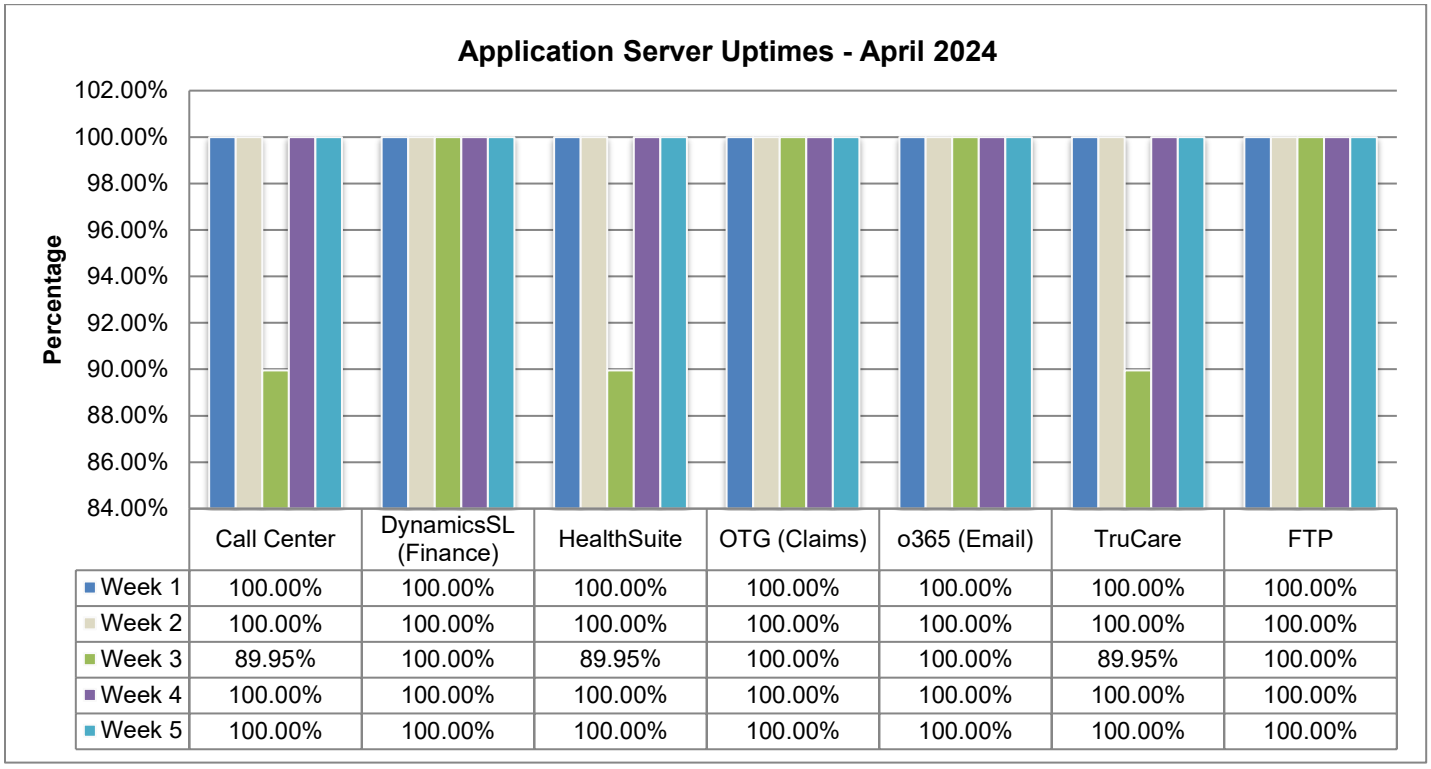
- 78 Change Requests Closed in the month of May 2024




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
82
59
109
97
85
94
77
103
96
91
107
81
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24

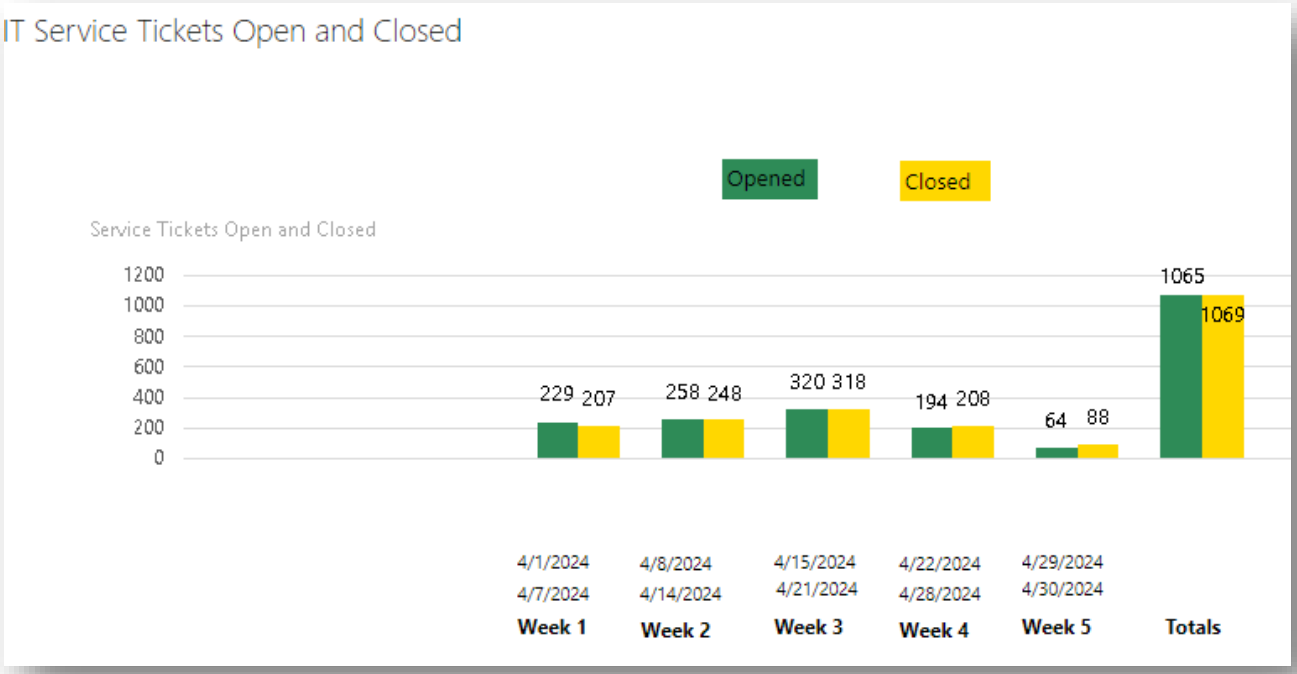

Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
65
69
55
74
86
61
86
86
80
94
67
78
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24

T Stats: Infrastructure



	Call Center	DynamicsSL (Finance)	HealthSuite	OTG (Claims)	o365 (Email)	TruCare	FTP
Week 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 2	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 3	89.95%	100.00%	89.95%	100.00%	100.00%	89.95%	100.00%
Week 4	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- All mission critical applications are monitored and managed thoroughly.
- On Friday, April 19th at 10:00am, the Alliance experienced a certificate issue that affected partial access to three major applications (HealthSuite, TruCare and Call Center).
  - The access issue was resolved within four hours.

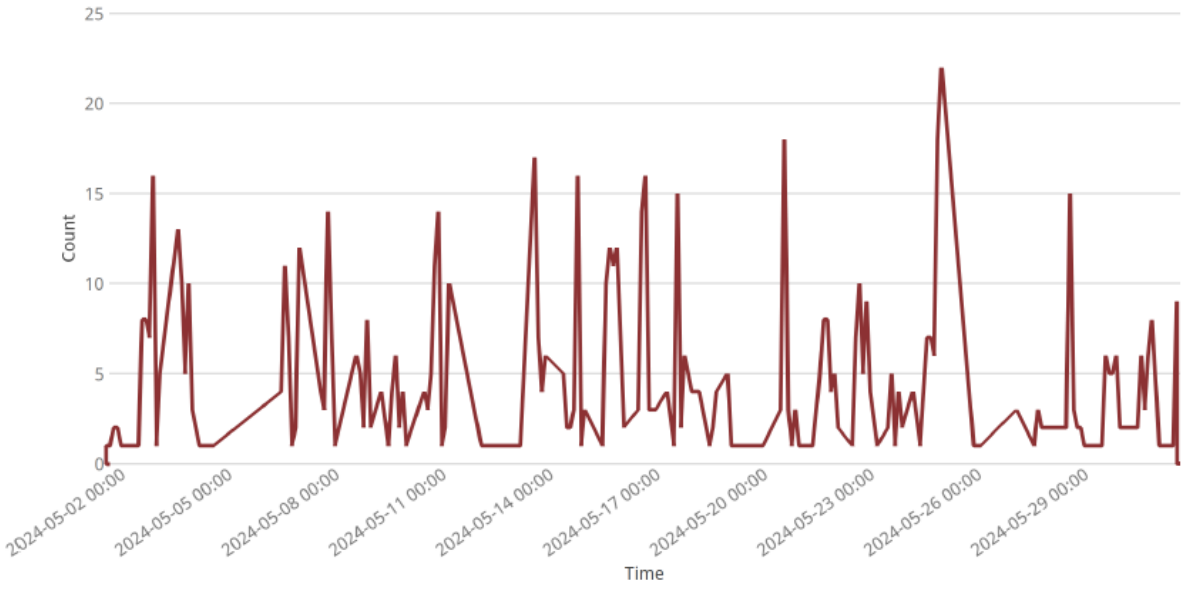


- 1065 Service Desk tickets were opened in the month of April 2024, which is 5.44% higher than the previous month (1007) and 14.36% higher than the previous 3-month average of 912.

- 1069 Service Desk tickets were closed in the month of April 2024, which is 0.37% higher than the previous month (1065) and 14.49% higher than the previous 3-month average of 914.

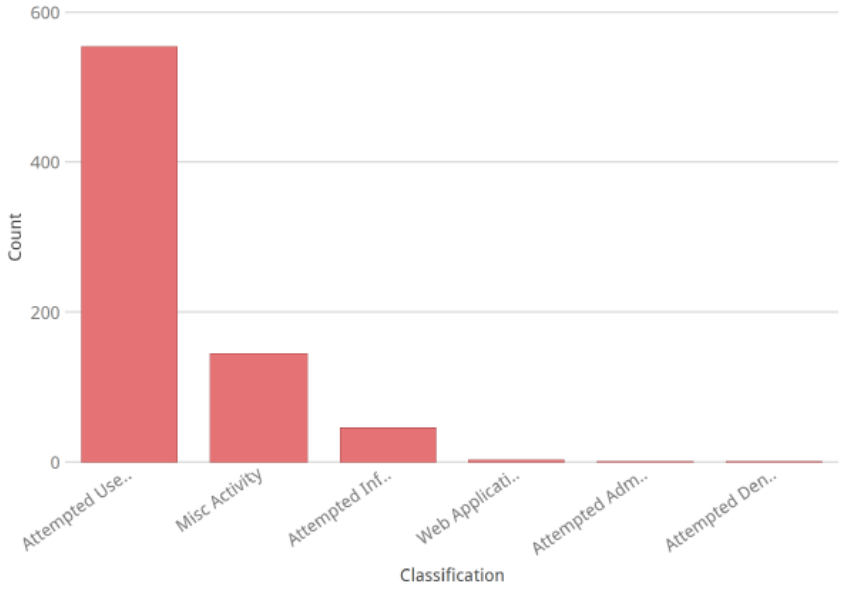
All Intrusion Events

Time Window: *2024-05-01 09:29:00 - 2024-05-31 09:29:00*



Dropped Intrusion Events

Time Window: *2024-05-01 09:30:00 - 2024-05-31 09:30:00*
Constraints: *Inline Result = !Alert,!Would **



Classification	Count
Attempted User Privilege Gain	554
Misc Activity	145
Attempted Information Leak	46
Web Application Attack	3
Attempted Administrator Privilege Gain	1
Attempted Denial of Service	1

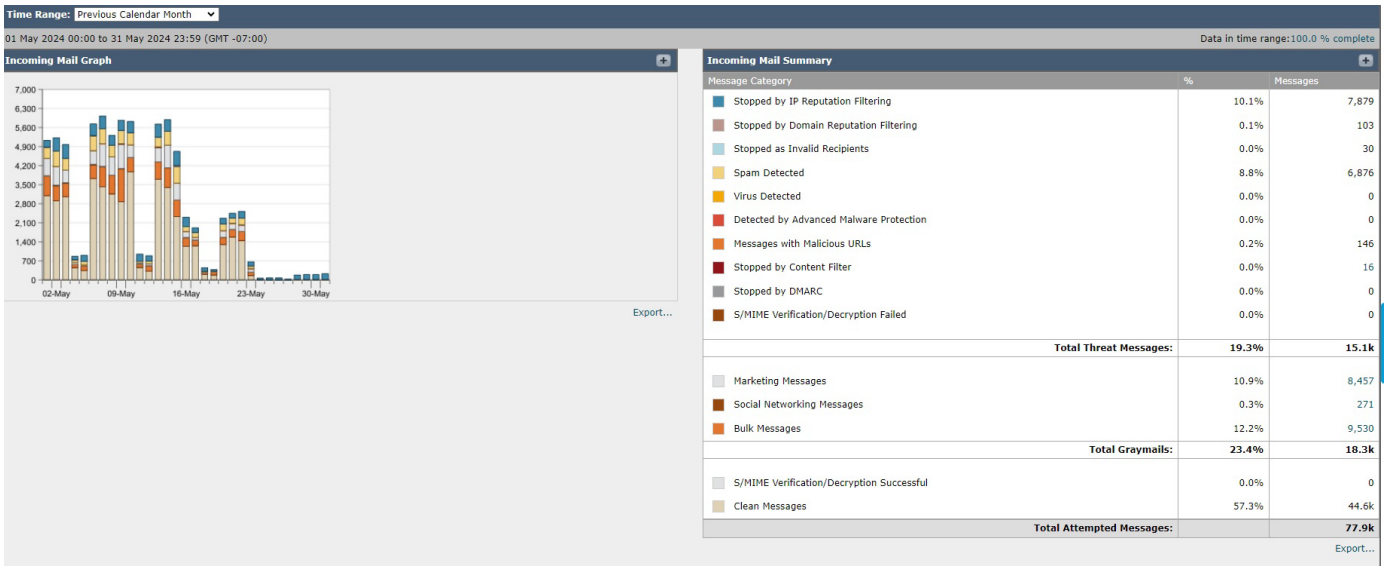
IronPort Email Security Gateways

Email Filters

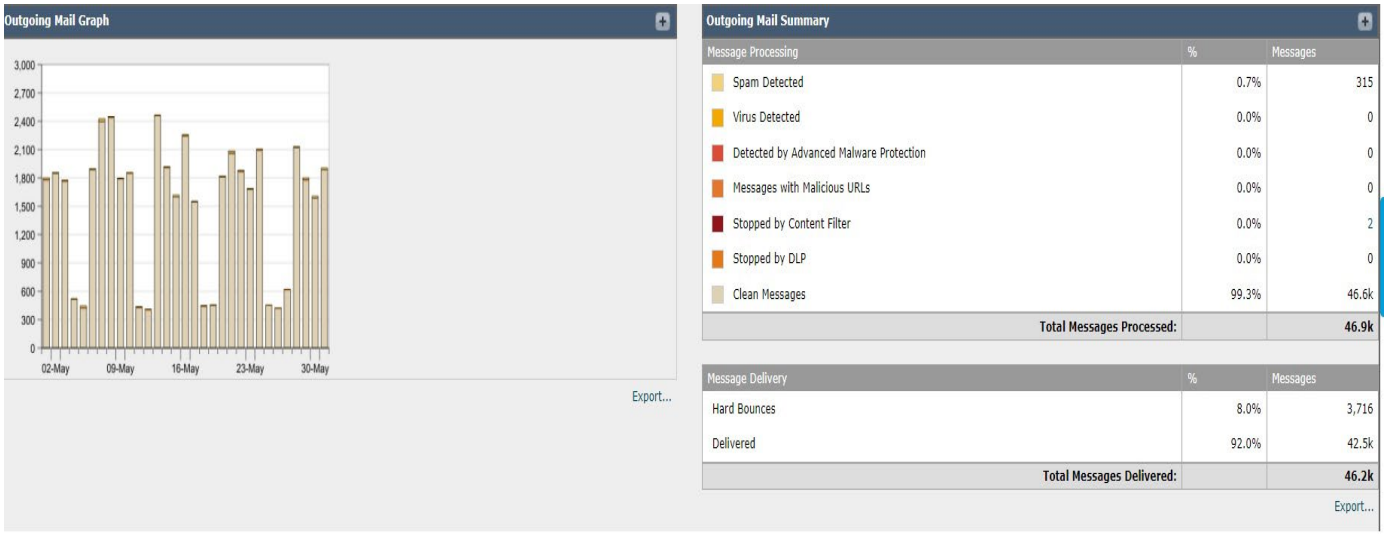
May 2024

MX4

Inbound Mail



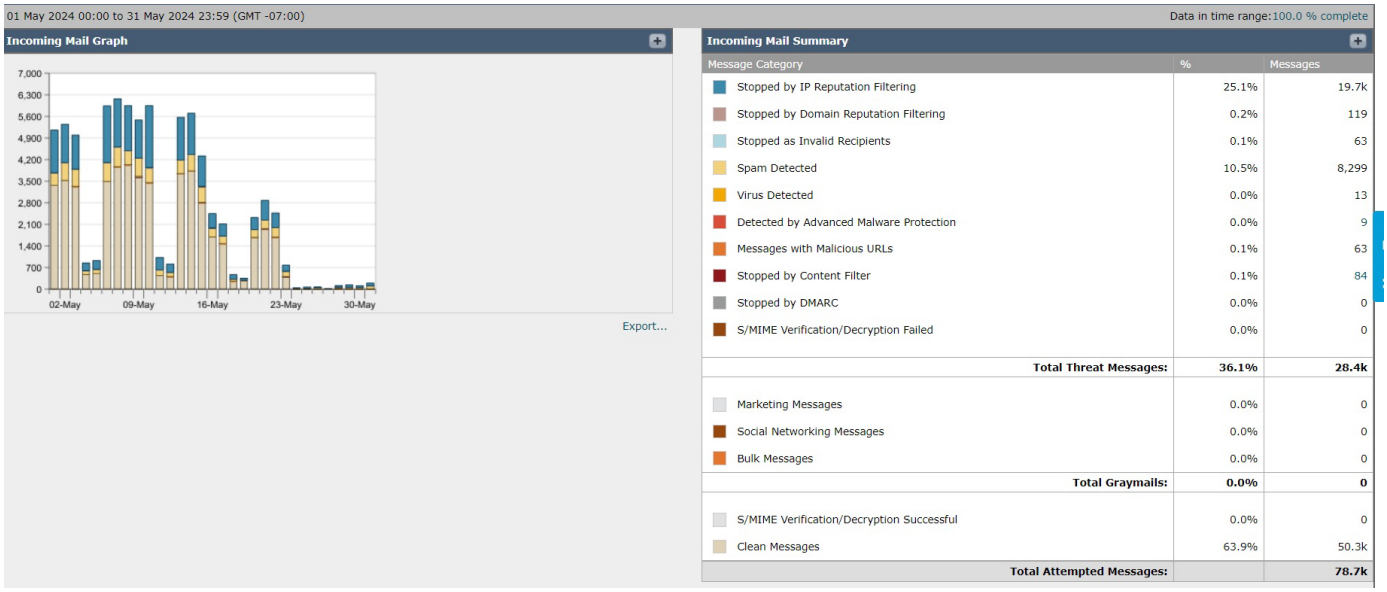
Outbound Mail



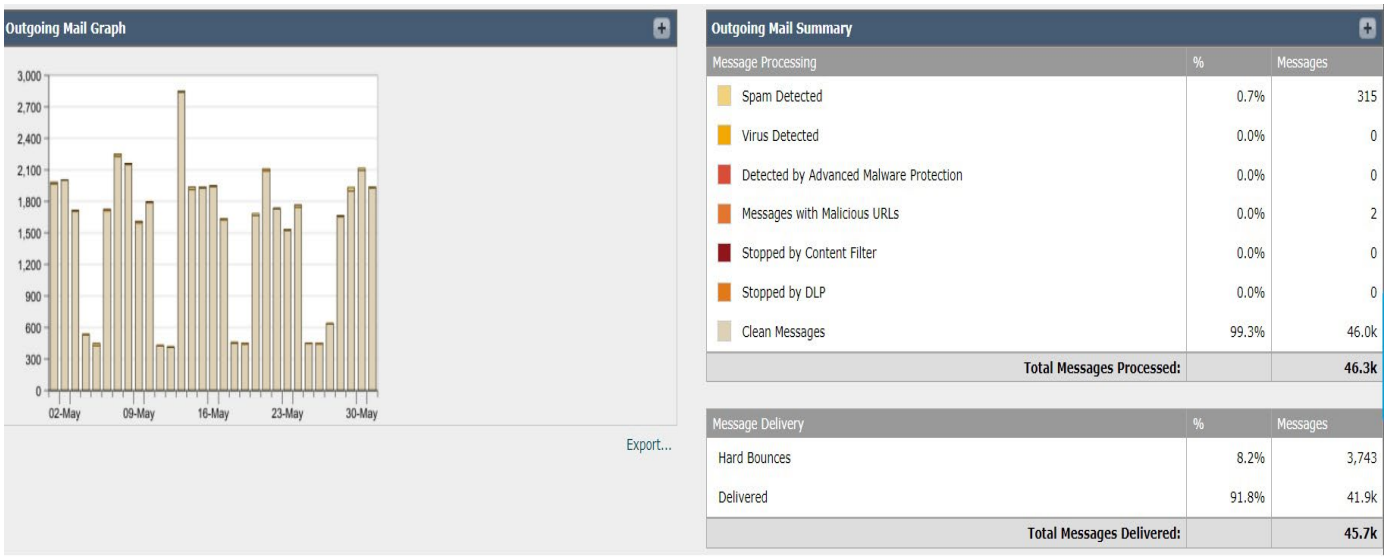
May 2024

MX9

Inbound Mail



Outbound Mail



- Email based metrics currently monitored with a return to a reputation-based block for a total of 70.5k.
- Attempted information leaks detected and blocked at the firewall is at 46 for the month of May 2024**.**
- Network scans returned a value of 0, which is in line with previous month’s data.
- Attempted User Privilege Gain increased at 554 from a previous six-month average of 297.

Projects and Programs

Supporting Documents

ALAMEDA Alliance FOR HEALTH

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

Analytics

Tiffany Cheang

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

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

Date: **June 14th, 2024**

Subject: **Performance & Analytics Report**

Member Cost Analysis

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

Current reporting period: March 2023 – Feb 2024 dates of service
Prior reporting period: March 2022 – Feb 2023 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 7.7% of members account for 88.5% of total costs.
- In comparison, the Prior reporting period was slightly higher at 9.5% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
    - The SPD (non duals) and ACA OE categories of aid decreased to account for 53.4% of the members, with SPDs accounting for 22.5% and ACA OE's at 30.9%.
    - The percent of members with costs >= $30K saw no change from 2.1% to 2.1%.
    - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.6%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 33.2%.
    - 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 7.7% is more concentrated in the 45-66 year old category (38.2%) compared to the overall population (20.8%).

Analytics

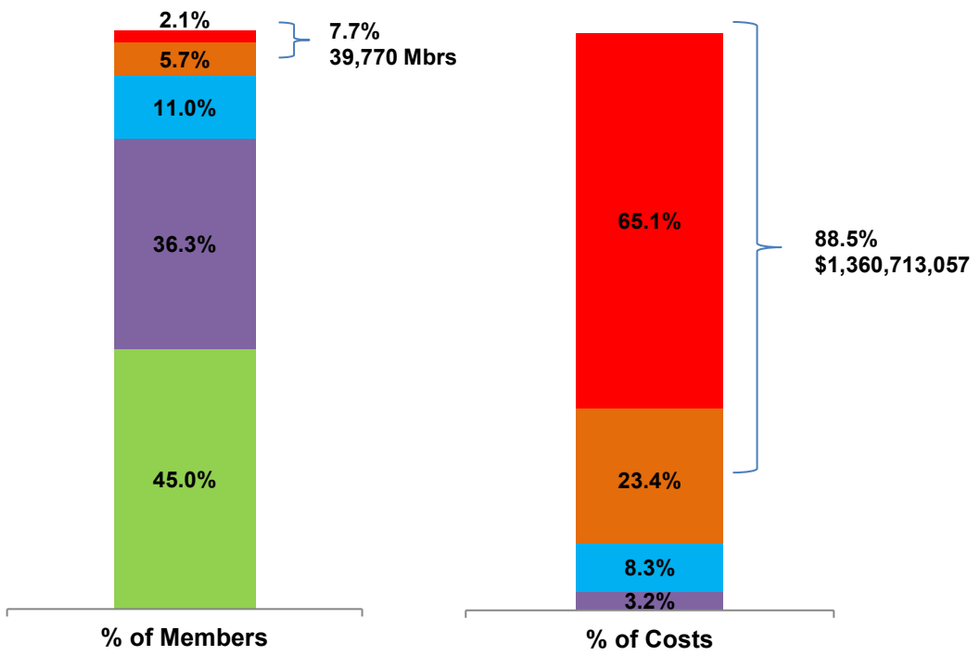
Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Mar 2023 - Feb 2024

Note: Data incomplete due to claims lag

Run Date: 05/28/2024

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	10,586	2.1%	$ 1,000,670,745	65.1%
$5K - $30K	29,184	5.7%	$ 360,042,312	23.4%
$1K - $5K	56,823	11.0%	$ 127,568,172	8.3%
< $1K	187,228	36.3%	$ 49,898,542	3.2%
$0	231,835	45.0%	$ -	0.0%
Totals	**515,656**	**100.0%**	**$ 1,538,179,770**	**100.0%**

Top 7.7% of Members = 88.5% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	2,978	0.6%	$ 586,981,525	38.2%
$75K to $100K	1,458	0.3%	$ 126,638,019	8.2%
$50K to $75K	2,202	0.4%	$ 134,321,107	8.7%
$40K to $50K	1,607	0.3%	$ 71,549,523	4.7%
$30K to $40K	2,341	0.5%	$ 81,180,571	5.3%
SubTotal	***10,586***	***2.1%***	***$ 1,000,670,745***	***65.1%***
$20K to $30K	4,356	0.8%	$ 105,439,768	6.9%
$10K to $20K	11,057	2.1%	$ 156,150,966	10.2%
$5K to $10K	13,771	2.7%	$ 98,451,578	6.4%
SubTotal	***29,184***	***5.7%***	***$ 360,042,312***	***23.4%***
Total	**39,770**	***7.7%***	**$ 1,360,713,057**	***88.5%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Feb 2024	403,064	$ 1,333,275,617
Dis-Enrolled During Year	112,592	$ 204,904,153
Totals	**515,656**	**$ 1,538,179,770**

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
7.7% of Members = 88.5% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Mar 2023 - Feb 2024
Note: Data incomplete due to claims lag
Run Date: 05/28/2024

7.7% of Members = 88.5% of Costs
22.5% of members are SPDs and account for 27.2% of costs.
30.9% of members are ACA OE and account for 30.5% of costs.
12.5% of members disenrolled as of Feb 2024 and account for 13.8% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	146	631	777	2.0%
MCAL	MCAL - ADULT	854	4,559	5,413	14.0%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	402	2,112	2,514	6.5%
	MCAL - ACA OE	2,919	9,000	11,919	30.9%
	MCAL - SPD	2,969	5,725	8,694	22.5%
	MCAL - DUALS	632	2,520	3,152	8.2%
	MCAL - LTC	113	62	175	0.5%
	MCAL - LTC-DUAL	699	402	1,101	2.9%
Not Eligible	Not Eligible	1,548	3,285	4,833	12.5%
Total		**10,282**	**28,296**	**38,578**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 10,946,377	$ 7,336,862	$ 18,283,239	1.4%
MCAL	MCAL - ADULT	$ 76,564,618	$ 52,763,029	$ 129,327,647	9.8%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 28,293,867	$ 24,465,744	$ 52,759,611	4.0%
	MCAL - ACA OE	$ 292,646,775	$ 110,200,263	$ 402,847,037	30.5%
	MCAL - SPD	$ 285,830,892	$ 73,916,197	$ 359,747,089	27.2%
	MCAL - DUALS	$ 54,483,534	$ 28,980,095	$ 83,463,629	6.3%
	MCAL - LTC	$ 16,962,728	$ 816,598	$ 17,779,327	1.3%
	MCAL - LTC-DUAL	$ 69,671,860	$ 4,798,606	$ 74,470,466	5.6%
Not Eligible	Not Eligible	$ 142,605,089	$ 39,468,805	$ 182,073,894	13.8%
Total		**$ 978,005,739**	**$ 342,746,200**	**$ 1,320,751,939**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
28.9% of members are SPDs and account for 31.6% of costs.
26.2% of members are ACA OE and account for 33.3% of costs.
14.0% of members disenrolled as of Feb 2024 and account for 11.2% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	31	1.1%
MCAL	MCAL - ADULT	179	6.2%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	50	1.7%
	MCAL - ACA OE	755	26.2%
	MCAL - SPD	835	28.9%
	MCAL - DUALS	207	7.2%
	MCAL - LTC	91	3.2%
	MCAL - LTC-DUAL	334	11.6%
Not Eligible	Not Eligible	405	14.0%
Total		**2,887**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 5,180,839	1.0%
MCAL	MCAL - ADULT	$ 42,372,849	8.1%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 9,690,129	1.8%
	MCAL - ACA OE	$ 174,769,430	33.3%
	MCAL - SPD	$ 165,987,243	31.6%
	MCAL - DUALS	$ 25,089,606	4.8%
	MCAL - LTC	$ 13,118,391	2.5%
	MCAL - LTC-DUAL	$ 30,285,482	5.8%
Not Eligible	Not Eligible	$ 58,973,786	11.2%
Total		**$ 525,467,756**	**100.0%**

% of Total Costs By Service Type

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs
$100K+	7%	0%	1%
$75K to $100K	3%	0%	0%
$50K to $75K	4%	0%	1%
$40K to $50K	5%	0%	2%
$30K to $40K	11%	0%	2%
$20K to $30K	3%	1%	3%
$10K to $20K	0%	0%	8%
$5K to $10K	0%	0%	12%
Total	**5%**	**0%**	**2%**

Breakout by Service Type/Location

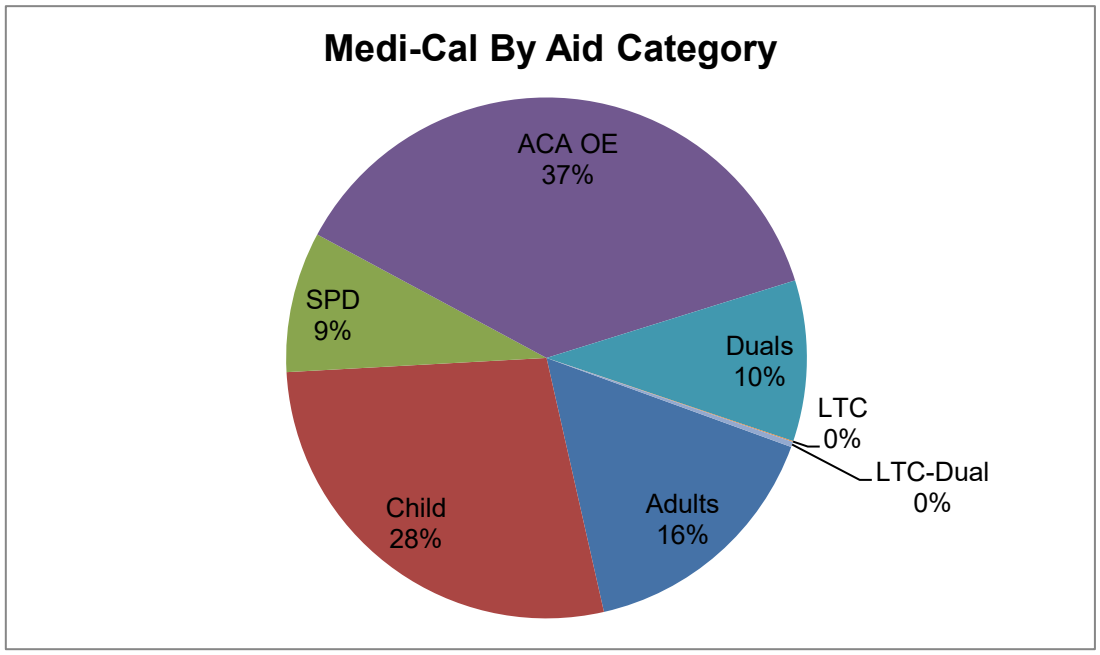
Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
0%	41%	1%	10%	3%	1%	27%
0%	24%	2%	5%	3%	4%	45%
0%	28%	3%	6%	4%	5%	30%
1%	30%	5%	5%	6%	1%	20%
0%	23%	12%	5%	5%	1%	17%
0%	22%	6%	7%	6%	1%	23%
1%	24%	5%	8%	7%	2%	18%
1%	24%	6%	10%	9%	2%	16%
0%	**32%**	**3%**	**8%**	**4%**	**2%**	**26%**

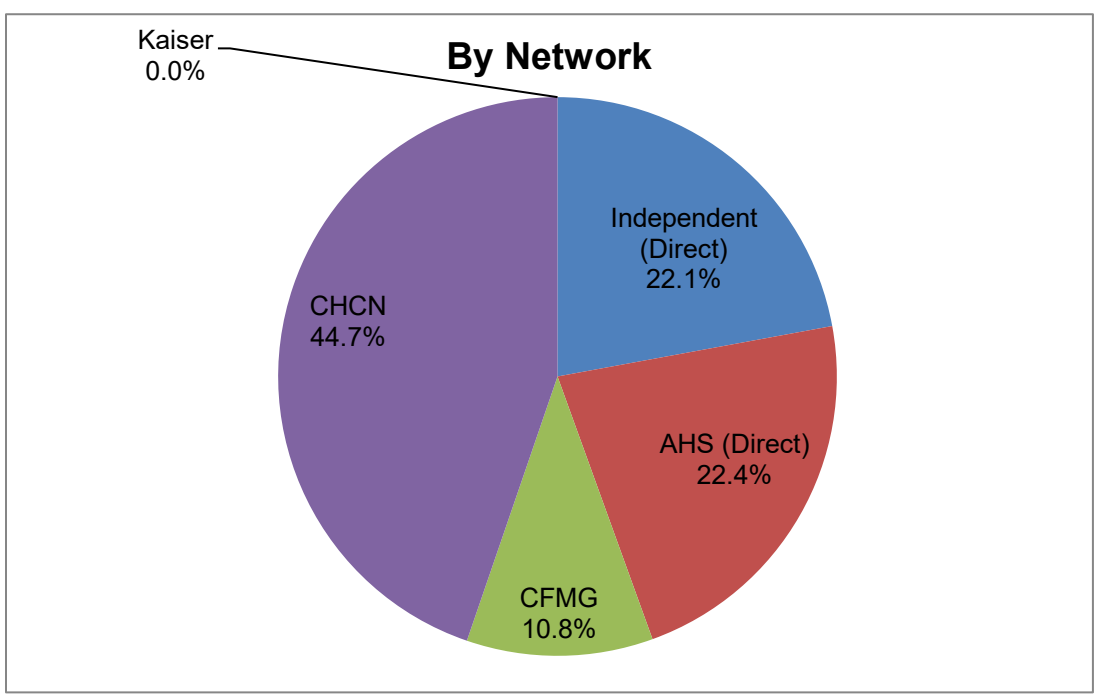
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Apr 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	63,551	16%	13,331	14,435	19	35,766	-
Child	110,566	28%	9,598	13,518	40,692	46,758	-
SPD	34,887	9%	11,348	5,484	1,429	16,626	-
ACA OE	149,154	37%	25,455	53,478	1,555	68,666	-
Duals	39,912	10%	26,211	2,846	7	10,848	-
LTC	223	0%	207	7	-	9	-
LTC-Dual	1,291	0%	1,289	-	-	2	-
Medi-Cal	399,584		87,439	89,768	43,702	178,675	-
Group Care	5,643		2,156	862	-	2,625	-
Total	**405,227**	**100%**	**89,595**	**90,630**	**43,702**	**181,300**	**-**
Medi-Cal %	98.6%		97.6%	99.0%	100.0%	98.6%	0%
Group Care %	1.4%		2.4%	1.0%	0.0%	1.4%	0.0%
	Network Distribution		*22.1%*	*22.4%*	*10.8%*	*44.7%*	*0.0%*
			% Direct:	**44%**		**% Delegated:**	**56%**

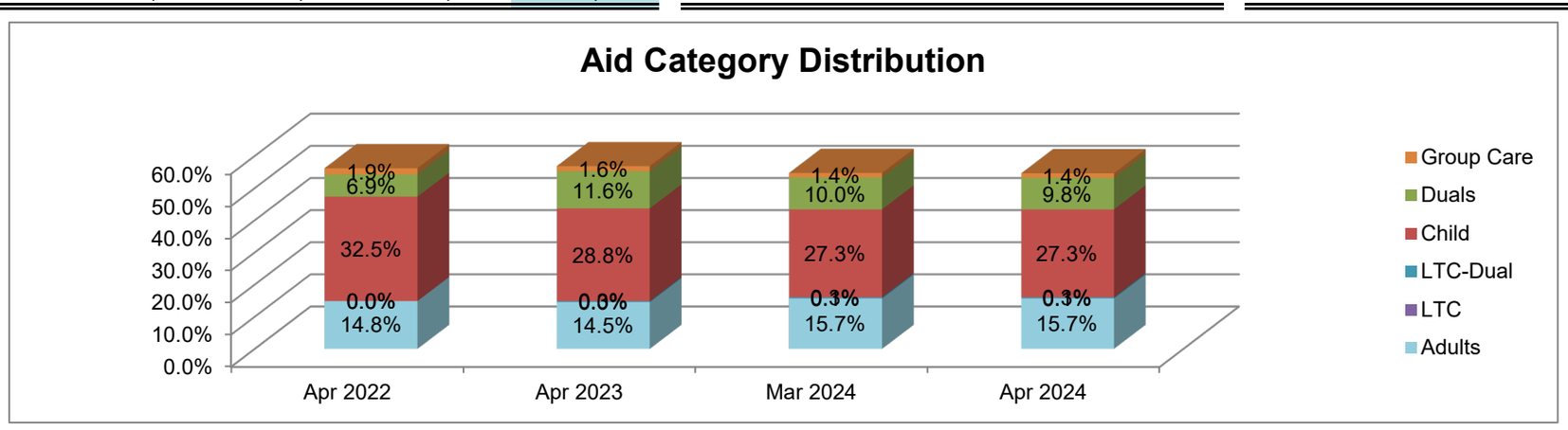




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

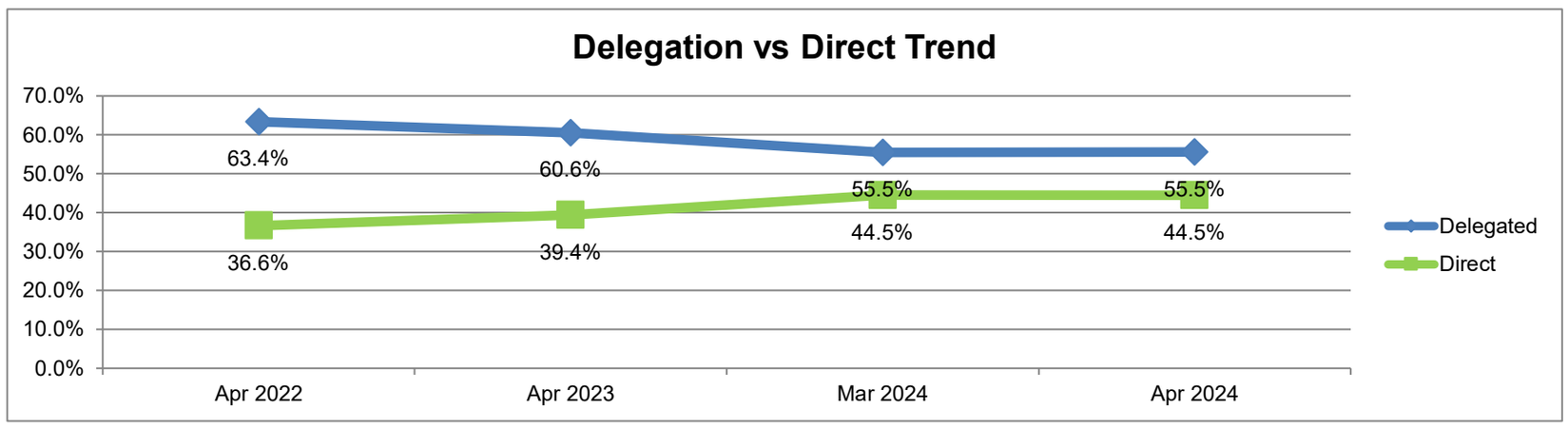
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
Adults	45,826	52,047	63,314	63,551	14.8%	14.5%	15.7%	15.7%	13.6%	22.1%	0.4%
Child	100,215	103,173	110,268	110,566	32.5%	28.8%	27.3%	27.3%	3.0%	7.2%	0.3%
SPD	26,848	31,130	34,972	34,887	8.7%	8.7%	8.7%	8.6%	15.9%	12.1%	-0.2%
ACA OE	108,568	123,606	148,065	149,154	35.2%	34.5%	36.7%	36.8%	13.9%	20.7%	0.7%
Duals	21,456	41,473	40,222	39,912	6.9%	11.6%	10.0%	9.8%	93.3%	-3.8%	-0.8%
LTC	-	145	216	223	0.0%	0.0%	0.1%	0.1%	0.0%	53.8%	3.2%
LTC-Dual	-	983	1,307	1,291	0.0%	0.3%	0.3%	0.3%	0.0%	31.3%	-1.2%
Medi-Cal Total	302,913	352,557	398,364	399,584	98.1%	98.4%	98.6%	98.6%	16.4%	13.3%	0.3%
Group Care	5,828	5,669	5,620	5,643	1.9%	1.6%	1.4%	1.4%	-2.7%	-0.5%	0.4%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**16.0%**	**13.1%**	**0.3%**



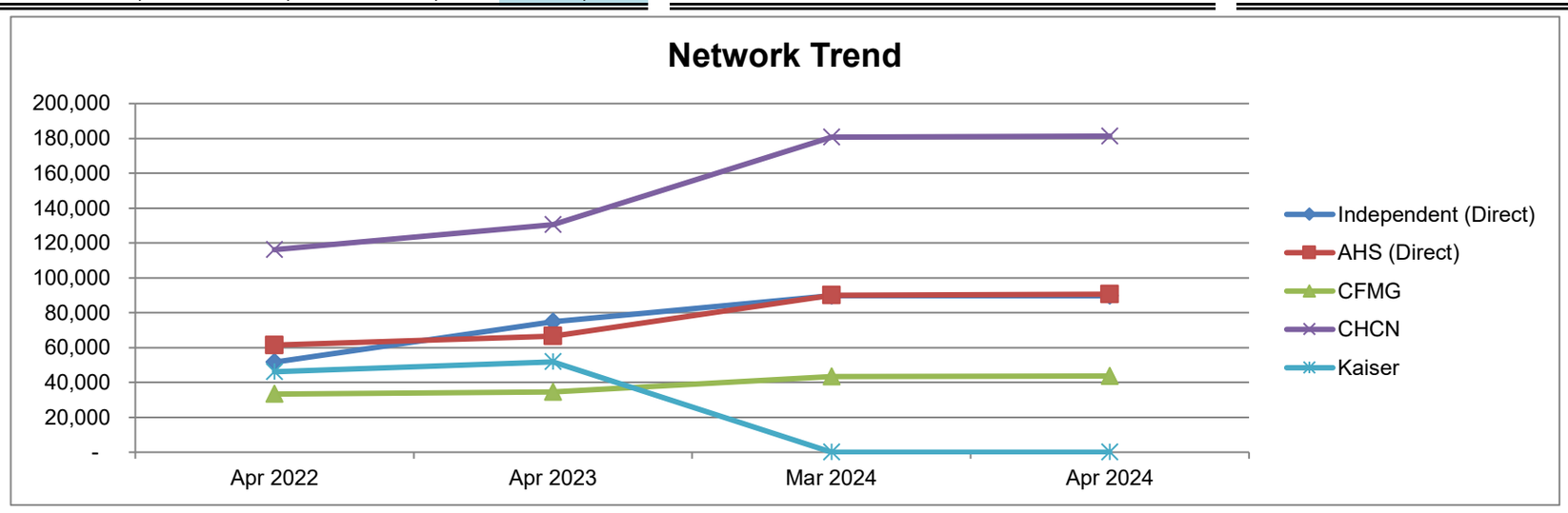
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
Delegated	195,637	216,961	224,105	225,002	63.4%	60.6%	55.5%	55.5%	10.9%	3.7%	0.4%
Direct	113,104	141,265	179,879	180,225	36.6%	39.4%	44.5%	44.5%	24.9%	27.6%	0.2%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**16.0%**	**13.1%**	**0.3%**



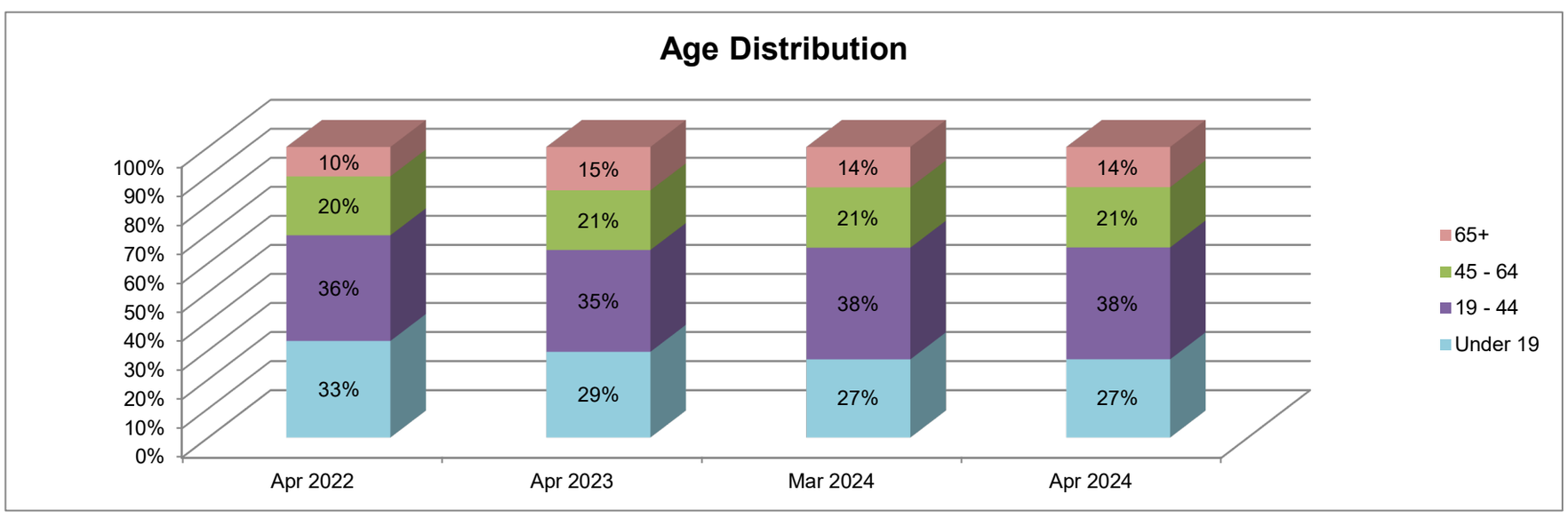
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
Independent (Direct)	51,662	74,713	89,790	89,595	16.7%	20.9%	22.2%	22.1%	44.6%	19.9%	-0.2%
AHS (Direct)	61,442	66,552	90,089	90,630	19.9%	18.6%	22.3%	22.4%	8.3%	36.2%	0.6%
CFMG	33,333	34,644	43,413	43,702	10.8%	9.7%	10.7%	10.8%	3.9%	26.1%	0.7%
CHCN	116,169	130,508	180,692	181,300	37.6%	36.4%	44.7%	44.7%	12.3%	38.9%	0.3%
Kaiser	46,135	51,809	-	-	14.9%	14.5%	0.0%	0.0%	12.3%	-100.0%	0.0%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**16.0%**	**13.1%**	**0.3%**

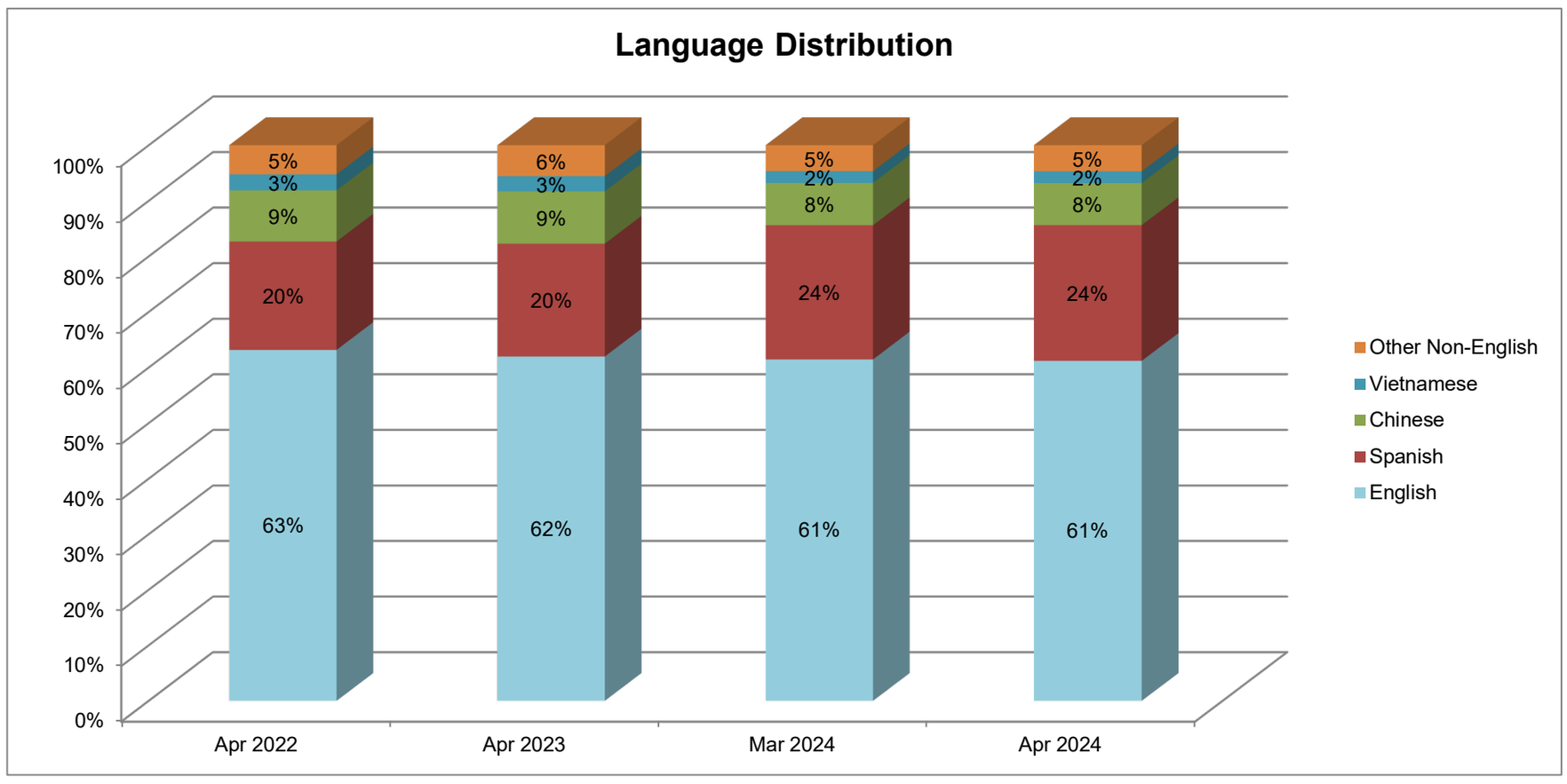


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Age Category Trend	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
Under 19	102,464	105,525	108,522	108,917	33%	29%	27%	27%	3%	3%	0%
19 - 44	112,308	125,496	155,233	156,001	36%	35%	38%	38%	12%	24%	0%
45 - 64	62,659	73,669	83,951	84,128	20%	21%	21%	21%	18%	14%	0%
65+	31,310	53,536	56,278	56,181	10%	15%	14%	14%	71%	5%	0%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



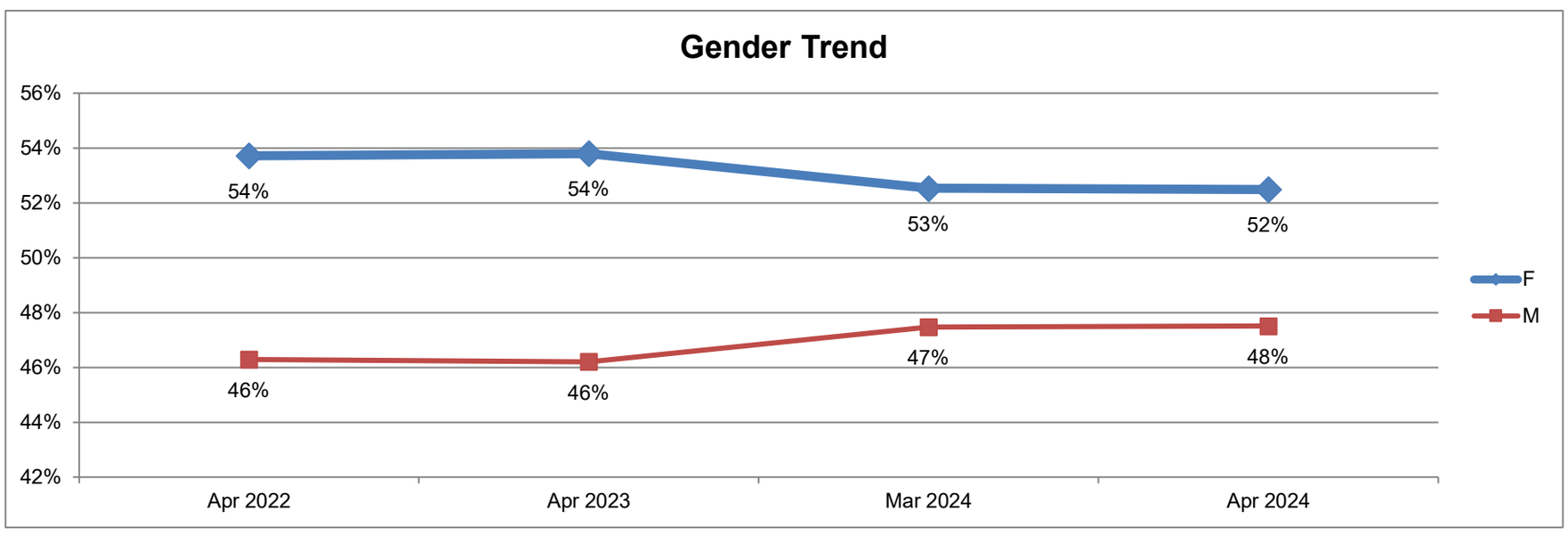
Language Trend	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
English	194,983	221,974	248,207	247,927	63%	62%	61%	61%	14%	12%	0%
Spanish	60,230	72,728	97,569	98,970	20%	20%	24%	24%	21%	36%	1%
Chinese	28,433	33,747	30,760	30,725	9%	9%	8%	8%	19%	-9%	0%
Vietnamese	8,863	9,787	8,536	8,548	3%	3%	2%	2%	10%	-13%	0%
Other Non-English	16,232	19,990	18,912	19,057	5%	6%	5%	5%	23%	-5%	1%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

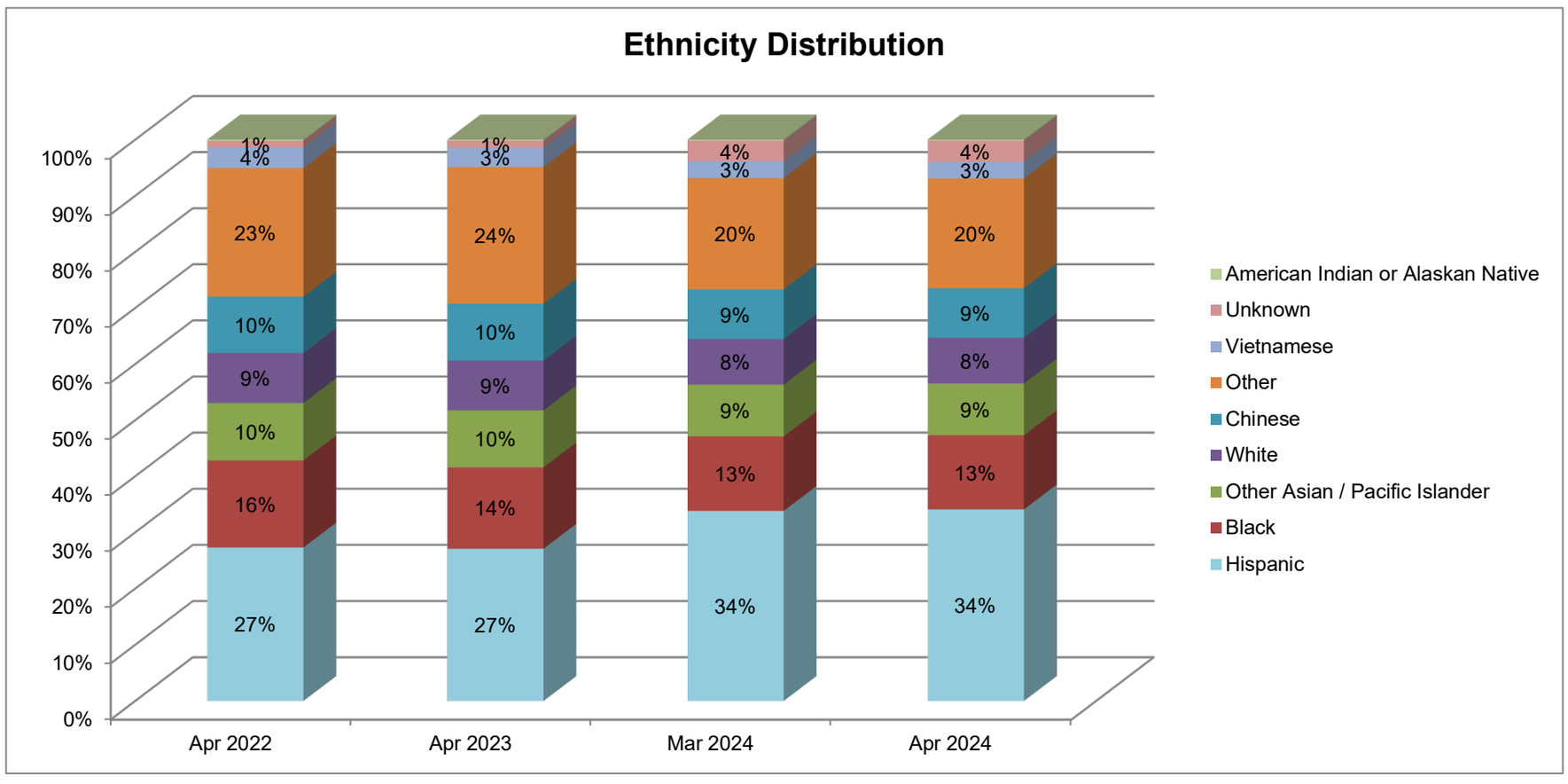
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
F	165,836	192,712	212,211	212,693	54%	54%	53%	52%	16%	10%	0%
M	142,905	165,514	191,773	192,534	46%	46%	47%	48%	16%	16%	0%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022	Apr 2023	Mar 2024	Apr 2024	Apr 2022 to Apr 2023	Apr 2023 to Apr 2024	Mar 2024 to Apr 2024
Hispanic	84,250	96,968	136,557	138,080	27%	27%	34%	34%	15%	42%	1%
Black	47,891	51,913	53,627	53,580	16%	14%	13%	13%	8%	3%	0%
Other Asian / Pacific Islander	31,590	36,482	37,287	37,409	10%	10%	9%	9%	15%	3%	0%
White	27,524	31,763	32,857	32,949	9%	9%	8%	8%	15%	4%	0%
Chinese	31,057	36,306	35,796	35,847	10%	10%	9%	9%	17%	-1%	0%
Other	70,736	87,251	80,230	79,277	23%	24%	20%	20%	23%	-9%	-1%
Vietnamese	11,420	12,333	12,036	12,050	4%	3%	3%	3%	8%	-2%	0%
Unknown	3,612	4,471	14,794	15,231	1%	1%	4%	4%	24%	241%	3%
American Indian or Alaskan Native	661	739	800	804	0%	0%	0%	0%	12%	9%	1%
Total	**308,741**	**358,226**	**403,984**	**405,227**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



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

Medi-Cal By City

City	Apr 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	161,674	40%	24,322	42,749	17,473	77,130	-
Hayward	63,447	16%	12,570	16,783	7,413	26,681	-
Fremont	36,430	9%	15,039	6,779	2,029	12,583	-
San Leandro	33,161	8%	8,175	5,708	4,266	15,012	-
Union City	14,623	4%	5,409	2,619	834	5,761	-
Alameda	14,047	4%	3,414	2,541	2,078	6,014	-
Berkeley	15,404	4%	4,282	2,182	1,771	7,169	-
Livermore	12,731	3%	1,921	701	2,233	7,876	-
Newark	9,197	2%	2,693	4,044	485	1,975	-
Castro Valley	9,424	2%	2,452	1,663	1,390	3,919	-
San Lorenzo	7,291	2%	1,451	1,636	829	3,375	-
Pleasanton	7,311	2%	1,794	440	778	4,299	-
Dublin	7,368	2%	1,976	455	881	4,056	-
Emeryville	2,776	1%	616	617	451	1,092	-
Albany	2,545	1%	687	276	563	1,019	-
Piedmont	483	0%	116	195	52	120	-
Sunol	85	0%	24	15	5	41	-
Antioch	32	0%	14	10	4	4	-
Other	1,555	0%	484	355	167	549	-
Total	**399,584**	**100%**	**87,439**	**89,768**	**43,702**	**178,675**	**-**

Group Care By City

City	Apr 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,780	32%	363	333	-	1,084	-
Hayward	624	11%	291	138	-	195	-
Fremont	623	11%	429	62	-	132	-
San Leandro	589	10%	242	83	-	264	-
Union City	299	5%	193	44	-	62	-
Alameda	295	5%	95	22	-	178	-
Berkeley	167	3%	52	15	-	100	-
Livermore	102	2%	34	3	-	65	-
Newark	132	2%	78	31	-	23	-
Castro Valley	191	3%	81	27	-	83	-
San Lorenzo	135	2%	45	20	-	70	-
Pleasanton	63	1%	20	2	-	41	-
Dublin	112	2%	38	6	-	68	-
Emeryville	37	1%	14	5	-	18	-
Albany	18	0%	10	1	-	7	-
Piedmont	11	0%	3	1	-	7	-
Sunol	1	0%	1	-	-	-	-
Antioch	23	0%	6	4	-	13	-
Other	441	8%	161	65	-	215	-
Total	**5,643**	**100%**	**2,156**	**862**	**-**	**2,625**	**-**

Total By City

City	Apr 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	163,454	40%	24,685	43,082	17,473	78,214	-
Hayward	64,071	16%	12,861	16,921	7,413	26,876	-
Fremont	37,053	9%	15,468	6,841	2,029	12,715	-
San Leandro	33,750	8%	8,417	5,791	4,266	15,276	-
Union City	14,922	4%	5,602	2,663	834	5,823	-
Alameda	14,342	4%	3,509	2,563	2,078	6,192	-
Berkeley	15,571	4%	4,334	2,197	1,771	7,269	-
Livermore	12,833	3%	1,955	704	2,233	7,941	-
Newark	9,329	2%	2,771	4,075	485	1,998	-
Castro Valley	9,615	2%	2,533	1,690	1,390	4,002	-
San Lorenzo	7,426	2%	1,496	1,656	829	3,445	-
Pleasanton	7,374	2%	1,814	442	778	4,340	-
Dublin	7,480	2%	2,014	461	881	4,124	-
Emeryville	2,813	1%	630	622	451	1,110	-
Albany	2,563	1%	697	277	563	1,026	-
Piedmont	494	0%	119	196	52	127	-
Sunol	86	0%	25	15	5	41	-
Antioch	55	0%	20	14	4	17	-
Other	1,996	0%	645	420	167	764	-
Total	**405,227**	**100%**	**89,595**	**90,630**	**43,702**	**181,300**	**-**

Human Resources

Anastacia Swift

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

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

Date: **June 14th, 2024**

Subject: **Human Resources Report**

Staffing

- As of June 1st, 2024, the Alliance had 596 full time employees and 1-part time employee.

- On June 1st, 2024, the Alliance had 62 open positions in which 25 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 37 positions open to date. The Alliance is actively recruiting for the remaining 37 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by division:

Division	Open Position June 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	5	3	2
Operations	37	15	22
Healthcare Analytics	1	0	1
Information Technology	8	4	4
Finance	3	0	3
Compliance	4	2	2
Human Resources	3	1	2
Health Equity	1	0	1
Executive	0	0	0
Total	62	25	37

- Our current recruitment rate is 10%.

Employee Recognition

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

  5 years:
  - Reya Johnson (Case/ Disease Management)
  - Carla Healy-London (Utilization Management)
  - Pedro Loli (Information Technology)

  6 years:
  - Randy Segura (Healthcare Analytics/Quality Analytics)
  - Jessica Jew (Quality Management)
  - Hope Desrochers (Utilization Management)
  - Leticia Alejo (Provider Services)
  - Aman Aseel (IT/ IT Infrastructure)

  7 years:
  - Rahel Negash (Pharmacy Services)
  - Kwan Park (IT/ IT Data Exchange)

  8 years:
  - Riandria Hollie (Claims)
  - Aracely Melendez (Claims)

  9 years:
  - Jeremy Alonzo (IT/IT-Ops and Quality Apps Mgt)

  11 years:
  - Michelle Lewis (Marketing & Communications)
  - Alicia Garibay (Utilization Management)

  12 years:
  - Linda Ayala (Quality Management)

  16 years:
  - Cecilia Gomez (Provider Services)

  21 years:
  - Nancy Kuo (Case/ Disease Management)