Board of Governors

Regular Meeting

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

1240 South Loop Road, Alameda, CA 94502

AGENDA

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

Video Conference Call or

1240 S. Loop Road

Alameda, CA 94502

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

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

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

YOU MAY SUBMIT COMMENTS ON ANY AGENDA ITEM OR ON ANY ITEM NOT ON THE AGENDA, IN WRITING VIA MAIL TO “ATTN: ALLIANCE BOARD,” 1240 SOUTH LOOP ROAD, ALAMEDA, CA 94502; OR THROUGH E-COMMENT AT jmurray@alamedaalliance.org. YOU MAY WATCH THE MEETING LIVE BY LOGGING IN VIA COMPUTER AT THE FOLLOWING LINK: Click here to join the meeting OR MAY LISTEN TO THE MEETING BY CALLING IN TO THE FOLLOWING TELEPHONE NUMBER: 1-510-210-0967 Conference ID 8650745#. IF YOU USE THE LINK AND PARTICIPATE VIA COMPUTER, YOU MAY, THROUGH THE USE OF THE CHAT FUNCTION, REQUEST AN OPPORTUNITY TO SPEAK ON ANY AGENDIZED ITEM, INCLUDING GENERAL PUBLIC COMMENT. YOUR REQUEST TO SPEAK MUST BE RECEIVED BEFORE THE ITEM IS CALLED ON THE AGENDA. IF YOU PARTICIPATE BY TELEPHONE, YOU MAY SUBMIT ANY COMMENTS VIA THE E-COMMENT EMAIL ADDRESS DESCRIBED ABOVE OR PROVIDE COMMENT DURING THE MEETING AT THE END OF EACH TOPIC.

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

1. CALL TO ORDER

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

2. ROLL CALL

3. AGENDA APPROVAL OR MODIFICATIONS

4. INTRODUCTIONS

5. CONSENT CALENDAR

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

a) JUNE 10th, 2022, BOARD OF GOVERNORS MEETING MINUTES

b) JULY 5th, 2022, FINANCE COMMITTEE MEETING MINUTES

c) 2021 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM EVALUATION

d) 2022 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM DESCRIPTION

e) 2021 UTILIZATION MANAGEMENT PROGRAM EVALUATION

f) 2022 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

g) 2021 QUALITY IMPROVEMENT – PROGRAM EVALUATION

h) 2022 QUALITY IMPROVEMENT – PROGRAM DESCRIPTION

i) 2022 CULTURAL AND LINGUISTIC – PROGRAM DESCRIPTION

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

b) FINANCE COMMITTEE

7. CEO UPDATE

8. BOARD BUSINESS

a) REVIEW AND APPROVE MAY 2022 MONTHLY FINANCIAL STATEMENTS

b) REVIEW AND APPROVE RESOLUTION #2022-02 NOMINATING YEON PARK FOR APPOINTMENT TO DESIGNATED AT LARGE LABOR SEAT

c) LONG TERM CARE INSOURCING UPDATE

9. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE

b) HEALTH CARE QUALITY COMMITTEE

c) PHARMACY AND THERAPEUTICS COMMITTEE

d) MEMBERS ADVISORY COMMITTEE

10. STAFF UPDATES

11. UNFINISHED BUSINESS

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

14. CLOSED SESSION

a) DISCUSSION REGARDING REVIEW OF EXTERNAL PRELIMINARY AUDIT OBSERVATIONS AND FEEDBACK (CALIFORNIA CODE, GOVERNMENT CODE SECTION 8545.1); PROTECTION OF CONFIDENTIAL AUDIT INFORMATION AND POTENTIAL REMEDIAL PLAN OF THE HEALTH AUTHORITY. ESTIMATED PUBLIC DISCLOSURE WILL OCCUR IN THE MONTH OF NOVEMBER 2022.

15. ADJOURNMENT

NOTICE TO THE PUBLIC

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

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

NOTICE TO THE PUBLIC

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

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

Meeting agendas and approved minutes are kept current on the Alameda Alliance for Health's website at www.alamedaalliance.org.

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

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

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

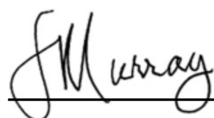
Public Input: If you are interested in addressing the Board, you may submit comments on any agenda item or on any item not on the agenda, in writing via mail to "Attn: Alliance Board," 1240 S. Loop Road, Alameda, CA 94502; or through e-comment at jmurray@alamedaalliance.org. You may also provide comments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

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

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

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

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org on July 4th, 2022, by 12:00 p.m.


Clerk of the Board – Jeanette Murray

Consent Calendar

Board of Governors Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
BOARD OF GOVERNORS
REGULAR MEETING
June 10th, 2022
12:00 pm – 2:00 pm
(Video Conference Call)
Alameda, CA

SUMMARY OF PROCEEDINGS

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

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

Guests Present on Conference Call:

Excused: Andrea Schwab-Galindo, Aarondeep Basrai

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
1. CALL TO ORDER			
Dr. Evan Seevak	The regular board meeting was called to order by Dr. Seevak at 12:02 pm. The following public announcement was read. "The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County levels, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with Assembly Bill 361 for the duration of the proclaimed State of emergency." "Audience, during each agenda item, you will be provided a reasonable amount of time to provide public comment."	None	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
2. ROLL CALL			
Dr. Evan Seevak	A telephonic roll call was taken of the Board Members, and a quorum was confirmed.	None	None
3. AGENDA APPROVAL OR MODIFICATIONS			
Dr. Evan Seevak	None	None	None
4. INTRODUCTIONS			
Dr. Evan Seevak	None	None	None
5. CONSENT CALENDAR			
Dr. Evan Seevak	Dr. Seevak presented the May 13h, 2022, Consent Calendar. a) May 13th, 2022, Board of Governors Meeting Minutes b) June 7th, 2022, Finance Committee Meeting Minutes Motion to Approve June 10th, 2022, Board of Governors Consent Calendar. A roll call vote was taken, and the motion passed. Dr. Seevak, Dr. Ferguson, and Dr. Marty Lynch thanked Nick Peraino for his service on the Board of Governors. Today is his last day on the Board. Dr. Seevak also announced CEO Scott Coffin's departure from the Alliance, effective May 31st, 2023.	Motion to Approve June 10th, 2022, Board of Governors Consent Calendar. Motion: Dr. Rollington Ferguson Second: Dr. Marty Lynch Vote: Yes No opposed or abstained.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP

6. a. BOARD MEMBER REPORT – COMPLIANCE ADVISORY COMMITTEE

Rebecca Gebhart	The Compliance Advisory Committee (CAC) was held telephonically on June 10th, 2022, at 10:30 am. Rebecca Gebhart gave the following Compliance Advisory Committee updates. Current Audits: • There are six audits that are running concurrently. The staff is doing an exceptional job. 2022 DHCS Routine Medical Services: • We are waiting for DHCS's report, and we have unpacked the self-identified findings at our prior meetings. 2022 DMHC Behavioral Health Investigation: • This is related to the Mental Health Parity and Addiction Equity Act (MHPAEA). It focuses only on the commercial plan, and it is a very challenging document and data production audit. It impacts the Alliance and our delegate, Beacon. • The DMHC is doing this investigation in phases. We are in phase two. The interviews are expected in early September and will include providers and Alliance staff. DMHC Routine Examination – Fiscal: • This is a routine examination that is focused on one (1) quarter, January 1st to March 30th, 2022. This will be looking at claims and fiscal compliance. • There are also two audits of our delegates – one is CHCN, and the other is CFMG. These are for the same time period – January 1st to March 31st, 2022. They will be looking at claims, compliance, and solvency for those two risk-bearing organizations (RBO's). The official start date is August. More information to come. • For CHCN, we sent in the requested deliverables on June 8th, and we are in the process of putting together the requested deliverables for CFMG.	Informational update to the Board of Governors. Vote not required.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	DMHC Routine Medical Survey 2021: • There were six (6) findings: three (3) in grievances and three (3) in prescription drugs - pharmacy. These findings are highly technical; the and are not difficult fixes. • For example, if there is an expedited review of a service which could be an emergency, the member services phone line staff would need to immediately verbally notify the member of their right to contact the State. The issue was that consistent documentation of this verbal notification was not in place – not that we weren't doing it, but that consistent documentation of the notification wasn't in place. • A second example is that the online grievance procedure was not accessible through a hyperlink with an ability to edit and that the form in the hyperlink had to say grievance form in all caps – it said grievance form, but it was not in all caps. Also, the form had to have the ability to edit, and it did not. The disclosure of the grievance process needed to be in all communications and in all member informing materials exactly as the law prescribes. A new law changed the disclosure language very minimally and the DMHC's website also did not have the new law's language. This is an easy fix. • The denial letter did not have accurate information related to grievance rights – it stated ninety (90) days instead of one-hundred-eighty (180) days. This is currently being fixed. • Prescription Drug Coverage: (1) The Plan did not inform members of their right to review formulary exception, request denials. This is currently being fixed. • Prescription Drug Coverage: The sixth finding was that our display of the formularies was not consistent with DMHC's standard formulary template and this includes website and collateral materials. Specifically, some of our formulary was on the second page of our documentation and DMHC would like it to be on the first page of our documentation. NCQA Reaccreditation: • We also briefly covered NCQA Reaccreditation, which CEO Scott Coffin will discuss in his CEO Report.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Question: The first survey mentioned mental health parity and addiction. Can you describe it and what is the survey? Answer: The name of the act is Mental Health Parity and Addiction Equity Act. The survey is to look and ensure that there is parity between how we're assessing mental health and the decision-making related to mental health and behavioral health to ensure there's no other barriers. That is the primary focus – each policy looking at each other and ensuring there's no additional barriers for the mental health side compared to utilization management. The primary concern is parity and assuring that the access is as aligned for behavioral health and mental health as it is for physical health. It hits every particular in terms of access authorizations, all of the pieces to ensure that mental health services are as accessible as physical health services. There is an on-site interview in September, so we will cover more on this going forward and at the next meeting. Informational update to the Board of Governors. Vote not required.		
6. b. BOARD MEMBER REPORT – FINANCE COMMITTEE			
Dr. R. Ferguson	The Finance Committee was held telephonically on Tuesday, June 7th, 2022. Highlights: • Tangible Net Equity (TNE) continues to be great at 574%. • Enrollment has increased by over 20,000 members over the past fiscal year. • Our Medical Loss Ratio (MLR) continues to be good at ninety-one-point-seven percent (91.7%) for the month of April 2022. • We continue to have some problems with our medical expense – our medical expense for the month ending April 30th, 2022 was $93.2M and our budgeted was $84.2M – nearly a $10.0M difference. The primary cause for this increase is the inpatient and ER services expenses. • One thing we need to address is how we control the ER expenses and inpatient expenses – this has been a consistent problem for the Alliance	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	in terms of our medical expenses. Over the years, we have implemented various policies and plans to control our medical expenses. At some point, we need to have a look back and see how we can better control those expenses. • Our revenue was up $101.6M, and this was due to the increase in enrollment. • Going forward and especially in the next fiscal year, our administrative expenses are going to increase significantly – most of it will be due to new hires. The plan is to hire around an additional one-hundred staff, and many of these new hires will be related to behavioral health. Informational update to the Board of Governors. Vote not required.		
7. CEO UPDATE			
Scott Coffin	Scott Coffin, Chief Executive Officer, presented the following updates: Scott thanked the Board of Governors and the Alliance staff for their years of service and accomplishments as he embarks on his eighth and final year as the Chief Executive Officer of the Alliance. The Board of Governors accepted and confirmed his retirement date of May 31st, 2023. Key Performance Indicators: • Operating Metrics: The regulatory metrics out of compliance in the month of May included the member expedited grievances, which was thirty-five percent (35%) below the compliance threshold, scoring sixty percent (60%) for the month of May. There was a total of five (5) expedited grievances that were processed, and three (3) were processed outside of the three-calendar day window. All of the expedited grievances were completed correctly.	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	- A remediation plan has been implemented, and a technology solution is being purchased to improve the regulatory compliance in addition to workflow changes between the health care services division and the operations division. We are continuing to work on bringing this regulatory metric back into full compliance – the challenge is it has such a small denominator. There are only five (5) expedited grievances, so if you miss one (1), you miss the minimum regulatory threshold. - Non-Regulatory Metrics: The non-regulatory metrics are defined internally as service standards. The Member Services team, led by the Chief Operating Officer, Matt Woodruff, have been doing great work and making progress. The Operations teams have improved over the last month; the call volumes were up slightly in the handling rates with an improvement by fifty percent (50%) month over month, meaning phones were being answered faster and there was a reduction in the abandonment rate. - The vacancy rate in hiring is at fifteen percent (15%), however, this number is inflated considering that we have twenty-one (21) signed offers currently pending. When adjusted for the signed offers, it brings the vacancy rate down to nine percent (9%) - great job to the Human Resources team. Also, thank you to the Analytics division for all the data and data management support that they provide and to the Information Technology division for keeping everything running – availability on our systems has been outstanding, and what the team has done is remarkable. These are all the enablers we need to achieve these results. Preliminary Budget – Fiscal Year 2023: - The preliminary budget for Fiscal year 2023 is being presented to the Board today for approval. - We are allowing for more time than we have in the past years to unfold the preliminary budget and talk through some of the implications because this is a significant year for changes in Medi-Cal managed care program. - The first change is in Long-Term Care – where skilled nursing facilities and custodial care are delivered in skilled nursing facilities. This benefit starts		

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	on January 1st, 2023. We have six (6) months of revenues and costs in the budget. • The second phase of the Long-Term Care benefit includes the intermediate care facilities, developmentally disabled care facilities, subacute facilities, and institutions for mental disease services. These services will be added six (6) to twelve (12) months later – sometime in July 2023 until possibly the end of the year. We are waiting on additional guidance from state regulators • The first Medi-Cal initiative, Long-Term Care, is a very significant benefit and implementation. The second major implementation is with Major Organ Transplants; this benefit started January 1st, 2022 for adult and pediatric transplant recipients and donors. This included all related services, such as the organ procurement, and the living donor care. • The services that are eligible through the California Children's Services program are carved out; however, the Alliance is responsible for all other transplant services for adults. The benefit launched six (6) months ago, and the patients who were matched to a donor at that time or currently scheduled for transplant surgery were excluded from the transition, so a majority of our members now on the transplant waitlist are being treated primarily by the University of California San Francisco (UCSF) and other UC centers. • As we reported previously, the University of California health system has not reached an agreement with the State of California on the Medi-Cal case rates. The DHCS reported this week at the CEO Quarterly Meeting about a pending resolution. • The Alliance is contracted with UCSF through individual letters of agreement for each patient, and we're paying these claims based on that agreement, however once a case rate is finalized, the paid claims will be repriced. The case rate is unknown at this time, and it is unclear on the financial impact in Fiscal Year 2023. • The third priority is the insourcing of the mental health and autism spectrum services. The budget contains eight (8) months of revenue and expense related to the administration of these services, which is scheduled to complete on November 1st, 2022. The Alliance currently pays a vendor (Beacon Health Options) to administer these services, but as we reviewed in the decision and approval process for insourcing; the annual recurring cost to administer the services internally is slightly higher than the		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	outsourcing however we expect to increase customer service and quality. Both product lines of Medi-Cal and Group Care benefit from the insourcing. Product Lines and Membership: • Group Care: The membership has averaged between fifty-five hundred (5,500) and six thousand (6,000) adults every month. The one change we have, which is reflected in our performance for the Fiscal Year 2023 is that we negotiated a rate increase that moves us closer to a fiscal break-even point. Group Care has been performing at a net loss historically for us. • Thank you to Alameda County, Social Services, the Public Authority, our County Administrator, Susan Muranishi, and the Board of Supervisors for supporting a rate increase. We have forecasted a net income of $1.4M for FY2023 in Group Care. Medi-Cal is the area that shows the larger net loss, which ultimately leads to what we see as our performance at the year-end of next year. • Enrollment continues to move upward for the next six (6) months, up to a maximum of about 322,000. After the Medi-Cal redetermination is engaged again, we're assuming that is going to be in January 2023 – then, there will be a reduction of about twenty-five thousand (25,000) adults and children. This brings us back to about two-hundred-ninety-seven thousand (297,000) members in June 2023. Highlights: • Staffing: Our current number of employees is three-hundred-seventy-five (375). By the end of the fiscal year on June 30th, we are going to be onboarding an additional twenty-four (24) staff. Looking at the Fiscal Year 2023 budget, we are asking for seventy-eight positions, and this adds nearly sixteen million dollars ($16M) to our administrative expense. This decision did not come lightly and took a lot of work by our Finance Team and by each one of the executives that oversee their division in the company. • Nearly fifty percent (50%) of these positions is tied to the insourcing of the Mental Health and Autism Spectrum Services, and the other half is divided into scaling the organization to meet customer service requirements,		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	meeting higher standards of regulatory compliance and accreditation, the project implementations that are ongoing (close to thirty projects in our portfolio), the addition of the CalAIM benefits and services, and to meet the new CalAIM reporting requirements that are derived by our regulatory agencies. All of these combined provide the basis for why we need the seventy-eight (78) positions. • In addition, a new Chief of Health Equity is proposed in the budget, and this is a new executive position that reports to the CEO and oversees the organization's efforts to promote diversity, equity, and inclusion. In addition, this officer will be responsible for aligning the corporate priorities and to meet the enforcement by DMHC and DHCS to focus more on health equity and quality standards. This individual will be collaborating with Health Care Services, Chief Medical Officer Dr. O'Brien, Dr. Bhatt, and our other clinical staff to reach these goals. • Fiscal Year 2022, which is ending in about twenty days, is outperforming our forecast, and we anticipate ending the year with about a $16 million net income. Conversely, in the Fiscal Year 2023, in light of all of the changes with the Group Care rates, the new Medi-Cal benefits and services, and the investments in the staffing and infrastructure, the reported net loss is forecasted at $14.9 million. NCQA Reaccreditation Survey: • The NCQA Reaccreditation Survey is scheduled in July 2022. The documents have been delivered to the NCQA survey team. This reaccreditation applies to both lines of business for calendar years 2020 and 2021, so we have two years in the survey period. • Last month I reported to the Board of Governors and Compliance Advisory Committee that a significant risk was self-identified during the survey readiness phase, and that our accreditation status could be negatively impacted. A mitigation plan is being developed to address these deficiencies, as we are in the process of inventorying the details of these deficiencies. An external audit is being scheduled through an external agency in the months of July and August to address our NCQA practices and to identify opportunities for improvement. A full report will be delivered by the CEO to the Board of Governors in the month of July.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Question: For expedited grievances, I think you mentioned there were six (6)? Is that the number we usually have on a regular basis? Answer: It is typically under ten (10), and it is one of those numbers that with such a small denominator, if we missed one, it triggers noncompliance. Matthew Woodruff provided the following comment: The average expedited grievances range from four (4) to nine (9) every month. There is a lot that gets sent over and a physician must actually de-expedite them. We are currently looking at the workflows and on June 1st, we implemented a workflow change, and hopefully that will help. Additionally, Carlos and our Member Services team have developed some homegrown software and it is workforce management – it is not just for expedited grievances, so the workforce management tool will be used for various items for member services. Eventually, we will roll it out to the provider call center as well. This will help with a lot more tracking, trending, being able to forecast different reports. It also has speech to text capabilities to help our Member Services team. We will be implementing this tool over the next six (6) months. Question: When you say the software is home-developed, did you mean it was developed at the Alliance? Answer: Yes, we are currently using an internally-developed system designed by Member Services staff over a six (6) to nine (9) month period. We're now moving toward a much bigger and more robust system with a lot more capability. Question: Since we're taking about self-developed tools, anything that is developed in-house, we have the rights to forever, for patents? Answer: Yes, that is correct. Informational update to the Board of Governors. Vote not required.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP

8. a. BOARD BUSINESS – REVIEW AND APPROVE APRIL 2022 MONTHLY FINANCIAL STATEMENTS

Gil Riojas	Gil Riojas gave the following April 2022 Finance updates: Enrollment: • For the month ending April 30th, 2022, the Alliance had an enrollment over 308,000 members, a net income of $2.3M, and the tangible net equity was 574% of the required amount. • Our enrollment has increased by over 1,900 members since March 2022, and on a fiscal YTD, we gained over 20,000 members since June 2021. Net Operating Results: • For the fiscal YTD ending April 30th, 2022, the actual net income was $15.2M, and the budgeted net loss was $2.3M. Revenue: • For the month ending April 30th, 2022, the actual revenue was $101.6M vs. the budgeted revenue of $93.9M. • For the fiscal year ending April 30thht, 2022, the actual revenue was $991.0M vs. the budgeted revenue of $971.1M. • For the month ending April 30th, 2022, the favorable revenue variance of $7.7M is largely due to $4.1M favorable Medi-Cal Base Capitation Revenue, due to higher enrollment. Additional favorability is due to $1.5M CalAIM Incentive Revenue, and $1.4M Behavioral Health Supplemental Revenue. Medical Expense: • For the month ending April 30th, 2022, the actual medical expense was $93.2M, and the budgeted medical expense was $84.3M. • For the fiscal year ending April 30th, 2022, the actual medical expense was $921.5M vs. the budgeted medical expense of $905.7M. • On a PMPM basis, medical expense is 0.5% favorable to the budget. Medical Loss Ratio (MLR):	Motion to Approve March 2022 Monthly Financial Statements as presented. Motion: Dr. Kelley Meade Second: Nicholas Peraino Vote: Yes No opposed or abstained.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• For the month ending April 30th, 2022, the MLR was 91.7% and 93.0% for the fiscal year-to-date. Administrative Expense: • For the month ending April 30th, 2022, the actual administrative expense was $5.8M vs. the budgeted administrative expense of $7.1M. • For the fiscal YTD ending April 30th, 2022, the actual administrative expense was $53.5M vs. the budgeted administrative expense $67.8M. Other Income / (Expense): • As of April 30th, 2022, our YTD investment revenue is $411,000 and the YTD claims interest expense is $337,000. Tangible Net Equity (TNE): • Tangible net equity results continue to remain healthy, and at the end of April 30th, 2022, the TNE was reported at 574% of the required amount. Cash Position and Assets: • For the month ending April 30th, 2022, the Alliance reported $284.7M in cash; $182.6M in uncommitted cash. Our current ratio is above the minimum required at 1.70 compared to the regulatory minimum of 1.0. Capital Investment: • Fiscal year-to-date capital assets acquired: $234,000. • Annual capital budget: $1.4M. Question: What are the capital assets that have been acquired? Answer: Capital assets that have been acquired this fiscal year are primarily IT assets, so we have been looking at servers, hard and storage solutions; also, there was the addition of the generator this year for the building, which was a big acquisition that we made this fiscal year. Question: What are the capital assets that we haven't purchased that were budgeted?		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Answer: It is probably around IT assets that we potentially thought we needed to purchase. Also, with the potential for us working a hybrid and remote schedule, there were probably some things for building improvements that we didn't need this fiscal year that were delayed. Those are the two areas that we have some savings; our budget is one-point-four million dollars ($1.4M), we continue to acquire things, but we are at the end of our fiscal year in June, so I don't imagine that capital asset number will go up significantly between now and the end of our reporting for June. Motion to Approve April 2022 Monthly Financial Statements as presented. A roll call vote was taken, and the motion passed.		
8. b. BOARD BUSINESS – REVIEW AND APPROVE FY2023 PRELIMINARY BUDGET			
Gil Riojas	Budget Process: • The FY 2023 preliminary budget was presented to, and approved by, the Finance Committee on June 7th, 2022 • On a call with DHCS, they announced that our rates, which are typically received in September, are going to be delayed by two (2) months; therefore, we are not going to be able to get our base rates for our next calendar year, probably by November. • This has a significant impact on our final budget timing – we need those base rates to help develop our revenue projections along with our expenses, and the fact that we are not receiving those until November is a problem for our presentation in December. Therefore, we are providing our first quarter forecast as scheduled in December 2022, and our final budget will be presented early, hopefully January 2023. This will depend on when we receive the rates from DHCS. Summary of Proposed Budget: • We are projecting a net loss of fourteen-point-nine million dollars ($14.9M); that is primarily driven by our Medi-Cal line of business, where we are projecting sixteen-point-three million dollar loss ($16.3M) and group care income is one-point-four million dollars ($1.4M). • The Tangible Net Equity changes to four-hundred-seventy nine percent (479%) as the requirement goes up, our TNE will be going down, which	Motion to Approve FY2023 Preliminary Budget as presented. Motion: Dr. Rollington Ferguson Second: James Jackson Vote: Yes No opposed or abstained.	None

	represents one-hundred-sixty-three-point seven million dollars ($163.7M) excess from our requirements. • A big driver of our budget for FY2023 is related to membership; the public health emergency has increased both revenue and expenses. We believe the public health emergency will end most likely in the first or second quarter of our fiscal year, and our membership will start to decline in the third or fourth quarter of our fiscal year. We are anticipating our membership in June 2023 to be at 297,000 members for Medi-Cal, and our group care remains essentially flat. That is 14,000 members lower than our FY2022 members. • Our revenue continues to go up at one-point-three billion dollars ($1.3B). The end of the year, our revenue was at seven-hundred-seventy-six million dollars ($776M) – we've had a sixty-eight percent (68%) increase in revenue over the last five and a half to six years, which is significant. Our revenue will be one-hundred-twenty-two million dollars higher than FY2022. • As programs are added to our responsibility and they transition from fee-for service to managed care like the long-term care, major organ transplant, CalAIM – all of these things make up the increase in revenue that we see, along with an increase in expenses. • Fee-for-service and capitation expenses are one-point-two billion dollars ($1.2B), one-hundred-twenty million dollars ($120M) higher – this relates to the revenue that we received for the member volume variances or member increases, changes to the pharmacy benefit, and the long-term care. All these different programs that are going in and out are impacting both our revenue and our expenses. • Our administrative expenses are six-point-six percent (6.6%) of the revenue, nineteen-point-five million dollars ($19.5M) higher than FY2022. With the increase in revenue to one-point-three billion dollars ($1.3B), a one percent (1%) change in that number represents about thirteen million dollars ($13M). As we grow, the percentage of our medical loss ratio and our administrative loss ratio grows as well. Administrative expenses are going up significantly, and that is primarily led by our labor costs, which is fifteen-point-seven million dollars ($15.7M). We also have grants that are		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	three-point-three million dollars ($3.3M) that our included in our FY2022 budget. • Clinical expenses are also going up as well – it's about nine-point-three million dollars ($9.3M) higher, and our labor costs are significantly increasing on the clinical side. We are seeing increases in expenses across the board that align with the increase in revenue, therefore, there will be major impacts to the budget staffing. Staffing: • We are anticipating four-hundred-seventy-eight (478) full time employees by the end of June 2023. We have new positions that are being added-fifty-seven (57) new positions budgeted across multiple departments. Enrollment: • Along with enrollment increases, some membership we believe will increase through December, and then as the predetermination process begins again, we anticipate most likely in January or February our membership will start decreasing. We've also included the impact of adding undocumented adults, ages fifty (50) and older as their transitioning from HealthPAC, which should be happening in July of this year. • Our Group Care enrollment remains steady at approximately six thousand (6,000) members. Revenue: • Ninety-eight percent (98%) of revenue is maintained at Medi-Cal revenue and two percent (2%) represents group care. • Our base rates are assumed to be increasing by about three-point-two percent (3.2%) on a per member/per month (PMPM) basis. • We also have the impact of a full years' worth of the pharmacy carve out happening in FY2023, so our pharmacy revenue will be significantly lower than it has in previous years. • We have the continuation of the CalAIM benefits, so adding the Enhanced Care Management (ECM) revenue along with any community support and major organ transplants revenue as well, so it is about forty-three-point-six million dollars ($43.6M) that we believe is included in those categories.		

- Long-Term Care data has not actually been received from the State for our financial assumptions; we have placeholder information in our budget based on our actuarial review and looking at some state guidance. We have included some projections for revenue and expenses, but we haven't received the information we need to look at our revenue.

Medical Expense:

- Our medical loss ratio we believe will be about ninety-four-point five percent (94.5%), below ninety-five percent.
- The CalAIM represents significant increases to our expenses and also our revenue. For Long-Term Care expenses, we anticipate seventy-five million dollars ($75M) for half of a year; we anticipate this to be a net positive, but we will know more once we get the actual data from the State, and we'll update those numbers when we see that information.

Hospital & Provider Rates:

- In our budget, about twenty-five million dollars ($25M) increases in our hospital contract rates.
- Professional capitation rates increase by five-point-four million ($5.4M).
- We have also included one-point-nine million dollars ($1.9M) for Behavioral Health Insourcing; in November, we anticipate that our rates will be a little bit higher than our current rates.

Preliminary FY 2023 Budget Comparison to FY 2022 Forecast:

- We think our net income will end at slightly above sixteen million dollars ($16.0M) this fiscal year FY2022.
- Our administrative expense ratio will end at about five-point-seven percent (5.7%), our medical loss ratio (MLR) at ninety-two-point nine percent (92.9%), and our TNE at five-hundred-seventy eight percent (578%).
- Negative Operating Margin projected at fifteen-point-four million dollars ($15.4M). For this budget FY2023, we anticipate our administrative expense to increase to six-point-six percent (6.6%). Our medical loss ratio (MLR) will be higher as well at one-point-seven (1.7%); both of these numbers are unfavorable for us, which also impact our TNE number.

	Question: What is the difference for our assumptions for inpatient costs for FY2022 and FY2023, and what direction are we assuming it is going to go? Answer: We think our unit costs for the cost of inpatient care will slightly decrease, but utilization per thousand we think is going to go up significantly. As a public health emergency, we would anticipate some of those inpatient costs to potentially increase. Our assumptions for utilization per thousand is for that to increase by ten percent (10%) over our current fiscal year, so unit cost assumptions will be relatively flat to slightly lower; utilization will go up significantly with the public health emergency ending, and that is potentially going to drive some of that efficient costs going higher. Question: Are we budgeting any additional utilization management or appropriate utilization intervention costs into our expense side? Answer: Yes, through our budget processes, we look at adding additional support in healthcare services, some of their focus for next year will be on those very things on an increased case management. There is a budget of dollars that are in our clinical administrative budgets that are reflecting increase in FTEs to support some of those things. We have reinsurance to cover high dollar cases, but we are not adding reinsurance for major organ transplant because the State has a risk corridor, whereas it is our major organ transplant costs that go above a certain percentage, and the State will kick in and support the Plans in offsetting some of those cost above the revenue that we receive. Question: Where do you anticipate the fee for service to go – what is the increase we are going to see, and is it going to be based mainly on increased number of increased cost-per-unit? Answer: On a utilization perspective, for both of those categories on a fee for service basis, we are expecting those to go up by about three percent (3%) from this current fiscal year. As the end of the public health emergency would assume, our members start going back to doctors, and getting both primary care and specialty care – therefore, we have increased our trend by about three percent (3%) from our existing year. It is mainly a volume expectation as opposed to a cost-per-unit. Question: Do you foresee any time of aid coming from the Governor's office, or grant further to be applied and applicable to this increase?		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Answer: That is a good question. What we have seen over this fiscal year and into the next fiscal year is an increase in the types of incentive programs that we are involved in, and the incentive programs are primarily tied to getting incentive dollars out to our community. We are acting as an intermediary for those incentives. There are measures and programs that are being added, and we anticipate that to increase and to continue into the next fiscal year. There may be certainly money that the Governor has added and as part of the budget process this fiscal year, and we anticipate that to continue into the next fiscal year. But again, most of these dollars are aligned with the community and getting those letters out to our providers. Question: The base rates are coming in November, and the long-term care plug you placed is $75M for half of the year. Is there a possibility that when rates are received, that it will take care of this net loss? Particularly in the long-term care area? Answer: I don't have anything that would warrant us changing our estimated rate impact, I think we won't know that until November, and when we get that information for long-term care rates, if they are significantly higher than estimates, that would be a positive thing for us. However, this will also potentially mean that our expenses will be higher as well. Mercer puts together the rate based on their actuarial work, and so when the rate is higher than we expect, we would expect expenses to be higher as well. I don't know if there would be enough of a margin for us to potentially reduce the projecting net loss, but I cannot say for certain until we get those rates. Question: How was the $75M calculated for long-term care? And is the long-term care fully staffed? Answer: We looked at what our actuarial support team has seen in other counties in terms of potential volume estimates and we compare that to an estimate of what our PMPM would be, and we took that information and extrapolated it for our county. That is how we divide both the revenue and the expenses for long-term care. We did use benchmark data, and we are hoping to get some fee for service data later in late June or early July that would give us more insight. The benchmark data we do think would give us a slight gross margin, but those members have a very high administrative load as well, so it is not only their MLR which is close to 100%. Long-term care has approximately		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	five (5) people dedicated and some consulting, and we have some new contracting as well. This is all reflected in our preliminary budget in FTE's. Question: What are the chances that the estimates for long-term care are way off, or that something changes? Answer: (Carol) The budget is always slightly off, it's just a matter of how much; for major organ transplants, we still don't have a lot of history. What we do know is compared to our first hopes, we're having a higher proportion, as opposed to Stanford where we have a favorable contract. We still don't have the rates that the State is requiring us to pay, UCSF – there is a lot of uncertainty there and there's a risk there. In terms of long-term care, one of our major risks is they've had some trouble with the State with flagging these members, so if they mistakenly just get in as SPDs or worse adults, or expansion, our revenue instead of being about ten thousand dollars ($10,000) per month would be about one-thousand dollars ($1,000) per month. Therefore, we are going to have to be quite vigilant in looking at every member and ensuring that they are classified as LTCs. I know the CCI plans have had a lot of issues with this. Scott Coffin made the following comment: The actual data has not been shared from the State yet – that has been delayed from the Department of Health Care Services for several months. We will have to also pick up the scope of the long-term care transition. They are breaking up the subacute from the Phase 1, skilled nursing facility in custodial care; that final scope is still being discussed in policy, so that could change as well, which could also have an impact on our assumptions and costs. Question: Do you think there is a chance that the State will expand coverage for undocumented people in their twenties, thirties, and forties? Answer: Yes, I do think there is a chance that will happen, but I don't think it will happen next fiscal year. I think that will be something we look at, during the end or middle to end of next calendar year, which would be our fiscal year 2024. Question: It looks like we will have positive net income from group care, is the new rate set? Answer: We're forecasting about a $2 million net loss this fiscal year, so we worked with the county to negotiate a higher rate, and with that higher rate, about a $1.4 million net income. In terms of where we are, I think the county's		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	agreed to that rate, we should be working on a formal contracting process to finalize that. Enrollment Year End: • We're anticipating ending this FY2022 with about three-hundred-eleven-thousand members (311,000) and decreasing to about two-hundred-ninety-seven thousand (297,000) into FY2023. Medical Loss Ratio by Line of Business: • We are anticipating our MLR for Medi-Cal to be slightly higher, and our MLR for group care to be slightly lower, and in part, that is because of our increasing revenue on our group care line of business. • As revenue increases, the percentage of medical loss ratio would decrease. • There are significant expenses associated with our long-term care population. Additionally, the big driver for our revenue and expenses is our enrollment. We anticipate enrollment to peak in December, and disenrollment to begin after, with enrollment declining in January or February. FY 2023 Administrative Expenses: • There will be a significant increase in our administrative expenses. We are increasing our employee expense by fifteen-point-seven million dollars ($15.7M) and having a reduction in our member benefits administration, primarily related to our pharmacy costs. • The total administrative expense increases about nineteen-point-five million dollars ($19.5M) from our FY2022 forecast. FY 2023 Capital Expenditures: • Our capital expenditures we anticipate will be lower in terms of how much we will purchase next fiscal year. We've broken down the two categories, and the main driver is information technology (IT), which represents six-hundred-forty thousand dollars ($640,000) of the total full year budget for capitalized purchases.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
Anastacia Swift	• Facilities – potentially adding some building improvements and some charging stations will be around three-hundred-thirty-nine thousand dollars ($339,000). Administrative & Clinical Expenses by Line of Business: • For this upcoming fiscal year, there will be eighty-seven-million dollars ($87M) of administrative department expenses and thirty-nine-point seven million dollars ($39.7M) in the clinical department. Staffing: Administrative & Clinical FTEs at Year-End • For FY2023, we are looking at seventy-eight (78) additional positions. We acknowledge current market conditions are tight and unemployment has decreased since March. However, we are not discouraged, and we have a plan to reach the goal. • We are looking at a two-pronged approach to fill these positions; the first prong is an internal process – as we prepare for anticipated growth with the projects and deliverables, we're preparing with assessing and modifying our internal processes to expedite reviews of applicants, interviews, selection and onboarding of those candidates. Our internal recruiting team is responsible for that internal process of tracking and onboarding hires. • We have increased our internal recruiting team to five (5) recruiters, and we are also accelerating the posting date of budgeted positions from sixty (60) to one-hundred-and-twenty (120 days, understanding that it may take anywhere from ninety (90) to one-hundred-and-twenty (120) days to fill a position from post date to hire date. • Externally, the approach is we are ramping up with outsourcing the recruiting function for source and candidates through partnership with two external agencies. These external recruiters will source candidates for both nonclinical and clinical positions. • We have already begun the recruiting process for twenty-nine (29) positions of the thirty-seven (37) roles assigned for behavioral health, and we have currently filled one (1) position related to behavioral health, and are currently interviewing and pending selection for seven (7). • The positions we are focused on right now are those positions that are in motion from the FY2022 budget. The remaining twenty-nine positions related to behavioral health, long-term care, CalAIM, etc. – those		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	positions will be rolled out and posted in the next month or two to provide that lead time for sourcing qualified candidates, for forty-five (45) non-clinical positions and thirty-three (33) clinical roles. • We will continue to assess and adjust salary structures annually to remain competitive. This means we will have to do our internal look back and look at ourselves and compare to the market as we have done in the past. Our goal is to fill roughly eight (8) positions per month. Dr. Ferguson addressed the need to ensure there is effort in hiring with diversity and inclusion in mind. Question: Do you have any incentives in place to attract qualified diversified candidates? Answer: We have not developed an incentive program for hiring a candidate, however, we have an employee referral program where our employees refer candidates, and they would receive a bonus for the referral. Rebecca Gebhart agreed with Dr. Ferguson's comment regarding hiring with diversity and inclusion in mind and endorsed the budget and the added number of FTEs. Question: Are we offering our new hires a remote arrangement to attract them? Answer: Currently, new hires are falling into our hybrid working model. There are some positions that have been designated by division to be hybrid or remote. There are not very many positions that are physically on site.		
Gil Riojas	Material Areas of Uncertainty: • We have not received long-term care data from DHCS, and both revenue and expense could differ significantly from the placeholders in the preliminary budget. • Additionally, the Department of Health Care Services is most likely going to adjust the methodology of risk adjustments, and that potentially could impact our base rate premium.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• The State is going to be dividing members in by category of aid, related to their immigration status; this is in response to a requirement from CMS, and it might potentially have an impact on our rates. It says aiming for net neutrality of the budget, but we don't know yet. • The number and cost of major organ transplants is also difficult to predict, but we do anticipate that to increase over the next fiscal year. • Another area of uncertainty is when the public health emergency will end and disenrollment will begin; we are anticipating January or February, and this would impact both our revenue and expenses. • Lastly, our contract changes for hospitals and our providers – we have projections in our budget, but we have not finalized all those contracts yet. Therefore, this may change. Question: When will we next hear back from you regarding the budget, will we get an update before November? Answer: We will go through our monthly updates as we do, and we will compare our results to the preliminary budget. We will provide our Q1 forecast in December, and the final budget in January or February. We will be unable to set forth a final, relevant budget earlier without our rates. Question: Would we be able to get the final budget one (1) month after the rates are received from the State? Answer: Yes, that would be reasonable. Motion to Approve FY2023 Preliminary Budget as presented. A roll call vote was taken, and the motion passed.		
9. a. STANDING COMMITTEE UPDATES – PEER REVIEW AND CREDENTIALING COMMITTEE			
Dr. Steve O'Brien	The Peer Review and Credentialing Committee (PRCC) was held telephonically on May 17th, 2022. Dr. Steve O'Brien gave the following Committee updates:	Informational update to the Board of Governors. Vote not required.	None

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	• We credentialed seventeen (17) initial applicants, including six (6) primary care providers. Additionally, forty-nine (49) providers were re-credentialed at this meeting. • There were twenty-four (24) providers that left the Alliance. Informational update to the Board of Governors. Vote not required.		
10. STAFF UPDATES			
Scott Coffin	None	None	None
11. UNFINISHED BUSINESS			
Scott Coffin	Dr. Ferguson asked for numbers to be presented that would project the decline in the Alliance's quality score related to the Kaiser contract in 2024, and what we are doing to offset that impact on quality.	Scott Coffin confirmed this will be added to the list and addressed at a future meeting.	None
12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS			
Scott Coffin	None	None	None
13. PUBLIC COMMENT (NON-AGENDA ITEMS)			
Dr. Evan Seevak	None	None	None
14. ADJOURNMENT			
Dr. Evan Seevak	Dr. Evan Seevak adjourned the meeting at 2:07 pm.	None	None

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

Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

July 5th, 2022
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted by Teleconference

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

Board of Governor members on Conference Call: James Jackson, Andrea Schwab-Galindo

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

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
CALL TO ORDER, ROLL CALL, and INTRODUCTIONS			
Dr. Michael Marchiano	Scott Coffin asked Dr. Michael Marchiano, as the senior Finance Committee member, to lead the meeting in Dr. Ferguson's absence. Dr. Marchiano called the meeting to order at 8:08 am. The following public announcement was read. "The Board recognizes that there is a proclaimed state of emergency at both the State and the local Alameda County level, and there are recommended measures to promote social distancing in place. The Board shall therefore conduct its meetings via teleconference in accordance with Assembly Bill 361 for the duration of the proclaimed state of emergency." A telephonic Roll Call was then conducted.		
CONSENT CALENDAR			
Dr. Michael Marchiano	Dr. Marchiano presented the Consent Calendar.	No vote was taken due to no-quorum status.	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	June 7th, 2022, Finance Committee Minutes were approved at the Board of Governors meeting June 10th, 2022, and not presented today.		
a.) CEO Update			
Scott Coffin	Scott Coffin provided updates to the Committee on the following: **<u>Insourcing Mental Health and Autism Spectrum Disorders:</u>** The insourcing of mental health and autism spectrum services is effective on November 1st, 2022. The termination letter has been signed and delivered to Beacon Health Options per the terms and conditions of our current contract, effectively ending our contract on October 31st, 2022, at which time we will assume all administration of delegated services. **<u>Carve-In of Long-Term Care (LTC) Medi-Cal Benefit</u>:** Transition of carve-out to carve-in takes place on January 1st, 2023. The difference between carve-out and carve-in lies in the fiscal and administrative responsibilities. As a carved out benefit, the State has been assuming responsibility, and as a carved in benefit, the Alliance will assume full responsibility. The first phase of the Long-Term Benefit includes Skilled Nursing Facilities and the custodial care administered in the skilled facility. Under the current policy, whenever a Medi-Cal beneficiary entered a LTC facility, they were disenrolled approximately 60 days after being admitted, and placed into the Medi-Cal Fee-For-Service system. As of January 1st, 2023, these members will no longer be disenrolled from the Alliance, and will remain enrolled during their stay at the LTC facility. Further changes to the LTC Benefit will occur in phases throughout 2023. We will discuss the financial impact anticipated as a result of these changes at the full Board meeting on Friday, July 8th. **<u>Quality Component added to Rate Development</u>:** In calendar year 2023, the Department of Health Care Services (DHCS) is introducing a quality component into the base Medi-Cal rates. This will be based on a subset of HEDIS scores from calendar year 2021. Future year rates will be based on the quality component from the HEDIS scores collected 2-years prior (i.e., CY2024 will utilize HEDIS subset score from calendar year 2022) This is a significant change and has a potential top-line financial impact on the Alliance. We will be conducting more analysis and will update as more policy guidance is issued by the DHCS.	Informational update to the Finance Committee Vote not required	

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
b.) Review and approve May 2022 Monthly Financial Statements			
Gil Riojas	**May 2022 Financial Statement Summary** **Enrollment:** Current enrollment is 310,758 and continues to trend upward. Total enrollment has increased by 2,017 members from April 2022, and 22,204 members since June 2021. Increases were primarily in the Child, Adult, and Optional Expansion categories of aid, and include slight increases in the Duals and SPD categories of aid. Group Care remains relatively flat. Monthly enrollment trends are projected to increase as the Public Health Emergency (PHE) is currently expected to be extended through October 2022. **Net Income:** For the month ending May 31st, 2022, the Alliance reported a Net Income of $5.2 million (versus budgeted Net Income of $3.4 million). The favorable variance is attributed to higher than anticipated Revenue, lower than anticipated Administrative Expense, and higher than anticipated Total Other Income. This was slightly offset by higher than anticipated Medical Expense. For the year-to-date, the Alliance recorded a Net Income of $20.3 million versus a budgeted Net Income of $1.1 million. **Revenue:** For the month ending May 31st, 2022, actual Revenue was at $99.4 million vs. our budgeted amount of $96.8 million. The favorable variance is most directly attributed to an increase in enrollment beyond what we had originally budgeted, due to the continuation of Public Health Emergency (PHE). The favorable Medi-Cal Base Capitation Revenue variance of $470,000 is net of unfavorable $1.4 million DHCS recoupment resulting from a recent Date-of-Death Audit spanning from Calendar Year 2011 through April 2022. As a reminder, the State did a similar recoupment in 2019. **Question:** James Jackson asked if it is incumbent upon the Alliance to proactively identify deceased members and make financial adjustments, and further inquired if there is any penalty associated or is it dollar for dollar. Gil Riojas answered that previously we had looked at ways we could initiate or instigate resolution sooner by tracking the death certificates to the county, but there seems to be a delay between when the County sends the death		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	certificate and when the State updates the record. The DHCS recoupment process serves to catch those that were missed. Our analytics team continues to look at ways to identify these records earlier so that we can set the funds aside. It is a straight dollar for dollar take-back, and no penalty. It is a function of the State cleaning up its records. The main consequence for the Alliance is that much of the money has gone through as capitation payments to our delegates for these deceased members and now must recoup from them. Our delegates may be impacted, with Kaiser being impacted the most. **Question:** Dr. Marchiano asked if there is a process being developed in order to be able to identify members that may be classified as terminal. Matt Woodruff answered that we currently do have a process that allows us to make note of information we receive on members that have been reported deceased or have moved away. We send a file to the County with this information every month. The County then will review, verify, and process the information and then send to the State to review and make determination. This process, when we have seen the changes, has taken an average of nine months. **Medical Expense:** Actual Medical Expenses for the month were $89.1 million, vs. our budgeted amount of $86.8 million. For the year-to-date, actual Medical Expenses were $1.0 billion versus budgeted $992.4 million. Primarily driven by the continuation of our enrollment increase beyond what we had budgeted in December 2021. Directly related to the Public Health Emergency (PHE). Drivers leading to this variance can be seen on the tables on page 11. Further explanation of the variances can be seen on pages 11 and 12. **Medical Loss Ratio:** Our MLR ratio for this month was reported at 89.6%. Year-to-date MLR was at 92.7%. **Question:** James Jackson asked what our target MLR is. Gil Riojas answered that our threshold related to requirements of the ACA is to be *above* 85% MLR. Our ideal MLR should range between 90-95%. Scott Coffin added that we intentionally do not set an upper end target, because we always want our focus to be on quality of care. He further added that we have seen historically that a MLR above 95% typically does not allow for any Administrative Expenses, and in those months we have posted a Net Loss.		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
	Administrative Expense: Actual Administrative Expenses for the month ending May 31st, 2022 were $5.6 million vs. our budgeted amount of $6.7 million. Our Administrative Expense represents 5.6% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date. Reasons for the favorable month-end variances, as well as the favorable year-to-date variances can be seen on page 13 of the packet. **Other Income / (Expense):** As of May 31st, 2022, YTD Investment Interest Revenue realized an $82,000 Net Loss. There are have a lot of changes in the market, particularly to interest rates, and we are hopeful that as we roll some of our investments off of lower interest rate earning investment vehicles to higher ones, our return will go up. YTD claims interest expense is $363,000. **TangibleNet Equity (TNE):** We reported a TNE of 594%, with an excess of $187.8 million. This remains a healthy number in terms of our reserves. **Cash and Cash Equivalents:** We reported $297.9 million in cash; $196.7 million is uncommitted. Our current ratio is above the minimum required at 1.72 compared to regulatory minimum of 1.0. **Capital Investments:** We have spent $234,000 in Capital Assets year-to-date. Our annual capital budget is $1.4 million.	No Vote Taken – No Quorum Informational update only	
UNFINISHED BUSINESS / DISCUSSION			
	None		

AGENDA ITEM SPEAKER	DISCUSSION HIGHLIGHTS	ACTION	FOLLOW UP
ADJOURNMENT			
Dr. Michael Marchiano	Dr. Marchiano adjourned the meeting. The meeting adjourned at 8:41 am.	Motion to adjourn: Scott Coffin No opposed or abstained.	

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

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

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

2021

Case Management/Care Coordination, Complex Case Management & Disease Management
2021 Program Evaluation

Signature Page

Date ____________________________________

Julie Anne Miller, LCSW
Senior Director, Health Care Services

Date ____________________________________
Donna Carey, MD
Medical Director, Case and Disease Management

Date ____________________________________

Sanjay Bhatt, M.D.
Senior Medical Director, Quality Improvement

Date ____________________________________

Steve O'Brien, M.D.
Chief Medical Officer, Medical Management
Chair, Health Care Quality Committee

Date ____________________________________
Scott Coffin
Chief Executive Officer

Date ____________________________________
Evan Seevak, M.D.
Board Chair

2021
Case Management
Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors and Quality Management Committee (QMC), senior management and the Health Care Quality Committee (HCQC), the Health Care Services 2021 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, 2021 through December 31, 2021.

Membership and Provider Network

The Alliance products include Medi-Cal Managed Care beneficiary's eligible thorough one of several Medi-Cal programs, e.g. TANF, 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 is an employer-sponsored plan serviced by The Alliance which provides low-cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County. The Alliance provides services to IHSS workers through the commercial product, Group Care.

Figure 1 2021 Trended enrollment by network and age group

Current Membership by Network By Category of Aid							
Category of Aid	Dec 2021	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	43,077	15%	9,049	8,992	671	16,519	7,846
Child	98,150	34%	8,232	8,820	29,714	33,435	17,949
SPD	26,450	9%	8,318	4,115	1,058	10,946	2,013
ACA OE	102,264	35%	16,029	33,514	1,130	38,210	13,381
Duals	20,964	7%	8,190	2,255	-	7,490	3,029
Medi-Cal	290,905		49,818	57,696	32,573	106,600	44,218
Group Care	5,823		2,470	894	-	2,459	-
Total	**296,728**	**100%**	**52,288**	**58,590**	**32,573**	**109,059**	**44,218**
Medi-Cal %	98.0%		95.3%	98.5%	100.0%	97.7%	100.0%
Group Care %	2.0%		4.7%	1.5%	0.0%	2.3%	0.0%
		Network Distribution	*17.6%*	*19.7%*	*11.0%*	*36.8%*	*14.9%*
			% Direct:	**37%**		**% Delegated:**	**63%**

Age Category Trend				
	Members			
Age Category	Dec 2019	Dec 2020	Nov 2021	Dec 2021
Under 19	91,641	97,399	100,206	100,408
19 - 44	78,271	93,280	104,239	105,212
45 - 64	54,210	57,679	60,571	60,685
65+	24,709	27,231	30,135	30,423
Total	**248,831**	**275,589**	**295,151**	**296,728**

For 2021, The Alliance membership increased, as seen in Figure 1, to about 297 thousand members, from 275 thousand members in 2020. This trend is in alignment with the increase in Medi-Cal Enrollment in California in 2021 and suspension of disenrollment due to the Covid Public Health Emergency.

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

Figure 2 Provider Network by Type and Enrollment

Provider Network	Provider Type	Members (Enrollment)	% of Enrollment in Network
Direct-Contracted Network	Independent	52,288	17.6%
Alameda Health System	Managed Care Organization	58,590	19.7%

Children First Medical Group	Medical Group	32,573	11.0%
Community Health Clinic Network	Medical Group	109,059	36.6%
Kaiser Permanente	HMO	44,218	14.9%
TOTAL		296,728	100%

The percentage of members within each network has been relatively steady from 2020 to 2021, varying by less than 1%

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

- Basic care management
- Care Coordination
- Care Management
- Complex Case Management
- Transitions of Care
- Health Homes

Delegation

The Alliance delegates 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: 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 assure capacity to meet standards and requirements.

The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with other respective 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 is responsible for the oversight of delegated activities and completes an annual performance evaluation of delegated case management operations. Results of the annual evaluation and any audit results are reviewed by the Compliance and Delegation Oversight Committee.

The Alliance shares the performance of CM activities with several delegates. The Alliance's CM delegates, as of the date of this document, are the following:

Figure 3 – 2021 the Alliance Delegated Network

2021 Alliance Delegated Network			
Provider Network/Delegate	**Provider Type**	**Delegated Activity- Care Coordination/CM**	**Delegated Activity- Complex Case Management**
Kaiser	HMO	Yes	Yes
CHCN	MCO	Yes	No
Beacon	MBHO	Yes	Yes

Delegation vs Direct Trend								
	Members				% of Total (ie.Distribution)			
Members	Dec 2019	Dec 2020	Nov 2021	Dec 2021	Dec 2019	Dec 2020	Nov 2021	Dec 2021
Delegated	154,621	168,412	183,640	185,850	62.1%	61.1%	62.2%	62.6%
Direct	94,210	107,177	111,511	110,878	37.9%	38.9%	37.8%	37.4%
Total	**248,831**	**275,589**	**295,151**	**296,728**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Overall, the network was sufficient to meet the needs of The Alliance membership and provider network through 2021. In 2021 there were ongoing improvements in the level of oversight, monitoring, reporting, and training of delegates to ensure they met the regulatory standards and Alliance requirements.

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 12-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 Health Care Quality Committee (HCQC) 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 HCQC. Utilization Management and Case Management activities are the responsibility of the Alliance Health Care Services staff under the direction of the Medical Director for Care Management and Special Programs and the Senior Director, Health Care Services in collaboration with the Alliance CMO.

Committee Structure

The Board of Governors appoints and oversees the HCQC, the Peer Review and Credentialing Committee (PRCC) 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 and Utilization Management and Case Management Programs. Committee membership is made up of provider representatives from The Alliance contracted networks and the community including those who provide health care services to Seniors and Persons with Disabilities (SPD) and Chronic conditions.

The HCQC Committee provides oversight, direction, makes recommendations, and has final approval of the UM and CM Programs. Committee meeting minutes are maintained summarizing committee activities and decisions and are signed and dated.

HCQC charters a sub-committee, the Utilization Management Committee (UMC) which meets at least once every 2 months (8 meetings in 2021,) serving as a forum for the Alliance to evaluate current CM activities, processes, and metrics. The UMC also evaluates the impact of CM programs on other key stakeholders within various departments and when needed and assesses and plans for the implementation of any needed changes.

The 2020 CM Program Evaluation and 2021 CM Program Description were developed and presented for review and approval at the March 18, 2021 HCQC 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.

In 2021 the UM Subcommittee of HCQC has continued to support the focus on CM activities, oversight for delegated CM activities, case management/care

coordination, complex case management, transitions of care, population health, integration of behavioral health and medical as well as regulatory compliance.

Evaluation of the level of 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.

During 2021 Dr. Aaron Chapman, a psychiatrist, and Medical Director of Alameda County Behavioral Health Care Services, actively participated in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications.

Program Scope and Structure

The Alliance promotes case management services through multidisciplinary teams that address member specific medical conditions, behavioral, functional, and psychosocial issues whether in a single health care setting or during the member's transitions of care across the continuum of care. 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, the health care delivery systems, and the various payer sources.

The comprehensive case management program is established to provide case management processes and procedures that enable the Alliance to improve the health and health care of its membership. Members from all Alliance health products are eligible for participation in the program. Alliance products include Medi-Cal and Alliance Group Care. The fundamental components of 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 closure of the case. The structure of comprehensive case management is organized to promote quality case management, client satisfaction and cost efficiency using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

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 2021 CM Program Description.

The assignment of work to the team, whether working on site or remotely for both clinical and non-clinical activities, is seamless to the process. In 2020, in response to the Covid 19 pandemic and public health requirements, the CM department transitioned to fully working from home, and have continued to do so throughout 2021. Staff were provided equipment, remote connectivity, and policies to follow to successfully work from home while maintaining full functionality and meeting regulatory requirements. The job descriptions with assigned tasks and responsibilities remained the same regardless of the geographical location of the team member.

In 2021, the leadership structure in the CM department is designed to meet the needs of the program and the staff:

- Medical Director of Case Management
- 1.0 FTE Manager
- 1.0 FTE Supervisor of CM.
- 1.0 FTE Lead CM.

The department was successful in hiring and retaining Complex Case Managers in 2021.

Delegated Case Management

As describe in the section above for Delegated Activities, The Alliance provides health services to our members through a partially delegated network.

For care management and complex case management (CCM), The Alliance delegates basic care management and care coordination to network providers. Currently, the Alliance only delegates complex case management to Kaiser (a NCQA-accredited entity) which represents a small proportion of its total membership.

Behavioral Health CM activities are delegated to and managed by the contracted managed behavioral health vendor (MBHO), Beacon Health Strategies.

The Compliance Department is responsible for the overall performance of the internal and external audits of delegates. CM Department staff are responsible for the review and reporting of the CM components of the annual process which includes standards and file review. The Compliance Department is responsible for finalizing the audit findings and issuing required corrective actions. All audit findings are reported into the Compliance Department and the HCQC.

In 2021, the CM staff conducted annual audits on the four (4) delegates. The threshold for CM audit compliance is 90%. For entities that do not meet the threshold, CM may require a corrective action plan which is tracked for compliance with the resolution of the deficiency. Entity audit results for 2021 were:

- One (1) group passed the CM audit (≥ 90.0%), 2 had findings and required corrective actions.

Figure 4 the Alliance Network – 2021 Annual Audit Score

Delegate	Provider Type	Delegated Activity- CM	2021 Audit Results	Corrective Action Required
Kaiser	HMO	X	No deficiencies found	None
CHCN	Medical Group	X	Deficiencies found, Corrective Action Plan Required	Yes: No documentation of member outreach, evaluation, and PCP collaboration
Beacon/College Health IPA (CHIPA)	Vendor-BH	X	Deficiencies found, Corrective Action Plan Required	Yes: No documentation of PCP collaboration and did not include review of clinical documentation

Additionally, the CM team is responsible for ongoing monitoring activities including review of the delegated entities annual work plans/evaluations, and semi- annual reporting.

Recommend Actions/Next Steps

For 2022, there is an opportunity to continue to improve the oversight of delegated CM activities. The CM Department leadership continues to develop a robust level of delegate oversight and performance monitoring. The activities include dedicated staff, monitoring activities, performance management, delegate feedback and CM training. In Q4 2022, Behavioral Health for members with Mild to Moderate illness will be insourced back into AAH, rather than delegating to Beacon/CHIPA. This will improve the integration of BH with medical care, particularly care coordination functions.

Case Management Processes and Information Sources

Case Management Information Systems and Sources

The CM Department utilizes 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 the use of 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.

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.

In July 2019, the CM Department conducted a comprehensive review of standard CM workflow using Lean Management principles. This included reviewing the functionality of the TruCare system. In 2020/2021, Casenet, the corporate parent of TruCare, worked in collaboration with CM and AAH IT

leadership to optimize and improve the functionality of the TruCare system. 2021 optimization was not fully completed, and work will continue into 2022.

In 2021, CM Department collaborated with Senior Leadership to align Disease Management criteria with the Population Health initiatives. The enhancements made were based on the Population Health initiatives, leading to a strengthening of the Disease Management Program in 2021.

The Alliance Health Care Services Departments area continues to review and update existing policies and workflows to address regulatory changes based on specific criteria. This includes any internal and delegate training or regulatory reporting needs.

Care Coordination and Case Management Processes

There are five (5) distinct levels/areas of Care Management to match the members identified risk level as described below:

- **Basic Case Management** or Low Risk level is provided by the Primary Care Physicians and their staff with a Network Provider Group's Care Management support.
- **Care Coordination/Service Coordination** or Moderate Risk level is provided at the Provider Group level, supporting the Primary Care Provider (PCP). AAH CM provides support to the PCP to coordinate care.
- **Targeted** Care Management is supported by The Alliance Care Management staff with designated community TCM programs.
- **Complex** Care Management is provided by The Alliance Care Management staff, consistent with NCQA Standards.
- **Specialty Programs** such as Transitions of Care, Continuity of Care, and Health Homes

Basic Care Management

The Primary Care Provider (PCP) is responsible for Basic Care 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 member enrolled in the Direct Network, the PCP works with the Alliance CM or UM teams to facilitate coordination.

Care Coordination

Care coordination is provided by the Provider Group CM staff for members needing assistance in coordinating their health care services. This level of CM may include ambulatory case management, referral coordination and/or focused disease management programs. For members in need of care coordination along the continuum of care, including arrangements for linked and carved out services, programs, and agencies, the Alliance CM team provides assistance using non-clinical staff, Health Navigators, with extensive training in facilitation and coordinating services both internally and with outside agencies. Health Navigators manage most of the care coordination, continuity of care, and low risk transitions of care cases. They also make referrals to Beacon, Alameda County Public Health, community resources, etc.

Targeted Care Management

The Alliance facilitates, and coordinates care for eligible members (including the Medi-Cal SPD and Expansion population) through Targeted Case Management (TCM) services. Alliance staff follow preset guidelines and collaborates with primary care providers when necessary to determine eligibility for TCM services. Members may be referred to receive TCM services through the Alliance or through the most appropriate contracted community partner.

Members eligible for TCM services have generally been identified as moderate or high risk. Once a member is identified and referred for TCM, they are assigned to an Alliance Case Manager, who takes responsibility for screening, referrals, care planning, and all other care coordination activities. Members are matched to a Case Manager who is specialized based on the prominence of medical or behavioral health needs. Though there is one assigned "lead," the support and expertise of other Case Managers may be harnessed to provide collaboration and comprehensive, multidisciplinary care. This approach is most important for those Members who are multiply diagnosed with medical, functional, cognitive, and psychosocial conditions.

Complex Case Management

Complex Case Management (CCM) is provided to members who meet the criteria for CCM. Members meeting criteria for CCM have conditions where the degree and complexity of illness or conditions is typically severe, the level of management necessary is typically intensive and the number of resources required for member to regain optimal health or improved functionality is typically extensive.

Complex Case Management is a collaborative process between the Primary and/or Specialty Care Providers, member, and Care Manager, who provide

assistance in planning, coordinating, and monitoring options and services to meet the member's health care needs.

Disease Management

The Alliance CM Disease Management (DM) program is integrated with the Quality Management Department and Population Health initiatives to provide interventions for members with targeted chronic illnesses. The Population Health initiative has identified target diagnoses affecting the Alliance membership at a disproportionate rate and/or with significant utilization. In 2021, the DM program worked with children and adult members with Asthma and adult members with Diabetes. Multiple approaches were taken to enhance the service, ranging from identification of members with the disease, ensuring standard work was employed related to the level of acuity of the member and their disease. The program worked with community partners: Asthma Start, for children with asthma, and a variety of community programs to provide services for members with diabetes. The planning for the launch of CalAIM Community Supports occurred in 2021, and Asthma Remediation as a Community Support was chosen to further support members with Asthma.

Population Health Initiative

In 2021, the Population Health initiatives at the Alliance were strengthened and further integrated into ongoing Alliance work with members. 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 wrap around Health Homes Program services. The CM interventions performed at each acuity level were identified, and the foci of CM work has been further targeted to the acuity level of the members.

Figure 5 Volume of CM cases in Population Health Target Diagnoses in 2021

Dx	Numbers with Disease State in the last 12 months	Care Coordination (Currently Enrolled)	Transitions of Care (Currently Enrolled)	Complex Case Management (Currently Enrolled)	Health Homes
CAD	6039	33	39	8	162
CHF	3637	27	41	15	160
Cervical CA	328	0	1	0	7
Lung CA	277	0	4	0	2

Emphysema	3358	28	33	11	147
ESRD	908	11	14	3	34
Schizophrenia	3216	22	19	1	65
Sickle Cell Disease	119	0	0	0	0
Hepatitis C	1077	10	10	0	21
Tuberculosis	125	1	0	0	5
SUD	8516	53	55	10	197
Asthma	23904	82	76	15	305
Breast CA	1060	3	4	0	5
Hyperlipidemi a	37217	69	57	14	305
Hypertension	39894	98	120	28	489
Diabetes	21016	55	80	19	325
Obesity	29342	36	56	9	200
Pregnancy	6472	6	3	0	11
Gingivitis	999	1	3	2	10
Burns-1st degree	416	3	1	0	4
Tobacco	12225	53	64	10	194
Total Unique Members any DX	200145	591	680	145	2648

The highest volume of members with the Population Health target diagnoses are served by the Health Homes program (HHP), which is to be expected, since the HHP serves the highest risk, most vulnerable members. The next highest is those members receiving Care Coordination, which reflects the volume of work assisting significant numbers of members to navigate the health care system. Complex CM is typically involved when members have multiple diagnoses, some of which are part of those targeted by the Population Health initiative.

Specialty Programs

Transitions of Care

In November 2019, the Transitions of Care (TOC) Program was enhanced. TOC is provided to members who meet the criteria of hospital discharge. The level of management necessary and the number of resources required for the member to regain optimal health or improved functionality varies, thereby involving any individual or combination of the Case Management disciplines: Nurse Case Managers, Social Workers or non-clinical staff, Health Navigators.

For 2020/2021, the Transitions of Care Program included the hospitals of the Alameda Health System, and expanded to also include any Alliance member hospitalized with COVID-19 (including members who are delegated to CHCN). There was improved collaboration between CM, Utilization Management (UM) and Pharmacy.

For 2021, the Transitions of Care Program expanded to include collaboration with Pharmacy for the high-risk Transitions of Care members described above.

For 2022, the Transitions of Care Program plans to expand beyond the three (3) current hospitals and to incorporate further collaboration between Utilization Management (UM), Pharmacy and CHCN to further meet the member's health care needs.

Case Management Processes

Health Risk Assessments

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 identified as at high health risk.
- 105 days of enrollment as a lower risk.

The Alliance outreaches to SPD members to administer the HRA and to develop a Care Plan. SPD members are re-assessed annually in the month of their enrollment. The responses from the HRA may result in the members being re-classified as higher or lower risk. (For some members, this HRA based re-classification may be different from their earlier classification based on the stratification tool.) 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

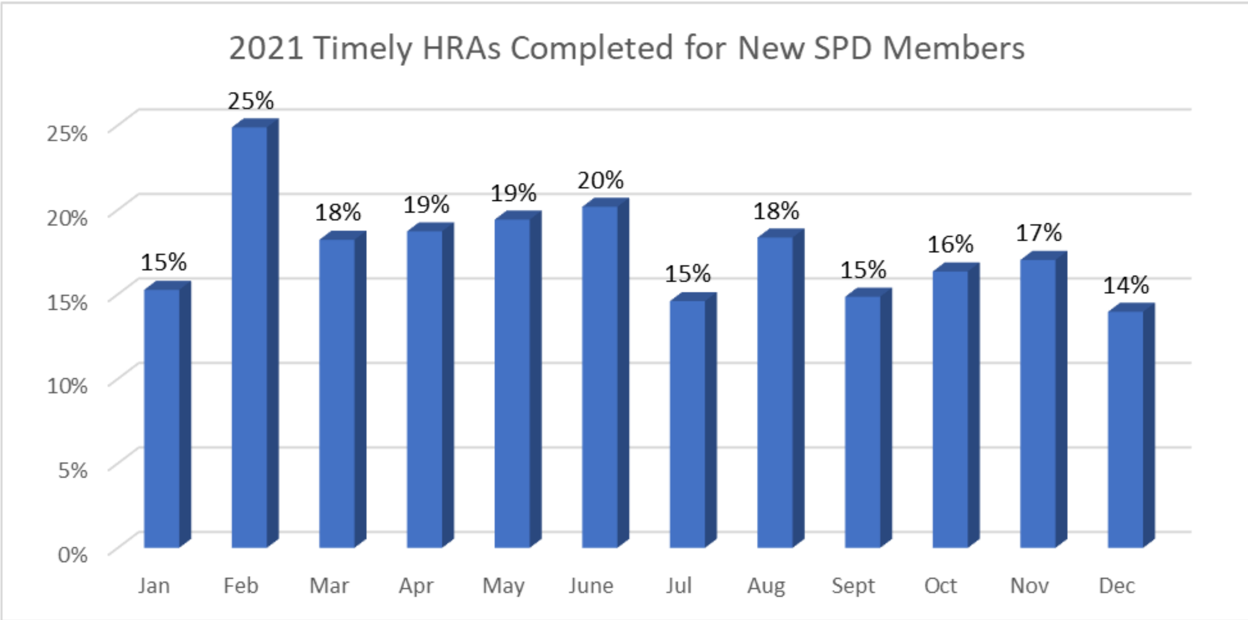
questions are for referral purposes only and are not meant to be used in classifying high and low risk members. After completion of the HRA, the Alliance develops Individualized Care Plans (ICPs) for members found to be at higher risk and coordinate referrals for identified LTSS, as needed.

CM staff is responsible for ensuring the Member Care Plan is completed and shared as well as providing any community or health resources. For Members who completed the HRA with a final stratification of Low Risk, CM staff review the HRA responses to identify Member needs, i.e. resources for transportation, IHSS, and Food Banks. The CM staff generates the care plan, attaches the resources, and prepares it for mailing. If the member remains Unable to Contact, (UTC,) CM Staff will create a standardized care plan based on the needs identified from the initial data used to stratify the Member. The Alliance generates the standardized high-risk care plan because there are additional health education resources and materials that can be provided to members even if they do not complete the HRA. All copies of the care plans are mailed to the Member and Primary Care Provider as well as to the Provider Group for potential care coordination needs. A HRA letter and resources are sent to the Member; a copy of the Care Plan is sent to the Primary Care Provider for care coordination.

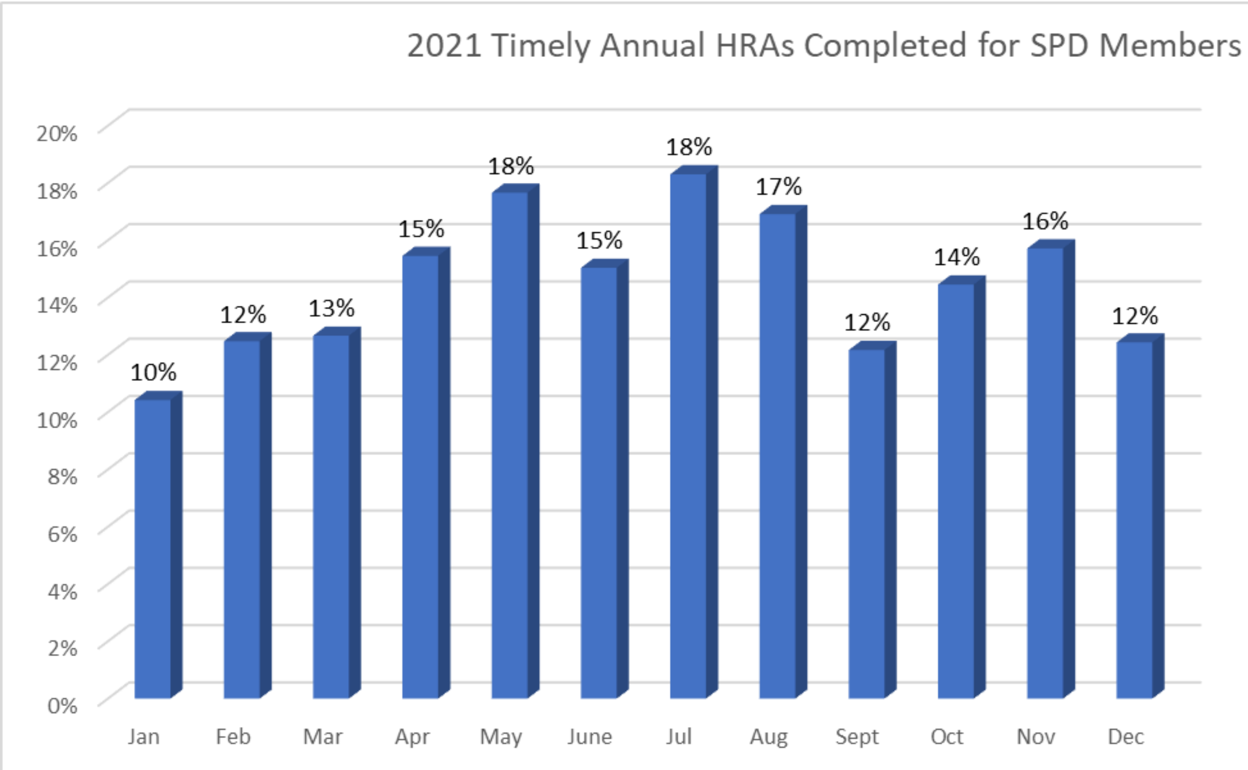
The Alliance uses Interactive Voice Response (IVR) calls to encourage members to complete an HRA. In 2021, the Alliance shifted from contracting with a vendor to the Alliance's internal IT team, to make Interactive Voice Response (IVR) calls to members. These IVR calls are made to members so that the Alliance can give members every opportunity to complete the HRA and have the results acted upon by the CM department.

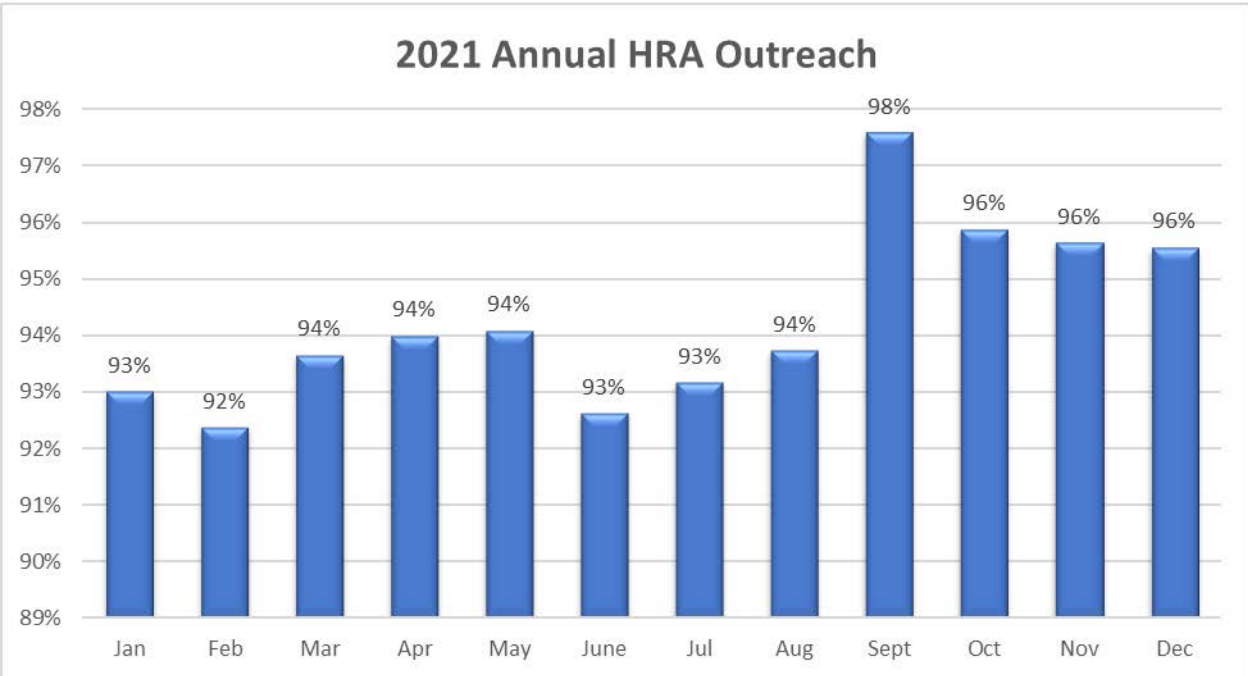
In collaboration with Healthcare Analytics, a HRA dashboard was created in 2018, to track compliance of outreach attempts and timely completion of the HRA for the SPD population, and this tracking continued in 2021.

New HRA completion for SPD Members



Annual HRA completion for SPD Members





The outreach rates for 2021 remained consistently above 90%, reflecting the engagement of the vendor to assist with the HRA process, to remind members to

return HRAs timely. The completion numbers increased in 2021, but never going above 25%. Because this remains low, there will be further evaluation in 2022 to identify any opportunities for improvement.

CM Referral and Identification

Members are identified as candidates for care management services through a variety of data sources and referrals. This includes:

- Self-referrals
- Direct referrals from provider networks
- Internal referrals, e.g. UM, Member Services, Appeals and Grievance, Leadership
- Predictive modeling, e.g. Care Analyzer

The Alliance's Care Management program emphasizes that the CM aligns with the members' needs. The four (4) primary level trigger areas used to determine CM identification:

- Health Risk Assessment (HRA),
- Data sources such as Utilization, Predictive Modeling, Admission, Transfer and Discharge (ADT) Feed
- Population Health Reports
- Direct referrals to care management.

The goal of the Health Risk Assessment (HRA) is to gather member self-reported information to proactively identify members who may have high risk needs and therefore need prioritized engagement into CM for further assessment. The HRA information is used as a starting point to develop an Individualized Care Plan (ICP) with the member, which is shared with an Individualized Care Team (ICT). Conducting the HRA is a requirement for Medi-Cal SPD lines of business.

The Alliance utilizes a predictive model application, CareAnalyzer, to aggregate utilization data and identify members who may be at risk and could benefit from CM interventions. Using CareAnalyzer, along with claims and authorizations, the HealthCare Analytics Department generates a monthly Population Health Report. Staff review the data and prioritize outreach to the top 1% on the Population Health Report.

Direct referrals into Care Management are received from multiple sources, such as the staff from disease management, utilization management, hospitals, Provider Groups, the Primary Care Provider (PCP), Specialist or from the member, members' family or caregiver. Additional internal departments may

refer based on their involvement with certain member situations, e.g. Grievance and Appeals, Member Services, Compliance, and Leadership.

CM cases identified through the data sources or referral sources cited above are reviewed by the 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 CCM and if appropriate opens a case in the CM information system and assigns a case manager. Members are deemed ineligible if the member is not on the Plan, has died, is receiving duplicative services or is in a long-term care facility.

Predictive Model Application

As stated above, The Alliance utilizes a predictive model application, CareAnalyzer, to aggregate utilization 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.

In 2017, the CM department collaborated with the Information System team to enhance the data stratification to target members for outreach. Adjusted Clinical Group, or ACGs, are the building blocks of The Johns Hopkins ACG System methodology. ACGs are a series of mutually exclusive, health status categories defined by morbidity, age, and sex. They are based on the premise that the level of resources necessary for delivering appropriate healthcare to a population is correlated with the illness burden of that population. ACGs are a person-focused method of categorizing patients' illnesses. Over time, each person develops numerous conditions. Based on the pattern of these morbidities, the ACG approach assigns each individual to a single ACG category. By adding the Johns Hopkins Resource Utilization Bands (RUBs) to the data sets, the team hoped to improve the sensitivity and specificity of the identified member data. ACGs were designed to represent clinically logical categories for persons expected to require similar levels of healthcare resources (i.e., resource groups). However, enrollees with similar overall utilization may be assigned different ACGs because they have different epidemiological patterns of morbidity.
In addition, the tool was enhanced to capture the Residual Risk Score (RRS) to apply predictability to the data. The enhancement identifies current and predictive changes based on utilization data.

Figure 6 - 2021 Care Analyzer data for Disease Management and Care Management Services

Care Analyzer	01/2021	02/2021	03/2021	04/2021	05/2021	06/2021	07/2021	08/2021	09/2021	10/2021	11/2021	12/2021
Asthma	1139	1064	2813	939	8792	N/A	263	1423	3244	715	163	7206
Diabetes (Excluding CCM)	2439	6405	5357	3913	13990	N/A	9122	1747	1706	1705	1564	1418
CCM (Diabetes + Non-Diabetes)	608	867	871	886	911	N/A	958	946	996	984	1024	1009
Care Coordination MCAL/Medicare members	90	103	111	132	133	N/A	118	116	127	131	133	134
Percentage of CCM												
5%	30	43	44	44	46	N/A	48	47	50	49	51	50
3%	18	26	26	27	27	N/A	29	28	30	30	31	30
1%	6	9	9	9	9	N/A	10	9	10	10	10	10

Figure 6 above shows the number of members identified by CareAnalyzer algorithm for potential candidates for CCM services in 2021. The top volumes were in Diabetes, averaging about 4500 per month, followed by Asthma at around 2500 per month.

Members are identified as candidates for CCM through a variety of data sources and referrals. The Population Health Report is one of the data sources. The criteria are determined using Care Analyzer data plus utilization history. The Care Analyzer data includes Member claims, including those for behavioral health, and pharmacy claims. The scores, together with the utilization history, provide a listing of Members who are most at risk. The criteria are subject to change at least annually but typically address 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

CM uses the Care Analyzer report and added the combination of co-morbidities (Diabetes, Renal Failure, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD)), inpatient admissions (greater than three (3)) and emergency room visits (greater than four (4)) in the prior six (6) months as additional criteria, based on staff experience with identifying at risk members. If a member has any combination of three (3) of the above filters, then the member is outreached by a Health Navigator, with a goal to enroll appropriate members in CCM.

With the changes made to filter the Population Health Report, in 2021, the case management team outreached to the members who meet criteria described above. (0.1% to 7.9%, depending on the month)

Review of the number of members outreached versus potential members to outreach, has led to improvement in the process of converting members to CCM from the Population Health Report. This process has been prioritized in 2022 for integration within the system of record (TruCare) for process automation.

Transitions of Care

In November 2019, Transitions of Care program was enhanced, piloting at the Alameda Health System (containing 3 hospitals), with the plan for further expansion in 2020. The criteria for Transitions of Care is a discharge from an inpatient stay from AHS hospitals, or (as of 2020,) a discharge from any hospital following a hospitalization for Covid. Continued collaboration is ongoing to prevent duplication of work by other Transitions of Care Programs.

The Admission, Transfer, Discharge (ADT) data from hospitals is used to identify members who are candidates for TOC, as well as referrals from the Inpatient Nurses. Upon discharge from the hospital, the members listed on the reports are entered into the Clinical Information System as a referral. The referral source is listed as 'Internal Report'. Prior to CM staff assignment, the referrals are reviewed by a triage nurse to evaluate medical history and utilization history from various data sources including the hospital discharge summary. The triage nurse makes a recommendation during the assignment process as to which CM team member role is appropriate to receive the referral. In collaboration with IT, CM automated referrals into the system of record, TruCare, to streamline the referral process.

The onset of COVID-19 in 2020, delayed the expansion of the TOC Program to other hospitals. Instead of expanding to more hospitals, CM expanded the criteria to include every Alliance member discharged from any hospital with a diagnosis of COVID-19 into the TOC Program. This list of members included members assigned to our delegates (including CHCN). This continued in 2021.

Further planning regarding expansion of the TOC Program to more hospitals into 2022 is ongoing. The goal is to expand to include 25% more members into the TOC Program by the end of 2022. This 2021 goal was not met due to continued public emergency of COVID-19. This has further delayed TOC program expansion. Instead, the Alliance Case Management Department focused efforts to establish relationships with the local hospital ambulatory teams. This

was done to mitigate and work collaboratively to provide the best appropriate care for our members.

The complex case management criteria includes specific diagnoses, including mental health diagnoses as well as other complex psychosocial needs. The CM workflow requires that every member referred for case management also be screened for Complex Case Management (CCM). If the member meets criteria, CCM is offered to that individual (even if the member is first enrolled in the TOC Program).

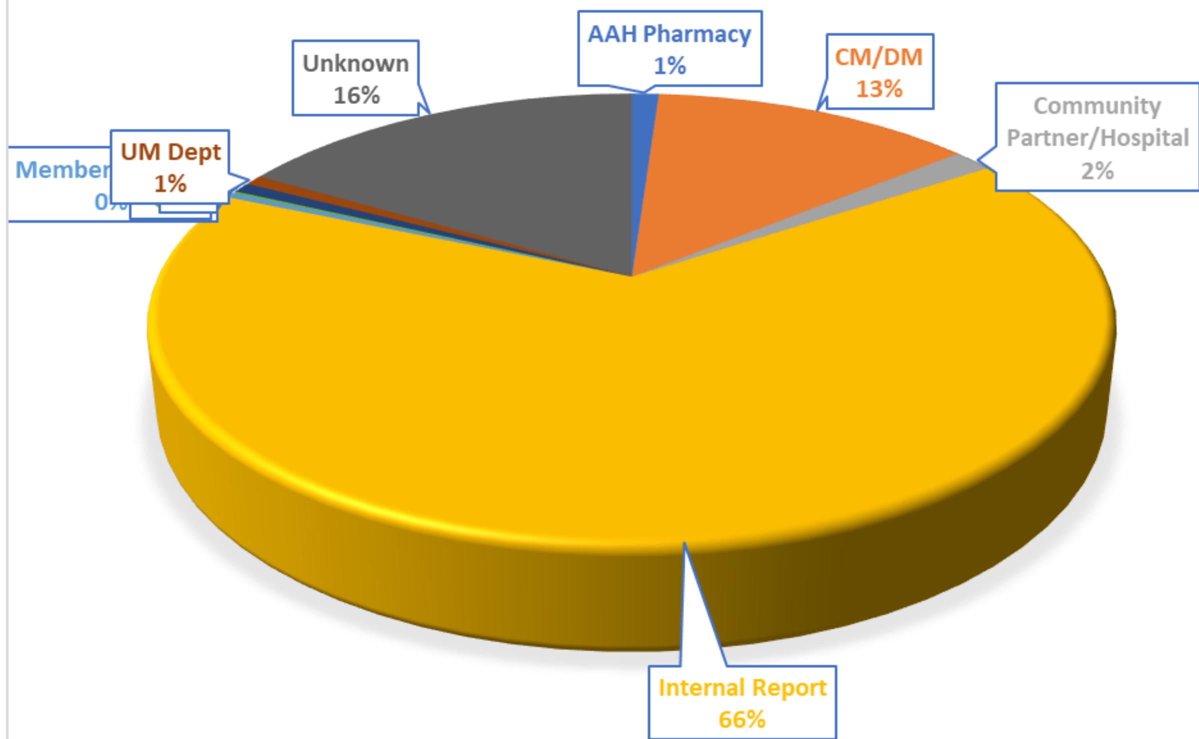
Methodology:

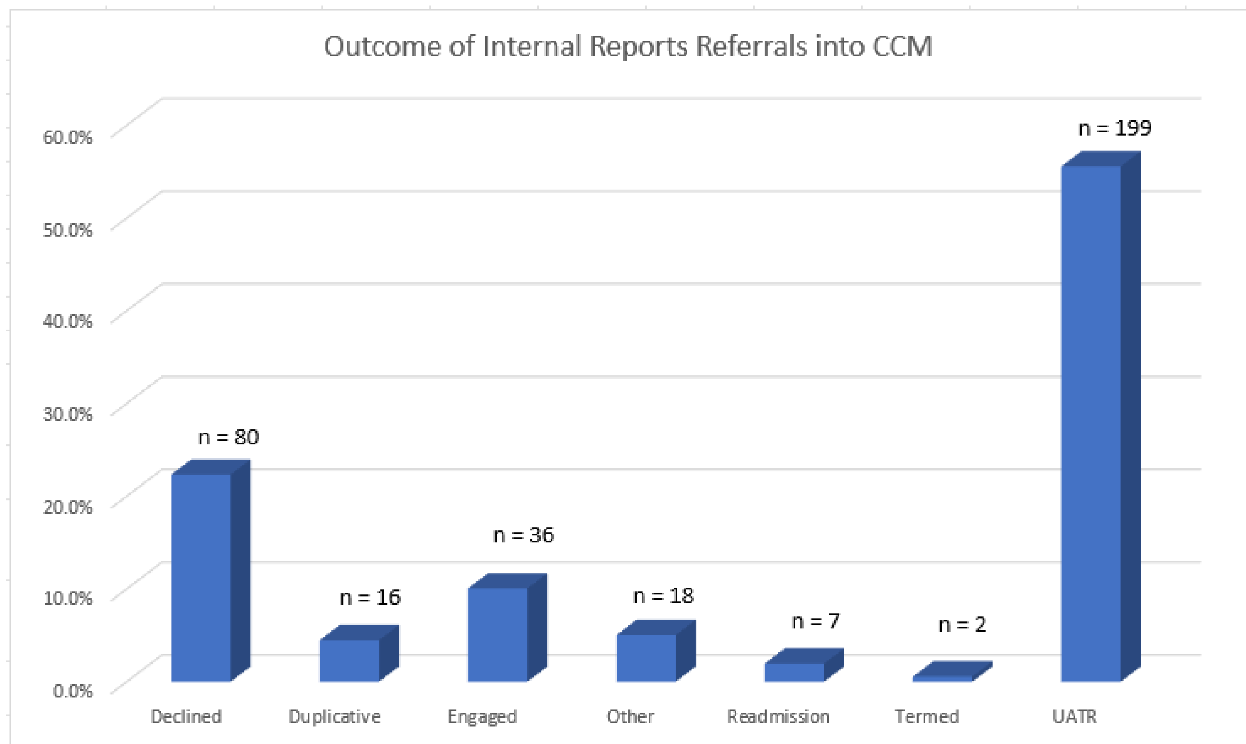
Using the Case Management Aging report, CCM cases created in 2021 were pulled and separated based on sources. Sixty-Six (66) percent (358 out of 538) of CCM cases came from an Internal Report. Including the Transitions of Care (TOC) Program, the Internal Report category includes the ADT Feed and the Population Health Report.

Complex Case Management

As discussed above, the CM Department aids members identified as needing assistance in navigating the health care system or in coordinating their health care services. The CM Department monitors referral sources and program activities to assess the effectiveness of the program as well as to identify patterns for potential educational opportunities.

The following data shows the referral sources of the Complex Case Managed members


2021 COMPLEX CASE REFERRAL SOURCES
AAH Pharmacy
1%
CM/DM
13%
Community
Partner/Hospital
2%
Unknown
16%
UM Dept
1%
Member
Internal Report
66%



Quantitative Analysis:
An analysis of CCM and population health as referral source reveals the following:

- Overall, for 2021, 66% of CCM cases were identified from the Internal Reports.
- CM/DM referral type is defined as CM department refers to other CM team members. For 2021, 13% of the referrals were these internal referrals.
- CM continued to have difficulty engaging members from the Internal Reports in the CCM program, with only 10% of potential cases successfully engaged in the program. (This is down from 20% in 2020.)
- Most cases identified through the Internal Reports were Unable to Reach (UATR) or Declined, while some Engaged in the program.

Qualitative analysis:
There has been improvement in identification and engagement of members with potential need for CCM from the Internal Reports, but there remains room for improvement:

- There were members identified as very high cost but did not appear on the Internal Reports, as might be expected.
- There were members identified on the Internal Reports but not successfully engaged.

In 2021, there were multiple initiatives to improve internal structures and processes. They included:

- Continued review and revisions of the Population Health Report and the CM Daily Aging Report

- Department trainings to improve consistency in outreaching members, talking to members and documentation in the electronic system of record.
- Launching collaborative efforts with hospital partners to discuss identifying and implementing alternatives to member outreach.
- Launching a productivity standard with a goal of increasing Complex member outreach.

Through discussion and feedback, the following has been identified as possible contributing factors resulting in low volume of members engaged in CCM and identifying members for the program:

- Reports pull from different sources and yield different results.
- "Cold calling" members on the Population Health Report continues to be less effective in engaging members in the program.
- Inaccurate contact information.

2022 Recommendations

- Continue to identify, implement, and evaluate different avenues to attempt to improve member engagement.
- Set SMART goal for:
    - Collaborative efforts with partnered hospitals
    - Productivity standard of Complex member outreach and engagement
    - Obtaining accurate member contact information.
    - Evaluating the use of the CHR for member engagement
- Findings will be collected and submitted as part of the 2022 CM program evaluation.

Figure 7 - 2021 CM Care Coordination Program by Referral Source

Care Coordination	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
AAH Pharmacy	0	1	5	2	0	0	1	0	2	1	0	1
Behavioral Health Program	0	1	2	2	0	1	0	0	1	0	2	1
California Children's Services	0	1	0	0	1	1	0	0	0	0	0	0
CM/DM	56	49	54	43	49	41	37	47	57	32	34	36
Community Partner/Hospital	28	24	30	35	15	21	26	15	23	16	16	21
Compliance Dept	5	1	1	2	0	0	1	1	3	1	1	6
Grievance and Appeal	7	3	6	3	3	19	15	10	3	6	6	3
Health Education	0	0	0	0	0	0	0	0	0	0	0	0
Internal Report	13	16	10	19	15	15	11	8	14	17	17	2
Member Services	75	66	80	77	70	83	67	99	63	78	51	59
Nurse Advice Line	3	4	5	3	4	0	4	1	1	2	2	0
Other	2	1	6	4	2	1	1	1	0	2	0	1
PCP/Specialty Provider	0	1	2	2	2	1	0	0	0	1	0	0
Provider Services Dept	0	1	0	0	0	0	0	0	0	0	0	0
Self	10	9	19	11	17	15	25	22	40	33	32	37
UM Dept	25	24	44	30	32	42	34	49	37	31	49	59
Total	**224**	**202**	**264**	**233**	**210**	**240**	**222**	**253**	**244**	**220**	**210**	**226**

Analysis of 2021 show the top three referral sources for Care Coordination cases are:

1) Member Services at 868
2) CM/DM at 535
2) UM Department at 456

Referrals from PCP/Specialty Providers remain low and represent an opportunity to work with the Physicians/Physician Offices on the services for improving care coordination.

Figure 8 - 2021 CM Care Coordination Program by Active Cases

Care Coordination	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
ACTIVE CASES												
New Cases	238	194	274	235	214	246	231	287	258	252	233	254
Total Cases In Progress	610	567	641	618	567	517	503	552	537	509	458	489
Total Assessments Completed w/in 30 Days of Referral	12	3	5	4	2	7	23	12	9	8	6	5
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	5%	1%	2%	2%	1%	3%	10%	5%	4%	4%	3%	2%

Figure 8 above describes the Active case activities by the number of new Care Coordination cases and the total open cases in program.

The data in Figure 8 shows the number of assessments completed and the timeframe for completing the assessment.

Though the Care Coordination Assessment to identify care coordination needs was developed in Q4 of 2020, it is not used often due to perceived lack of utility. In 2022, re-education will be provided to the CM team, and monitoring its use and efficacy.

Figure 9 - 2021 CM Care Coordination Program by Case Closure

Care Coordination	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
CASE CLOSURE BY CLOSURE REASONS												
Admission	0	0	0	0	0	0	0	0	2	0	0	0
Already in Program	5	6	6	2	1	0	5	3	5	10	3	9
Completed Program	43	31	47	40	40	31	41	48	38	28	25	39
Condition stable with no further Case Management needs	64	43	46	54	51	59	67	79	81	79	79	62
Condition stable with no further Disease Management needs	1	0	1	0	0	1	0	1	0	0	0	0
Deceased	0	0	2	1	2	0	1	2	1	0	0	1
Duplicate member record	0	1	2	2	1	0	0	2	0	0	0	0
Duplicative Program	5	2	5	4	5	3	2	2	7	1	2	2
Escalate services to higher level program	5	9	15	19	12	15	8	7	7	9	4	11
Inappropriately identified for program	0	0	1	2	2	0	1	0	1	0	0	0
Lost Contact	14	27	27	29	34	14	22	38	24	39	19	29
Member/AOR declines continued case management services	0	0	0	0	0	0	0	0	1	5	0	6
Member/AOR declines program	4	2	4	6	6	3	4	8	6	3	3	1
Member/Caregiver refuses services	1	0	0	1	0	2	1	0	0	0	0	0
Member declines continued Case Management services	3	2	0	1	0	2	4	2	1	0	0	0
Member declines continued Disease Management services	0	0	0	3	2	1	0	0	0	0	0	0
Member Ineligible	4	3	9	5	5	2	3	5	4	0	0	0
Member non-compliant	0	0	0	0	3	1	0	0	3	0	0	2
Member transferred to Delegate/Other	8	3	7	5	6	9	4	2	4	7	5	5
New case open	2	2	0	0	0	5	3	3	2	0	1	2
Other	20	21	26	23	40	40	27	23	44	44	23	35
Readmission	2	1	5	3	3	2	1	3	1	0	2	1
Referred to Disease Management	0	0	0	0	0	1	0	0	0	0	0	0
Step down to lower level program	0	0	0	0	0	0	0	0	0	1	0	0
Termination of coverage	0	1	3	1	7	3	3	4	1	4	4	3
TruCare cleanup	0	0	0	0	0	0	0	0	0	0	0	0
Unable to contact member	56	46	52	64	76	51	41	41	47	54	53	31
Total	**237**	**200**	**258**	**265**	**296**	**245**	**238**	**273**	**280**	**284**	**223**	**239**

As noted in Figure 9, the top three reasons for case closure were:

1) Condition Stable with no further need for CM at 764 members
2) Unable to Contact at 612 members
3) Completed Program at 451 members.

Condition Stable with no further need for CM and Completed Program are similarly defined reasons for case closure, warranting further refinement of the data tool and clearer definitions of the reasons for case closure, including understanding the "Other" category.

Plan for 2022

Continued efforts to improve reporting process to accurately depict Referrals, Active Cases and Case Closure numbers.

Complex Case Management

Complex Case Management (CCM) is provided to members who meet the criteria for CCM.

Members are identified as candidates for CCM through a variety of data sources and referrals. A full description of the data sources is included in the CM Program description.

Figure 10 – 2021 Complex Case Management – Referrals by Source

Complex	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
AAH Pharmacy	0	0	2	1	3	0	0	0	0	0	0	0
CM/DM	13	13	16	15	25	26	11	12	7	2	9	3
Community Partner/Hospital	1	1	1	2	1	2	0	0	2	2	1	0
Internal Report	9	12	20	27	58	127	5	2	13	54	67	24
Member Services	0	0	0	0	0	1	0	0	0	1	0	1
Other	0	1	0	0	1	0	0	0	0	0	0	0
Self	0	0	0	1	1	0	2	0	1	1	0	0
UM Dept	2	1	0	0	1	1	0	1	0	0	0	0
Total	**25**	**28**	**39**	**46**	**90**	**157**	**18**	**15**	**23**	**60**	**77**	**28**

For 2021, the top three referral sources were:

1) Internal Report at 418
2) CMDM at 152
3) Community Partners/Hospitals at 13.

It is noted that the referrals to CCM are low overall. This is an opportunity to evaluate and improve the CCM intervention and stakeholder communication about the CM program. This may also include working with the Physicians/Physician Offices and the UM department on the services available to members through complex case management.

Figure 11 2021 CCM Active Cases and Case Assessments Rates

Complex	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
ACTIVE CASES												
New Cases	21	23	44	44	80	141	20	20	30	59	77	28
Total Cases In Progress	64	50	81	100	145	220	146	90	84	109	123	68
Total OptOut Assessments	0	2	0	0	12	5	1	0	2	6	15	4
Total Assessments Completed w/in 30 Days of Referral	6	10	11	12	11	21	7	4	7	10	8	6
Active Participation Rate % (Total Assessments Completed w/in	24%	36%	28%	26%	12%	13%	39%	27%	30%	17%	10%	21%

Figure 11 above describes the 2021 Active case activities by the number of new cases, (587) the total open cases in program (1,280) and the number of cases in which the members was identified and referred but opted not to engage in the program, (47).

In addition, the data in Figure 11 monitors the number of assessments completed and the timeframe for completing the assessment from the referral. This value is created based on the assessments completed within 30 days of referral over the number of referrals. This part of the report does not reflect the required timeframes, which is 30 days from the time of identification of CCM, so it will be retired as a metric.

The current process is that the Case Manager attempts to begin the initial assessment in the first contact call. An initial assessment is performed as expeditiously as the Member's condition allows (and may be completed by multiple calls) but must be created/initiated within 30 calendar days and completed within 60 days from date of identification. Barriers to completing the full CCM assessment include the member's ability to participate in a long assessment conversation, and difficulty with maintaining contact with the member over more than one call. Strategies to improve this will be required.

Methodology for Data Validation:
Using the Daily Aging Report, all cases referred and created in 2021 were pulled to identify the assessment status. CCM assessments completed were pulled and evaluated for timeliness.

2021 Results:

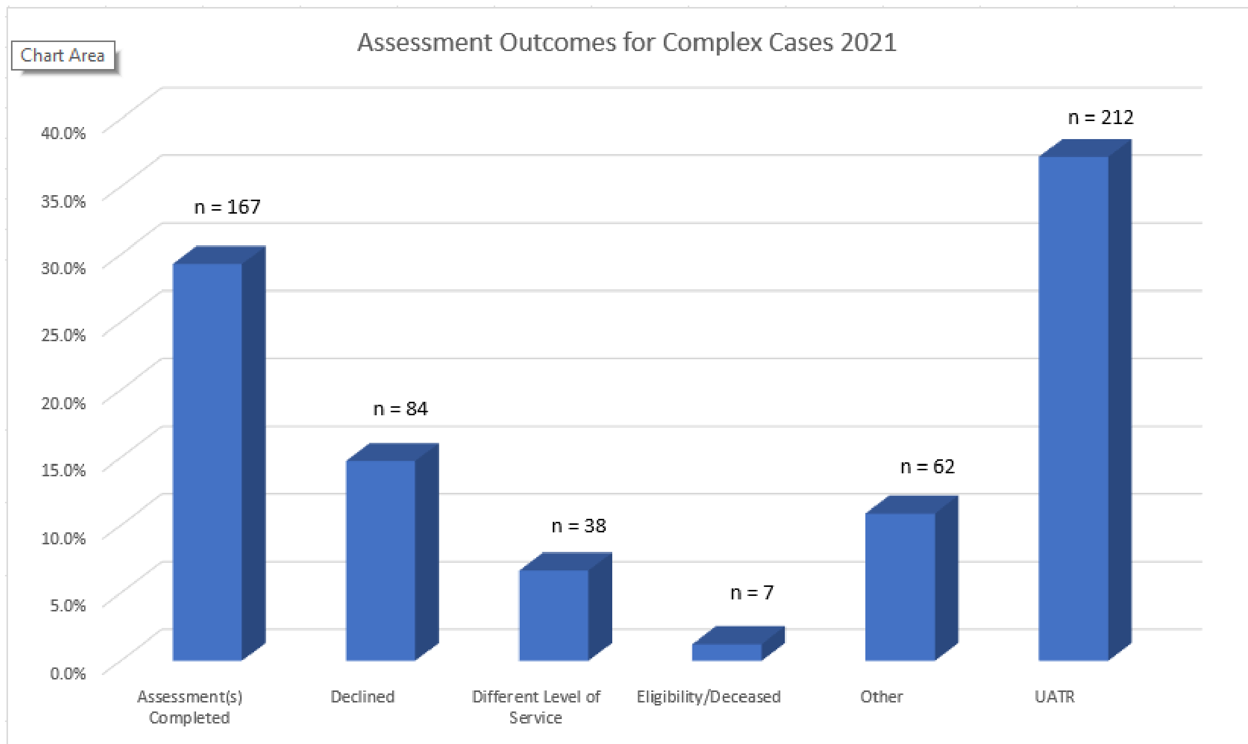
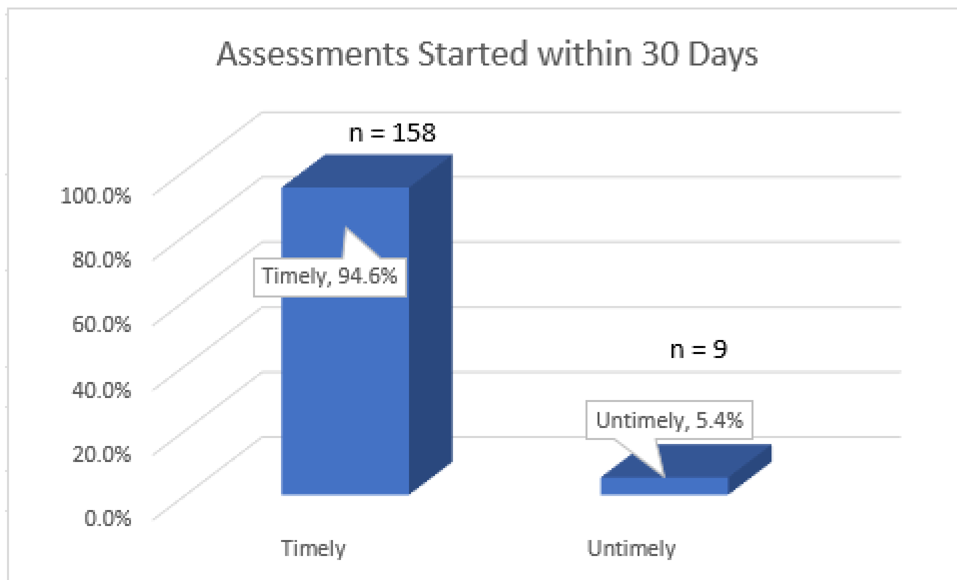
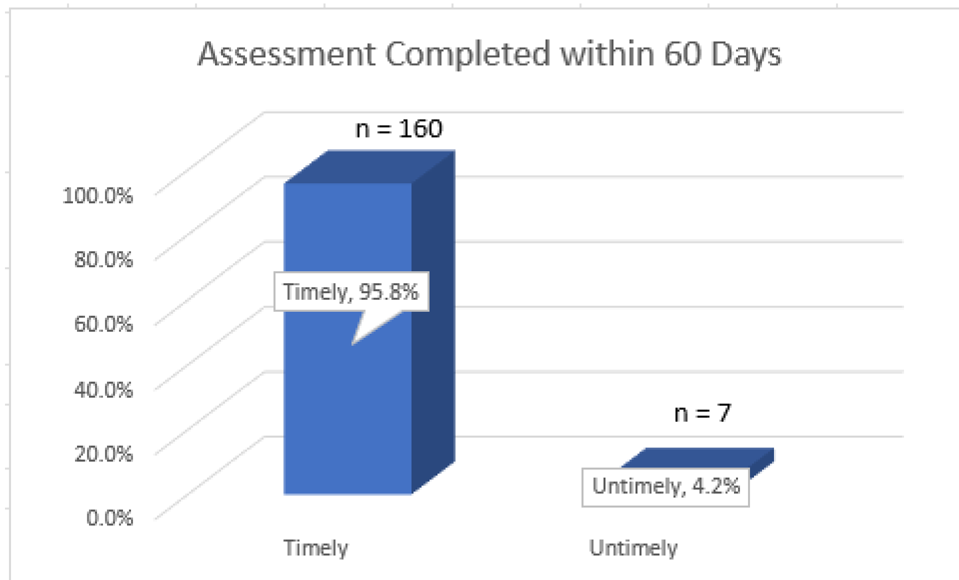


Chart Area
Assessment Outcomes for Complex Cases 2021
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
n = 167
n = 84
n = 38
n = 7
n = 62
n = 212
Assessment(s) Completed
Declined
Different Level of Service
Eligibility/Deceased
Other
UATR


Assessments Started within 30 Days
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
n = 158
Timely, 94.6%
n = 9
Untimely, 5.4%
Timely
Untimely



Quantitative Analysis:
An analysis of CCM assessment timeliness shows the following:

- Out of 167 assessments (up from 23 in 2020), 158 were started within 30 days and only nine (9) were started after the 30-calendar day timeframe, at 94.6%.
- Out of 167 assessments, 160 were completed within 60 days and only seven (7) were completed after the 60-calendar day timeframe, exceeding the goal at 95.8%.

Qualitative analysis:
The following provides a qualitative analysis of CM assessment timeliness from both the quantitative analysis of CCM Aging Report, and the outcome of chart review and case review feedback with staff:

- The 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.
- The seven assessments that were not completed within 60 days were due to members who were challenging to re-engage to complete the assessment.

During 2020, CCM standard of work was created, and staff were trained. In 2021 a productivity standard was implemented to encourage staff to engage members and offer CCM. This had a positive outcome, with the number of CCM assessments completed in 2021 increasing to 167, from 23 during 2020. There continues to be ongoing problem-solving discussions within the CM team regarding CCM cases and further refinement and system optimization for the system of record, TruCare, to streamline the process of recording the CCM assessment.

Interdisciplinary Care Team **(IDT)**

Case Management evaluated timeliness of presenting to Interdisciplinary Care Team (IDT) Rounds for cases that were open for 90 days or more.

Methodology:

Review all cases that have been open for 90 days or more, regardless of case type.

IDT Rounds are held bi-weekly, and using the Daily Aging Report, staff are notified of cases that are open at 60 days or more, to prepare to present the case at the next IDT meeting. Upon notification, all cases are logged within the Complex Case Log.

CM identified 22 CCM cases (open for at least 90 days) from the Complex Case Log (and validated with the Daily Aging Report).

2021 Results:

Complex Cases ≥ 90 days	Outcome of IDT	% of Timely IDT based on Report
0	No IDT	0%
19	Timely	95%
1	Untimely	5%

Every CCM case open for 90 days or more was presented at IDT meeting. Of the one (1) case that was not presented timely, this occurred because the case was incorrectly closed before all team members were able to complete their interventions with the member.

This led to 95% of timely IDT presentation (up from 86% in 2020 and 19% in 2019). The successful improved process will be continued into 2022.

Figure 12 - 2021 Complex Case Management Case Closures by Reason

Complex	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
Admission	0	0	0	0	0	0	0	0	0	1	3	0
Already in Program	1	0	0	0	2	4	1	0	0	1	0	0
Completed Program	3	1	2	2	6	7	2	5	7	7	3	2
Condition stable with no further Case Management needs	2	0	3	1	2	5	4	5	5	5	2	1
Condition stable with no further Disease Management needs	0	0	0	0	0	0	0	0	0	0	0	0
Deceased	1	0	0	0	1	0	2	0	2	1	1	0
Duplicate member record	0	0	2	0	0	0	0	0	0	0	0	0
Duplicative Program	1	1	4	1	2	5	4	2	1	1	4	1
Escalate services to higher level program	0	5	3	5	4	4	1	2	0	1	0	0
Inappropriately identified for program	0	0	0	0	2	3	0	0	1	0	0	0
Lost Contact	5	0	2	4	10	11	12	12	3	14	13	7
Member/AOR declines program	0	1	1	3	11	13	3	0	3	9	16	3
Member/Caregiver refuses services	0	0	0	2	5	3	1	0	0	0	0	0
Member declines continued Case Management services	1	0	0	1	0	0	1	1	0	0	0	0
Member Ineligible	1	0	0	0	0	0	0	1	0	0	0	0
Member non-compliant	1	0	0	2	0	1	0	1	0	1	1	2
Member transferred to Delegate/Other	0	1	0	0	0	0	0	0	1	0	0	0
New case open	0	0	0	0	0	1	0	0	1	1	1	1
Other	4	0	1	2	4	9	4	0	3	3	5	0
Readmission	0	0	1	1	0	1	2	1	1	0	0	0
Step down to lower level program	1	0	0	0	0	0	2	2	3	0	1	2
Termination of coverage	0	0	0	0	1	0	0	0	0	0	1	0
TruCare cleanup	0	0	0	0	0	0	0	0	0	0	0	0
Unable to contact member	16	4	6	11	16	27	37	4	3	18	32	13
Total	37	13	25	35	66	94	76	36	34	63	83	32

As noted in Figure 12, the top three reasons for case closure in 2021 were:

1) Unable to Contact (187)
2) Lost Contact (93)
3) Member/AOR Declined the Program (63)

Recommended Interventions/Next Steps for 2022:

An opportunity to continuously improve the quality oversight of the current CM processes has been identified. This will be accomplished by internal monitoring of CM/CCM files on a periodic basis. This also includes reviewing and revising the standardized reports focused on monitoring of CM activities: referral management, outreach, case closure and PCP communications. Strategies to address the Unable to Contact issues will need to be developed.

Performance Measures

The Alliance maintains 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 13 – CM Performance Measures

	Goal	Measure	Measurement	Performance Goal	2021 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%	85.6%	No
# 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	19.0% overall, not specific to CCM	NA
# 3	Improve member outcomes	Emergency Room Visit Rate	ER rates for members enrolled in CCM	Report in development	Not Available	NA
# 4	Achieve optimal member functioning.	Health Status	% of members in CCM responding that their health status improved because of CCM	90%	85.7%	No
# 5	Use of Appropriat e Health Care Services	Use of Services	Improvement in measures of office visits within Alliance Network	Report in development	Not Available	NA

Figure 13 captures the 2021 Performance Measures. Of the five measures, two had an established benchmark.
For 2021, CM continued to achieve the goal of achieving and maintaining high level of satisfaction with CM services at 85.6%
The overall all cause readmission rate was reported at 19.0%, but this is not specific to the CCM population. It is noted that most measures are not specific to members enrolled in CCM. With the assistance with the Analytics department, a report is being developed to identify the readmission rate for members who are enrolled in CCM. This report will also include Emergency Room Visit Rates for members enrolled in CCM (Performance Measure #3).
The member surveys showed that 85.7% of members in CCM responded that their health status had improved because of CCM.
In collaboration with, Analytics a report is being developed to evaluate the use of appropriate Health Care Services by measuring office visits for members receiving CM services.

Assessing Members Experience with the CM Process

On an annual basis, 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 Alameda Alliance in measuring how well their complex case management program is meeting member's expectations and identifying areas for improvement.

The goal of the Complex Case Management Program 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

In 2021, CM Department received a total of 11 surveys.

Figure 14 – 2021 Survey Results

	N	%	Sample Size	Goal Met?
Member Experience Criteria	Very Satisfied			
Time Spent with CM	9	81%	11	N
CM Understands Concerns	9	81%	11	N
Information to Manage Health	5	45%	11	N
Overall Experience	8	72%	11	N
Member Experience Criteria	Moderately Satisfied			
Information to Manage Health	2	19%	11	N
Overall Experience	1	9%	11	N
Member Experience Criteria	Slightly Satisfied			
Information to Manage Health	2	19%	11	N
Member Experience Criteria	Moderately Dissatisfied			
Overall Experience	1	9%	11	N
Member Experience Criteria	Very Dissatisfied			
Time Spent with CM	2	19%	11	N
CM Understands Concerns	2	19%	11	N
Information to Manage Health	2	19%	11	N
Overall Experience	1	9%	11	N
Member Experience Criteria	Much Improved			
Better Manage Health Condition	5	45%	11	N
Overall Health & Well-Being	7	64%	11	N
Member Experience Criteria	Improved			
Better Manage Health Condition	3	27%	11	N
Overall Health & Well-Being	2	19%	11	N
Member Experience Criteria	Somewhat Improved			
Better Manage Health Condition	2	19%	11	N
Member Experience Criteria	Same			
Better Manage Health Condition	1	9%	11	N
Overall Health & Well-Being	2	19%	11	N
Member Experience Criteria	Always True			
Ability to Speak to CM	6	54%	11	N
Member Experience Criteria	Usually True			
Ability to Speak to CM	1	9%	11	N
Member Experience Criteria	Neutral			
Ability to Speak to CM	4	36%	11	N
Member Experience Criteria	Highly Likely			
Recommend CM Services	8	72%	11	Y
Member Experience Criteria	Likely			
Recommend CM Services	3	27%	11	Y

Of the eleven surveys returned; the combined satisfaction was 85.6%%.

Another way to assess member experience is through review of the filed complaints against Case Management:

Figure 15 – 2021 Complaints Filed Regarding CM Process

Grievances Filed Against	Access to Care		Other		Quality of Service	Total
	Lack of Telephone Accessibility	Delay in Referral	Misc.	Discrimination / Sensitivity	Poor Provider / Staff Attitude	
Case Management	44	9	22	1	10	87

There was a total of 87 complaints for 2021. There were 44 complaints related to Lack of Telephone Accessibility, typically regarding reaching a specific staff member. The call volume had also increased in 2021, coinciding with the increase in membership. CMDM worked in 2021 to improve the telephone accessibility issue by changing the daily staffing plan to assign one person to answer the phones and triage/transfer as indicated. There were 10 complaints with Quality of Service – Provider/Staff Attitude, primarily the Provider. Strategies included staff assignment re-organization, customer service communication and member engagement training, which provided to all staff. The live answer rate was increased by 10% in 2021, and complaints will be monitored ongoing to determine efficacy in reducing the number of complaints.

Recommended Interventions/Next Steps for 2022:

In 2022, there is an opportunity to ensure the CM Department:

- Review and revise the process on how CM initiates and collects the satisfaction survey to continue to increase the response rate.
- Identifies CM performance measures, goals, and benchmarks.
- Collaborates with Health Care Analytics to ensure the performance measures can be captured and reported semi-annually.

Special Programs

Transitions of Care

Health Care Delivery Systems are challenged with reevaluating their hospital's transitional care practices to reduce 30-day readmission rates, prevent adverse events, and ensure a safe transition of patients from hospital to home. Successful transitional care programs include a "bridging" strategy with both pre-discharge and post-discharge interventions, often including a dedicated transitions coordinator involved at multiple points in time. The key strategies of a Transitions of Care (TOC) program include patient engagement, use of a dedicated

transitions coordinator, and facilitation of communication with outpatient providers. These strategies have the aim of improving patient safety across the continuum of care and require time and resources.

In 2019, the Alliance revamped the existing TOC program to better support partner hospital efforts when Alliance members transition out of the facility to home. With the collaboration of IT, a new way of identifying members was created through a report called the Admission, Discharge, Transfer (ADT) Feed sent from various hospitals. The TOC pilot program continued into 2021 with Alameda Health Systems (containing 3 local hospitals). With the arrival COVID-19 in 2020, the TOC program expanded to include any member discharged from any hospital with a diagnosis of COVID-19, and it continued into 2021.

Figure 16 - 2021 Transitions of Care Referrals

Transitions of Care	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
AAH Pharmacy	0	0	0	1	0	0	0	0	0	0	1	0
Behavioral Health Program	0	0	1	0	0	0	0	0	0	0	0	0
California Children's Services	0	1	0	0	0	0	1	0	0	0	0	0
CM/DM	30	21	32	37	27	17	26	12	11	8	8	9
Community Partner/Hospital	38	26	14	18	8	15	12	14	28	12	17	11
Compliance Dept	0	0	0	0	0	0	0	0	0	0	0	1
Grievance and Appeal	0	0	0	0	0	0	0	0	0	1	0	0
Health Education	0	0	0	0	0	0	0	0	0	0	0	0
Internal Report	208	194	193	226	210	181	192	173	178	202	161	207
Member Services	1	1	0	1	0	0	1	1	1	1	0	0
Nurse Advice Line	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	0	0	0	0	1	1	0	0	0	0	1
Self	0	0	0	0	0	0	1	0	0	0	0	0
UM Dept	52	22	18	26	15	11	13	54	32	20	24	29
Total	**330**	**265**	**258**	**309**	**260**	**225**	**247**	**254**	**250**	**244**	**211**	**258**

With the resurgence of the TOC Program, Figure 16 shows the top three sources of referrals were:

1) Internal Report at 2325
2) UM Dept at 316
3) CM/DM at 238

The Internal Reports refer to the ADT Feed and the COVID-19 Report.

Figure 17 – 2021 Transitions of Care Active Cases

Transitions of Care	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
ACTIVE CASES												
New Cases	281	246	261	264	220	237	211	267	240	248	241	260
Total Cases In Progress	584	560	538	507	476	478	427	480	465	484	479	487
Total OptOut Assessments	2	0	0	0	1	3	2	3	2	1	1	1
Total Assessments Completed w/in 30 Days of Referral	82	81	84	88	103	81	57	86	81	52	72	58
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral /	25%	31%	33%	28%	40%	36%	23%	34%	32%	21%	34%	22%

The data noted in Figure 17 shows a stabilization in TOC cases throughout 2021. The Active Participation Rate is calculated from the total assessments completed within 30 days of referral and the total referrals.

Analysis shows that some assessments were not completed because the corresponding referrals were declined because they were duplicate referrals, or the member was already enrolled in another CM program.

Re-education of the Transitions of Care program and completion of the TOC assessment is recommended for 2022, to improve the Active Participation Rate % score.

Figure 18 – Transitions of Care Case Closures

Transitions of Care	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
CASE CLOSURE BY CLOSURE REASONS												
Admission	0	0	0	0	0	0	0	0	7	8	1	2
Already in Program	6	1	1	1	1	0	3	2	3	2	1	0
Completed Program	31	35	29	17	35	29	26	21	39	54	41	47
Condition stable with no further Case Management needs	32	24	34	28	16	26	22	23	27	20	29	18
Condition stable with no further Disease Management needs	0	1	0	0	0	1	0	0	0	0	0	0
Deceased	5	7	5	7	0	0	1	1	5	2	4	4
Duplicate member record	0	0	1	1	0	2	0	4	0	0	0	0
Duplicative Program	5	7	5	6	7	4	7	6	5	4	4	6
Escalate services to higher level program	9	9	17	16	19	21	9	19	12	5	13	8
Inappropriately identified for program	2	0	1	2	0	1	0	1	1	0	0	0
Lost Contact	21	26	23	16	19	29	25	33	21	22	22	20
Member/AOR declines continued case management services	0	0	0	0	0	0	0	0	0	1	1	0
Member/AOR declines program	3	6	4	3	5	5	0	6	9	4	0	3
Member/Caregiver refuses services	1	2	3	5	3	3	2	0	0	0	0	0
Member declines continued Case Management services	3	3	1	2	1	5	3	0	0	0	0	0
Member declines continued Disease Management services	0	0	0	0	0	1	0	0	0	0	0	0
Member Ineligible	2	7	3	2	2	3	1	7	1	0	0	0
Member non-compliant	0	0	0	0	1	0	0	0	0	0	1	0
Member transferred to Delegate/Other	2	5	2	2	1	0	1	1	1	1	1	4
New case open	0	1	0	0	0	0	1	5	5	5	2	1
Other	12	32	24	28	25	23	19	36	18	22	20	18
Readmission	16	25	36	37	26	31	25	33	22	26	34	22
Step down to lower level program	1	0	0	0	0	0	0	2	1	0	0	0
Termination of coverage	1	1	1	0	0	0	1	0	1	3	2	3
TruCare cleanup	0	0	0	0	0	0	0	0	0	0	0	0
Unable to contact member	118	91	105	78	74	78	68	55	51	67	76	66
Total	**270**	**283**	**295**	**251**	**235**	**262**	**214**	**255**	**229**	**246**	**252**	**222**

As noted in Figure 18, the top three (3) reasons for TOC Case Closure in 2021were:

1) Unable to Contact Member (927)

2) Completed Program (404)
3) Readmission (333)

Efforts to improve the connect rate with members as they transition out of hospitals is needed. Discussions with AHS case management and transitions leadership about how to engage members before discharge is underway to develop strategies during the hospital stay. Using the Community Health Record to identify points of contact for members will be explored as well

Continuity of Care

The CM Department collaborates with the UM Department and Member Services on the management of the continuity of care program. CM is responsible for assisting members who have been approved to see providers outside of the network and need to be transitioned back in network after the Continuity of Care period has ended as well as members for whom Continuity of Care conditions have not been satisfied (ex. out of network provider not accepting Medi-Cal rates.) CM is notified of the need to assist members back in network via a report developed by HealthCare Analytics which captures data from the UM authorization. Staff also assist members based on direct referrals into the care coordination program, such as from UM staff who make referrals needed as a result of the Authorization Review process.

The UM department takes the leadership for assisting members who have exhausted a benefit or who are aging out of a benefit, i.e. California Children Services, or have needs beyond those provided by partner agencies. The UM Department coordinates these services through the care coordination referral process and identifies members who are aging out of CCS eligibility to ensure that they transition to appropriate providers, or other needs, and refers to CM as needed for further assistance to ensure that members receive the services required. Further work on these processes will occur in 2022.

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Alliance is responsible for ensuring Members who are eligible to receive LTSS services are identified and referred. The CM Department works with UM department to refer members who may benefit from LTSS for services. The UM Out of Plan (OOP) RN performs the initial assessment and referral into the appropriate Community Based Adult Services (CBAS) center. The OOP RN also provides re-assessments and re-authorization and refers to the CM department for additional services not provided at the CBAS center as needed.

INTEGRATION OF MEDICAL AND BEHAVIORAL HEALTH

Behavioral health is managed through delegation to Beacon Health Options, the MBHO. The behavioral health practitioners are involved in key aspects of the delegate's UM/CM program ensuring BH focus in policies and procedures, aligning the medical necessity guidelines with medical necessity guidelines and participation in the UM committee meetings. The MBHO dedicates a clinical team to assist in the co-management of the activities.

In 2021, the teams worked on efforts crossing the medical and behavioral health services which included:

- Enhancing CCM outreach to 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 Beacon at the Interdisciplinary Care (IDT) Team meetings to collaborate, advise, refer, and provide additional insight into CCM cases.

A full description of the MBHO UM and CM Program and Evaluation can be found in the HCQC minutes.

In 2022, the services for members with Mild/Moderate Behavioral Health issues will be insourced back to the Alliance, which will help with further integration of BH and medical care.

HEALTH HOMES PROGRAM:

The state funded Health Homes Program for chronic physical conditions started in July of 2019, and members with serious mental illness (SMI,) were added in January of 2020 in Alameda County. Since July of 2019 and continuing through 2021 the Alliance employed a network of community-based care management entities (CB-CME's) to integrate primary, acute, and behavioral health care services (SMI beginning in January 2020) as well as community based needs (ex. housing) for the highest risk Medi-Cal enrollees. The HHP includes six core services, delivered through the managed care system: 1) Comprehensive care management; 2) Care coordination; 3) Health promotion; 4) Comprehensive transitional care; 5) Individual and family support; 6) Referral to community and social support services.

The primary program goal is to achieve improved health outcomes for eligible members by providing them additional supportive ("wrap around") care via the plan's network of CB-CME organizations. In 2021 Alameda Alliance

simultaneously helped build and oversee the capacity of CB-CME's to address the needs of the population and orchestrate reporting of encounter data and program results.

In 2021 the HHP (and the associated Whole Person Care (WPC) services through the Alameda County Health Care Services Agency (HCSA)) was integral to the planning for the transition to the CalAIM Enhanced Case Management (ECM) benefit, as well as the Community Support services to be provided by AAH, effective 1/1/2022. Members who were receiving HHP services on 12/31/2021 will "grandfathered" into the ECM services benefit on 1/1/2022. Members receiving housing support from HCSA WPC on 12/31/2021 were "grandfathered" into the housing bundle of the CalAIM Community Supports offered by AAH on 1/1/2022.

Health Homes Patient Characteristics (enrollment criteria)

Eligibility Requirement	Criteria Details
1. **Chronic condition criteria** (*Must meet at least one of the above to be enrolled.)	· **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR · **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR · **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR · **Asthma**

2. **Acuity/Complexity criteria** (*Must meet at least one of the above to be enrolled.)	· Has at least 3 or more of the HHP eligible chronic conditions; OR · At least one inpatient hospital stay in the last year: OR · Three or more emergency department visits in the last year; OR · Chronic homelessness.

Staff in 2021 included a Clinical Program Manager, a Health Navigator, a Housing Navigator, and a Physician Champion, the CM Medical Director. Work also had begun on AAH CM team to become an internal CB-CME, however, this work was placed on hold with the planning for the CalAIM Enhanced Care Management (ECM) benefit noted above, which was launched 1/1/2022. Work shifted to planning and preparing the Alliance CB-CME network to transition to the new ECM benefit structure and Community Supports services. This included training and re-certifying the AAH CB-CME network as new ECM Providers, and successfully identifying & transitioning all HHP and WPC enrolled members into ECM on 01/01/2022, and WPC members receiving housing services into the housing bundle of Community Supports.

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Program Outcomes: As of 12/31/2021, the HHP program had served 980 members at the 17 CB-CME sites in Alameda County:

CB-CME Site	Members Served in HHP in 2021
AHS Eastmont	52
AHS Highland	84
AHS Hayward	37
California Cardiovascular Consultants	113
CHCN Asian Health Services	61
CHCN Axis Community Center	24
CHCN La Clinica De La Raza	50
CHCN LifeLong Medical Care	161
CHCN Native America Health Center	52
CHCN Tiburcio Vasquez Health Center	72
CHCN TriCity Health Center	76
CHCN West Oakland Health Council	16

EBI	28
Family Bridges	19
Roots	95
Roots STOMP	10
Watson Wellness	30
Total Members Served	**980**

Next Steps in 2022

Continue to develop, train, and maintain the AAH ECM Provider network in preparation for additional Populations of Focus coming into CalAIM on January 1, 2023.

Launch Alameda County Behavioral Health (ACBH) as an ECM Provider to provide network expansion for SMI/SUD Population of Focus on July 1, 2022

Continue to develop and train new ECM providers in preparation for expansion of CalAIM populations of focus on January 1, 2023.

Coordination with Regulatory Compliance

The Alliance CM Department works closely with the Compliance Department in preparation for regulatory audits. In 2021, the department participated in DHCS and DMHC regulatory audits. The DHCS audit identified the following findings:

- The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members.
  - HRA tracking was refined in 2021. HRAs were sent out within the required timeframes, and Interactive Voice Response (IVR) calls were made to low-risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls were made by CM staff on high-risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log was kept to ensure that the required timelines were met, and close monitoring of the adherence to requirements was implemented.

- The plan did not ensure coordination of care in certain cases where EPSDT services were medically necessary.
  - This finding related to UM staff not making referrals to CM for coordination of care for EPSDT. UM staff were trained on identifying members who need coordination of care for EPSDT services from PA requests and referring members to CM.

- The plan did not ensure the completion of ICPs for members enrolled in CCM.
    - CM staff were re-trained on standard work for ICPs and revised the CM Aging report to capture completion of ICPs. Monitoring is ongoing.

- The plan did not ensure the development of care plans in collaboration with the PCP
    - Staff were retrained on development of care plans in collaboration with PCP and revised the Daily Aging Report to capture the date the care plan letter was sent to the PCP. Monitoring is ongoing.

- The plan did not conduct periodic evaluations to ensure the provision of CCM based on members' medical needs. The plan did not implement procedures for monitoring time frame standards or maintain monthly contact with members.
    - AAH developed a workflow to maintain regular contact with members, developed a Complex Criteria Checklist to ensure that the continuation of CCM is based on medical needs, trained staff, and revised the Aging Report to monitor adherence to requirements.

- The plan did not ensure that IDT assessments were included in the updating of the members' care plans.
    - AAH revised the CCM case log to monitor timely entry of IDT round note into TruCare, developed a workflow to include IDT in updated Care Plans, and monitors adherence.

The interventions include processes for ongoing monitoring and reporting to mitigate further regulatory deficiencies.

Recommended Interventions/Next Steps for 2022:

To ensure the effectiveness of the internal CM process, Alliance CM Department will conduct ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. Alliance CM Department will implement a monitoring program for the early identification of potential compliance risks.

In addition, the program includes an opportunity to provide quality oversight of the current CM processes. This is accomplished by internal monitoring of CM files on a periodic basis.

Conclusion

Overall, the 2021 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 the established targets or are developing strategies to meet targets. 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 AAH used a comprehensive approach to the CM program structure, practicing physicians provided input through the UM Committee and subcommittees.

CM Program Recommendations for 2022

As a result of internal performance monitoring performed in 2021, opportunities for improvement were identified and will be incorporated into the 2022 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Focus on key CM activities, monitoring through the UM Committee and HCQC.
- Revise the CM staffing model to address operational needs.
- Ensure information systems are accurate reflections of reporting needs for compliance monitoring and oversight, both internal and external.
- Identify appropriate performance measures and goals for CM and develop monitoring reports of performance toward the measures. This includes developing CM related activities to address improvement with the measures.

- A key focus in 2022 is the implementation of the CalAIM Enhanced Care Management benefit, Community Supports services, and Major Organ Transplant. This will include iterative process improvements in the structure, the planning for expansion of additional ECM and CS providers, and additional providers to focus on additional populations of focus and additional Community Supports services.
    - Work with the Alliance Project Management Office and all relevant Alliance departments to:

  Launch the CalAIM ECM benefit and Community Supports services.
  Expand the ECM provider network for current needs
  Plan for the additional Populations of Focus in ECM in 2023
  Identify and plan for additional Community Supports services.
  Launch Major Organ Transplant initiative to insource from FFS Medi-Cal

- Develop educational program for PCPs and Network Provider Groups on identification of members in need of CM/CCM, referral processes and engagement with CM team on management of ICPs and IDTs.
- Enhance reporting and analysis of CM activities focused on member experience with CM.
- Develop process for implementing activities addressing improved member experience with CM, including analysis of a member survey and member complaints.
- In collaboration with the Compliance Department, develop a department program focused on monitoring internal compliance and quality review of CM department operations.
- Revise the continuity of care program to accurately reflect CM involvement and activities, including regulatory reporting and CCS program.
- Continue to enhance the Palliative Care Program in collaboration with Alameda Health Systems.
- Enhance delegation oversight activities for CM, Care Coordination, CCM, and TOC.
- Collaborate with Health Care Analytics on identifying enhancements to the predictive model algorithm to improve the identification of appropriate members for CCM.
- Continue internal auditing of cases for Care Coordination, CCM and TOC.

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

2022

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

2022 Program Description

Signature Page

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Alameda Alliance for Health

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 through the Medi-Cal and Group Care programs. Alliance Members choose from a network of over 1,700 doctors, 17 hospitals, 68 community health centers, and more than 200 pharmacies throughout Alameda County. Through active partnerships with healthcare providers and community partnerships, 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.

Comprehensive case management is one such Alliance service offering that 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 Alliance oversees and maintains the following case management services in the comprehensive case management program:

- Health Risk Assessments
- Basic Case Management
- Care Coordination/Service Coordination
- Complex Care Management
- Transitions of Care
- Specialty Programs
- Continuity of Care

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 individual program descriptions for each of the three case management services that comprise the comprehensive case management program.

II. Purpose and Scope

The purpose of the Alliance comprehensive case management program is to provide case management processes and structures to a Member who has complex health issues. Case management is defined by the Case Management Society of America 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 promotes case management services through multidisciplinary teams that address Member specific medical conditions, behavioral, functional, and psychosocial issues in a single health care setting or during the Member's transitions of care across the continuum of care. 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, the health care delivery systems, and the various payer sources.

The comprehensive case management program is established to provide case management processes and procedures that enable the Alliance to improve the health and health care of its Membership. Members from all Alliance health products are eligible for participation in the program. Alliance products include Medi-Cal and Alliance Group Care. The fundamental components of Alliance case management services encompass: Member identification and screening; Member assessment; care plan development, implementation, and management; evaluation of the Member care plan; and closure of the case. The structure of comprehensive case management is organized to promote quality case management, client satisfaction and cost efficiency through the use of collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

III. Goals and Objectives

A. Goals

The overall goal of the comprehensive case management program is to support the mission of making high quality health care services accessible and affordable to the Alliance Membership. In doing so, more specific goals for the program include:

- To 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.
- Support the foundational role of the primary care physician and care team to achieve high-quality accessible, efficient health care.
- Coordinate with community services to promote and provide Member access to available resources in the Alliance service area.
- Provide 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.

B. Objectives

The comprehensive 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 Health Care Quality Committee (HCQC) and Utilization Management Committee (UMC) are have authority and responsibility 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. The objectives of the comprehensive case management 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.

IV. Program Oversight and Staff Responsibility

A. Health Care Quality Committee (HCQC)

The HCQC Committee provides oversight, direction and makes recommendations, and final approval of the UM Program. Committee meeting minutes are maintained summarizing committee activities and decisions and are signed and dated. A full description of the HCQC Committee responsibilities can be found in the most recent Quality Improvement Program Description.

The HCQC provides the external physician involvement to oversee The Alliance QI and UM Programs. The HCQA includes a minimum of four (4) practicing physician representatives. The UM Committee include in its Membership physicians with active unrestricted licenses to practice in the State of California. The composition includes a practicing Medical Director 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 HCQC functional responsibilities for the CM Program include:

- Annual review and approval of the CM Program Description.
- Oversight and monitoring of the CM Program, including:
  - Define the strategies direction for population health.
  - Define the goals and measures to the target population.
  - Assist in identifying the target population along with programs/services to be provided.
  - Recommend policy decisions.
  - Oversight of interventions to the provision of the programs and services.
  - Recommend necessary actions.

B. The Utilization Management Committee

The Utilization Management Committee (UMC) is a sub-committee of HCQC. 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.

UM Committee Structure

The UM Committee is a sub-committee, of the HCQC which reports to the full Board of Governors. The HCQA supports the activities of the UM Committee and reviews and approves the UM activities and program annually. Reporting through the HCQC integrates CM activities into the Quality Improvement system.

Authority and Responsibility

The HCQC 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 Quality Oversight Committee has delegated authority to the UM Committee for certain UM functions.

This delegation of authority is pursuant to the annual review and approval of the Case/ Care Management Program, CM Policies/Procedures, CM Clinical Criteria, and other pertinent CM documents such as the CM Delegation Oversight Plan.

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 Directors, UM

- The Alliance Medical Director, CM
- The Alliance 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 Director, Compliance
- The Alliance Director, Member Services
- The Alliance Director of Provider Relations and Provider Contracting
- The Alliance Director, Quality Assurance
- The Alliance Director of Social Determinants of Health
- The Alliance Manager, Healthcare Analytics
- The Alliance Manager, Case Management
- The Alliance Manager, Enhanced Care 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 HCQC. 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 HCQC for review and approval.

UM Committee Functions

The UM Committee is a forum for facilitating clinical oversight and direction. The UMC 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 Medical Services.
- Provide mechanism for oversight of delegated CM functions, including review and trend CM reports for delegated entities to identify improvement opportunities.

UM Committee responsibilities are to:

- Maintain the annual review and approval of the CM Program & Evaluations, CM Policies/Procedures, CM Criteria, and other pertinent UM documents such as the CM Delegation Oversight Plan.
- Participate in the utilization management/ continuing care programs aligned with the Program's quality agenda.
- Review and analysis of utilization data for the identification of trends
- Assist in monitoring performance of CM activities and recommend appropriate actions when indicated.
- Review and provide input into the annual CM effectiveness reports, i.e. Experience with the CM experience, Annual Performance Evaluations.

The UMC reports to the HCQC and serves as a forum for the Alliance to evaluate current UM activities, processes, and metrics. The UM committee 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.

V. Staff Resources

The Case Management and Disease Management Department in the Alliance is responsible for comprehensive case management program and activities. A department of multi-disciplinary staff administers the comprehensive case management program. (The organizational chart in Appendix A displays the reporting relationships for key staff responsible for comprehensive case management activities at the Alliance.)

The following are the primary staff with roles and responsibilities in the implementation of the comprehensive case management program:

I. **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.

II. **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.

III. **Senior Director, Health Care Services**

The Senior Director of Health Care Services, a Licensed Clinical Social Worker, 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. The Senior Director works with the Director to carry out program goals.

IV. **Director of Social Determinants of Health**

The Director of Social Determinants of Health provides operational leadership to the Case and Disease Management, Community Supports 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.

V. **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.

VI. **Clinical Manager of Enhanced Care Management**

The Clinical Manager of Enhanced Care Management is responsible 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.

VII. **Supervisor of Case Management and Disease Management**

The 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 Supervisor of Case and Disease Management includes supervision of department staff; allocation and management of program resources; and accountability for the quality of care and services.

VIII. **Lead Case Manager**

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.

IX. **Complex Case Manager**

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.

X. **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.

XI. **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.

XII. **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.

VI. Population and Member Needs Assessment

The Alliance routinely assesses the characteristics and needs of the Member population, including relevant subpopulations. Alliance analyzes claims and pharmacy data, as well as enrollment and census data to obtain the population characteristics of its total Membership. Population characteristics for Member participation in the comprehensive case management program include:

- 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

To effectively address Member needs, after the collection of Member population data, the CM Medical Director, Senior Director of Health Care Services, 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 versus 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.

VII. Case Management Clinical Systems

A. Clinical Information Systems

Delivery and documentation of case management services directly provided by Alliance staff is accomplished through a clinical information system. Alliance uses 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 the use of 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; records actions or interactions with Members, care givers and providers; and 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.

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. Clinical guidelines are reviewed and approved by the UMC and HCQC.

VIII. Care Coordination and Case Management Services

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

- **Health Risk Assessments** clinical processes are managed by the Alliance Care Management Department including High Risk HRAs and Care Planning, as well as Low Risk care plan development, with communication to Member and Provider.
- **Basic Case Management** for Low Risk level is provided by the Primary Care Physicians and their staff with a Network Provider Group's Care Management support. In the case of Direct Network Providers, the Alliance Case Management program provides Basic Case Management services.
- **Care Coordination/Service Coordination f**or Moderate Risk level is provided at the Provider Group level or The Alliance, supporting the PCP.
- **Specialty Programs** such as Transition of Care, Continuity of Care. Transitions of Care is provided by The Alliance Care Management staff for Members with a recent hospitalization. The level of management necessary is dependent upon the degree and complexity of illness or conditions to regain optimal health or improved functionality.
- **Complex Care Management** is provided by The Alliance Care Management staff for Members with conditions where the degree and complexity of illness or conditions is typically severe, the level of management necessary is typically intensive and the amount of resources required for Member to regain optimal health or improved functionality is typically extensive**.**
- **Enhanced Care Management (ECM)** The Alliance has developed and oversees a network of ECM Provides providing in-person comprehensive multidisciplinary care coordination and care management for the ECM target populations. The same network of teams also provides care for Members identified by the Alliance as high risk/high cost and/or meeting the ECM benefit criteria as defined by DHCS.
- **Community Supports (CS)** The Alliance is providing six Community Supports services as part of the CalAIM initiative: 1) Housing Transition Navigation, 2) Housing Deposits, 3) Housing Tenancy and Sustaining Services, 4) Recuperative Care, (Medical Respite) 5) Medically Tailored/Medically Supportive Meals, and 6) Asthma Remediation. The aim of the services is to address social drivers of health and provide cost effective, appropriate alternatives in lieu of higher-level services.

A. Health Risk Assessment

To ensure that the appropriate level and quality of care is delivered to newly enrolled, non-dual Seniors and Persons with Disabilities (SPD), the Alliance makes every effort to identify each Member's individual

medical and resource needs. On July 11, 2017, Department of Health Care Services issued a new All Plan Letter for Requirements for Health Risk Assessments of MediCal Seniors and Persons with Disabilities. This revised APL supersedes the existing notification and clarifies the Plan's responsibilities for the early identification of Members who need early intervention and care planning to prevent adverse outcomes. The new guidance also requires development of a process for utilizing the standardized LTSS referral questions to identify and ensure the proper referral of Members who may qualify for and benefit from LTSS services. 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 classifying high and low risk Members.

The Alliance utilizes a standardized HRA questionnaire to identify member care needs and provide early interventions for Members at higher risk for adverse outcomes. The questions are focused at 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 is completed 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 Alliance arranges for the assessment of every new SPD Member through a process that stratifies all new Members into an assigned risk category based on self-reported or available utilization data as either High Risk or Low Risk. 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 identified as High Risk.
- 105 days of enrollment as Low Risk.

The Alliance CM Department works in collaboration with the two vendors, KP LLC to send out the forms, and the Alliance IT Department for interactive voice calls to encourage members to return the HRAs to complete the HRA process. CM Staff are responsible for the outreach and assessment for Members who are initially stratified as high risk. Designated vendors for mailing and phone call are responsible for the initial outreach process for Members stratified as low risk.

High Risk Members are referred to Complex Case Management team for completion of the HRA, review of the HIF/MET when available, development of a care plan and completion of care coordination. For Members initially identified as Low Risk, a vendor performs the initial outreach to complete the HRA. Vendors submit the outreach report to AAH every month including those HRAs who have scored as Low Risk either by HRA scoring or are initially scored as Low Risk but are Unable to Contact (UTC) and complete the HRA. The responses from the HRA may result in the Members reclassification of Members as higher or lower risk. (For some Members, this re-classification based on the HRA may be different from their earlier classification based on the stratification tool.) Members re-classified/scored as High Risk are routed to the CCM team for review and processing. The HRA and LTSS Questionnaire can be found in Appendix F and G.

CM staff is responsible for ensuring the Member Care Plan is completed and shared as well as providing any community or health resources. For Members who completed the HRA and the final stratification is Low Risk, a CM staff will review the HRA responses to identify Member needs, i.e. resources for transportation, IHSS, food banks. The CM staff will generate the Care Plan, attach the resources, and prepare for mailing. If the Member remains UTC, CM staff will create a standardized care plan based on the needs identified for the initial data used to stratify the Member. The Alliance has chosen to generate the standardized high-risk care plan because this care plan includes additional health education resources as well as health education materials. All copies of the care plans are mailed to the Member and Primary Care Provider as well as to the Provider Group for potential care coordination needs. A HRA letter and resources are sent to the Member; a copy of the Care Plan is sent to the Primary Care Provider for care coordination.

SPD Members are re-assessed annually in the month of their enrollment. All HRAs are reviewed for needs provided by a Social Worker, with member is identified as Low Risk or High-Risk Member.
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 Members, The Alliance uses utilization data to re-stratify Members. The Alliance follows the process outlined above for interventions based on the UTC Members. The CM team will create a standardized high-risk care plan and follow the communications activities to Member and PCP. For Members that are re-stratified from Low to High based on the annual re-assessment activities, a report will be sent to the CCM team for CM Nurse assignment, 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. Case Management

Case Management will be provided using a combination of staffing models:

- Care team approach comprised of a RN Complex Case Manager, Health Navigator and Social Worker working together to manage a group of Members with complex and care navigation needs.

- Extended care teams to support specific needs of the care teams. The extended team members work across teams providing additional support and interventions as needed. The extended care team includes Medical Director, pharmacy, behavioral health, nurse liaison community care and health education.

Care teams are assigned specific roles on the team to address the needs of the 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 is 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 teams are directed by defined workflows between the team Members. Communication is key to the effectiveness of the program. The team meets daily to discuss the needs and expectations for the day.

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.

Care teams also serve as sources to identify and refer Members to the Enhance Care Management (ECM) and Community Supports (CS) programs.

1. Basic Case Management Services

Basic Case Management services are made available to Alliance Members (including the Medi-Cal SPD and Medi-Cal Expansion population) when appropriate and medically indicated.

Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and out of plan services are considered basic case management services.

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

- Initial Health Assessment (IHA)
- Initial Health Education Behavioral Assessment (IHEBA)
- 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.

2. Initial Health Assessment and Behavioral Risk Assessment

The PCP schedules with the Member and performs an Initial Health Assessment (IHA) and an Individual Health Education Behavioral Assessment (IHEBA). The IHA includes a history and physical evaluation sufficient to assess the acute, chronic, and preventive health needs of the Member. The IHEBA includes a series of age specific questions to evaluate risk factors for developing preventable illness, injury, disability, and major diseases. The PCP and/or the office staff are responsible for identifying and arranging for care needs. This includes referrals to the various linked and carved out County and State programs. For medical services that are needed but managed through The Alliance, providers are responsible for contacting and arranging for UM or CM servicers to meet the identified needs.

C. Care Navigation (Case Management/Care Coordination)

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

1. Case Management/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.

The Alliance facilitates, and coordinates care for eligible Members (including the Medi-Cal SPD and MediCal Expansion population) through Case Management services. Alliance staff follows preset guidelines and collaborates with Primary Care Providers when necessary to determine eligibility.

Members eligible for care management/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/case management, they are assigned to an Alliance lead Case Management unit to take responsibility 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 multiply diagnosed with medical, functional, cognitive, and psychosocial conditions.

Alliance-based 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

2. Targeted Case Management Services

The Alliance facilitates, and coordinates care for eligible Members (including the Medi-Cal SPD and Medi-Cal Expansion population) through targeted case management (TCM) services. Alliance staff follows preset guidelines and collaborates with primary care providers when necessary to determine eligibility for TCM services. Members may be referred to receive TCM services through the Alliance or through the most appropriate contracted community partner.

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.

Once a Member is identified and referred for TCM, they are assigned to an Alliance lead Case Management staff member to take responsibility for screening, referrals, care planning, and all other care coordination activities. Members are matched to the Case Management unit that is specialized based on the prominence of medical or behavioral health 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 multiply diagnosed with medical, functional, cognitive, and psychosocial conditions.

For Members who are already connected to services through a community social service, or behavioral health provider, the responsibilities of lead Case Manager will fall to that agency. Generally, TCM services are delegated to the external agency with demonstrated expertise in the referred Member's most pressing needs. For example, Members who require primary support for developmental disabilities are referred to community partners such as Regional Center of the East Bay for the provision of TCM services.

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

- Screening and enrollment
- Comprehensive clinical assessment
- Development and implementation of an Individualized Care Plan ("ICP") also referred to as 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

If a Member receives TCM services as specified in Title 22 CCR Section 51351, the Alliance is responsible for coordinating the Member's health care with the TCM provider and for determining the medical necessity of diagnostic and treatment services recommended by the TCM provider that are covered services by the Alliance.

For Members under age of twenty-one (21) 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.

D. Special Programs

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

- Transitions of Care
- Care Coordination for Members receiving continuity of care (CoC) with non-contracted providers.
- CCS
- Enhanced Care Management (ECM)
- Community Supports
- Major Organ Transplants

1. Transitions of Care

Alliance Case Management staff maintains procedures to assist Members who were recently discharged from the hospital. 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.

Once a Member is identified and referred for care coordination/case management, they are assigned to an Alliance lead Case Management unit to take responsibility 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 multiply diagnosed with medical, functional, cognitive, and psychosocial conditions.

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

- Enrollment
- 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 delivery, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

2.Continuity of Care 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 out of network for the Member, until services are completed or the Member can be safely transitioned back into The Alliance medical home. Continuity of Care may be provided for one of the following situations:

- Newly enrolled
- SPD, Newly Enrolled
- Members with terminated providers
- Medical Exceptions Requests for Newly Enrolled Medi-Cal Enrollees

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. One month prior to the termination of the CoC arrangement, CM staff contact the Member and treating Provider to ensure communication of the transition to all parties and identify any ongoing care needs. CM staff will also obtain any necessary information to share with the assigned PCP/Provider Group on the ongoing care coordination needs. Case Management staff are responsible for ensuring care is continued with out of network providers. The CM staff ensure the coordination of

services with the Primary Care Providers and Specialists. A full description of the various CoC programs in found in the relevant UM Policies.

2. 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.

3. Enhanced Care Management (ECM)

ECM offers comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members as part of the CalAIM initiative, 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.

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

4. Community Supports Services

Community Supports (CS) services are provided as part of the CalAIM initiative that 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 2022, the Alliance is providing six CS services:

Housing Navigation

Housing Deposits

Housing Tenancy and Sustaining Services

Recuperative Care (Medical Respite)

Medically Tailored/Medically Supportive Food

Asthma Remediation

Each CS service has eligibility criteria and specific services provided per CS service, following the DHCS requirements.

5. Major Organ Transplants

In 2022, Major Organ Transplants (MOT) are being carved back into the Plan from FFS Medi-Cal. This uniquely vulnerable set of members are 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, wrap around services throughout. The Alliance program is a collaboration between the UM and CM department as well as other Alliance departments. The full program is described in the UM policies and procedures.

E. Complex Case Management

Complex Case Management services are made available to Alliance Members (including the Medi-Cal SPD and Expansion population) with chronic and complex medical conditions. Complex case management services are offered through the Alliance Complex Case Management program and a limited number of primary care provider entities. 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.

IX. Case Management Program Description

A. Case Management

1. Identifying Members for Case Management

Members are identified as candidates for care management services through a variety of data sources and referrals. This includes:

Data Sources

Aggregate data is processed or reviewed to identify Members with CCM triggers

- The predictive model, CareAnalyzer, includes claim and encounter data, pharmacy data, and health risk assessment data, as well as data supplied by the State of California (as purchaser for Medi-Cal) which may include claims data and service authorizations;
- Provider Groups provide registry data and supplemental reports (e.g., Catastrophic Medical Condition reports for Genetic Conditions, Neoplasms, organ/tissue transplants, and multiple traumas and provides data regarding Members with HIV/AIDS and ESRD)
- Inpatient census reports
- Hospital discharge reports
- Health Risk Assessments (HRA)
- Readmission Report
- Laboratory Results
- Opiate Utilization Report

Referral Sources

Individual Members may be referred by:

- Medical Management/Internal referrals, e.g. UM, Disease Management, Health Information Line, Member Services, Appeals and Grievance, Leadership
- Direct referrals from Discharge Planners
- Self-referrals, e.g. Members, Caregivers
  - Instructions for self-referral and the phone number are provided in the Member handbook and on the Alliance website. In addition, Member Services and Health Navigators explain the process for self-referral when appropriate.

- Practitioners/provider network referrals, e.g. PCPs, Specialists, Medical Group Medical Directors
  - Instructions for referral and the phone number are documented in the provider manual and notified through Provider update communications.

- Predictive modeling, e.g. Care Analyzer

The cases identified through the data sources or referral sources cited above are reviewed by the 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. Members are deemed ineligible if the Member is not in the Plan, has died, is receiving duplicative services, or is in a long-term care facility.

2. Case Management Process

The Alliance maintains policies and procedures for case management services. Case management procedures and processes include:

A. Intake
When a Member is identified, or a referral is received for case management, the Alliance staff enters the referral into the care management system and coordinates case management services with the Member's PCP.

B. Identification of Care Needs
The PCP in collaboration with Alliance Utilization Management and Case Management staff identify appropriate providers and facilities to meet the specific health condition needs of the Member to ensure optimal care delivery to the Member.

C. 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 Alameda Utilization Management and 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.

D. Coordination of 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. Utilization Management and Case Management staff coordinates access to community services, monitor service delivery, advocate for Member needs, and evaluate service outcomes.

E. 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 the IHEBA and identification of appropriate healthcare services.

F. Identification of Barriers to Care

Alliance Case Management staff monitor barriers to care such as a Member's lack of understanding of condition, motivation, financial or insurance issues and transportation problems. The Case Management staff identify interventions to reduce or resolve Member specific healthcare barriers.

G. Case Closure

The PCP in collaboration with Alliance Case Management staff terminate case management services for Members based on established case closure guidelines. 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

B. Targeted Case Management

1. Identifying Members for Targeted Case Management

Alliance Case Management staff facilitates services to Members eligible for targeted case management services to Regional Center of the East Bay (RCEB), community partner such as Community Based Adult Day Centers (CBAS) or other local government health program. 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.

2. Targeted Case Management Process

The Alliance maintains policies and procedures for targeted case management services. Targeted case management procedures and processes include:

A. Referral

When a Member is identified, or a referral is received for targeted case management, the staff enters the referral or prior authorization into the care management system and coordinates case management services with the RCEB as appropriate.

B. Documented Assessment

The TCM partner assesses the Member's health and psychosocial status to identify the specific needs of the Member.

C. Development of Comprehensive Service Plan

The TCM partner develops a comprehensive service plan to include information from the Member assessment as well as Member input regarding preferences and choices in treatments, services, and abilities. The Regional Center or local government health program in collaboration with Alliance utilization and Case Management staff assist Members with accessing services identified in the service plan. The Regional Center or a local government health program periodically reviews with the Member progress toward achieving goals identified in the service plan.

D. Coordination of Services

The TCM partner 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. Utilization management and Case Management staff coordinates access to community services, monitor service delivery, advocate for Member needs, and evaluate service outcomes.

E. Crisis Assistance

The TCM partners in collaboration with Alliance Case Management staff coordinate and arrange crisis services or treatment for the Member when immediate intervention is necessary or in situations that appear emergent in nature.

F. Monitoring of Regional Center or a Local Government Health Program Services

Alliance Case Management staff monitor the Member's condition, responses to case management interventions, and access to appropriate care. The Alliance ensures the TCM partner performs the necessary activities of targeted case management services such as performing a documented assessment and developing an individual comprehensive service plan.

G. Identification of Barriers to Care

Alliance Case Management staff monitor barriers to care such as Member lack of understanding of condition, motivation, financial or insurance issues and transportation problems. The utilization management and Case Management staff identify interventions to reduce or resolve Member specific healthcare barriers.

H. Case Closure

The PCP in collaboration with Alliance Case Management staff terminate targeted case management services for Members based on established case closure guidelines. The criteria for case closure include, but not limited to:

- 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 participate in the program appropriately and actively.

IX. Complex Case Management Program Description

A. Identifying Members for Complex Case Management

1. Criteria

Criteria for identifying Members for complex case management are developed under the guidance of the Chief Medical Officer. Routinely, but no less than annually, the Alliance evaluates the criteria and its staff resources to determine if there are sufficient staff to provide complex case management to those Members who are at high-risk and are potential participants in the complex case management program.

The criteria are determined using the DST Care Analyzer data plus utilization history. The DST CareAnalyzer data includes Member claims, including those for behavioral health, and pharmacy claims. The scores, together with the utilization history, provide a listing of Members who are most at risk.

The criteria are subject to change at least annually but generally address 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 the previous six (6) months

- Multiple hospitalizations in the previous six (6) months
- Mental Health diagnosis
- Complex Psychosocial Needs (i.e. Homelessness)

In addition to the above medical criteria, Members must also meet the following qualifications to be eligible for complex case management:

- Member is eligible with the health plan on the date Case Management staff reviews program eligibility
- Member can be contacted
- Member expresses interest in program enrollment and provides consent.

2. Data Sources

The Alliance uses the following data sources to continuously identify appropriate Members for participation in complex case management:

- Claims and pharmacy data (CDPS and PerformRx) from the data warehouse and analyzed by the Health Care Analysts.
- Members are identified monthly from this data source Data from Admission, Transfer, Discharge (ADT) report, generated by various community hospitals
- UM data from preauthorization and concurrent review Data from purchasers (Medi-Cal and Commercial)

Information provided to Alliance from Members, caregivers and community-based programs that support the Member, Data from Member Health Risk Assessment, Data from practitioners (Referral and Medical Records)

3. Referrals to Complex Case Management

There are multiple referral avenues for Members to be considered for Complex Case Management services. Services are available to all Alliance Members who meet the general criteria for case management, regardless of specific line of business. Referral sources include:

A. Health Information Line referral

Alliance has mechanisms in place to gather information from the phone-based health information line, the AAH Nurse Advice Line, to identify Members who are eligible for complex case management. CM staff receive daily activity reports from the health information line vendor, and they assign Members to staff for CM services as appropriate.

b. DM program referral

The Disease Management staff have criteria to assist them in identifying high-risk Members for case management.

c. Hospital discharge planner referrals

The Alliance has relationships with discharge planners at hospitals in the provider network and they will refer to case management Members they believe are at high risk.

d. UM referral

The Utilization Management program identifies Members in need of case management at admission, discharge, and concurrent review.

e. Member, caregiver, and practitioner referrals

The Member Services Department receives calls from Members, caregivers and practitioners and refers them to case management based on either a request by the caller or if the nature of the call indicates that the Member would benefit from the service. At least annually, Members and Providers are informed about their ability to make referrals in the Provider and Member newsletters.
With the update to the member portal, Members and caregivers are now able to directly refer to Case Management for CM services.

f. Community-based referrals

The CM department may receive referrals for case management from community organizations/partners such as hospitals, CCS, etc.

g. Behavioral health referrals

The CM department may also receive referrals for case management services from the behavioral health delegate, Beacon.

4. Date of Eligibility for Complex Case Management

Members identified or referred for Complex Case Management are reviewed for health plan enrollment and eligibility prior to beginning a general assessment. The Alliance considers a Member eligible for case management once a Member is provided 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.

B. Complex Case Management Process

The Alliance Complex Case Management Program uses a systematic approach to patient care delivery and management. Primary steps of the Alliance complex case management process include: Member identification and screening; Member assessment; care plan development, implementation, and management; evaluation of the Member care plan; and closure of the case.
The Alliance maintains policies and procedures for the complex case management process. Complex case management procedures and processes include:

1. Referral & Screening

When a Member is identified, as described in Section IX.A ("Identifying Members for Complex Case Management") or a referral is received for case management, the CM staff enters the referral into the care management system and verifies Member health plan enrollment and eligibility. After health plan eligibility is confirmed the staff submits the referral. The Case Manager then screens and determines program eligibility in complex case management or other appropriate programs by performing the initial screening assessment with the oversight of the Medical Director. 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. Appendix C & D contain the 2022 Case Management Criteria and Screening Checklist to assist clinical teams in consistency in assessment for CCM services.

2. Assessment of Health Status

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.

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.

3. Documentation of Clinical History Including Medications

As part of the General Assessment, the Case Manager reviews and documents Member 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.

4. Assessment of Activities of Daily Living

The Case Manager or Social Worker evaluates Member functional status related to activities of daily living such as eating/feeding, bathing, dressing, going to the toilet, continence, transferring, and mobility. The Case Manager or Social Worker collects this information in the General Assessment and uses the information to determine barriers to care and to identify issues to include in the Member care plan.

5. Assessment of Behavioral Health Status Including Cognitive Functions

During the General Assessment and ongoing evaluations as appropriate, the Case Manager or Social Worker evaluates Member mental health status, including psychosocial factors, cognitive functions, and depression. The Case Manager or Social Worker also completes an alcohol and drug use screen as part of the General Assessment. As part of the assessment of cognitive and communication limitations, the Case Manager or Social Worker assess the member's ability to communicate, understand instructions, and their ability to process information about their illness. Referrals are made to behavioral health clinicians for case management Members that meet specified criteria.

6. Assessment of Social Determinants of Health

The Case Manager or Social Worker assesses for social determinants of health, 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 case management goals. As part of the assessment the following are being assessed by Case Managers or Social Workers:

- 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

7. Assessment of Life-Planning Activities

Member preferences about healthcare and treatment decisions may impact the care plan. The General Assessment and case management process includes an assessment of Member life planning activities such as wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life Sustaining Treatment (MOLST or POLST) forms. The Case Manager or Social Worker (SW) documents situations when life-planning activities are not appropriate, and mails appropriate information (e.g., advance directive) to Member when needed.

8. Evaluation of Cultural and Linguistic Needs, Care Preferences or Limitations

Communication issues can compromise effective healthcare for the Member. To identify communication methods best suited for the Member, cultural and linguistic needs, care preferences or limitations are assessed by the Case Manager or Social Worker during the General Assessment. The Case Manager or Social Worker assesses whether there are any personal, religious, cultural preferences or any cultural restrictions to consider in a plan of care with the member. The CM or SW also assesses the member's ability to communicate, understand instructions, and their ability to process information about their illness.

9. Evaluation of Visual and Hearing Needs, Preferences or Limitations

To ensure an appropriate care plan and healthcare needs are effectively met, Member visual and hearing needs, preferences or limitations are assessed by the Case Manager or Social Worker during the

General Assessment. In the event Case Managers or Social Workers identify impairment, details such as use of hearing aids and eyeglasses, or any future known surgery will be provided to assist in the development of care planning.

10. Evaluation of Caregiver Resources and Involvement

The Case Manager or Social Worker evaluates caregiver resources such as family involvement and decision making about the Member's individualized care plan. The Case Manager or Social Worker collects this information in the General Assessment and uses the information to determine barriers to care and to identify issues to include in the Member Care Plan.

11. Evaluation of Health Plan Benefits and Community Resources

The Intake Coordinator verifies Member health benefits, and the Case Manager or Social Worker assesses resources impacting care including caregiver, community, transportation, and financial resources. When indicated for the Member, the Case Manager or Social Worker accesses 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.

12. Development of Individualized Person-Centered Case Management Plan

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 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.

These goals are incorporated into the care plan which also includes:

- Timeframe for re-evaluation
- Resources to be used in meeting the goals and addressing the Member's needs.
- Plans for addressing continuity of care needs, transitions, and barriers.
- Involvement of the family and/or caregiver in the plan
- Educational needs of the Member
- Plans for supporting self-management goals.

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.

13. Identification of Barriers to Goals or Compliance with Plan of Care

The CCM procedures address barriers to care such as Member lack of understanding of condition, motivation, language, financial or insurance issues and transportation problems. The Care Plan identifies barriers to care and intervention actions to reduce or resolve Member specific healthcare barriers.

The Case Manager or Social Worker 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. 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.

14. Facilitation of Member Referrals to Resources and Follow-up Process

The Care Plan includes follow-up to reduce or eliminate barriers for obtaining needed health care services. The case management process facilitates 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.

15. Development of Schedule for Follow-up and Communication

The Care Plan includes a schedule for follow-up that includes, but is not limited to, counseling, referral to disease management, education, or self-management support. Complex case management workflows and processes specify when and how the Case Manager or Social Worker follows up with a Member.

16. Development and Communication of Member Self-Management Plan

The Case Manager 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).

17. Process to Assess Progress

The Case Manager or Social Worker continuously monitors and reassesses the Member's condition, responses to case management interventions, and access to appropriate care. The case management plan includes an assessment of the Member progress toward overcoming barriers to care and meeting treatment goals. The complex case management process includes reassessing and adjusting the care plan and its goals, as needed.

18. Case Closure

The Case Manager terminates case management services for Members based on established case closure guidelines. 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 participate in the program appropriately and actively

19 Patient Safety

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.

20. Member Engagement and Consent/Member Right to opt Out of CCM

Engagement CCM services are performed telephonically. An outbound engagement call is placed to the Member to offer CCM services and obtain Member consent. Member consent is a program requirement. Case Managers are responsible for fully explaining the program and benefits of the program to assure that the Member is making an informed decision.

If the Case Manager or Social Worker is unable to contact a newly assigned Member, the Case Manager or Social Worker sets a task in the care management system to attempt a second and third call in the next two days, at different times of day. If the Member is not reached following these three attempts, an Unable to Contact letter is sent to the Member, to explain the CCM program and to invite the Member to call the Case Manager or Social Worker to engage in services. All contact attempts and the letter are documented in the case management system.

If the Case Manager or Social Worker is able to contact the Member and obtain consent to participate, the Case Manager may begin the initial CCM assessment, or may schedule an assessment appointment based on the Member's availability and preference.

If the Member is contacted and declines to participate, the Member's wishes are respected. The CCM program is based on active participation. 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.

21. Initial Assessment

The Member is sent a welcome letter that describes the services and introduces the Case Manager and describes the interdisciplinary care team management concept. Members are advised of their rights in selecting care team participants.

The Case Manager or Social Worker may begin the initial assessment in the first contact call. 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 (i.e. date identified by triage nurse as eligible for complex case management or date identified from a report that Member meets CCM criteria).

22. Individualized Care Plan

Following the initial assessment, the Case Manager and/or Social Worker develops an Individualized Care Plan (ICP), consisting of goals and interventions. 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 ICP is crucial to the success of care management activities. 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 development and communication of the self-management goals refer to the instruction or materials provided to Members or their caregivers to help them manage their condition. These activities are suggested by the Member or the Member's primary caregiver in consultation with the care manager to support the Member's management of their condition, when appropriate. These are components of the care plan and do not require a separate plan. Member self-management activities include, but are not limited to:

- Maintaining a prescribed diet.
- Charting daily readings (e.g., weight, blood sugar).
- Changing a wound dressing as directed.

Case Managers may also set goals for themselves, such as following up with a family Member to discuss a transportation barrier.

Case Managers must develop an ICP within 30 calendar days of completing the Initial Assessment or within 30 calendar days of HRA completion.

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 condition or circumstance. 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).

Care plans 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. The Case Manager or Social Worker approves available add-on benefits and services for vulnerable Members such as disabled or those near end-of-life.

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.

23. Ongoing Management

The Case Management staff establish a communication schedule with the Member and/or Member representative, that is appropriate for Member's condition and to which the Member will commit. The Case Management staff will establish the communication plan in the case management system which will prompt the Case Management staff to keep the communication schedule. All Member contact will be tracked in the system, and each contact and case note will include a unique identifier for the Case Management staff, along with the date and time of contact or case note entry. Interdisciplinary care team Members are noted in the case management system where care team meetings are scheduled and documented.

Case Management staff make referrals for care and services, and follow-up with Member and/or practitioners to assure the Member has acted on referrals. Some referrals are prompted by the assessment.

The Case Manager or Social Worker assesses the Member's progress toward individual goals through regular interaction with the Member and diligence in reviewing additional information that becomes available, such as a preauthorization request, ER visit, hospital admission, call to the health information line, or other information provided by a practitioner or family Member. Goals are adjusted as appropriate. When a top priority goal is achieved or eliminated, then other goals are evaluated and moved up to a higher priority.

The Case Management staff closes the case when criteria are met as defined in Section B.18 Case Closure. 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 identify the established goals are appropriate, and if additional goals are needed or referrals to additional services are warranted.

24. Case Management Integration

Complex Case Management staff cannot be effective working 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.

25. Inter-Disciplinary Care Teams

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 as well as provide assistance and direction to the dedicated care teams.

XI. Community Based Integration

As part of the CalAIM initiative, the Alliance has partnered with community-based agencies to provide both the Enhanced Care Management (ECM) benefit and Community Supports (CS). The purpose of the program is to build community infrastructure to improve integration, reduce unnecessary utilization of health services and improve health outcomes. AAH has contracted with Community Based Organizations (CBOs) to provide the ECM and the CS services. The ECM providers include both clinic-based CBOs and social agencies (see appendix I for full list.) CS Partners include the Alameda Health Care Services Agency (HCSA,) for housing services, 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 AAH 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 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, standardized approach to allocation of limited housing resources and access to high quality community case management services.

The target populations of focus for the ECM benefit and CS services programs are based on the DHCS definitions of eligibility for each (a combination of complex chronic illnesses, health care utilization, and other high risk factors like homelessness, mental illness and other social determinants of health (SDOHs).)

The Alliance has dedicated clinical and non-clinical staff to participate in the planning and development of Alliance activities for ECM and CS in partnership with community providers/agencies. Staff works at developing mechanisms to identify Members and provide services to meet the overall goals. The processes are defined in CM Policies and Procedures.

XII. Disease Management

The Alliance has two dedicated disease management programs based on patient population needs and prevalence. The Pediatric Asthma and Adult Diabetes Disease Management programs aim to improve health status of its participants by fostering self-management skills and providing support and education. Programs provide education, chronic care management, patient activation and coordination of care. All programs interventions are based on data-identified patient needs and are developed using evidence-based practice guidelines and care pathways. Members are identified by claims, Pharmacy, and lab data as well as direct referrals from physicians or community partners.

- Pediatric Asthma – Serves Members who under 19 years old and identified with asthma based on clinical, pharmacy, and utilization data or direct referral.

- Adult Diabetes – A Member living with diabetes if they are > 21 years or older and identified based on clinical, pharmacy and utilization data or direct referral.

A full description of the Disease Management program activities is listed in Appendix H.

XIII. 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 ICT 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 HCQC on a quarterly basis.

XIV. Program Effectiveness

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

A. Complex Case Management Performance Measurement

The Alliance maintains 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 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:

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

3. Achieve optimal Member functioning.

Measure Four – Health Status Rate

4. Use of Appropriate Health Care Services

Measure Five – Use of Services (Primary Care)

A full description of the measures, goals, methodology and sources is available in Appendix E – 2022 Performance Measures.

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.

B. 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 CCM. Any Member complaints received regarding CCM are also used, whether the complaint was made during the case or submitted with the post-discharge survey. 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.

XV. Annual Complex Case Management Program Evaluation

The Chief Medical Officer 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 HCQC for review and feedback. The UMC and HCQC make recommendations for corrective action interventions to improve program performance, as appropriate. The Senior Director of Health Care Services is responsible for implementing the interventions under the oversight of the Chief Medical Officer.

XVI. Delegation of Case Management Activities

The Compliance Department is responsible for the overall performance of the internal and external audits of delegates. CM Department staff is responsible for the review and reporting of the CM components of the annual process which includes a file review to evidence compliance with the activities. The Compliance Department is responsible for finalizing the audit finding and issuing required corrective actions. All audit findings are reported into the Compliance Department and the HCQC. The CM team is responsible for ongoing monitoring activities including review of the delegated entities annual work plans/evaluations, and semi- annual reporting.

For HRAs, care management, care coordination, CCM and disease management, The Alliance may delegate these services to network providers. The Alliance delegates the following services to contracted providers:

Delegate	Provider Type	HRA	Care coordination/ CM	CCM	DM
Kaiser	HMO	X	X	X	X
CHCN	Managed Care Organization	No	X	No	No
Beacon/College Health IPA (CHIPA)	MBHO	No	X	X	No

Alliance is also responsible for ensuring the delivery of quality, cost effective services. Through 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 CM team 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 Provider Relations to create an appropriate delegation agreement which requires the delegated entity to comply with the regulatory and accreditation requirements to evidence. The oversight of a delegated activity includes regular reporting of CM services provided to Alliance Members. (e.g., monthly, quarterly, semi-annually, or annually).

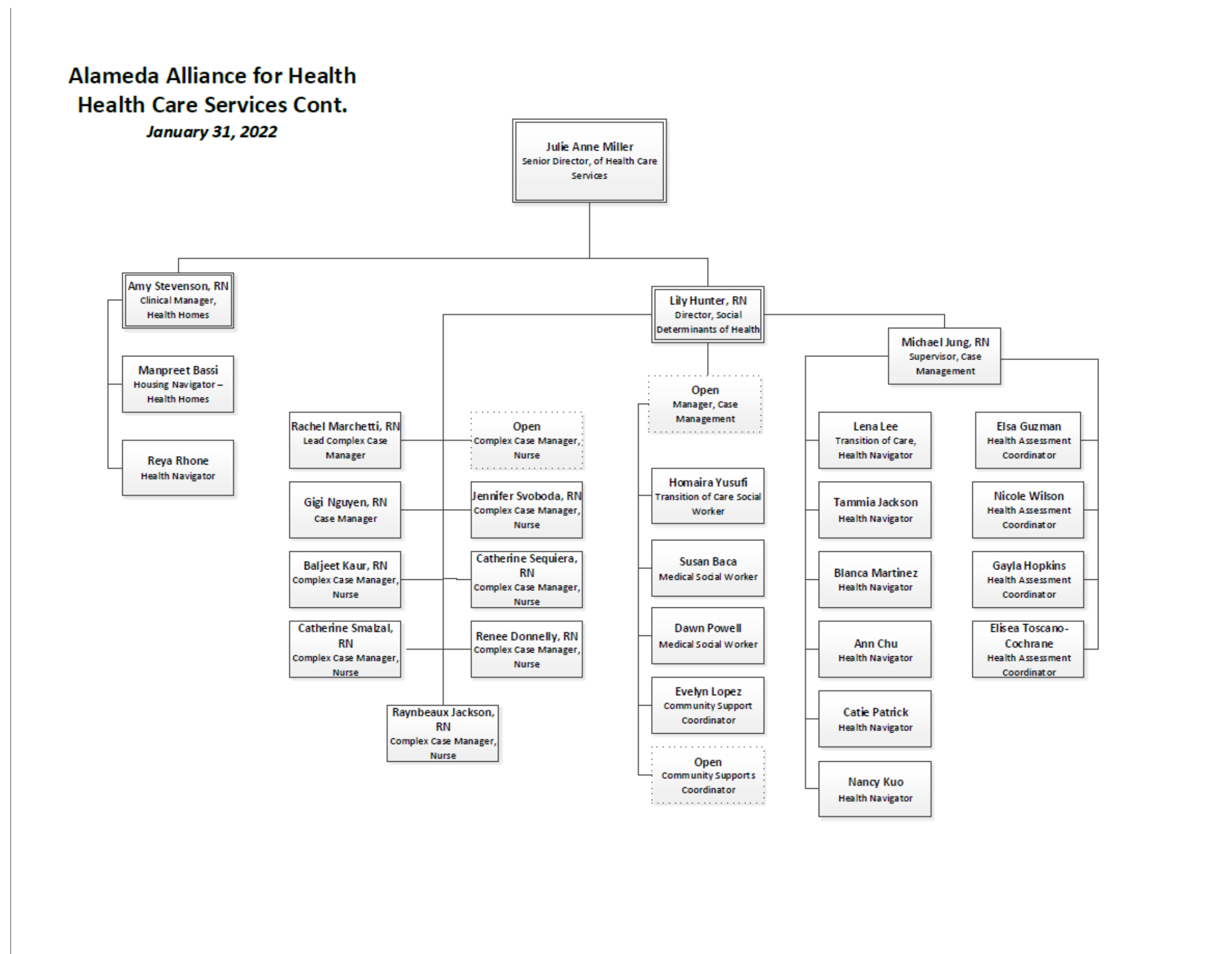
The Alliance's CM Management Team is responsible for the oversight of delegated activities and will participate in the annual performance review. Results of the annual evaluation and any audit results are reviewed by the Compliance and Delegation Oversight Committee.

All delegation is conducted in accordance with Alliance's delegation policies and procedures, assuring consistent, thorough oversight and evaluation of delegated case management activities.

2022 Improvement Opportunities Summary:

- Continue to redesign the CM program to focus on key CM activities, monitoring through the UM Committee and HCQC.
- Ensure information systems reflect reporting needs for compliance monitoring and oversight, both internal and external.
- Continue to identify appropriate performance measures and goals for CM and develop monitoring reports for the measures.
- Maintain and expand the ECM program with community-based collaborations.
- Maintain and expand the Community Supports services with community-based partners.
- Complete the transition for enrolled Health Homes and Whole Person Care (AC3) members into CalAIM Enhanced Care Management (ECM) and Community Supports, launched on January 1, 2022.
- Continue the development of focused services for vulnerable populations, such as Oncology, Major Organ Transplant and ESRD/Dialysis.
- Develop educational program for PCPs and Network Provider Groups
- Enhance reporting and analysis of CM activities focused on member experience with CM.
- Continue to enhance the Palliative Care Program
- Enhance delegation oversight activities for CM, Care Coordination, CCM, and TOC.
- Collaborate with Health Care Analytics on identifying enhancements to the predictive model algorithm to improve the identification of appropriate members for CCM.

APPENDIX A: Case Management Organization Chart



APPENDIX B: Clinical Care Guidelines

TruCare 4.7 Disease Specific Content References

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Cancer

- NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) https://www.nccn.org/professionals/physician_gls/default.aspx. The NCCN Guidelines are copyrighted by the NCCN. All rights reserved. NCCN Guidelines and illustrations (including algorithms) may not be reproduced in any form for any purpose without the express written permission of the NCCN. *(AAH 2018 QI Clinical Practice Guidelines).*

Preventive Health Guidelines

The following guidelines were approved by the Health Care Quality Committee of Alameda Alliance for Health (Alliance) in August 2017. The Alliance recommends its provider network follow the most current versions of the following preventive guidelines. The Alliance recognizes that these guidelines are continually updated; therefore, providers need a reasonable amount of time for implementation of any updates:

- **Asymptomatic Healthy Adults**

For Asymptomatic Healthy Adults, the Alliance follows the current edition of the Guide to Clinical Preventive Services of the U.S. Preventive Services of the U.S. Preventive Services Task Force (USPSTF), specifically USPSTF Grade "A" and "B" recommendations for providing preventive screening, testing and counseling services.

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

- **Members Under 21 Years of Age**

For members under 21 years of age, the Alliance adheres to the most recent American Academy of Pediatrics (AAP)/Bright Futures age-specific guidelines and periodicity schedule for preventive services. Search for "Periodicity Schedule" at: www.aap.org

- **Perinatal Services**

For pregnant members, the Alliance provides perinatal services according to the most current standards or guidelines of the American College of Obstetrics (ACOG). http://www.acog.org/

- **Immunizations**

For all members, the Alliance provides immunizations according to the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) Immunization Schedules.

- Child and Adolescent Immunization Schedule: https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
- Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

Appendix C – 2022 Criteria for Case Management

The overall goal of complex case management is to help Members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the Member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

The Alliance offers a variety of programs to its Members and does not limit eligibility to one complex condition or to Members already enrolled in the organization's CM programs.

Referrals that are selected for CCM are based on the following general criteria:

a. The degree and complexity of the Member's illness is typically severe.
    1. Multiple specialties involved.
    2. Level of specialty management (tertiary providers)
    3. Primary diagnosis with complication(s)
    4. Higher levels of disease staging
b. The level of management necessary is typically intensive.
    1. Multiple services needing coordination.
    2. Frequency of care management contacts needed.
    3. Large number of external care coordination services
c. The amount of resources required for the Member to regain optimal health or improved functionality is typically extensive.
    1. Multiple hospitalizations in the past 6 months
    2. Multiple ED visits in the past 6 months
    3. High cost and utilization of pharmacy

The conditions and examples below are used as guidance to assist staff and potential referral sources in identifying eligible Members through the UM processes or data captured.

1. High Risk Diabetes
    a. Criteria
        i. 2 or more comorbidities
        ii. 2 Inpatient Admits within 6 months (excluding delivery admits) OR
        iii. ≥ 3 Outpatient Emergency Department visits within 6 months

2. Cancer and possible cancer indicators:
    a. Criteria
        i. Lung, brain, head, and neck, pancreatic, liver cancer

        ii. Metastatic cancer
        iii. Malnutrition, dehydration, nausea/vomiting
        iv. Chronic pain

3. Cerebrovascular disease:
    a. Criteria
        i. Stroke requiring intensive rehabilitation or prolonged facility admission.
4. Complex Diabetes
    a. Criteria
        i. Diabetes with heart disease, peripheral vascular disease, cerebrovascular disease, kidney failure
        ii. Type 1 diabetes with ketosis or severe complications
5. Cardiovascular disease:
    a. Criteria
        i. Heart failure
        ii. Cardiomyopathy
        iii. Cor pulmonale
6. Infectious disease:
    a. Criteria
        i. Diseases possibly indicating immunosuppression, opportunistic infection, presence of other disease, or causing encephalopathies.
        ii. Histoplasmosis
        iii. Jakob-Creutzfeldt
        iv. Leukoencephalopathy
7. Respiratory diseases:
    a. Criteria
        i. Severe asthma
        ii. Chronic obstructive pulmonary disease
        iii. Respiratory failure
8. Dementia and progressive neuro muscular disease
    a. Criteria
        i. Dementia
        ii. Amyotrophic lateral sclerosis
        iii. Bulbar palsy
9. Major organ failure:
    a. Criteria
        i. heart failure
        ii. liver failure
        iii. kidney failure
10. Preterm birth:
    a. Criteria

            i. babies requiring prolonged facility admission or complex home care.

11. Trauma:
    a. Criteria
        i. severe trauma with head injury and/or requiring prolonged facility care or complex home care.
        ii. spinal cord injuries
        iii. brain injury
        iv. burns
12. Readmission:
    a. Criteria
        i. readmission to facility within 30 days of discharge due to complications or multiple admissions for same condition
13. Mental health:
    a. Criteria
        i. requests for residential treatment facilities
        ii. multiple psychiatric or chemical dependency admissions within the past 12 months
        iii. history or threat of suicide
14. Other:
    a. Criteria
        i. Any recommendation from Health Services management or direct referral from referral provider

Appendix D- REFERRAL TO COMPLEX CASE MANAGEMENT CHECK LIST

Referrals that are selected for CCM are based on the following criteria:

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 - 2022 CCM Performance Measures

#	Measure	Purpose	Indicator	Measure	Methodology	Sampling
1	Member Satisfaction Rates	Achieve and maintain high levels of satisfaction with CM services.	Member Satisfaction	90% of Member responses for the overall satisfaction with the care management	All Members in CCM for > 60 days or upon discharge.	Total number of "satisfied" or "very satisfied" respondents/Total number of respondents.
2	All-Cause Readmission Rate	Improve Member outcomes	Acute hospital readmission rate for Members enrolled in CCM	10 percentage point reduction from prior to CM enrollment	Acute care readmissions, all causes, for all Members in CCM for >60 days	Aggregate utilization reports specific to Members enrolled in CCM
3	Emergency Room Visit Rate	Improve Member outcomes	ER rates for Members enrolled in CCM	10 percentage point reduction from prior to CM enrollment	ER rate for all Members in CCM for >60 days	Aggregate utilization reports specific to Members enrolled in CCM
4	Health Status Rate	Achieve optimal Member functioning	percentage of Members who received CCM services and responded that their health status improved because of CCM services	85% of Members responses will report improvement in their perceived health status	All Members in CCM for > 60 days or upon discharge	Total number of "greatly improved" or "somewhat improved" response/ Total number of responses.
5	Use of Services	Appropriate Use of Health Care Services	PCP visits for Members enrolled in CCM per Member per year	10 percentage point increase from prior to CM enrollment	All Members in CCM for > 60 days or upon discharge	Aggregate utilization reports specific to Members enrolled in CCM

Appendix F: HRA Questionnaire

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

CONFIDENTIAL

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

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.
Tier 1 LTSS Questions:

Long-Term Services and Supports Referral Questions *APL 17-013 Requirements for HRA for MediCal SPD
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 *APL 17-013 Requirements for HRA for MediCal SPD
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 – Disease Management Program Activities

Disease Management (DM) services at Alameda Alliance for Health (the Alliance) are provided to all Alliance members with a diagnosis of diabetes or asthma that meet certain age criteria. The Alliance 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.

DM Identification and Screening

Members are eligible for DM if they have a diagnosis of diabetes and are over 18 years of age or have a diagnosis of asthma and are between 5 and 12 years of age.

The Alliance informs practitioners about the DM programs through multiple methods, including but not limited to, 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.

1. 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 into low, moderate, or high risk.
    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 source or report from a source includes, but is not limited to, self-referral, caregiver, Primary Care Providers or Specialists, discharge planners at medical facilities and internal department referrals such as Utilization Management (UM), Case and Disease Management and Member Services.

Information needed for a DM referral includes:

i. Referral or data source (name, affiliation, and contact information).
ii. Date referral received by Intake. If secondary referral, document initial contact information and date.
iii. Member information
iv. Reason for referral
v. Diagnosis (asthma or diabetes)
vi. Level of urgency
vii. Additional information, as necessary.

2. Laboratory results data is used to identify diabetic members eligible for the DM program.

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

4. Upon receipt of the necessary information for a referral, the CM/DM designee shall document the referral into Clinical Information System. Members assigned to a delegate entity that provides Disease Management will be referred to the delegate.

5. If the member is no longer eligible for services, the case should be closed and the reason for case closure will be marked as coverage termed.

DM Risk Stratification

1. The CM/DM designee shall stratify 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:

    a. 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.

    b. Moderate Risk Diabetes: Eligible age members with diabetes and other comorbidities and at higher risk for complications.

    c. Low risk Diabetes: Eligible age members with diagnosis of diabetes and who do not fall into the high or moderate risk category

    d. High Risk Asthma: Eligible pediatric age members identified with pediatric asthma, ER and hospital utilization, and asthma medications.

    e. Low Risk Asthma: Eligible pediatric age members not in the high-risk category.

4. Members referred into the program: those with a diagnosis of diabetes will be initially classified as Moderate Risk and referred to the Health Navigator. Members with a diagnosis of asthma, will be classified as High Risk and will be further assigned.

5. 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 designee 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.

Enrollment

1. High Risk and Moderate Risk.
    a. Referrals will be assigned to staff based on existing caseload and specialization.
    b. Case Managers (CMs) and Health Navigator staff assigned to the case will enroll the member in the specific program/level or update their existing Care Plan with the new information.
    c. Case Manager will document one of the following programs member is enrolled into:
        i. DM – Diabetes High Risk
        ii. DM – Diabetes Moderate Risk/Navigator
        iii. DM – Asthma High Risk

2. Low Risk Programs. a. Members identified for the Low Risk programs will be counted as enrolled by sending the appropriate DM Welcome Letter.

Assessment

1. After enrolling the member, staff assigned responsibility for High and Moderate programs will click on perform the assessment within the Clinical Information System using one of the pre-built assessments appropriate for the risk level.

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.

3. The Asthma High Risk assessment tool has been modified to accommodate the pediatric population. As such, sections on cognitive, life planning and social use history have been omitted as not appropriate for this population.

4. The Diabetes Moderate Risk Program is designed as a short-term case management program with a focus on managing hemoglobin A1c levels.

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 that 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 in a timely manner (within 7 business days of identifying the need) and follow up on these referrals will occur within 30 calendar days after the referral is made.

DM Case Evaluation and Closure

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

2. 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.* CMs should aim to close the case within 6 months of enrollment allowing for 30 days of conducting the assessment.

3. Diabetes DM Program enrollees will also be evaluated for closure to DM services using CM-003 P&P criteria. However, the length of time in program should not exceed 6 months of participation in the program.

4. Low Risk Program enrollees will be considered disenrolled at the time a new DM Low Risk report is provided. If the member is no longer identified as having gaps in care, he/she will no longer be in the program.

5. All closure actions will be documented in the Care Plan as applicable and the Program Enrollment section of Clinical Information System except for Low Risk Program enrollees who will be considered automatically disenrolled as described above.

6. At the time of case closure, a satisfaction survey, and a case closure letter if appropriate will be sent.

Appendix I – Enhanced Care Management Community Based Organizations

Enhance Case Management (ECM) Sites
AHS Eastmont
AHS Highland
AHS Hayward
California Cardiovascular Consultants
CHCN Asian Health Services
CHCN Axis Community Center
CHCN La Clinica De La Raza
CHCN LifeLong Medical Care
CHCN Native America Health Center
CHCN Tiburcio Vasquez Health Center
CHCN TriCity Health Center
CHCN West Oakland Health Council
EBI
Family Bridges
Roots
Roots STOMP
Watson Wellness

2021
Utilization Management
Program Evaluation

2021 Utilization Management Program Evaluation

Signature Page

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2021
Utilization Management (UM) Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (the Alliance) Board of Directors and Quality Management Committee (QMC), senior management and the Health Care Quality Committee (HCQC), the Health Services 2021 Utilization Management Programs were 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, 2021 through December 31, 2021.

Membership and Provider Network

The Alliance products include Medi-Cal Manage Care beneficiaries eligible thorough one of several Medi-Cal programs, e.g. Temporary Assistance for Needy Families (TANF), Seniors and Persons with Disabilities (SPD), Medi-Cal Expansion (MCE) 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 is an employer-sponsored plan services by the Alliance that provides low cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County. The Alliance provides services to IHSS workers through the commercial product, Group Care.

Figure 1. 2021 Trended Enrollment by Category of Aid and Age Groups:

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Dec 2019	Dec 2020	Nov 2021	Dec 2021	Dec 2019	Dec 2020	Nov 2021	Dec 2021	Dec 2019 to Dec 2020	Dec 2020 to Dec 2021	Nov 2021 to Dec 2021
Adults	32,066	38,150	42,623	43,077	12.9%	13.8%	14.4%	14.5%	19.0%	12.9%	1.1%
Child	89,056	94,969	97,935	98,150	35.8%	34.5%	33.2%	33.1%	6.6%	3.3%	0.2%
SPD	25,687	26,339	26,427	26,450	10.3%	9.6%	9.0%	8.9%	2.5%	0.4%	0.1%
ACA OE	78,154	91,050	101,508	102,264	31.4%	33.0%	34.4%	34.5%	16.5%	12.3%	0.7%
Duals	17,776	19,127	20,832	20,964	7.1%	6.9%	7.1%	7.1%	7.6%	9.6%	0.6%
Medi-Cal Total	242,739	269,635	289,325	290,905	97.6%	97.8%	98.0%	98.0%	11.1%	7.9%	0.5%
Group Care	6,092	5,954	5,826	5,823	2.4%	2.2%	2.0%	2.0%	-2.3%	-2.2%	-0.1%
Total	**248,831**	**275,589**	**295,151**	**296,728**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.8%**	**7.7%**	**0.5%**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Age Category Trend	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Dec 2019	Dec 2020	Nov 2021	Dec 2021	Dec 2019	Dec 2020	Nov 2021	Dec 2021	Dec 2019 to Dec 2020	Dec 2020 to Dec 2021	Nov 2021 to Dec 2021
Under 19	91,641	97,399	100,206	100,408	37%	35%	34%	34%	6%	3%	0%
19 - 44	78,271	93,280	104,239	105,212	31%	34%	35%	35%	19%	13%	1%
45 - 64	54,210	57,679	60,571	60,685	22%	21%	21%	20%	6%	5%	0%
65+	24,709	27,231	30,135	30,423	10%	10%	10%	10%	10%	12%	1%
Total	**248,831**	**275,589**	**295,151**	**296,728**	**100%**	**100%**	**100%**	**100%**	**11%**	**8%**	**1%**

Before 2020, the Alliance membership had been slowly declining over time with a total enrollment loss of 6% between 2018 and 2019. However, the 2020 pandemic and economic downturn, as well as a freeze on MCP disenrollment statewide correlated with an increase in enrollment in the Alliance, resulting in an overall increase of an additional increase 8% by the end of 2021. The biggest jump in enrollment was in the Adult category (13% increase) and ACA/Optional Expansion category (12%.) The percentage of Child members to total membership declined from 37% in 2018 to 34% in 2021 but had remained stable at 34% from 2020 to 2021. The percentage of younger adults (19-44) increased from 31% in 2018 to 35% in 2021. There has also been an increase in the percentage of adults over 65 from 9% to 10%. The economic downturn is a likely driver of the percentage increases in the adult and ACA/OE membership as adults lost employer-based health coverage.

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

Figure 2 2021 Provider Network by Type, Enrollment and Percentage

Provider Network	Provider Type	Members (Enrollment)	% of Enrollment in Network
Direct-Contracted Network	Independent	52,288	17.6%
Alameda Health System	Managed Care Organization	58,590	19.7%
Children First Medical Group	Medical Group	32,573	11.0%
Community Health Clinic Network	Medical Group	109,059	36.6%
Kaiser Permanente	HMO	44,218	14.9%
TOTAL		296,728	100%

The percentage of members within each network has been relatively steady from 2018 to 2021, varying by less than 1%.

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

- Ambulatory care
- Hospital care
- Emergency services
- Behavioral health (mental health and addiction medicine)
- Home health care

- Hospice
- Palliative Care
- Rehabilitation services
- Skilled nursing services - Skilled
- Managed long term services and support (MLTSS)
    - Community based adult services
    - Long Term SNF Care (limited)
- Transportation
- Pharmacy
- Care coordination along the continuum of care including arrangements for linked and carved out services, programs, and agencies.

These services are provided through a contracted network of providers that include hospitals, nursing facilities, ancillary providers, and contracted vendors. Currently, the Alliance provider network includes:

Figure 3 The Alliance Ancillary Network

The Alliance Ancillary Network	
Hospitals	17
Skilled Nursing Facilities	64
Health Centers (FQHCs and non-FQHCs)	75
Behavioral Health Network	1
DME Vendor	1 Capitated, 19 Non-Capitated
Transportation Vendor	1
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200

The delegates or vendors are responsible for the provision of identified functions or services through contractual arrangements. Functions may be delegated to Hospitals, PBMs, and Behavioral Health Organizations. Vendor services include Transportation, Health Risk Appraisal, and Self-Management tools. A full description of delegated activities is provided below.

<u>Delegation</u>

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; 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 assure capacity to meet regulatory and accreditation standards and requirements—no new delegates were added in 2021. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with the UM Department and other respective 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 submitted 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 Industry Collaborative Efforts UM Reporting Templates as an acceptable format of reporting Results of the annual evaluation and any audit results are reviewed by the Compliance and Delegation Oversight Committee. The UM Department performs oversight audits of UM outpatient and inpatient activities as well

as works with delegates on operational issues to ensure that members receive services from delegates that are in line with the Alliance's established policies and procedures.

The Alliance shares the performance of UM activities with several delegates. The Alliance's UM delegates, as of the date of this document, are the following:

Figure 4 – 2021 The Alliance Delegated Network

Delegate	NCQA Accreditation or Certification	Provider Type	Delegated Activity -UM	Delegated Activity – Grievance and Appeals
Kaiser	Yes	HMO	X	X
CHCN	No	Medical Group	X	
CFMG	No	Medical Group	X	
Beacon/College Health IPA (CHIPA)	Yes	MBHO	X	

Overall, the network was sufficient to meet the needs of the Alliance membership and provider network throughout 2021. The organization clarifies issues related to delegated activities and responsibilities as needed. The issues have led to additional clarification in contractual documents as well as additional training to delegates on roles and expectations. In 2021, Joint Operation Meetings (JOMs) facilitated communication and operational alignment. These JOMs, which are collaborative meetings between the Alliance and Delegates/Vendors to address operations and performance outcomes are also used to identify joint opportunities for improvement. For 2022, there will continue to be opportunities to continue to improve the level of oversight, monitoring, reporting, and training of delegates. Additionally, through quarterly delegate audits, UM will continue to analyze opportunities to further identify denial patterns and begin to monitor approval type patterns to further ensure the appropriateness of decision making.

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 12-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 Health Care Quality Committee (HCQC). The CMO and the HCQC provides 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 Medical Services staff under the guidance of the Medical Director for Utilization Management and the Senior Director of Health Care Services, under the direction of the Alliance Chief Medical Officer.

Committee Structure

The Board of Governors appoints and oversees the HCQC, the Peer Review and Credentialing Committee (PRCC) 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 is made up of provider representatives from the Alliance contracted networks and the community including those who provide health care services to Seniors and Persons with Disabilities (SPD) and Chronic Conditions.

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

HCQC charters a sub-committee, the Utilization Management Committee (UMC) which meets at least quarterly every year, serving as a forum for the Alliance to evaluate current UM activities, processes, and metrics. The UMC also evaluates the impact of UM programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes. HCQC assumes responsibility for oversight of the UMC activities and monitoring its areas of accountability as needed. The structure of the committee meetings is designed to promote engagement from all participants.

In 2021 the HCQC approved the UM Department 2021 Evaluation, 2021 Description, and UM 2021 Workplan on March 18, 2021, 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. The UM Committee had eight meetings in 2021.

In 2022 the UM Subcommittee of HCQC will continue to support the focus on UM activities, oversight for delegated UM activities, case management/care coordination, population health, CalAIM implementation, integration of behavioral health and medical as well as regulatory compliance.

Evaluation of the level of involvement of senior-level Physician and Behavioral healthcare practitioners

The Alliance CMO acts as the senior level physician involved in the UM program to:

- Set UM policy
- Supervise program operations.
- Review of UM Cases/Appealed Cases as needed.
- Participate on the UM Committee and the HCQC committee.
- Evaluate the overall effectiveness of the UM Program.
- Delegate senior level physician involvement to provide clinical expertise and guidance to program development.

Behavioral healthcare involvement in UM has been performed in partnership by two entities, Beacon Health Strategies and Alameda County Behavioral Health. The behavioral health practitioner involvement reflects the behavioral health benefit administered by the Alliance. Behavioral health representation is provided by both entities to participate in UM Program development and oversight. Each entity provides committee participation in the role of a behavioral health practitioner:

- Alameda County Behavioral Health System (ACBHS) - For MediCal beneficiaries, the management of severe and persistent behavioral health conditions is managed by the County Mental health Program, ACBHS.
- Beacon Health Strategies (Beacon) - For mild to moderate behavioral health conditions and behavioral health management for IHSS enrollees, the Alliance contracts with Beacon Health Strategies

The behavioral health entities have provided senior level behavioral health practitioner involvement in the UM Program by:

- Setting UM behavioral healthcare policies
- Reviewing UM behavioral healthcare cases, as needed
- Participating in the various UM Committees
- Evaluation of the overall effectiveness of the UM Program (Beacon)

Program Scope and Structure

The Alliance UM Program encompasses the management and evaluation of care across the scope of UM. This includes prior authorization, concurrent and retrospective review of institutional care, acute care, behavioral health and chemical dependency, rehabilitation, skilled nursing, pharmaceuticals, ambulatory services. The UM Program involves the medical and behavioral management of all members at the most appropriate site and level of care. (For behavioral health activities, refer to the Managed Behavioral Health Organization's [Beacon Health Strategies] UM Program for a description of delegated behavioral health UM activities.

UM Program activities include the following but are not limited to:

- Prior authorization of services and pre-admission education
- Admission and concurrent review
- Discharge planning: pre-admission, concurrent, and post hospital discharge follow-up/referrals with the member
- Retrospective review
- Quality improvement projects within the UM Program
- Integration of medical and behavioral health in collaboration with the behavioral health vendor and ACBHS
- Continuity and coordination of care for members when a provider is terminated from the network.
- Continuity and coordination of care for members newly eligible for Alliance coverage who are receiving active care and treatment from a non-Alliance provider.
- Evaluate and refer for members needing care coordination, (ex. EPSDT, CCS, ECM, etc.)
- Ensuring that denials related to utilization issues are handled efficiently according to UM timeliness standards.
- Review of overturned PA Appeals
- Monitoring and auditing delegated entities UM activities for compliance to contractual requirements with implementation of corrective action plans as appropriate
- Internal monitoring and auditing for compliance to DHCS, DMHC, and NCQA requirements
- Departmental policies, procedures, and processes with implementation of corrective action plans as appropriate

Utilization Management Resources

The Alliance UM Department is staffed with physicians, nurses and non-clinical support staff including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2021 UM Program Description.

The assignment of work to the team, whether working on site or remotely, for both clinical and non-clinical activities, does not change the team member's job responsibilities or job description. In 2020, in response to the Covid 19

pandemic and public health requirements, the UM department transitioned to fully working from home, and this continued through all of 2021. Staff were provided equipment, remote connectivity, and policies to follow to successfully work from home while maintaining full functionality and meeting regulatory requirements. The job descriptions with assigned tasks and responsibilities remained the same regardless of the geographical location of the team member.

In 2021, based on the established staffing ratios and roles, the UM Department hired for department roles. Budgeting for a Clinical Supervisor for Outpatient UM and an RN for Major Organ Transplant was done in 2021, and hiring is expected to occur in Q1 of 2022. With the onboarding of new staff, the Health Care Services Department teams reviewed the current organization goals and restructured some clinical assignments in the Department to achieve those goals.

Delegated Utilization Management

As described in the section above for Delegated Activities, the Alliance provides health services to our members through a delegated network. UM activities for members enrolled to the HMO products are performed predominantly by the delegated health provider networks.

The Alliance has several levels of UM delegation: For Knox Keene licensed Health Plans, UM may be fully delegated. For certain medical groups, UM decision making is a shared risk; the Medical Groups are delegated for the performance of outpatient referral management and UM decision making while the Alliance UM Department maintains responsibility for certain outpatient services and inpatient care. All delegates perform levels of UM decision making based on their contracts and performance. The Alliance maintains responsibility for UM decision making associated with transportation, MLTSS, and pharmacy. The resolution of clinical grievance and appeals are only delegated to the Alliance's Knox Keene licensed Health Plan (Kaiser.) For care management and complex case management, the Alliance delegates basic care management and care coordination to network providers. Currently, the Alliance delegates complex case management to Kaiser and Beacon. For Delegates unable to fulfill the delegated activities, the entity is subject to remediation activities up to and including revocation of delegation.

Behavioral health UM activities are delegated to and managed by the contracted managed behavioral health organization (MBHO), Beacon Health Strategies.

The Compliance Department is responsible for the overall performance of the internal and external audits of delegates. UM Department staff are responsible for the review and reporting of the UM components of the annual process which includes standards and file review. The Compliance Department is responsible for finalizing the audit findings and issuing required corrective actions if needed. All audit findings are reported into the Compliance Department and the HCQC.

In 2021, the UM staff conducted annual audits on the four (4) delegates. The threshold for UM audit compliance is 90%. For entities that do not meet the threshold, the UM staff may require a corrective action plan which is tracked for compliance with the resolution of the deficiency. Entity audit results for 2021 were:

- Four groups did not pass UM audit ($\geq$ 90.0%), and corrective actions were required.

Figure #5 The Alliance Network – 2021 Annual Audit Score

Delegate	Provider Type	Delegated Activity-UM	2021 Audit Results	Corrective Action Required
Kaiser	HMO	X	Deficiencies found, Corrective Action Plan Required	Yes or No: TBD Final audit report has not been issued; issue date is TBD

Delegate	Provider Type	Delegated Activity- UM	2021 Audit Results	Corrective Action Required
CHCN	Medical Group	X	Deficiencies found, Corrective Action Plan Required	Yes or No: TBD Final Audit report to be issued on 5/6/22
CFMG	Medical Group	X	Deficiencies found, Corrective Action Plan Required	Yes or No: Yes UM decision not made within required timeframe NOA letters did not provide specific reason for denial, did not provide a reference to the benefit, guideline or similar criteria on which decision was made, did not provide notification that expediated external review can occur currently with internal appeal process
Beacon/College Health IPA (CHIPA)	MBHO	X	Deficiencies found, Corrective Action Plan Required	Yes or No: TBD Final audit report to be issued on May 6, 2022

Additionally, the UM team is responsible for ongoing monitoring activities including review of the delegated entities annual work plans/evaluations, and semi- annual reporting.

For 2021, the current UM delegates continued to meet the program's scope of activities. The individual issues of compliance to 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. In 2021, the team continued to collaborate with Senior Health Care Services Leadership and Compliance staff to resolve on-going corrective actions identified during regulatory audits.

Recommend Actions/Next Steps

For 2021, there will be additional opportunities to improve the oversight of delegated UM activities. The UM Department leadership is continuing the development of a robust level of delegate oversight, performance monitoring and engagement with operational processes. The activities include dedicated staff monitoring activities, quarterly chart audits, performance management, delegate feedback and UM training.

Utilization Management Processes and Information Sources

Utilization Management Decision Making

Decision and screening criteria are designed to assist UM staff and delegates in assessing the appropriateness of care for clinical and behavioral health situations encountered in the clinical setting. Application of the criteria is not absolute but based upon the individual health care needs of the member, medical risk factors, and social determinants of health, and in accordance with the member's specific benefits plan and capacity of the health care delivery systems. The decision criteria are made available to the member, providers or public upon request by contacting the UM Department. A full description of the criteria utilized for UM decision making is available in the 2021 UM Program Description.

For 2021, the Alliance UM Department utilized the clinical criteria as defined in the UM Program. In 2021, the Alliance used the Milliman's CareWebQI® interactive software tools which integrate the MCG® guidelines into the core information system, TruCare, using the 24th Edition MCG® criteria. The 25th Edition MCG® criteria was released in 2021, but the updated MCG® criteria software was unable to embed into the UM platform TruCare (TC) due to TC upgrade delays into 2022, which led to the UM department continuing to use the 24th Edition MCG® criteria . Upon review of member needs and the requirement to use alternative criteria as appropriate, there were no changes to the clinical criteria informed by the UM Medical Necessity hierarchy, applying first and foremost the DHCS Provider Manual guidelines, then MCG®, followed by the MCP's Policies, and other evidenced based clinical criteria including UpToDate®. In 2021 there were no requests from members, and no requests from providers for copies of the decision-making clinical criteria.

In 2021 the Alliance UM staff collaborated with Senior Leadership to ensure that Transportation processes continued to match the benefits defined in APL 17-010 for Non-Emergency Medical and Non-Medical Transportation and the requirement to provide non-medical transportation for Medi-Cal services that are not covered under the MCP contract. The Alliance monitors the performance of ModivCare's (formerly Logisticare) provision of this benefit by conducting operational meetings and JOMs, regular review of G&As, and performance metrics.

Consistency in Application of Criteria

The Alliance UM Department assesses the consistency with which physicians, pharmacist, UM nurses, Retrospective Review nurses and non-physician reviewers apply criteria to evaluate inter-rater reliability (IRR). A full description of the testing methodology is available in the UM Program and Health Care Services policy for IRR. UM has set the overall IRR passing threshold as noted in Figure 6.

Figure #6 Inter-rater Reliability Thresholds

Score	Action
High – 90%-100%	No action required
Medium – 61%-89%	Increased training and focus by Supervisors/ Managers
Low – Below 60%	Additional training provided on clinical decision-making. If staff fails the IRR test for the second time, a Corrective Action Plan is required with reports to the Senior Director of Health Services and the CMO. 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 uses hypothetical but realistic UM cases. IRRs included a combination of acute and/or outpatient IRR modules offered by MCG® specifically designed for staff training, educational, and IRR purposes. To maintain a high level of consistency in the performance of UM, the threshold to pass IRR was increased to 90%, and 5 cases were increased to 10 for UM staff.

All new hire staff will train and participate in the IRR process upon completion of their training. Results are tallied as they complete the process, appropriate feedback and follow-up education are provided, and corrective actions implemented

as needed. When opportunities for improving the consistency in applying criteria, UM staff addresses corrective actions through requiring global or individualized training or completing additional IRR case reviews (see Figure #6).

UM Clinical Group	2021 Overall Passing Rate
OP Nursing	100%
IP Nursing	90%
G&A Nurse	100%
MDs	100%

For 2021, IRR testing was performed in Q3 for UM clinical staff and non-clinical staff to establish consistency in practice and outcomes for members, using 10 cases.

OP Performance

- The overall passing rate meeting the minimum threshold was met by 100% of the OP nurses.

IP Performance

- The overall passing rate meeting the minimum threshold was met by 90% of the nurses, however 1 nurse failed all modules after 3 attempts.

G&A

- The overall passing rate meeting the minimum threshold was met by the G&A nurse.

MDs

- The overall passing rate meeting the minimum threshold was met by 100% of the MDs.

Qualitative Analysis

Overall, the overall scoring showed all team members except one nurse passed the IRR modules for their respective areas.

Opportunities for Improvement

1. Share collective information with clinical staff for team education.
2. Continued evaluation by managers of individual staff and MDs by UM Medical Director to ascertain the issues that required multiple attempts, and when re-education is needed.
3. Initiate IRR testing and MCG support for new and temporary hires.
4. Continued staff education on appropriate use of system for MCG IRR modules.

Management of non-delegated medical determinations – Prior Authorization/ Concurrent Review/Post-Service

The monitoring of referral management activities performed by delegates is reported in the annual UM Program Evaluation. Services provided by full risk providers are reported through the Compliance Department and HCQC. Services normally assigned through the shared risk contracts, and managed by delegate include:

- Professional services, in-network
- Laboratory services in clinic
- In-office medications/injectable medications

The Alliance UM Department retains responsibility for UM determinations of non-delegated services or activities for non-delegated providers, e.g. Transportation Vendor and DME Vendor. Services that are the responsibility of the Alliance and are not delegated to Medical Groups include:

- Hospital services, including acute, long-term acute and acute rehabilitation.
- Skilled Nursing Facilities services
- Sub-Acute Facility services
- Durable Medical Equipment
- Prosthetics/Orthotics/Medical Supplies
- Outpatient Facility Based Services (i.e. specialized radiology or diagnostic procedures, dialysis, etc.)
- Hospice
- Out of Network, Tertiary
- Out of Area Services (Per Contract)
- Managed Long Term Services and Support/Community Based Adult Services (CBAS)
- Long Term Care, month of admission plus the following month
- Transgender Services
- Transportation
- Major Organ Transplant Services
- Acupuncture
- Home Health
- Medications covered under the pharmacy benefit - i.e., non-formulary, some self- injectable medications.
- Experimental/investigational procedure/services determination
- Cancer clinical trial determinations

1. Kindred long-term acute admissions had denied services at some time during the stay. Findings were that the appropriate criteria were used, and the cases were adjudicated appropriately using the criteria. There were findings about opportunities for improved communication and frequency of reviewing once denials were issued, improved support provided to the facility around difficulty placements, and evaluation for alternative placement options to lower levels of care. Administrative day level was added to the Kindred LTACH contract when medical necessity was not met and there was no safe discharge to a lower level of care.

<u>Opportunities for Improvement</u>

1. Develop schedule for continued stay review of the UM decision making for delegated services.
2. Improved oversight of active discharge planning
3. Continued placement searches and escalation for difficult placement hospitalizations
4. Continued administrative day monitoring for acute change in status and medical necessity
5. Share collective information with delegate's clinical staff for education.

UM Information Systems

The Alliance maintains a core information system, TruCare®, that is utilized by both UM and case management and Pharmacy staff. UM and CM staff have identified opportunities to enhance the functionality of the system to assist in managing UM referrals and case management functions, and in 2019 a major initiative to optimize the TruCare® platform was launched. It was completed in 2021 and resulted in both optimization of the software itself and upgrade to version 8.0 in December 2021. These optimization and upgrades included staff training to ensure standard workflows are in use and staff is competent in the use of the software. Continued information system optimization through education sessions are planned for staff into 2022.

UM DETERMINATIONS

The Alliance is responsible for the referral management responsibilities performed for non-delegated entities or for non-delegated services. This includes reviews for pre-authorization, concurrent, post-service, and retrospective claims review.

The Alliance referrals are tracked and monitored for compliance of both regulatory requirements; timeliness of decision-making (turn-around times), usage of specialty referrals and the rates for services denied as not meeting medical necessity or benefit (denial rate).

The Alliance maintains a list of non-delegated services that require prior authorization and a process for UM staff to evaluate referrals for specified services or procedures.

Referrals are tracked and reported by:

- Total Number of referrals
- Total Number approved
- Total Number denied
- Total Number partially denied

Denials are reported in relationship to:

- the total number of referrals to total number of denied services or “denial rates”.
- The established threshold for UM denials at 5%.

Referrals are also monitored to ensure staff process requests within the required timeframes or Turn-Around Times (TAT).

- The performance goal for TAT is 95% for routine and urgent authorizations.

Quality of NOA letters regarding all types of authorization requests are monitored to ensure clear and concise language, reading literacy to the 6th grade level, and that they are containing all regulatorily required content and references. In 2019 AAH received regulatory findings of deficits in outpatient NOA content and continues to employ multiple strategies in 2021 to maintain the improved performance in this area. This includes NOA template standardization, concurrent (before sending out,) retrospective review of the quality of the NOAs, annual and focused audits, feedback to all staff and MDs involved in the production of NOAs, ongoing training of all staff and MDs as indicated, active workgroup attention to new and expanding NOA needs, and ongoing quality monitoring of the NOA letters. Additionally, expanded language translation was added to larger sections of the NOA and approval letters in the key threshold languages in accordance with APL 21-004 that took effect in 2021. Language translation is provided by an external vendor, AvantPage.

Usage of specialty referrals are monitored to ensure members have access to specialty services within or outside of the network to support continuity of care, timely access, and specialty and/ or tertiary/ quaternary care that is not available within the network.

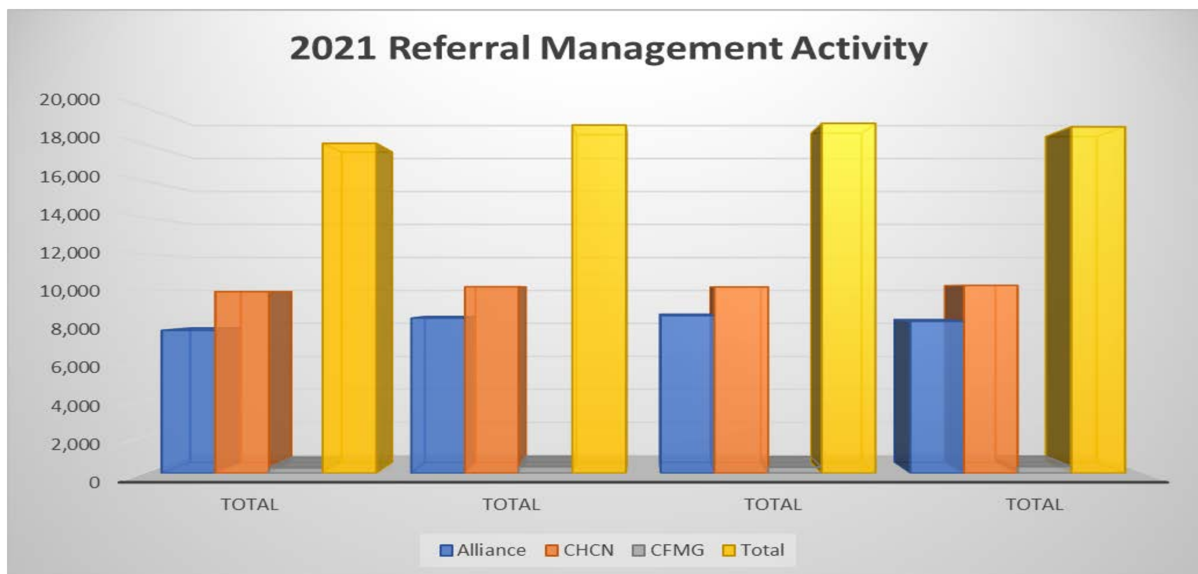
As discussed in a previous section, the Alliance manages two products, Medi-Cal and Commercial (Group Care). For the purpose of data analysis, because the commercial network, IHSS, represents only 2% of the total membership and 4% of the referral activities, the data is aggregated for reporting. In key areas where the activities are specific to a network, the report will note the differences.

Utilization Management Referral Management Data

Quantitative Analysis

The data presented in Figures 7 – 11 represents key UM referral management functions by provider group, product, and UM determination.

Figure #7 2021 Referral Management Activity



Outpatient Referral Management data by quarter based on number of authorizations managed by the Alliance by date of service; Reporting period is January 1 through December 31, 2021 for all Delegates and all products. Totally referral volume decreased from 2020, due to decreases in referral volume by Alliance, increases by CHCN, and marginal increases from CFMG networks compared to 2020.

Figure #9 2021 Referral Management Activity by Determination

Outpatient Referral Management data using the final determination, reported by quarter, based on number of authorizations managed by the Alliance by date of service; Reporting period is January 1 through December 31, 2021 for all Delegates and all products. Relative approval, denial, partial denial, and total rates were similar to 2020, with incremental increases from the early quarters compared to the later quarters in 2021.

Figure #10 Comparisons of 2020 and 2021 Outpatient Referral Denial Rate

OP Denial Rates	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
2020	4.9%	4.6%	3.9%	3.9%	3.5%	3.8%	4.4%	4.4%	4.4%	3.7%	3.7%	3.3%	4.1%
2021	4.9%	5.3%	4.7%	4.9%	5.1%	5.3%	5.3%	5.5%	5.0%	4.8%	4.8%	4.6%	5.0%

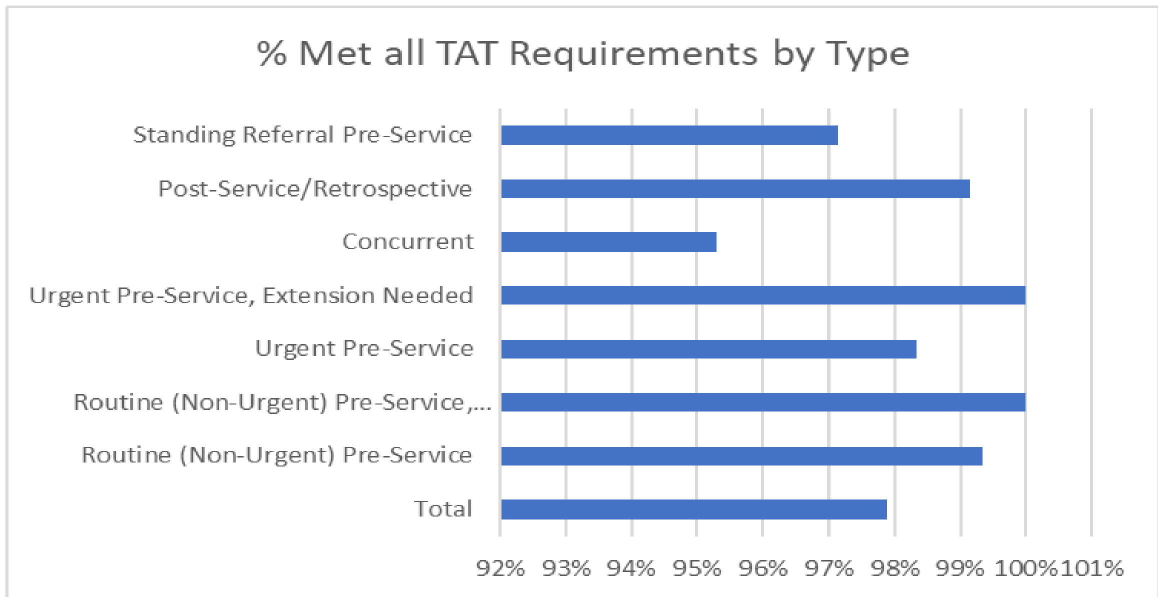
Outpatient Referral Management Denial Rate by month is based on number of authorizations by date of service through December 31, 2021 for all Delegates. The 2021 Year to Date (YTD) denial rate was 5.0%, which is an increase of 0.9 percentage points from 2020 and is in the range of an expected rate.

Referrals are also monitored to ensure staff process requests within the required timeframes or Turn-Around Times (TAT). The Compliance Department monitors turn-around time performance and reports it to the HCQA. The performance goal for TAT is 95%. For 2021, TAT performance maintained an overall TAT of 98%, MediCal TAT of 98%, and Group TAT of 99%.

Figure #11a 2021 Referral Management TAT Reports

2021 Performance Referral Management TAT						
	Q1	**Q2**	**Q3**	**Q4**	**YTD**	**Goal**
Overall	98%	98%	97%	98%	**98%**	**95%**
MediCal	98%	98%	97%	98%	**98%**	**95%**
Group	99%	99%	99%	98%	**99%**	**95%**

Figure#11b 2021 Referral Management TAT Reports



The percent of all TAT requirements by referral type were measured to the performance threshold of 95%. Overall % Met TAT was almost 98%. The higher percent met TAT was for Urgent pre-service, extended needed (100%) and Routine (non-urgent) pre-service (100%), followed by Routine (non-urgent) pre-service (>99%), Post-service/ Retrospective (>99%), Urgent Pre-service (>98%), and Standing Referral Pre-service (>97%). The lowest percent type was for Concurrent however, it still met the 95% performance threshold. Identification of incorrect IT design methodologies for Inpatient TAT helped identify this lower performing referral type in the 2021 quarters and will be a focus for process improvement for 2022.

Qualitative Analysis

The overall referral volume managed by the network recovered in 2021 from the abrupt and sustained decrease during Covid 19 pandemic in 2020. The volume of referrals by network provider aligns with the volume of enrollment, with CHCN having the highest volume of referrals and the largest membership which includes adults, MCE and SPD members; CFMG having the lowest referrals and lowest membership, which includes primarily children and adolescents.

The 2021 Year to Date (YTD) denial rate of 5.0% is in line the established performance threshold of 5%. In 2021, a review of custodial SNF authorizations was undertaken for Q3 and Q4, revealing opportunities for enhanced UM clinical review processes and improved nurse-MD communications for dual members. Deep dives were undertaken in Q3 to understand patterns for Catastrophic inpatient stays, readmission risk factors for medically complex members, and root causes of facility service avoidable delays and/ or difficult placement search or delays. UM will continue to analyze opportunities to further identify denial patterns and begin to monitor approval type patterns to further ensure the appropriateness of decision making.

Overall authorization Turnaround Time for 2021 for both Medi-Cal (98%) and Group Care (99%) met the established goal.

Quality of NOA letters has improved and continues to remain an area of focus to ensure compliance with all regulatory requirements, as well as addressing APL releases and CAP. Close monitoring of UM processes for PAs enables the department leadership to ensure that TATs are met.

While the volume of referrals is reported in terms of product, ancillary network and determination, there is an additional opportunity to further assess the types of services by requested services and by type of authorizations, auto approved or clinical review. Attention will be placed on Rehabilitation Services, Major Organ Transplant, Tertiary-Quaternary level of care, Out of Network, Catastrophic stay reason capture, Administrative Day Inpatient Approvals, and Concurrent Inpatient utilization for the next year. Additionally, steps were taken to improve data capture of medical necessity for both approval and denials, as well as the reasons for these final determinations. In 2022, the program will analyze opportunities to increase the number of requests that may appropriately be automatically authorized, thus improving throughput for members' care. This will also assist in validating an appropriate staffing ratio for the department. Lastly, efforts will be explored for standardizing documentation of medical decision making by Medical Directors for referrals.

Tracking of Unused Authorizations

The Alliance monitors the use of authorizations to ensure Members are accessing approved services and to identify potential specialty access concerns. An unused authorization report is run mid-cycle during the authorization period. A letter is sent out to members to remind them to use their approved authorization. Since the unused authorizations are based on claims sent in, there is a lag in knowing whether a given authorization was actually used or not. In Q3, Unused Authorization data was reviewed in UMC and identified the most commonly unused service types were in Hand Therapy and Podiatry office visits. Emphasis was placed on the population of diabetics who commonly require standing referrals for specialty Podiatry care and who missed this service visit.

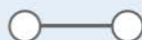
Tracking of Specialty Care Authorizations

Tracking of Specialty Care Authorizations captures the full picture of specialty authorizations, and it is analyzed and reported regularly at UMC. It includes all Specialty Referrals that require authorization, by service type, in or out of network, approved/partially approved/denied, by determination reason, by network, by Provider, with TAT:

Specialty Referrals By Service Type

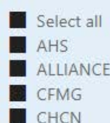
Auth Request Period

1/1/2021 12/31/2021



Line of Business

Network



Auth Status

Requested in:

December 2021

Acupuncture
13
Auths

Chiropractic
8
Auths

Palliative Care
4
Auths

Podiatry
130
Auths

Transplant Eval
18
Auths

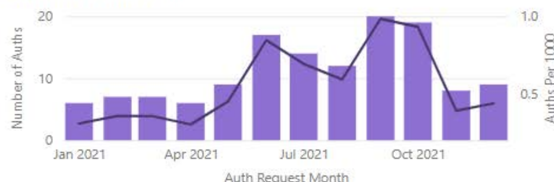
Professional Services

In Network
252
Auths

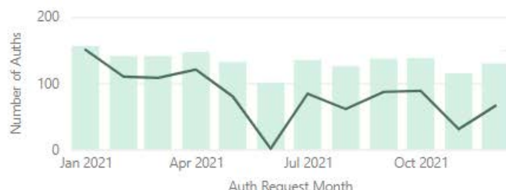
Out of Network
346
Auths

Acupuncture

Chiropractic

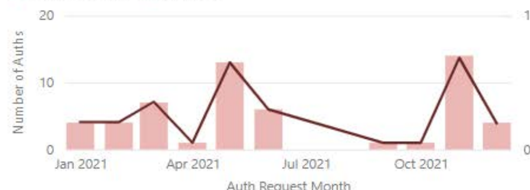


Podiatry



Transplant Eval

Palliative Care



Professional Services

Qualitative Analysis

In reviewing the tracking outcomes for Specialty Referrals, it is noted that there may be some underutilization of the Palliative Care benefit, as there are relatively few referrals. At the end of 2020, the Alliance began an engagement with a network partner, AHS, to enhance and extend the use of this benefit by our seriously ill members, and this will continue into 2022. Due to the 2022 carve in of major organ transplants, transplant evaluations will increase, beyond the previous corneal and renal transplant referrals. There was a notable rise in chiropractic referrals in the 2nd and 3rd quarter with proportionally corresponding denials.

Recommendations/Next Steps for 2022:

Continue to improve the quality oversight of the current UM processes. This will be accomplished by continued internal monitoring of UM files on a periodic basis and interventions as indicated. Training of staff will be aimed at maintaining standard processes across the UM reviewers. This also includes reviewing and revising the standardized reports focused on referral management. This will continue to include the trending of out of network utilization to identify potential inappropriate use or access to care issues related to lack of providers or services in key areas. In particular there is opportunity to explore referral patterns for chronic pain management.

TRANSPORTATION

The Alliance is responsible for the provision of transportation services to enrollees based on their benefit package with the defined regulatory body. Each product benefit package is different, and therefore requires specific procedures to managing the services.

The Alliance maintains a contract with a specialty vendor, ModivCare, (formerly called Logisticare,) to provide the necessary transportation services, which includes the determination of the necessity for the services, the mode and the benefits associated with the transportation.

Benefits are administered based on the program guidance. The Alliance does not delegate UM decision making to the Logisticare. All UM determinations related to transportation for non-full risk provider groups is managed by the Alliance UM Department.

Currently, the Alliance maintains four types of transportation:

- Emergency – all products, no authorization required.
- Non-emergency Medically Necessary Transportation (NEMT) - Medi-Cal, medically necessity required,
- Non-Medical Transportation (NMT) – Medi-Cal/EPSDT services

The Medi-Cal benefit includes NEMT for services deemed to be 1) to access medically necessary services and 2) member cannot be transported safely in other means of public transportation, or only NMT for access to EPSDT services.

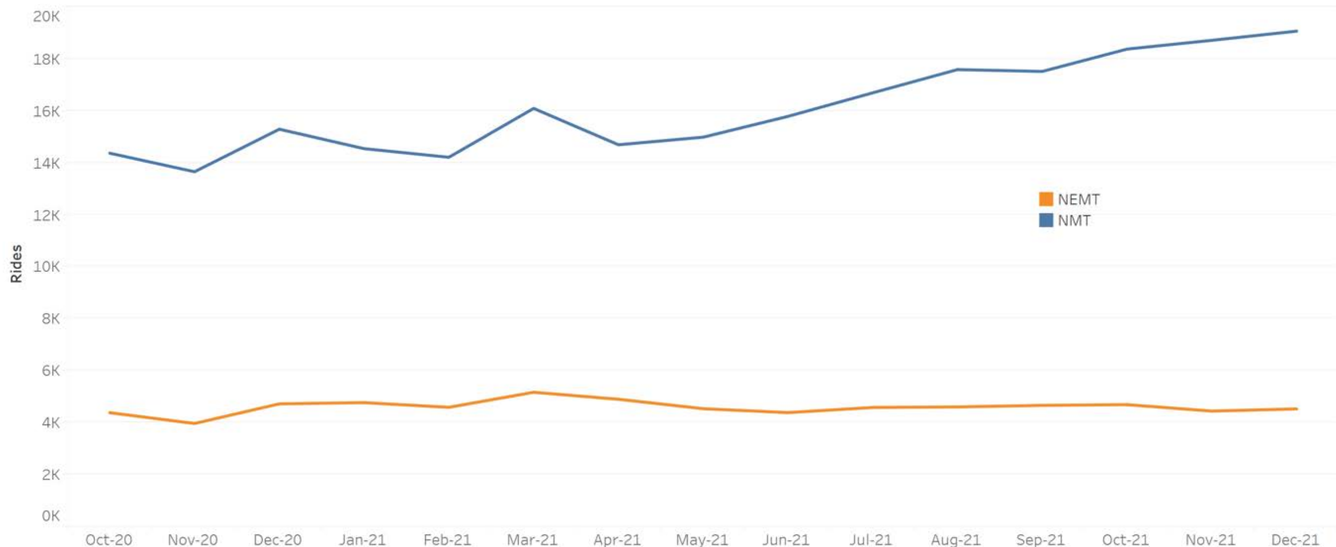
QUANTITATIVE ANALYSIS

Figure#12 – 2021 Transportation Utilization

	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		1,818			1,891			1,931			2,008		1,912	1,912
Utilization	Gross Reservations	All Reservations taken including cancelled trips	59,140	19,713	100.0%	59,005	19,668	100.0%	65,439	21,813	100.0%	69,537	23,179	100.0%	253,121	253,121
	Utilization Rate	Transportation utilization rate (completed trips/total enrollment)		5.7%			5.6%			6.0%			6.1%		5.87%	
Call Center	Calls Received	Measures number of Reservations calls received	9,152	3,051		9,241	3,080		7,652	2,551		9,575	3,192		2,968	35,620
	Average Hold Time	Average hold time should be less than 3 min for 90% of calls		00:43			01:06			01:09			01:08		01:01	
	Service Level	Goal: 80% of calls answered within 30 seconds		87.1%			69.6%			70.2%			81.8%		77.2%	
Quality Mgmt	Complaints - Total	Measures the number of valid complaints Goal: 1% or less	92	31	0.2%	152	51	0.3%	225	75	0.3%	229	77	0.3%	698	698
	Complaint Percentage	Total complaint percentage based on gross reservations		0.16%			0.26%			0.34%			0.33%		0.3%	
Timeliness	On Time Performance*	Goal: 90% on time for all legs		82.4%			82.1%			81.1%			75.3%		80.2%	
	Will Call On Time	Goal: 90% on time for Will Call Legs		96.9%			96.8%			96.3%			95.5%		96.4%	

NMT vs NEMT

NMT/NEMT	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
NEMT	4,377	3,962	4,718	4,765	4,584	5,163	4,894	4,531	4,381	4,578	4,599	4,659	4,687	4,439	4,524
	23.36%	22.50%	23.58%	24.69%	24.40%	24.30%	24.99%	23.22%	21.73%	21.53%	20.73%	21.02%	20.33%	19.18%	19.18%
NMT	14,363	13,650	15,287	14,538	14,206	16,087	14,688	14,980	15,780	16,687	17,581	17,510	18,369	18,707	19,060
	76.64%	77.50%	76.42%	75.31%	75.60%	75.70%	75.01%	76.78%	78.27%	78.47%	79.27%	78.98%	79.67%	80.82%	80.82%



QUALITATIVE ANALYSIS

In 2021, the Alliance continued to ensure the provision of the transportation benefits, using ModivCare as the provider. ModivCare quality outcomes show that they are meeting the performance metrics for request response times and have a low rate of complaints. Complaints are monitored through the G&A process and reported at UMC for review and action as needed.

The amount of Ambulatory transport has a sustained increase since 2019, reflecting the increased use of the NMT benefit. However, the Covid 19 pandemic affected the use of the NEMT benefit starting in March of 2020 due to social distancing but have been normalizing into 2021. The NMT transports remained steady over the two years. The majority

of the NMT trips are for Dialysis, which is an ongoing clinical need, even during a pandemic. Work continued over the course of 2021 to ensure that members who needed transportation after leaving hospitals had timely responses, and improvement was made during the year. Of note, there was a DHCS finding of not having PCS forms completed before taking NEMT, and the Alliance worked with ModivCare to educate them and develop a process to ensure that the correct level of care was provided.

Recommendations/Next Steps for 2022:
The Alliance UM Department will continue to monitor provision of the transportation benefit using criteria to allow appropriate members in need of non-medical transportation to access the transportation benefits and ensure timely responses to requests. AAH will ensure that vulnerable members receive transportation services to get to needed care. This includes the process to ensure that PCS forms are obtained for NEMT trips.

Monitoring of Over/Under Utilization

The Over/Under Utilization Report is a collaborative report with the Quality Management and Utilization Management Department.

The Utilization Management Department monitors over- and under-utilization for selected activities using UM measures to identify issues that may indicate barriers to accessibility for routine health care services. Monitoring activities were further developed to include a special focus for monitoring for potential under-utilization of out of network services and Primary/Preventive Care in the capitated setting.

The Alliance UM Department monitors, analyzes, and annually evaluates network performance against several relevant data types for each product line, Medi-Cal and Commercial. The UMC reviews quantitative and qualitative analysis of potential areas of under and over – utilization, identifying opportunities for improvement and implementation of a corrective action plan if necessary.

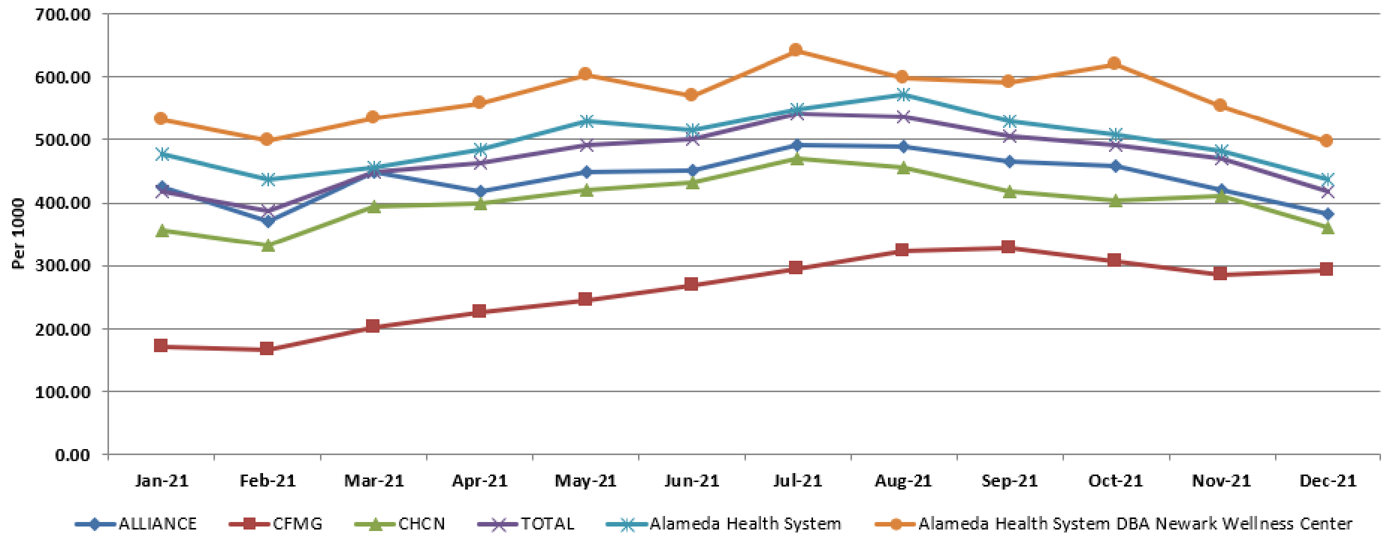
The UM Department has established monitoring activities to include:

- Acute hospitalization (Emergency Room, bed days, average length of stay and discharges, readmissions)
- Ambulatory services (primary care visits, specialist services, preventive health care services, emergency room visits)
- Out of network activities, both medical and behavioral health
- Behavioral Health utilization data
- Pharmacy utilization, (e.g., antibiotics, opioid use, medication management.)
- HEDIS use of service metrics.

Acute Hospitalization

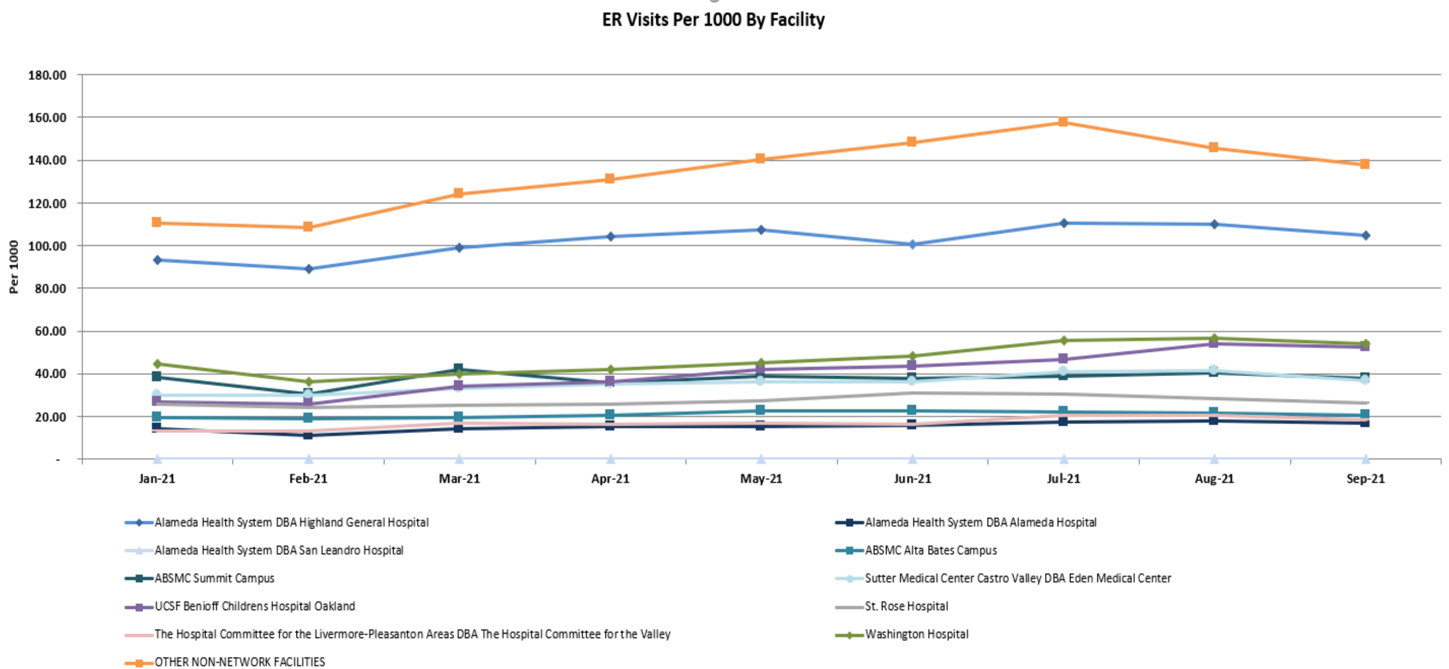
Emergency Room

Figure #13 depicts ER utilization by product from January to December 2021.



The data in Figure 13 show ER utilization across all products. There had been a precipitous drop in ER visits in March/April of 2020, coinciding with the onset of the Covid 19 pandemic. There was a slow increase in volume over the next months, and the numbers stabilized at about 100 visits per 1000 less than before the pandemic, across the entire network.

Figure 14 depicts ER Utilization by Facility for 2021



The data in Figure 14 show ER utilization across ER facilities/hospitals across time, with increase from the drop in the spring of 2020 that coincided with the onset of the pandemic, and a progressive rise in the following months.

Qualitative Analysis

The 2021 ER visit volume stabilized at about 100 visits/1000 fewer than the pattern seen before the onset of the Covid-19 pandemic in 2020. This pattern was seen in the number of visits by network, at all hospitals, and additionally at OON hospitals. Prior to the pandemic, the reporting data appeared to run parallel to the seasonality of ER utilization. In reviewing the CDC FluView Interactive for the 2021-2022 Flu Season, Influenza activity in the California was at maximum in late December 2021 and tapered down until February 2022, so is not coinciding or likely contributing to higher ED visits.

In reviewing ER visits by facilities, the top three centers for ER visits are 1) Non-network ERs, 2) Highland General (Alameda Health Systems), and 3) Washington Hospital. This is a different pattern than 2020. There were also notable peaks in ER use during Covid-19 surges and during the periods of time following these Covid-19 variant surges. Vaccinations were also increasing over this time, and it is possible that members traveled more, and been more likely to sustain injuries with increased outside activity compared to previously sheltering in place.

Hospitalization Measures

Concurrent/continued stay review for acute hospitalization focuses on:

- Facilitating timely and efficient provision of services
- Promoting adherence to established UM and Discharge Planning standards of care
- Identification of any Quality of Care needs or delayed services rendered while hospitalized
- Coordinating timely and efficient transfer to the most appropriate level of care
- Implementing proactive and effective discharge planning
- Identification of ongoing case management needs in the ambulatory setting

The Alliance UM Department is responsible for providing clinical oversight of the inpatient concurrent review process. The UM team is also responsible for discharge planning designed to identify and coordinate quality, cost efficient post-hospital care at the point of admission, (or the first day UM is notified of an admission) by:

- Identifying a member's medical/psycho-social issues with potential need for post-hospital intervention
- Communicating to the attending physician, specialists, and member regarding covered benefits for 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.
- Referral to the Case Management department for coordination of care and follow up for the members.
  - Identification of any Disease Management condition prioritized by the Case Management Department
  - Identification of Community Resources or Enhanced Care Management needs
  - Assessment for Readmission risk and facilitating referrals and/or support to mitigate

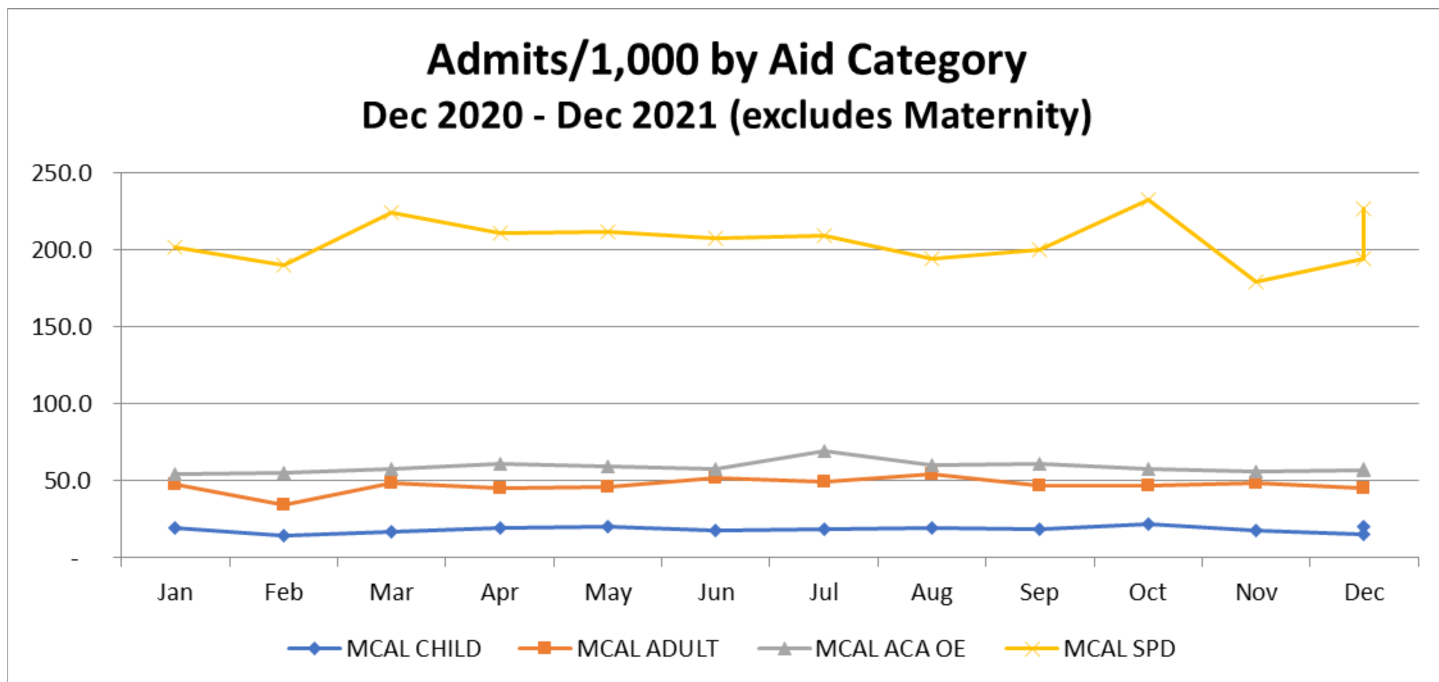
Quantitative Analysis

The Alliance has established benchmarks for inpatient admissions:

Figure #15– 2021 Hospitalization Targets

Inpatient Barometer All Products	
Metric	Target
Admits/1000	60
Bed Days/1000	297
Average Length of Stay (ALOS)	5.2

Figure #16 2021 Hospitalization admits per thousand by Aid Category.



The data above represents the 2021 performance for all lines of business in inpatient management by admits per thousand. Medi-Cal SPDs continue to have the highest admits per 1000 members while all other member aid categories remain relatively flat. This is as expected for the SPD population, who often have higher complex medical needs and more frequent utilization. Admits have stabilized to normal levels after the pandemic associated dip in 2020 By Network, the Alliance has the highest volume of admits/ 1000: 76.9, followed by AHS 65.5, then CHCN 56.6, and CFMG 10.1. AHS members are preomdinantly hospitalized at AHS Highland, and Alliance members are hospitalized predominantly at Washington Hospital. CHCN member are distributed across 2 main facilities: Alta Bates Summitt and AHS Highland. CFMG members are predominantly hospitalized at UCSF Benioff-Childrens Hospital. The facilities with the highest admits/ 1000 in decreasing order are: AHS Highland (9.9), Alta Bates Summitt (9.3), Washignton Hospital (6.2), Out of Network (5.9), Eden Medical Center (5.4), and St Rose (3.4).

Figure #17 **2021 Hospital bed days per thousand by Aid category**

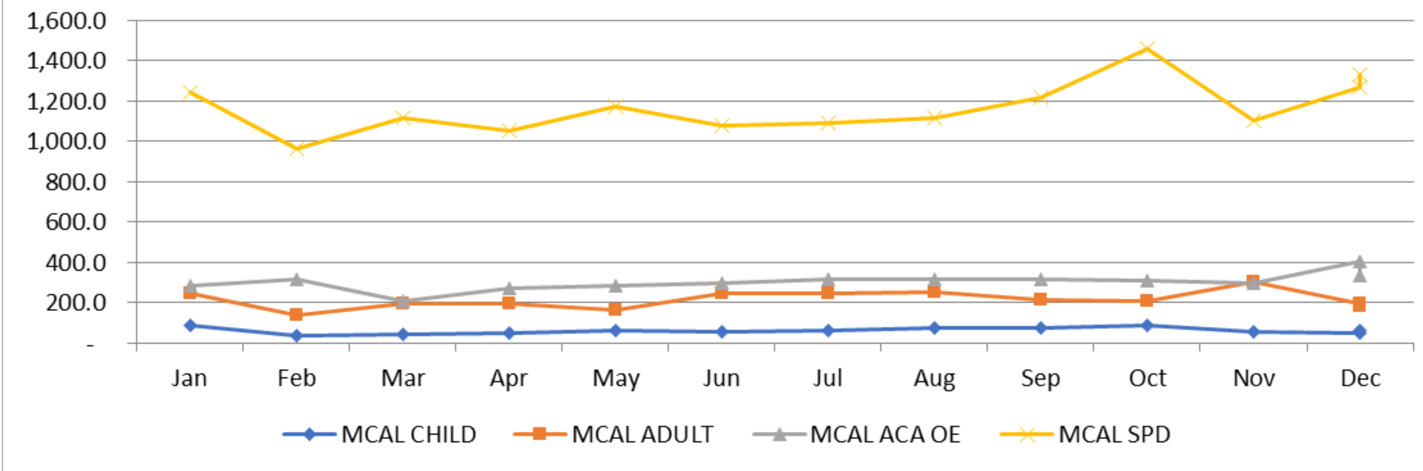
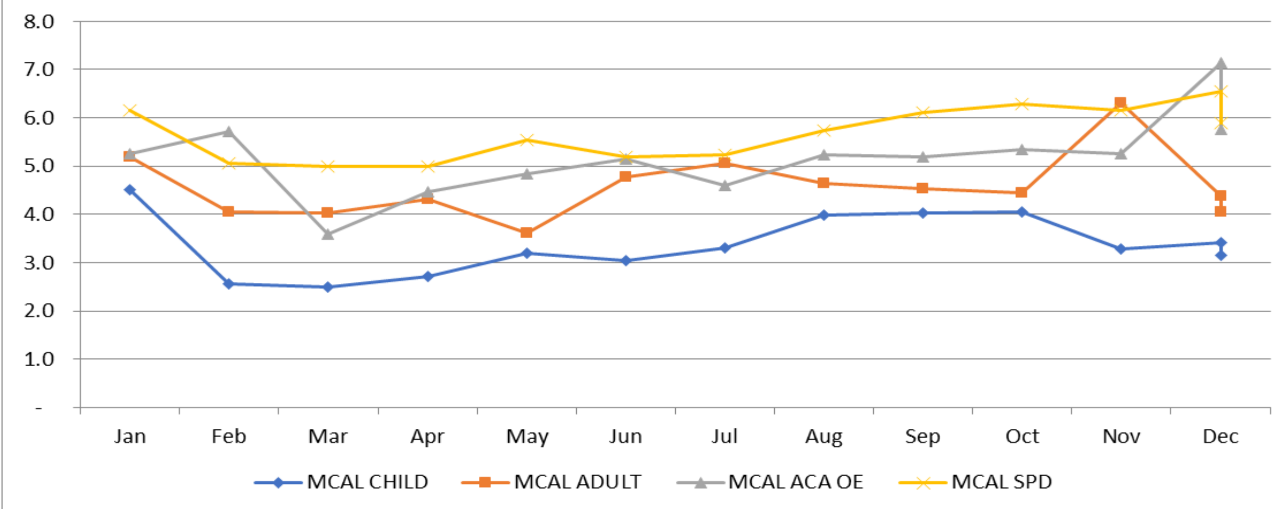


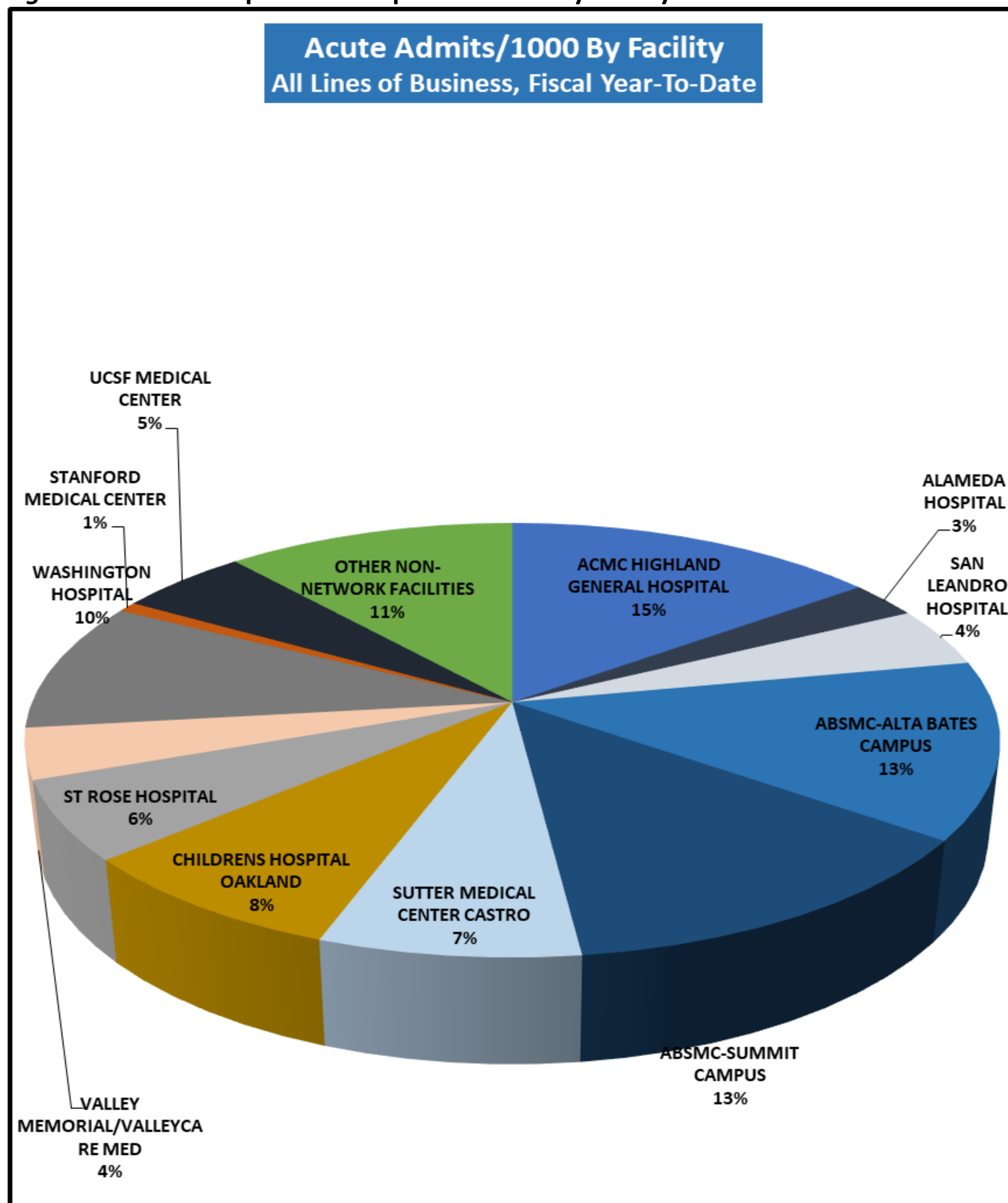
Figure #17 represents the 2021 performance for all lines of business in inpatient management by bed days per thousand. The data above again shows Medi-Cal SPDs as having the highest bed days per 1000 members while all other member aid categories remain relatively flat. However, Medi-Cal Expansion membership bed days per thousand began to rise in December 2021. Two networks decreased their days/ 1000 in 2021 compared to 2020 with CHCN 303.7 days/1000 (-6.7) and CFMG was 18.2 days/1000 (-0.4). While the following networks increased their days/ 1000: Alliance 452.2 (+27.7) and AHS 330.1 (+1.5). By facility, AHS Highland has the highest days/ 1000: 52.4 (-4.7), following by Alta Bates Summitt 46 (-0.6). Washingon Hospital increased their days/ 1000: 39.5 (+3.1). UCSF also increased their days/ 1000: 20.2 (+6.4). For the LTACHs, Kindred had 13.3 days/ 1000 (+3.0) and Kentfield 2.5 (+1.5).

***Figure #18* 2021 Hospital average length of stay per thousand by Aid Category.**



The data above shows considerable variability, but Medi-Cal SPD and Medi-Cal Expansion (MCE) have the longest stays for inpatient hospitalizations, as expected for these medical complex populations. The aid categories that increased the most from 2020 to 2021 were Medi-Cal SPD (+0.2) and Adult (+0.1). Those that decreased from 2020 to 2021 were IHSS (-1.0), MCE (-0.6), and Child (-0.5). The overall ALOS (5.2) in 2021 was affected by patients admitted with Covid, and staffing shortages across the health system that negatively impacted efficient progression of care and placement availability. During variant surges there were local covid-19 outbreaks in the hospital and skilled nursing settings impacting patients and staff that created barriers to hospital discharge due to county-imposed lockdowns, and decreased bed availability to accommodate isolation protocols. Initially the patients admitted with Covid had long ALOS, but that LOS came down over the course of the year. However, it is notable that overall ALOS (5.2) has not returned to pre-pandemic metrics (4.8 in 2019).

Figure #19 **2021 Hospital admits per thousand by facility.**



There was a slight decrease in % of admissions to Sutter facilities (-2%) and a slight increase in % of admissions to Alameda Health System facilities (+1%) between 2020 and 2021. LTACH all had the highest ALOS with Kentfield (49.5) and Kindred (35.6), and followed by Tertiary/ Quartenary facilities: Stanford Health Care 3.1 ALOS (+0.3 from prior year), and UCSF had 6.6 (0.0 from prior year).. Washington Hospital had a 6.2 ALOS (+0.2) which is an outlier compared to other network community hospitals which all fall well below 6 ALOS. A comparable hospital with similar admits/1000 is Eden Hospital which has 4.6 ALOS (+0.1). Even out of network hospitals where AAH UM team has more difficulty in assisting with out of area discharges, has 5.6 ALOS.

Qualitative Analysis

The Alliance evaluates inpatient utilization per 1000 members and Emergency Room (ER) visits per 1000 members as key utilization performance measures, by network. The Seniors and Persons with Disabilities and Medi-Cal Expansion membership is evaluated separately due to the significantly different clinical demand of SPD members compared to MCE members as reflected in the target rates. Duals are excluded because the Alliance is the secondary coverage and therefore don't render UM determinations for hospital care. The rates shown are based on claims and encounter data. Medi-Cal performance is compared to the DHCS rate targets.

As seen across the Medi-Cal beneficiary data, the SPD population continues to be the highest utilizers across all hospital categories. The Medi-Cal Expansion is slightly higher in average length of stay (ALOS) as well as admits and bed-days.

Data provided to assess admissions by facilities, the top three hospitals are 1) ABSMC Facilities (Summit, Alta Bates, and Eden), 2) Highland Hospital, and 3) Washington Hospital. Two of the three hospitals also align with the ER utilization data by facilities as highly utilized facilities. Given the high number of admissions to Sutter facilities and Alameda Health System facilities, in 2021 the Alliance engaged both Sutter and Highland leadership and staff to develop strategies to support throughput and appropriate care transition program for Alliance members. Joint initiatives related to throughput, discharge options, and care coordination occurred throughout 2021. Of note, members who were enrolled with the Health Homes program showed decreases in both ED visit volume and ALOS when hospitalized. This metric will continue to be tracked as the Health Homes program transitions to the Enhanced Care Management (ECM) benefit in 2022. Due to the outlier performance for Washington Hospital, attention will be placed to increased oversight for hospital stays, to exploring new strategic coordination between the facilities and to initiate discussion about potential hospitalist management for AAH members.

Readmissions

All Cause Readmission rate, defined as readmission within 30 days of discharge, is trending above goal of 18%. Relevant activities should include early interventions prior to discharge and co-management with Case Management. Readmissions rates have remained relatively unchanged despite these interventions hovering between 20-19% for 2021. For 2021, the overall network readmission rate was 19%, and note that November data below is incomplete due to delayed claims processing.

Quantitative Analysis

Figure #20 **- 2021 Hospital Readmission Overall and by Network**

Claims Utilization: Inpatient Acute - v6 Readmits

Data Updated: 2/14/2022

Exclude Planned Readmits? No / ◉ Yes

Admit Dates: 1/1/2021 – 12/31/2021

Maternity Incl: N

Aid Category: Multiple s...

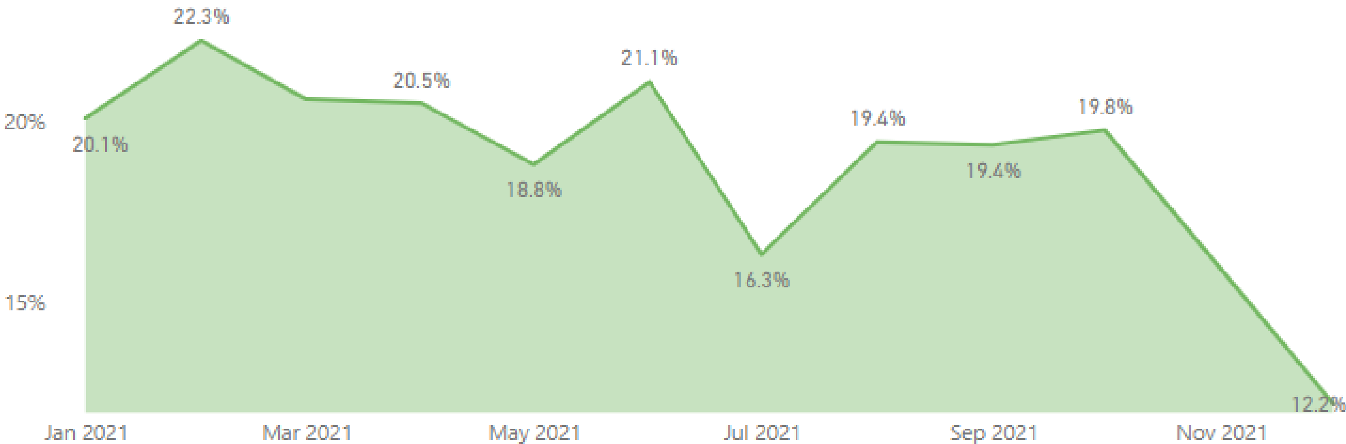
Network: All

Readmit Rate	Readmits
19.0%	1,892

Totals for Date Range

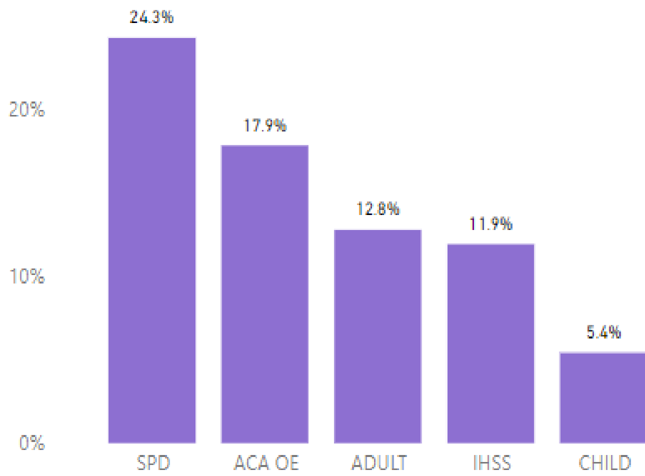
Network	Readmits	Admits	Readmit_Rate
AHS	547	2806	19.5%
ALLIANCE	465	2509	18.5%
CFMG	18	304	5.9%
CHCN	862	4364	19.8%
Total	**1,892**	**9982**	**19.0%**

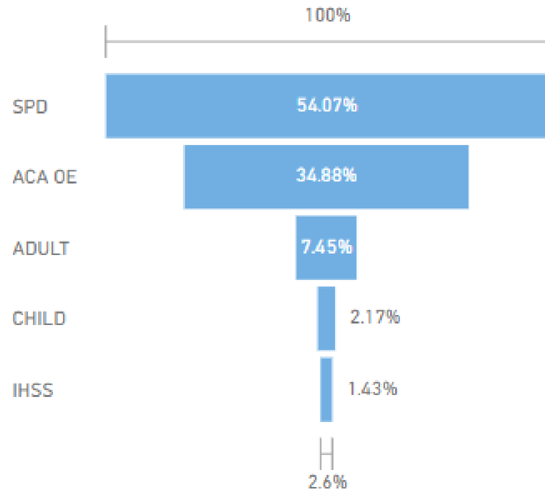
Monthly Trend



Data identified in Figure 20 notes the overall readmission rates, and the rates per Network. The overall readmission rate represented by Health Plan total (19%) is above the goal of 18%, and the highest readmit rate is at AHS at 20.3%. There has been no significant reduction in overall readmission rates from 2020. November is incomplete due to the delay in claims processing.

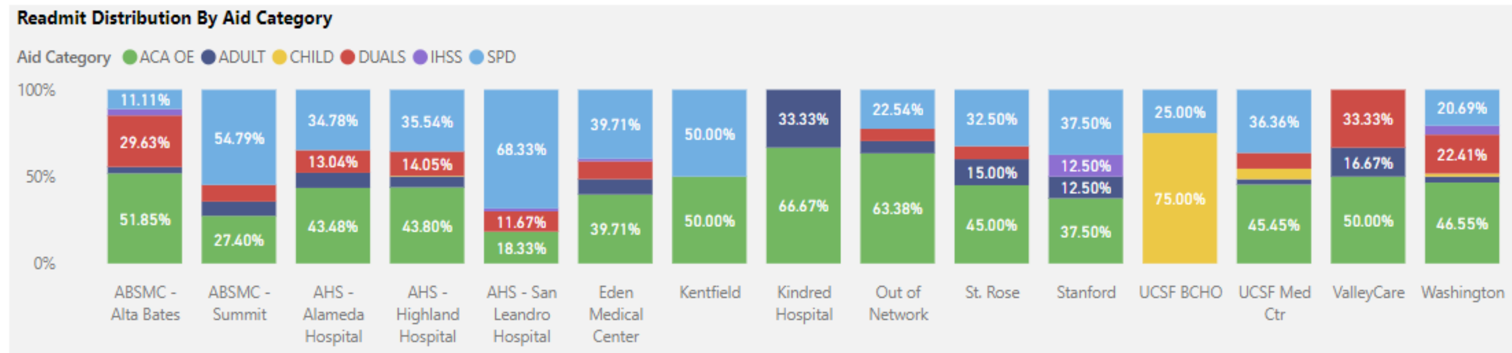
Figure #21 2021 **Hospital readmission rates by Aid Category and Distribution of Aid Category**





SPD contributes to the highest rates of readmission across the MCP and delegate networks, followed by Medi-Cal Expansion membership.

***Figure #22 2021* Readmit Distribution by Aid Category and Hospital by Facility**



Data in Figures 21 notes readmission rates by Aid category. As expected, the SPD members have both the highest readmit rate, and are the majority of all members readmitted. The overall health plan rate for SPD also exceeds the readmission goal rate of 18%. Members identified as non-SPD are consistently below the threshold rate. Figure 22 notes readmissions at facility/ hospitals, by Aid Category. During a review of all catastrphoic cases in Q3 and Q4 in 2021, SPD members made up a significant portion of these hospital stays. A non-specialty hospital, AHS San Leandro Hospital has the highest proportion of SDP members. In that same catastrophic stay review, there were notable opportunities to address progress of care and discharge planning delays that would benefit from increased UM oversight in 2022.

Reduction in readmissions is the focus of the Transitions of Care (TOC) program. The TOC program had started in 2020 as a pilot with Alameda Health Systems, reflecting both inpatient and outpatient coordination of services. The volume of TOC cases has steadily increased over 2021, and now includes members discharging

out of AHS facilities and members discharging with a Covid 19 diagnosis. The Alliance has also been working with the Health Homes program and CHCN to standardize the elements of an effective TOC process.

Continuity of Care

Following the requirements to provide Continuity of Care (CoC), Alliance members with pre-existing provider relationships who made a continuity of care request to the Alliance were given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider who agreed to the terms and conditions used by the Alliance.

A member transitioning from MediCal Fee-for-Service (FFS) into the Alliance may request to complete a course of treatment with an existing FFS or non-participating health plan provider.

a. The Alliance treated every exemption on the MER report as an automatic CoC request for the identified beneficiary. That included CoC requests for PCP, Specialty Care, or mental health. Additionally, special consideration for CoC was applied for medical exception for designated type of problem or condition (i.e. Acute conditions, serious chronic condition, pregnancy, terminal illness, care of a child under 5 years old, previously scheduled surgery/ procedure, or behavior health services that includes acute, serious, or chronic services).
b. Very few denials for CoC requests were seen in 2021.

Out of Network Services

Out of the network services are defined as any service provided by non-participating practitioners or facilities. Members may access OON services either through an emergency or as a direct referral for specialty services not available within the network, timely access standards not met, continuity of care, quality of care concerns, or for continuity of treatment. The Alliance analyzes data related to OON services to address network deficiencies. This activity is focused at assessing requests for OON specialty services which may indicate the lack of availability of specific specialty types or geographic locations.

Figure 24a OON Report #01592

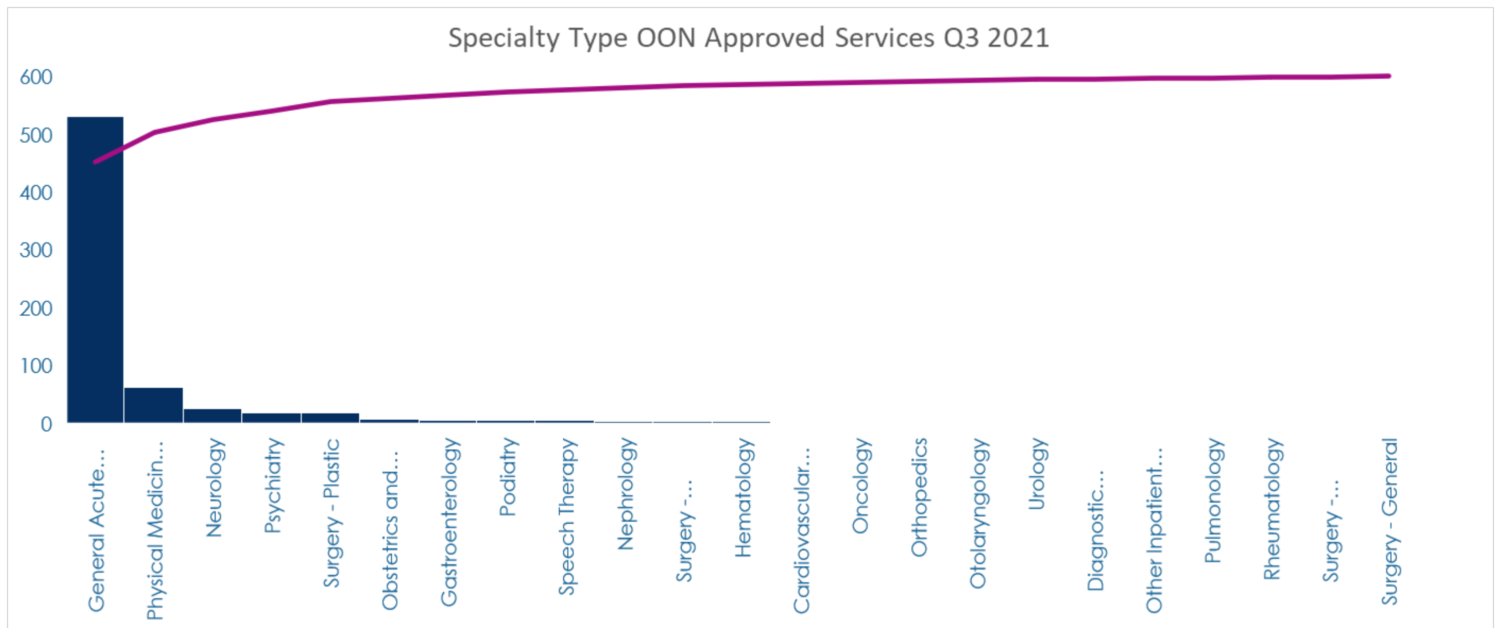
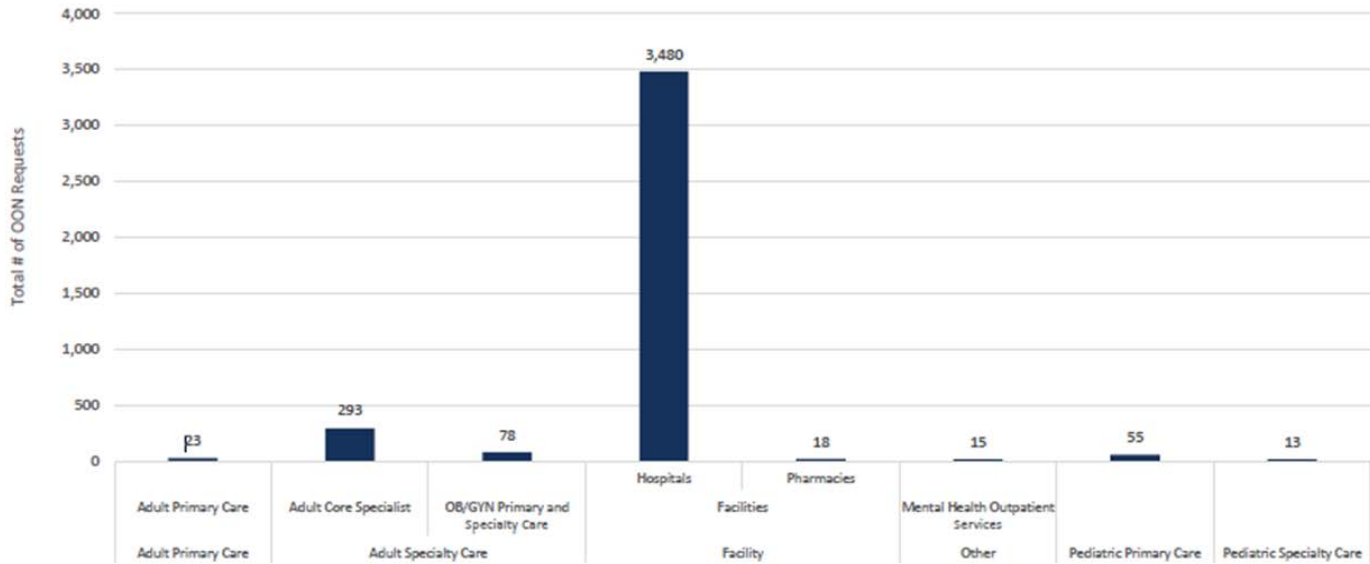


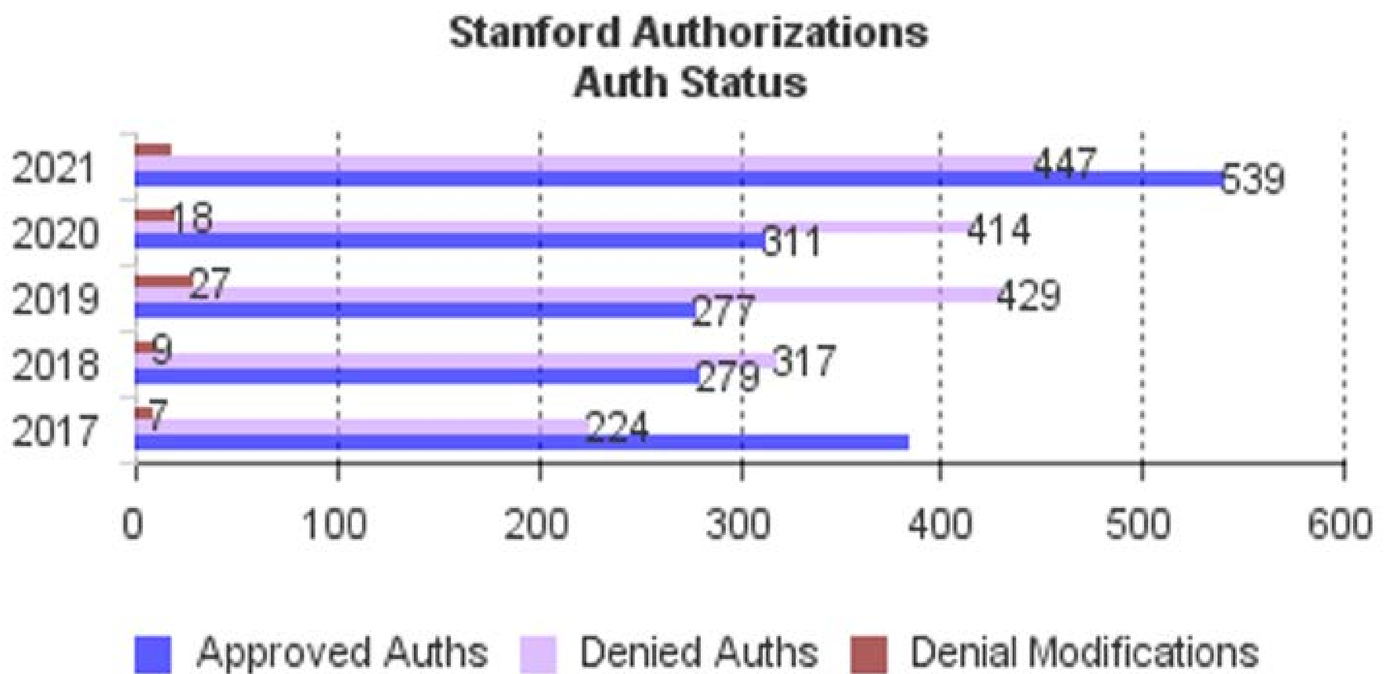
Figure 24b OON Report MCPDP



In 2021, the Alliance continued to review OON requests and approvals, and in the 4th quarter recognized that there is a data discrepancy between the previous DHCS OON report and the new MCPDP OON report, shown in figures 24a and 24b. This discrepancy is being evaluated for data integration issues between delegates and the MCP, OON data validation across networks, and specialty and OON data coding and mapping issues. An example of mapping issues involves the need to distinguish LTACH, subacute, ARU, outpatient rehabilitation and home health referrals which impacted the 2nd largest category attributed to the physical medicine. Similarly, code taxonomy and data validation steps were responsible for an inaccurate report for OON pediatric primary care visits.

AAH contracts with 16 hospitals in the East Bay, and reports show acute hospital stays account for the highest volume OON category. Drivers for most OON hospital volume is admissions through ED and there was increase in OON hospitals stays during the pandemic, potentially due to member mobility for remote work, family caregiving, and pleasure travel. The top volume requested OON provider is Stanford Hospital Systems, so the additional monitoring of each Stanford OON service request for medical necessity and the appropriateness to re-direct to an in-network provider continued. AAH continued its contracting efforts with Stanford, and now includes carveouts specialty care for Oncology Services in 2021 and Major Organ Transplants in January 2022. Adult specialties make up the next significant OON category, in particular Neurology and Plastic Surgery due to Autonomic Dysfunction diagnosis and management at Stanford Health Care. Most Gender Affirmation Surgeries are conducted in Marin County through existing LOAs. OB-GYN care continues to be notable due to continuity of care for low risk pregnancies, and the network OB-GYN referrals to OON Maternal Fetal Medicine for high risk pregnancies.

Figure 24a OON UM Determinations –



Data in Figure 24a show the Authorizations requests to Stanford for services from Q1 2017 to Q4 2021, measuring the number of referrals to Stanford by the authorization determination: approved, modified, or denied. Up until 2020, the authorization requests reflected OON requests because all of Stanford was non-PAR. However, a new contracted service for Oncology services was launched in late 2020, and as a consequence approved auths for Stanford in 2021 began to reflect a rise in PAR requests, and coincidentally a rise in non-oncology related specialty referrals.
The data over time demonstrated that the number of approved auths continued to decrease and the number of denials continued to increase, until 2021. In the future, the OON requests for Stanford will need to be separated from PAR Oncology service requests and MOT requests respectively in 2022. Continued attention around oncology second opinions will also be monitored in 2022.

Quantitative Analysis

In both OON Q3 reports, hospitalizations remain the highest volume OON category, but the next highest volume categories were different. Upon review, it was recognized that there are errors in some categories of data: taxonomy codes, mapping of data element categories from some delegates, data integration between delegates and the MCP, lack of OON data validation, and incorrect NPI numbers for some providers who have more than one treatment site or different delegate or MCP networks. A team is being created to track and correct the errors in the OON data.

The chart in Figure #24a shows the continued trend of decreased approvals and increased denials at Stanford, up until the launch of the Oncology services contract in late 2020. The Alliance launched the Oncology initiative with Stanford for oncology services to be provided within the AAH network, to expand oncology services and access to clinical cancer trials for Alliance members, improved timely access, improved geographic location for the southern part of the county, and to ensure access to high quality specialty care. In 2022, Stanford will also be a Major Organ Transplant in-network Center of Excellence.

The process for denials of OON requests is accompanied by confirmation of the requested service within the Alliance network and within time and distance requirements, as well as continuity of care considerations. OON approval and denial reasons are measured. OON approval reasons are most often met for specialty care is not available in network, and due to timely access needs. The most common OON denial reason is due to existing specialty care available within the network. OON denial determinations are also routed to the AAH Case Management Department for assistance with care coordination and redirect assistance within the PAR network.

Pharmacy Utilization

The management and monitoring of Pharmacy utilization and activities is reported through the Pharmacy and Therapeutics Committee and HCQC. A full review of these activities can be found in the P&T Committee minutes. In collaboration with Pharmacy, UM undertook the initial steps to review and develop methodologies for updating the Prior Authorization for Infusion Drug list, and whose efforts will continue into 2022.

Recommendations/Next Steps for 2022:

In 2022, the Alliance UM Department identified opportunities to improve the monitoring and the reporting of over/under utilization management activities, which included:

- Enhance UM system reporting to capture required elements for over/under utilization monitoring reports, to include access to OON specialty services.
- Emergency Room
    - Use monitoring reports identify potential frequent utilizers of ER services.
    - Document CM interventions for high utilizers and high-risk members, including those on hemodialysis, including ER services.
- Hospital Utilization
    - Continue to assess drivers resulting in longer than expected length of hospital stays.
    - Full implementation of a Transition of Care Program, with a goal of expanding to all hospital discharges.
    - Implement process to support the early identification of members at risk for readmission which will include frailty scores and additional UM parameters such as medication monitoring to identify members at risk for readmission, developing targeted interventions to improve outcomes.
- Ambulatory Setting - identify measures to monitor for care in the capitated setting.
    - Specialty Care encounters per thousand
    - Primary/Preventive Care in the capitated setting with UM interventions–, i.e. flu vaccine, pneumococcal vaccine. Mammography, Colonoscopy, through the Quality Improvement department.
- For OON:
    - Data: Develop process to review detailed OON reports to include more specific providers and services to support prospective analysis. Separate the Par requests for services at Stanford. Correct errors in reporting to accurately capture OON referrals.
    - Continue efforts to attempt contracting with tertiary and limited availability service providers, particularly Stanford.
    - Continue to explore contracting options for providers who resist conventional contracting.

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Alliance is responsible for ensuring Members who are eligible to receive LTSS services are identified and referred. Since 2020, the UM Department has taken responsibility for Community Based Adult Services (CBAS), to ensure that CBAS eligible members are identified, referred, and assessed appropriately and timely. The UM

department Out of Plan RN provides assessment, re-assessments, and re-authorizations of services to the members.

Figure 25 - 2021 CBAS Enrollment by Facility by Delegate

CBAS Enrollment by Facility by Delegate
Based on Active Approved Authorizations, excluding MediCal terminated members

Run Date: 1/5/2022

Number of Members					
Facility Name	**Alliance**	**IHSS**	**CHCN**	**Kaiser**	**Total**
Alzheimer Services of The East Bay	7	0	9	0	16
Berkeley Community Physical Therapy	1	0	0	0	1
Family Bridges Inc.	81	0	202	0	283
Golden Castle Adult Day Health Care Center	5	0	0	0	5
Grace Adult Day Healthcare	8	0	0	0	8
Silicon Valley Adult Day Health Care	3	0	2	0	5
Total	105	0	213	0	318

As seen in the Figure 25, there were a total of 318 members receiving services through one of the six CBAS centers. The Center with the highest volume is Family Bridges, by a considerable margin. In 2020 and into 2021, the impact of the Covid 19 pandemic was felt in the CBAS centers. The CBAS Centers continued to provide remote services and remain in telephonic communication with their members. The Alliance stayed in close contact with the centers to ensure that the services were provided, to problem solve with the CBAS Centers, and to ensure the continuous support for these vulnerable members.

BEHAVIORAL HEALTH

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 are referred to the contracted behavioral health delegate, Beacon Health Strategies
- Medi-Cal members diagnosed with a severe persistent mental health is carved-out and managed by Alameda County Behavioral Health Care Services Department (ACBHCS).
- Commercial members access mental health benefits through the contracted BH delegate, Beacon Health Strategies.

The Alliance works closely with both ACBHCS and Beacon to identify members who may benefit from co-management of both medical and behavioral health services.

The UM Department is 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 conditions to the appropriate ACBHCS programs as well as facilitate coordination activities for co-existing medical and behavioral health disorders to assist with their treatment access and follow-up care.

The Alliance contracts with Beacon to administer the applicable Medi-Cal for members with Mild/Moderate behavioral health needs and Commercial (IHSS) mental health benefits.

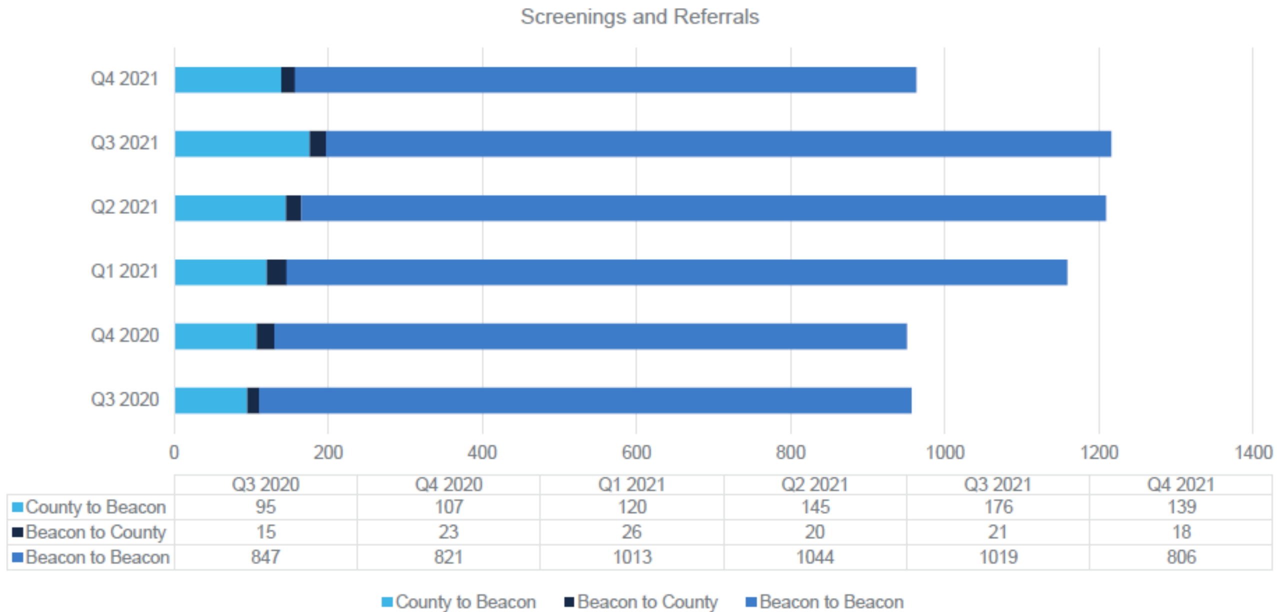
Beacon and College Health IPA (CHIPA) work collaboratively to perform all behavioral health plan management functions. College Health IPA (CHIPA) is the clinical arm of Beacon performing contracting and any utilization management decisions. CHIPA maintains the NCQA accreditation. The relationship and operations are coordinated on behalf of members and providers.

Figure #26– 2021 Beacon Health Strategies Agreement

Beacon – CHIPA Division of Responsibility Function	Beacon (Admin)	CHIPA (Clinical)
Contracting for Outpatient Professional services		X
Credentialing	X	
Member Services	X	
Utilization Management		X
Claims Adjudication/Payment	X	

Figure #26A 2020Q3 to 2021Q4 Beacon Screening and Referrals

Screenings and Referrals: Q4 2021



	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021
County to Beacon	95	107	120	145	176	139
Beacon to County	15	23	26	20	21	18
Beacon to Beacon	847	821	1013	1044	1019	806

Figure 26b 2020Q2 to 2021Q4 Referrals to Beacon Care Management

Total Care Management Referrals by Quarter

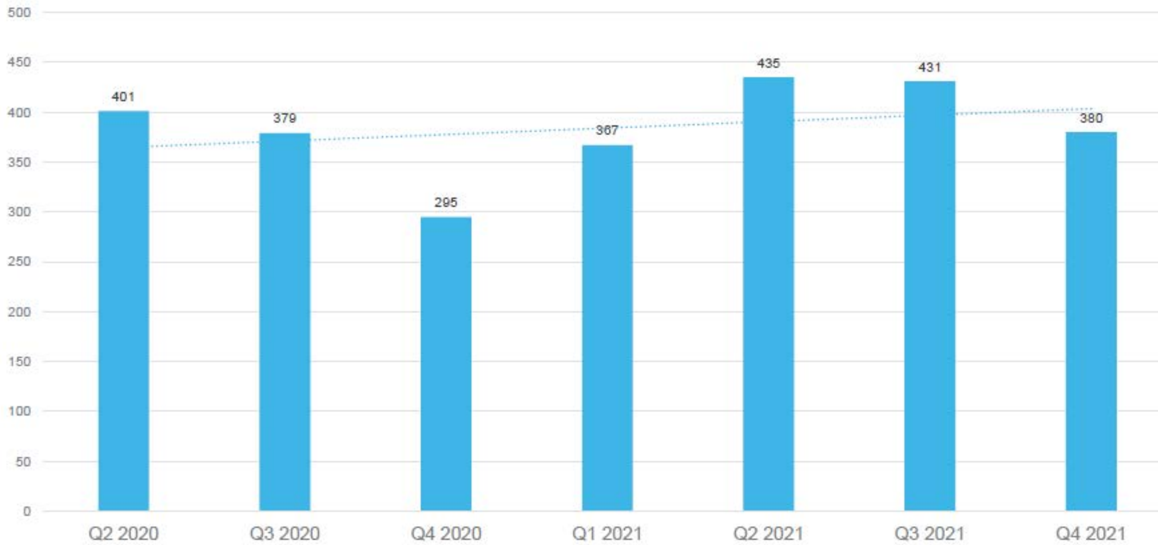


Figure 26a reflects the integration between Beacon for mild to moderate BH and the Alameda County Behavioral Health for Severe Mental Illness, showing the referrals between the entities based on member acuity. The Alliance has developed multi-disciplinary team to analyze data and identify opportunities for collaboration between medical and behavioral health. Figure 26b reflects AAH members who were referred to Beacon for additional support to access mental health treatment. About a quarter of the referrals to Beacon Care Management come from the clinical staff at AAH. A full description of the program activities is defined in the Beacon Behavioral Health Program Evaluation and UM Program Description. The Beacon BH documents are reviewed at the Alliance HCQC.

Integration with Quality Improvement/Management

The UM Department collaborates with the Quality Management on reports which impact health services. In particular, the HEDIS reports are reviewed at UMC as part of the under-utilization trend monitoring. The QM Department provides data to the UMC for analysis to use for quality improvement activities. There is opportunity for UM and Quality to continue collaboration around quality of care issues (PQI capture), and to explore identification of provider preventable conditions (PPCs) for acute hospital stays.
https://www.dhcs.ca.gov/individuals/Pages/PPC_Definitions.aspx

Assessing Members and Practitioners' Experience with the UM Process

Provider satisfaction survey that includes experience with the UM process results will be presented to HCQC in 2021. The Benchmark is a comparison of the Alliance outcomes to the other plans participating in in the 2021 SPH survey:

Figure #27 2021 Provider Satisfaction with Utilization Management

Question	2019	2020	2021	Benchmark
Access to UM Staff	46%	**49%**	43.6% (87th percentile)	30%
Obtaining Pre-Auth Info	45%	**55%**	48.0% (90th Percentile)	32%
Timeliness of Pre-Auth Info	48%	**54%**	47.4% (90th Percentile)	32%
Facilitation of Care	50%	**45%**	46.3% (93rd Percentile)	30%
Coverage of Prevention	59%	**60%**	53.8% (91st Percentile)	39%

The Provider Satisfaction Survey results for 2021 show that the overall scores from 2019 to 2021 have fluctuated somewhat for most questions. However, the 2021 scores still place AAH at or above the 87th percentile into the 90th percentiles compared to other plans for these metrics. The satisfaction rates are noted to be considerably higher than the benchmarks with other plans, hence the high percentile ranking. Provider satisfaction likely remained strong in 2021 with the implementation of the Provider Portal for online authorization requests and feedback on authorization request status. Further adoption of the Portal use by AAH Providers may improve satisfaction further.

Figure #28 2021 Member Satisfaction with Utilization Management

	Member Satisfaction with Utilization Management		
CAHPS Question	**2020**	**2021**	**Percentile Rank**
Getting Care Quickly	71.7%	72.4%	<5% Percentile
Getting Needed Care	82.6%	79.0%	15TH Percentile
Coordination of Care	80.3	83.0%	34th Percentile

Member experience with the UM process is assessed using established survey Consumer Assessment of Healthcare Providers and Hospital Systems (CAHPS) which measure patient experience across health plans, providers, and health care facilities. UM utilizes three questions to assess patient experience with UM, 1) Getting Care Quickly, 2) Getting Needed Care and 3) Coordination of Care. The results will be presented in 2022 at HCQC, and a description of the full survey can be found in the Quality Program Description.

As identified in Figure #28, the trending shows Member satisfaction with Getting Care Quickly has hovered in the low 70% between 2020 and 2021. Getting Needed Care decreased from 83% in 2020 to 79% 2021, to the 15th percentile. Member satisfaction with Coordination of Care increased from 80% in 2020 to 83% in 2021, which was at the 34th percentile. Overall, while member satisfaction shows approximately 61.3% of the surveyed members are satisfied with

getting the care from their physicians, these are lower outcomes compared to other health plans. The continued high performance in Turn Around Time for authorizations and the high rates of approved Authorization requests suggests that the dissatisfaction with these metrics are more driven by provider services than UM processes per se. Member satisfaction will need to have increased focus in the future, in collaboration with Provider Services, to assist in reminding Providers to communicate across Providers regarding members' care needs.

Recommended Interventions/Next Steps for 2022:

In 2022, there is an opportunity to ensure the UM Department participate in the analysis of the data and development of activities associated with the member and provider experience with the UM processes. While Provider Satisfaction is above the comparative benchmark and is over 50% for access to staff and auth info, and at or above 50% for care facilitation of care and preventive care coverage. However, Member experience is low compared to other health plans, and specific activities to address this will be required.

The continued lack of improvement with member satisfaction in 2022 will require a strategy with Provider Services to address this lack of improvement for Member experiences with the obtaining care.

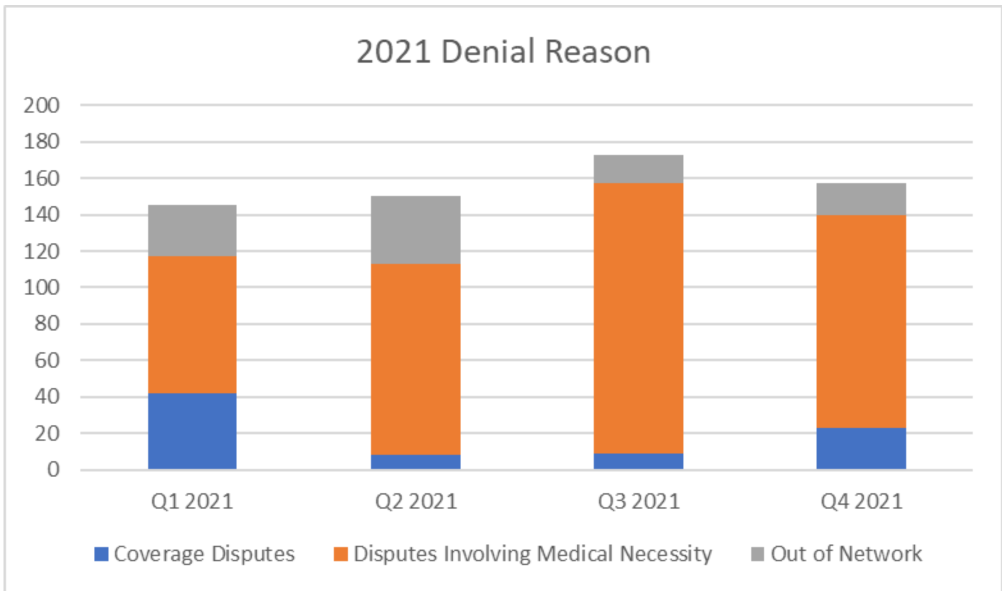
Analysis of Clinical Appeals

Quality integration activities continued with UM involvement in the analysis of member clinical appeals and overturns for medical and pharmacy services. UM participates in the analysis of clinical appeals through the UMC and HCQC. This include analyzing data by provider group responsible for the determination, by product and service type. As the Alliance only delegates the resolution of complaints and appeals to Knox Keene licensed Health Plans, the data below is inclusive of appeals of determinations made by the Alliance UM Department and all delegated provider groups except Kaiser.

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 the overturn determination of 25%. There is opportunity to explore mapping the service and provider trends for Appeals and separately overturns to identify upstream authorization optimization and processes.

Quantitative Analysis

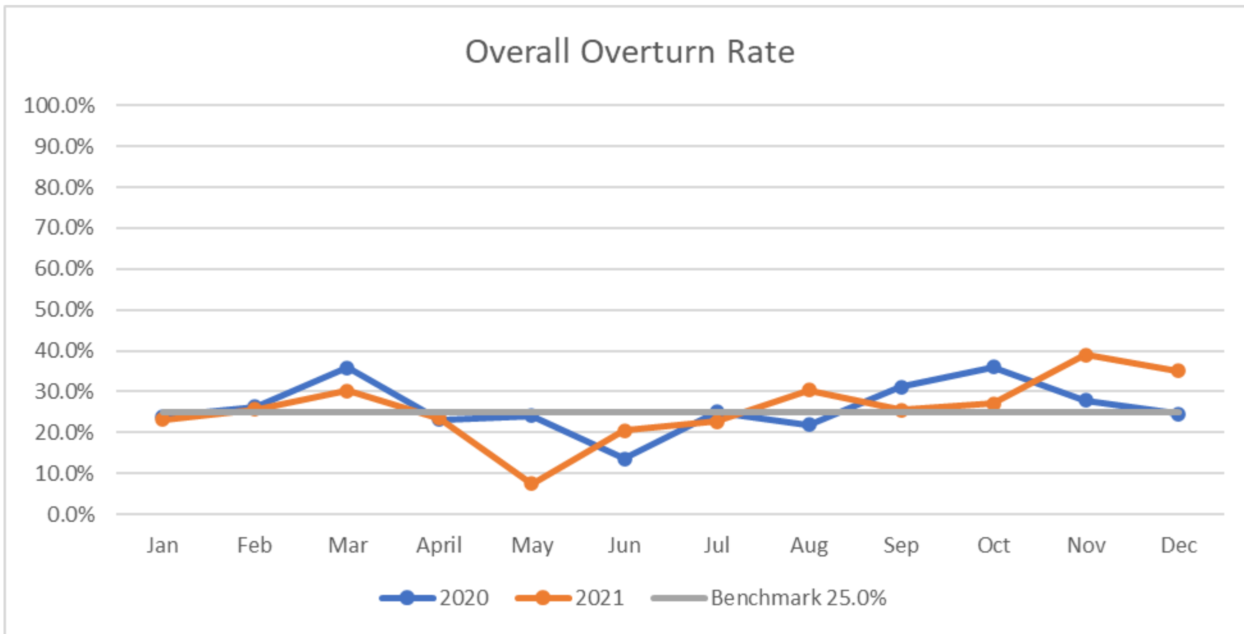
Figure #28 – 2021 Clinical Appeals



In Q4 2021, there were inconsistencies on how coverage disputes were captured, resulting in a higher number of denials based on coverage. G&A Department will research the issues and report on it in Q1 2022.

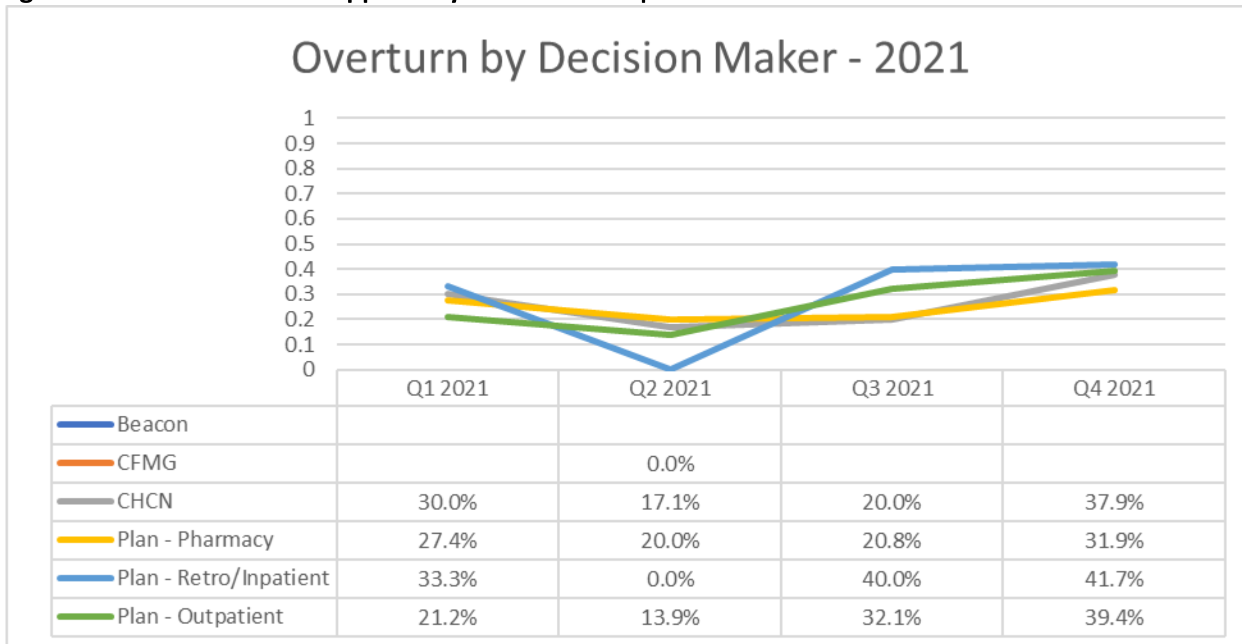
2021 Update: Pharmacy appeals were incorrectly being categorized as coverage disputes when denied based off of our MRG. In the beginning of Q2 2021, this was changed to capture them as dispute involving medical necessity, evident in the decrease of coverage disputes from Q1 2021 to Q2 2021.

Figure #29a – 2021 Clinical Appeals by Resolution/ Overturn – Threshold Compliance



The Alliance had an average overturn rate of 25.8% for 2021, just slightly over our internal benchmark of 25.0%. Most months were consistent excluding a large dip in May and an increase at the end of the year in November and December; however, with the annual overturn meeting our benchmark no interventions were identified.

Figure #29b – 2021 Clinical Appeals by Provider Group and Resolution



	Q1 2021	Q2 2021	Q3 2021	Q4 2021
Beacon				
CFMG		0.0%		
CHCN	30.0%	17.1%	20.0%	37.9%
Plan - Pharmacy	27.4%	20.0%	20.8%	31.9%
Plan - Retro/Inpatient	33.3%	0.0%	40.0%	41.7%
Plan - Outpatient	21.2%	13.9%	32.1%	39.4%

- There is not enough data to identify any trends with Beacon or CFMG.
- CHCN had experienced an increase in Q1 2021, which can be attributed to a change in process on how CHCN was reviewing care being requested at a tertiary facility. CHCN was inappropriately denying authorizations to a tertiary facility as being out of network (OON), instead of for appropriateness for the level of care. CHCN was advised to stop using denial for OON to the contracted provider. A new policy and procedure were developed to outline the appropriate process for reviewing services requested at a tertiary and quaternary facility, which was adopted by CHCN. This was put into place in Q2 2021; therefore, there was a decrease in the overturn rate.
- The Plan – Pharmacy appeals showed a decrease over the year compared to 2020, which can be attributed to weekly meetings that are being held between the Pharmacy Department and Grievance and Appeals Department to review overturned cases for quality improvement purposes.
- The Plan – Numbers were so low to identify any trends.
- The Plan – Increase in Q3 and Q4 of 2021, we continue to meet with the Medical Directors on a bi-weekly basis to review all overturns.
- There was a significant increase in Q4 2021 across all appeal types, the Grievance and appeals department will have to investigate the Q4 data to see if there are any trends.

Recommended Interventions/Next Steps for 2022:

The Pharmacy Carve Out to Medi-Cal was implemented on January 1, 2022, this change will result in a large decrease of appeals overall.

For 2022, we will continue to track the overturn rate to see if there are any trends. There was a significant increase of overturns in Q4 2021, we will compare to Q1 2022 to see if we experience a decrease closer to our benchmark or if there are any interventions to be taken based on the original decisions.

Integration of medical and behavioral health

Behavioral health is managed through delegation to the MBHO. The behavioral health practitioners are involved in key aspects of the delegate's UM program, ensuring BH focus in policies and procedures, aligning the medical necessity guidelines with medical necessity guidelines and participation in the UM committee meetings. The MBHO dedicates a clinical team to assist in the co-management of the activities.

In 2021, the teams worked on efforts crossing the medical and behavioral health services which included:

- Involvement of Behavioral Health practitioners in the HCQC.
- HEDIS activities related to behavioral health measures.
- Enhancing CCM outreach to 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.
- In 2021, planning began for the insourcing of mild to moderate BH back into the plan from the current delegate, Beacon Health Options in Q4 2022. The integration between BH and medical care is expected to be enhanced by AAH providing this service directly instead of via delegate.

A full description of the MBHO UM Program and Evaluation can be found in the HCQC minutes.

Coordination with Regulatory Compliance

The Alliance UM Department works closely with the Compliance Department in preparation for regulatory audits. In 2021, the department participated in audits from DHCS and DMHC. As a result of the reviews, several internal workgroups met to identify activities targeted at resolving the identified UM related issues. The workgroups managed these activities via ongoing work-plans. The activities identified are on target for completion within the established timeframes. The activities include mechanisms for ongoing monitoring to mitigate further regulatory deficiencies.

Recommended Interventions/Next Steps for 2022:

To ensure integrity the of the internal UM process, Alliance UM Department will conduct ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. Alliance UM Department will implement a monitoring program for the early identification of potential compliance risks.

In addition, the program includes an opportunity to provide quality oversight of the current UM processes. This is accomplished by internal monitoring of UM authorization files on a periodic basis.

Conclusion

Overall, the 2021 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 Covid 19 pandemic had affected volume trends in multiple areas, but as the volumes returned to normal rates, Alliance maintained the required processes within the regulatory timelines, tracked the effect of the pandemic on members, and change processes to mitigate any potentially negative effects and meet the regulatory requirements of pandemic related APLs. The UM program activities have met most of the established targets, including a reduction in regulatory findings. The UM department has provided leadership to the preparations for carving in the Major Organ Transplant services in 2022. The Alliance leadership has played an active role in the UM Program structure by participating in various committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements.

UM Program Recommendations for 2022

As a result of internal performance monitoring performed in 2021, opportunities for improvement were identified and will be incorporated into the 2022 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Improve monitoring of network utilization (over/under), including out of network authorization requests with a continued focus on the Stanford Health Care analysis and referring providers.
- Continue monitoring of Specialty Referrals, both approved and denied
- Collaboration with the Alliance Compliance Department on the full implementation of the UM process for internal performance monitoring of UM decisions.
- Continue using the analysis of hospital data to work with hospital partners on individual hospital strategies for management of members for appropriate length of stay and timely discharge planning.
- Tighten concurrent reviews for progression of care and early discharge planning, increased internal oversight and identification of catastrophic stays, and escalating complex discharge barriers.
- Strengthen programs around oversight of clinical decision making, both internally and for Delegates.
- Provide leadership to the initiative on Major Organ Transplant carve in, including expanding staffing to manage this vulnerable population, in collaboration with all relevant Alliance departments.
- Explore Quality initiatives with the Quality Department around PQIs, HEDIS measures, and PPCs.
- Refine the ADT feed coming from contracted hospitals to enable automatic case creation in TruCare.
- Analyze the opportunity and implement the process to increase the number of authorizations that are appropriate for automatic approval.
- Continue implementation for tracking and intervening with unused Authorizations to ensure that members receive appropriate care and follow up.
- Work with AHS to improve the use of the Palliative Care benefit for members.
- Work with the Alliance Case Management Department and all relevant Alliance departments to engage on UM aspects of CalAIM for ECM and CS in 2022.
- Continue the care transition program in partnership with Highland Hospital and extend to other hospitals, with attention to readmission risk screening and disease management
- Provide leadership in collaboration with Case Management to enhance service coordination for members being managed by CCS.
- Provider leadership to the initiative for enhanced care coordination for high-risk hemodialysis members with DaVita.
- Improve reporting and analysis of grievance and appeals activities related to UM decision making and analysis for member and provider experience with UM.
- Enhanced IRR training and educational enrichment for UM staff.

- Hardwire a standard process for policy review and revision that ensures UM processes maintain operational and regulatory compliance.

2022
Utilization Management Program Description

2022 Utilization Management Program

Signature Page

Date

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Julie Anne Miller, LCSW
Director, Health Care Services

Date

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Rosalia Mendoza, MD
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Steve O’Brien, M.D.
Chief Medical Officer, Medical Management
Chair, Health Care Quality Committee

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Scott Coffin
Chief Executive Officer

Date

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Evan Seevak, M.D.
Board Chair
Alameda Alliance for Health

- **<u>Changes in UM Program Description from 2021 Version</u>**
    - **Grammatical corrections**
    - **Pagination corrections**
    - **Addition/correction of relevant regulatory references**
    - **Addition of CalAIM Initiatives**
    - **Pharmacy change to Medi-CalRx**
    - **Updated Recommendations for 2022**

Introduction

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 lower-income people of Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents.

The Alliance provides health care coverage to over 250,000 children and adults through the Medi-Cal and Alliance Group Care programs. Alliance members choose from a network of over 1,700 doctors, 17 hospitals, 68 community health centers, and more than 200 pharmacies throughout Alameda County. The Alliance cares about the health of our community and reflects the community's cultural and linguistic diversity in the health plan's structure, operations, and services. In addition, many of the Alliance providers, employees, and Board of Governors (BOG) live in areas that we serve. 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's Utilization Management (UM) Program was established to provide basic and complex 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 is compliant with Health and Safety Code Sections 1363.5, 1367.01, 1368.1, 1374.16, 1374.72 and Title 28, CCR, Sections 1300.1300.67.2, 1300.70(b)(2)(H) & (c).

The UM Program Description includes a discussion of program objectives, structure, scope, and processes.

The annual evaluation of the effectiveness of UM processes was conducted and the recommendations were documented in the 2021 UM Program Evaluation. Based on those recommendations, the Alliance will focus on the following areas for 2022:

- Monitor the existing UM infrastructure to ensure that it meets the needs of the members, providers, and the organization.
- Continue to optimize opportunities to enhance the existing clinical information system reporting capabilities to focus on the improvement of monitoring operational activities, i.e. Turn-around Time monitoring, referral types.
- Focus on strategies and tactics to reduce readmissions.
- Improve monitoring of network utilization (over/under), including out of network and specialty referrals.
- Enhance reporting and analysis of member and provider complaint data related to UM decision making to improve experiences with UM process.
- Implementing activities to improve member experience with UM, targeting CAHPs measures for "getting needed care" and "getting care quickly" as it relates to primary and specialty care.

- Provide leadership to the initiative on Major Organ Transplant carve in, including expanding staffing to manage this vulnerable population, in collaboration with all relevant Alliance departments.
- Provide leadership in collaboration with Case Management to enhance service coordination for members being managed by CCS.
- Strengthen internal oversight of UM processes.
- Strengthen oversight of delegates; and
- Continue to focus on activities to mitigate regulatory audit deficiencies related to UM activities.
- Secure staffing and resourcing to support these initiatives.

Section I. Program Objectives & Principles

The purpose of the Alliance 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 services.
- Improve health outcomes; and
- Assure the effectiveness and efficiency of healthcare services.

The Alameda Alliance for Health adheres to the following operating principles for the UM Program:

- 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

Section II. Program Structure

A. Program Authority and Accountability

1. Board of Governors

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 12-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of Alliance programs and is responsible for approving the Quality Improvement and UM Programs. The Board of Governors delegates oversight of Quality and UM functions to the Alliance Chief Medical Officer (CMO) and the Health Care Quality Committee (HCQC) and provides the authority, direction, guidance and resources to enable Alliance staff to carry out the UM Program. UM oversight is the responsibility of the HCQC. UM activities are the responsibility of the Alliance Medical Services staff under the direction of the Medical Director for Utilization Management and the Senior Director, Health Care Services in collaboration with the Alliance CMO.

2. Committee Structure

The Board of Governors appoints and oversees the HCQC, the Peer Review and Credentialing Committee (PRCC) and the Pharmacy and Therapeutics Committee (P&TC) which, in turn, provide the authority, direction, guidance and resources to enable Alliance staff to carry out the Quality Improvement and UM Programs. Committee membership is made up of provider representatives from Alliance contracted networks and the community including those who provide health care services to Seniors and Persons with Disabilities (SPD) and 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.

The HCQC Committee provides oversight, direction and makes recommendations, and final approval of the UM Program. Committee meeting minutes are maintained summarizing committee activities as well decisions and are signed and dated. A full description of the HCQC Committee responsibilities can be found in the most recent Quality Improvement Program.

The HCQC provides the external physician involvement to oversee the Alliance QI and UM Programs. The HCQA includes a minimum of four (4) practicing physician representatives. The UM Committee include in their membership physicians with active unrestricted licenses to practice in the State of California. The composition includes a practicing Medical Director 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 HCQC functional responsibilities for the UM Program include:

- Annual review and approval of the UM Program Description.
  Oversight and monitoring of the UM Program, including:
    - Recommend policy decisions.
    - 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; and
    - Recommend necessary actions.

B. Utilization Management Committee

The Utilization Management Committee (UMC) is a sub-committee of HCQC. 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.

1. UM Committee Structure

As a sub-committee of the HCQC which reports to the full Board of Governors, the HCQA supports the activities of the UM Committee and reviews and approves the UM activities and program annually. Reporting through the HCQC

integrates UM activities into the Quality Improvement system.

2. Authority and Responsibility

The HCQC 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 HCQC has delegated authority of the following functions to the UM Committee:

- Annual review and approval of the effectiveness of the UM Program
- Annual review and approval of the UM Program
- UM Policies/Procedures,
- UM 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.

3. 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 Directors, UM
- The Alliance Medical Director, CM
- The Alliance 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 Director, Compliance
- The Alliance Director, Member Services
- The Alliance Director of Provider Relations and Provider Contracting
- The Alliance Director, Quality Assurance
- 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

4. UMC Voting Privileges

For the purposes of voting at the UM Committee, only physician and Director level members of the UM committee may vote.

5. UMC Quorum

A quorum is established when fifty one percent (51%) of voting members are

present.

6. UMC Meetings

The UMC meets at least quarterly but as frequently as necessary. The meeting dates are established and published each year.

7. 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 HCQC. 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 HCQC for review and approval.

8. UM Committee Functions

The UM Committee is a forum for facilitating clinical oversight and direction. The UMC 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 benchmarks 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 Medical Services.
- Provide mechanism for oversight of delegated UM functions, including review and trend authorization and utilization 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 our providers and network.

UM Committee responsibilities are to:

- Maintain the annual review and approval of the UM Program, UM Policies/Procedures, UM 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.
- Participate in the utilization management/ continuing care programs aligned with the Program's quality agenda.
- Assist in monitoring for potential areas of over and underutilization and recommend appropriate actions when indicated.
- Review and analysis of utilization data for the identification of trends
- Recommend actions to the Quality Oversight 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,

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.

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 HCQC 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 UMC reports to the HCQC and serves as a forum for the Alliance to evaluate current UM activities, processes, and metrics. The UM committee also evaluates the impact of UM programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes.

C. Program Oversight and Staff Responsibility

The Alliance Health Care Services Department is responsible for management and coordination of programs including the UM Program. The UM Department staff administer the UM Program. Non-clinical staff may receive and log utilization review requests to ensure adequate information is present.

Appropriately qualified and trained clinical staff use approved criteria to conduct utilization reviews and make UM determinations relevant to their positions, e.g. Non- physician staff may only approve services; qualified non-clinical staff may make non- medical necessity denial decisions (example: not eligible); potential denials are referred to physician reviewers. The CMO, Medical Director, or licensed MD staff review requests that require additional clinical interpretation or are potential denials. A qualified physician reviews all denials made, whole or in part, based on medical necessity. The CMO or a Medical Director makes medical necessity denial decisions for medical and pharmacy service requests. The Alliance Pharmacist, a licensed Pharm. D., may approve, defer, modify, or deny prior authorization requests for pharmaceutical services.

1. 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 HCQC 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 Department of Health Care

Services (DHCS) and Department of Managed Health Care (DMHC) within the required timeframe.

2. 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 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.

3. Senior Director, Health Care Services

The Senior Director, Health Care Services is a Licensed Clinical Social Worker and is responsible for overall UM Department operations, staff training, and coordination of services between departments. The Director’s management 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 the regulatory standards.
- Monitor utilization data for over and under-utilization.
- Coordinate interventions with the CMO to address under and over utilization concerns when appropriate.
- Monitor utilization 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 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.

4. Pharmacy Services Senior Director

The Pharmacy Services Senior Director 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:

- Render pharmaceutical service decisions (approve, defer, modify, or deny) pursuant to criteria established for specific line of business by the CMO and the Alliance Pharmacy and Therapeutics Committee.
- Assure that the Alliance maintains a sound pharmacy benefits program.
- Manage the Alliance Medication Formulary on an ongoing basis.
- Manage the Drug Utilization Review program.
- Monitor compliance with delegation requirements and the performance of the Pharmacy Benefits Management and other pharmacy vendor firm's services.
- Provide clinical expertise and advice for the on-going development of pharmacy benefits.
- Review medication utilization reports to identify trends and patterns in medication utilization.
- Develop and manage provider and client education programs to improve medication prescribing patterns and to increase patient compliance.
- Ensure compliance with Federal and State regulatory agencies; and
- Manage the contract with, and delegated activities of, the pharmacy benefits management organization.

5. Utilization Review Clinicians

UM Review Clinicians with a current unrestricted California nursing license, California Physician Assistant license, and/or California Nurse Practitioner are responsible for the review and determinations of medical necessity coverage decisions. Clinicians may approve prospective, concurrent, and retrospective inpatient or outpatient medical necessity coverage determinations using established and approved evidenced-based.

medical criteria, tools, and references as well as their own clinical training and education. UM Review Clinicians, who are qualified clinical non-physician staff, may approve non-medical necessity benefit denial decisions. (Example: not eligible.). Licensed Vocational Nurses, (LVNs) Nurse Reviewers are under the supervision of a Registered Nurse, (RN,) and do not make clinical approval or denial decisions. Utilization Review Clinicians also work collaboratively with case managers and assist with member transition of care and discharge planning. For cases that do not satisfy medical necessity guidelines for approval, the UM Review Clinicians are referred to a Medical Director for final determination. The CMO or Medical Directors are available to the nurses for consultation and to make medical necessity denials. All clinical staff involved in the authorization review process must identify and refer any potential quality issues appropriately for further investigation.

6. UM Coordinators

The UM Coordinators are non-clinical staff responsible for performing basic administrative and operational UM functions. Clinical staff provides oversight to the non-clinical staff.

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 and
    - Manage and complete UM Member and Provider communications.
    - Complete administrative denials for non-eligibility, as defined in UM Policy 057 – Authorization Requests.
- Inpatient UM Coordinators:
    - monitor and collect facility admissions census data.
    - Complete data entry of initial cases.
    - Maintain member and provider communications.
    - Assist in requesting additional information as needed
    - Review of hospital referral to ensure appropriate case closure.
    - Approve inpatients services as defined in UM Policy UM-057 Authorization Requests.
- Ensuring the efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic UM nurse staff.

Section III. Program Scope, Processes & Information Sources

The UM Program consists of comprehensive and systematic functions, services, and processes that provide care management to members and include medical necessity determinations regarding the appropriateness of health care services in accordance with definitions contained in the member evidence of coverage. The UM Program also encompasses delegated utilization management functions, activities and processes for behavioral health and pharmacy services.

A. Utilization Management Activities

Referral Management includes Prior Authorization Review, Concurrent Review, and Post Service Review of requests for authorization:

- Services exempt from Prior Authorization means services for which the health plan cannot require advance approval.
- Pre-service Review means a formal process requiring a requesting health care provider to obtain advance approval to provide specific services or procedures.

Preauthorization, Prior Authorization, and Pre-Certification are terms also used to describe Pre-service Review.

- Concurrent Review means a review for an extension of a previously approved, ongoing course of treatment over a period or number of treatments. Concurrent reviews are typically associated with inpatient care, residential behavioral care, intensive outpatient behavioral health care, and ongoing ambulatory care.
- Post Service Review means the assessment of the appropriateness of medical services after the services have been provided. This is also called Retrospective Review.
- After Hours and Emergency Care

Emergency health care services are available and accessible within the service area 24 hours a day, seven days a week. The Alliance provides 24-hour 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. A Physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

Emergency 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.

A "Prudent Layperson" is 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. The Alliance will honor health plan coverage for services when directed by any Alliance staff member or delegated representative.

B. Communication Services for UM Process with Members and Providers

The Alliance members, providers, and the public may contact the UM department to discuss any aspect of the UM program. Members contact the Member Services Department at 510-747-4567 and may be warm transferred to an UM Manager or Director. Providers 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 hours 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 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.

Both the UM staff voice mail phone message line for utilization review information and the computer network system are controlled by a secured password system, accessible only by the individual employee. The facsimile machines used for utilization review purposes are located within the Department to assure monitoring of confidential medical record information by the Alliance's UM staff.

C. Decision Support Tools

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 nursing review staff apply professional judgment during all phases of decision-making regarding the Alliance members.

"Decision Support Tools" are intended for use by qualified licensed nursing review staff 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 important professional judgment. The Medical Director evaluates cases that do not meet review criteria/guidelines and is responsible for authorization/denial determinations.

UM staff clearly document the Review Criteria/Guidelines utilized to assist with authorization decisions. If a provider questions a medical necessity/appropriateness determination, any criteria, standards, or guidelines applied to the individual case supporting the determination is provided to the provider for reference.

The following describes the approved Department "Decision Support Tools" that have been implemented and are evaluated and updated at least annually.

D. UM Review Criteria, Guidelines and Standards

The Alliance, Provider Groups and Vendors delegated for UM functions must utilize evidenced based nationally recognized criteria for UM decision making. UM criteria are used to determine medical necessity in the Authorization Request review process.

Standards, criteria, and guidelines are the foundation of an effective UM Program. The tools are utilized to assist during evaluation of individual cases to determine the following:

- Services are medically necessary.
- Services are rendered at the appropriate level of care.
- Quality of care meets professionally recognized industry standards.
- UM decision-making is consistent.

The following standards, criteria, and guidelines are utilized by UM staff and Medical Directors as resources during the decision-making process:

- Regulations and Guidelines
- UM Medical necessity review criteria and guidelines.
- Length of stay criteria and guidelines
- Clinical Practice Guidelines
- Referral Guidelines
- Policies and Procedures

Examples of regulations and guidelines are as follows:

- Regulations:
    - 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

- Guidelines:
    - Medi-Cal Guidelines (Medi-Cal Provider Manuals)

1. Application of UM Criteria

The Alliance requires that UM criteria be applied in a consistent and appropriate manner by physician and non-physician UM staff based on available medical information and the needs of individual Members. For use in determining the appropriateness of UM determinations at the Alliance Plan level for the direct requests for authorization, the Alliance adopts and maintains approved criteria with current versions of the following UMC approved UM Criteria hierarchy:

- Regulatory contractual requirements, such as DHCS regulations, Provider Manuals, All Plan Letters.
- Evidence based guidelines, such as MCG®, InterQual, and UpToDate. Alliance specific guidelines
  - UM Auto Authorization List as approved by the UM Committee.
  - Other Utilization Management Committee Approved Criteria
  - Pharmacy Therapeutics Committee Approved Criteria
  - When none of the above criteria are applicable, consider the following and two (2) or more of the following criteria are applicable, then MCG® criteria are to be used as the first choice.
    - MCG® Guidelines
    - UpToDate.com
- National medical association guidelines, such as American Commission of Obstetrics and Gynecology (ACOG), American Association of Pediatrics (AAP), American Diabetes Association (ADA), World Professional Association for Transgender Health (WPATH).
- Definition of Medical Necessity (Product Line specific when the above criteria do not apply to a specific request for an UM decision).
- Other resources

Due to the dynamic state of medical/health care practices, each medical decision must be case specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition, or the need for a referral.

2. Clinical Review Criteria

Utilization review determinations to approve, defer, modify, or deny requested services are made based on a consistently applied, systematic evaluation of utilization management decision criteria. The criteria adopted by the Alliance are reviewed and discussed by the UMC. They are selected based on nationally recognized and evidence-based standards of practice for medical services and are applied based on individual need. Primary criteria used for utilization review decisions are from MCG® Care Guidelines. Other applicable publicly available clinical guidelines from recognized medical authorities are referenced when indicated. Also, when applicable, government manuals, statutes and laws are referenced in the medical necessity decision making process. The UMC annually reviews the MCG® Care Guideline criteria and applicable government and clinical guidelines for changes and updates.

Additionally, the Alliance has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion

in benefit plans to keep pace with changes and to ensure that members have equitable access to safe and effective care. The UMC reviews and approves all new coverage policies before implementation.

For the Medi-Cal line of business, the term “Medically Necessary” will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. {Title 22, CCR, Section 51303(a)}. When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, “Medical Necessity” is expanded to include the standards set forth in Title 22, CCR, Section 51340 and 51340.1.

The above definition of medically necessary applies to any line of business without a product specific definition.

The Alliance is accredited by the National Committee for Quality Assurance (NCQA) and adheres to the latest NCQA Standards and Guidelines.

NCQA defines medical necessity review as a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the member’s circumstances, relative to appropriate clinical criteria and the organization’s policies.

3. Access to and Disclosure of UM Criteria and UM Procedures and Processes

UM Criteria and UM Procedures and Processes are available to the Alliance practitioners, providers, members, and the public upon request in accordance with established regulatory and contractual requirements.

If criteria are requested, the organization makes them available:

- In person, at the Alliance
- By telephone, mail, fax, or email.

E. Benefits

The Alliance administers health care benefits for members, as defined by contracts. Benefit coverage for requested service is verified by the UM staff during the authorization process as follows:

- Medi-Cal member benefits are developed by the State of California, DHCS and DHCS mandated benefits for Medi-Cal Members. DHCS benefits, available on the DHCS Web site, defined by, but not limited to:
    - Service requests for Medi-Cal beneficiaries.

- Medi-Cal Manual of Criteria
    - Medi-Cal DME.
    - Medi-Cal Hospice
    - Medi-Cal Waivers.
    - Medi-Cal Linked and Carve Out Programs
    - Medi-Cal Enhanced Care Management (ECM)
- IHSS benefits are developed by Public Authority of Alameda County

Benefit resource guides for all Product Lines are maintained by Member Services Department. Benefits resource guides describe in detail the covered and non-covered services, procedures, and medical equipment for the line of business. These guides are aligned with the applicable product line benefits.

1. 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.

2. 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.

3. 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 benefits plan 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 UM Committee is responsible for evaluating and recommending coverage status for a new technology to the UM Committee or the Pharmacy and Therapeutics Committee, and to the Health Care Quality Committee. This includes evaluation of medical and behavioral health procedures, pharmaceuticals, and devices. 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.

Based on the decision of the UM Committee, P&T Committee and recommendations through the appropriate Quality Committees, the approval of a new technology or new application of an existing technology by the Quality BOG Committee shall be deemed to be the Alliance's policy on coverage. 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. A full description of the process is defined in UM policy and procedure.

4. Member Eligibility Verification

Authorization is based on member eligibility at the time of service and is verified by the UM staff at the time of the request. Medi-Cal eligibility is on a month-to-month basis. The Alliance Direct members may become eligible retrospectively, in which case their claims would be subject to retrospective review**.**

5. Determination Information Sources

UM clinical staff collects relevant clinical information from health care providers to make prospective, concurrent, and retrospective utilization review for medical necessity and health plan benefit coverage determinations. 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.

F. UM Determinations

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 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. 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. Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria. In addition to guidelines and criterion, patient records and conversations with appropriate practitioners are used in the decision-making process. Qualified health care professionals also supervise utilization review decisions. Under the supervision of a licensed medical professional, non-clinical staff collect administrative data or structured clinical data to administratively authorize cases that do not require clinical review.

Only a Medical Director, with a current license to practice without restriction in California, makes medical necessity denial determinations. A Medical Director is available to discuss UM denial determinations with providers. Providers are notified how to contact the Medical Director about determination processes in the denial letter.

In accordance with the DHCS contract, only qualified health care professionals supervise review decisions, including service reductions. A qualified physician will review all denials that are made based on medical necessity. 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.

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.

Board certified physician 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.

Decisions affecting care are communicated in writing to the provider and member in a timely manner, in accordance with regulatory guidelines for timeliness, 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. Notification must reference the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based. 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, must be included in the notification.

Providers are informed how to contact and speak with the Medical Director who made the decision. Notification communication 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.

G. UM Referral Management and UM Review Processes

The scope of medical management services and activities includes utilization review determinations, referral management, discharge planning, complex case management, and UM documents.

1. Services Exempt from Prior Authorization

Exemptions from Prior Authorization services for members differ by product line and are listed in the member’s benefit handbook, online at www.alamedaalliance.org and in the specific provider manuals. Exemptions include:

- Emergency Services, whether in or out of Alameda County; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
- Urgent care, whether in or out of network
- Primary Care Visits
- Preventative Services
- 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 – a woman can go directly to any network provider for basic pre-natal care.
- Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention.
- HIV testing and counseling
- Initial Mental Health Assessments
- Early and Periodic Screening, Diagnostic and Treatment

2. Auto-Authorization

- Services approved on the most recent copy of the Medical Management Auto Authorization Matrix.
- Direct - Services for which UM requests are not required, include but are not limited to:
  - Specialty visits, direct network
  - Preventive health diagnostic services, i.e. mammogram, colonoscopy

3. Services Requiring Prior Authorization

The Alliance develops, reviews, and approves at least annually, lists of auto authorizations. Any procedure, treatment, or service not on these lists requires prior authorization. The Alliance communicates to all contracted health care practitioners the procedures, treatments, and services that require prior authorization and the procedures and timeframes necessary to obtain such prior authorization.

Authorization requirements for medical services are listed on the website, at www.alamedaalliance.org. Providers can also review the approved drug formulary at this website.

The services that currently require prior authorization include, but are not limited to:

- Non-emergency out of area care, outside of Alameda County
- Out of network care, for services not provided by a contracted network doctor.
- Inpatient Admissions, non-emergency/elective
- Inpatient Admission to 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 such as CT Scans, MRIs, cardiac catheterization, PET
- Durable Medical Equipment, standard or customized; rental or purchased.
- Medical Supplies
- Prosthetics and Orthotics
- Podiatry services
- Home Health Care, including skilled nursing, nursing aides, rehabilitation therapies, and social workers.
- Transportation
- Transplant Services
- Experimental or Investigational Services
- Cancer Clinical Trials
- Medications not on the Alliance Approved Drug List and/or exceeding the monthly medication limit.
- All admissions to LTSS services - CBAS and Long-Term Care (LTC) facilities
- Acupuncture, greater than 4 visits per month.
- Chiropractic Services- See Prior Authorization grid for detail.
- Radiology Services (i.e. CT, MRI, PET)
- Second Opinions

- Select behavioral health services.

The Alliance also routinely analyzes past utilization patterns to determine whether it would be in the member's best interests to remove any of the listed services from the prior authorization requirement or add additional requirements. The Alliance makes any adjustments to this list by amending the Prior Authorization Policies, as appropriate.

4. Medical Director Responsibilities

The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and health services.

The CMO and Medical Directors, with support of the UM Committee, have the authority, accountability, and responsibility for denial determinations. Physician review and determination is required for all final denial decisions based on medical necessity for requested medical services. The review of the denial of a pharmacy prior authorization for medical necessity, however, may be carried out by a qualified Physician or Pharmacist. For those contracted entities that are delegated UM responsibilities, the entity's Medical Director has the sole responsibility and authority to deny coverage; the Medical Director may also provide clarification of policy and procedure issues, and communicate with entity practitioners regarding referral issues, policies and procedures, etc.

5. Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. Only physicians, pharmacist, or doctoral level behavioral health specialists can make decisions/determinations for denial or modification of care based on medical necessity.

6. Timeliness Standards

The Alliance maintains established timeliness standards for UM determinations for routine and urgent Authorization Requests in compliance with Regulatory Standards for each Product Line as described in corresponding Policies/Procedures. The timeliness of UM decisions shall be commensurate with the seriousness and urgency of the request whether the request is routine or expedited. Time sensitive requests cannot be delayed waiting for medical information. Response to requests must meet required regulatory timeframes.

7. Utilization Review Processes

The UM Program includes the following utilization review processes:

Prospective Review

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

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 Review

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.

Submissions received within 30 days from the date of service will be reviewed for medical necessity. Submissions received after 30 days from the date of service will be denied for not obtaining prior authorization. Exceptions include member eligibility issues, if the services were emergent/urgent, or inpatient services where the facility is unable to confirm enrollment with the Alliance. If the exceptions are met, then the submission will be reviewed for medical necessity regardless of when it was received.

The Alliance maintains instructions for the authorization process on the website and provider training which is available to contracted and non-contracted providers. For non-contracted facilities, the Alliance maintains a 24-hour UM contact notification process on the California DMHC website. The Alliance maintains a full list of conditions eligible for retrospective review by the Department and is reviewed annually for any changes.

8. Outpatient Referral Management

Alliance network physicians are the primary care managers for member healthcare services. Based on the member's assignment, referrals 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. For services identified as requiring prior authorization, PCPs must submit and coordinate prior authorization for several 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.

The UM Program clinical information system tracks all authorized, denied, deferred, and modified service requests and includes timeliness records. These processes are outlined in the Provider Manual and in internal policies and procedures.

Practitioners and providers send referrals and requests for prior authorization of services to the UM Department by mail, fax and/or telephone, based on the urgency of the requested service. Request 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 *(See Section: Minimum Clinical Information for Review of UM Requests for Authorization)*

Requests for services are reviewed in accordance with approved UM criteria and the member's benefit structure. When decisions on coverage are based on medical necessity, relevant clinical information is obtained and consultation with the treating practitioner occurs, as necessary.

Requests for Authorization determinations related to Medi-Cal and IHSS Product Lines are defined differently as follows**:**

- Pre-Service Determinations for Medi-Cal and IHSS are defined in the following terms:
    - 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)

UM staff receive requests for authorization of outpatient services and elective procedures prior to admission to ensure that admission to a healthcare facility is appropriate/medically necessary. Non-Clinical UM staff may approve services which can be auto-authorized, within their scope when the specific elements of the policy are met. Clinical UM staff will review services that require prior authorization based on medical necessity. The medical necessity clinical review is based on the severity and complexity of the individual case, unless there are questions regarding the medical necessity of services.

Should the UM staff question the medical necessity of services to be rendered, or appropriateness of the level of care for service based on review criteria and guidelines, the Medical Director will be consulted for case review. The Medical Director, or physician designee, will contact the attending physician to discuss the case, if necessary.

Should the Medical Director or physician designee determine that proposed services are not medically necessary or indicated, a denial determination may be made by the Medical Director. Denial notification and communication will be made 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.

9. Second Opinion

The 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 medical group, a referral is provided within the Alliance's network. If the 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

10. Standing Referrals

The Alliance maintains process to provide enrollees a standing referral to a specialist. The procedure shall provide for a standing referral if the PCP, in consultation with both the specialist, if any, 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).

The Alliance may require the PCP to submit a treatment plan during care or prior to the referral from the enrollee 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 enrollee, 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 of time during which visits are authorized, or required that the specialist provide the PCP with regular reports on the care and treatment provided to the enrollee.

The Alliance maintains guidelines for standing referral requests for enrollees that required specialized medical care over a period and who have a life-threatening, degenerative, or disabling condition, to a specialist or SCC that has expertise in treating the condition or disease for having specialist coordinate he enrollee’s health care. Standing referral 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 to enrollee, as determined by the PCP in consultation with the Medical Director and as documented in the treatment plan.

11. Concurrent/Continued Stay Review (Acute, Skilled, Rehabilitation)

The Alliance provides telephonic UM services and on-site UM at a sub-set of network hospitals. Appropriate inpatient medical management is ensured through consistent and coordinated Concurrent Review of members, irrespective of the presence or utilization of a contracted hospitalist. Concurrent/Continued Stay Review is a process coordinated by the UM staff during a member's course of hospitalization, which may include acute hospital, skilled nursing, and acute rehabilitation facilities, to assess the medical necessity and appropriateness of continuation at the requested level of care. Concurrent/Continued Stay review also involves the telephonic or on-site medical record review that occurs after admission if no pre-admission review has occurred.

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 Case Management and Transitions of Care Services

The Concurrent Review Procedure shall be followed throughout the member's hospitalization, utilizing approved criteria and guidelines. Telephonic, facsimile reviews or on-site are coordinated by the UM staff daily, or on cyclic intervals based on individual case requirements. In the event a scheduled review date falls on a weekend or holiday, the UM staff will coordinate a Concurrent Review on the work day prior to the scheduled review date, or not later than the first work day after the holiday or weekend.

Continued hospital care and/or ancillary services that do not meet continued stay criteria are referred to the Medical Director, 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.

12. Transition of Care and Discharge Planning

Transition of Care 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 facility. Transition of Care refers to activities related to movement of a member from a clinical setting to a home or community setting.

Discharge planning begins as early as possible during an inpatient admission, 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 staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential need for post-hospital intervention
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member's care.
- Communication to 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, and UM staff.
- Referral to Transitions of Care programs or Home Health Programs within or outside of AAH programs.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director, as previously noted in the Concurrent Review Process.

UM Review Clinicians work with facility discharge planners, attending physicians and ancillary and community service providers to assist in making necessary arrangements for member post- discharge needs. The UM Review Clinicians integrate with the Case Management Population Health driven initiatives by identifying, referring, communicating, and making recommendations that will help meet members' needs and address medical and psychosocial issues that result in hospitalization.

For SPD members, UM Review Clinicians are responsible for ensuring discharge planning is in place ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for discharge planning activities includes:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.
B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical, and mental function, financial resources, and social supports.
C. Services needed after discharge, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.
D. Summary of the nature and outcome SPD beneficiary/representative of the SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action

contemplated by the hospital/institution.

13. Denial Notifications

Adverse Benefit Determination letters or/and Notice of Action (NOA) letters for denials are provided to members and their practitioners in compliance with the member's regulatory appeal requirements. All potential denials and/or modifications of service are discussed with the appropriate Medical Director, who makes the final determination.

Services that are denied, modified, delayed shall contain the following elements:

- Clear, concise, and easily understandable explanation of the reason for denial in the Notice of Action (NOA) or adverse determination letter
- Reference to the specific benefit, guideline, protocol, or other similar criterion on which the denial decision is based.
- Statement that members can obtain a copy of the actual benefit, guideline, protocol, or other similar criterion on which the decision was based.
- Member Rights
- Appeal Rights and Process

In addition to the above for ongoing services that are terminated for all members, the NOA shall include:

- Agreement to an alternative treatment plan by attending practitioner for hospital concurrent decisions and by the PCP for Ambulatory Concurrent decisions
- In addition to the above for Medi-Cal members:
- Citation to the criteria used to support the decision (Medi-Cal only)
- Information about the member's State Hearing rights and process
- "Aid Paid Pending" process, as applicable for Medi-Cal, must also be included.

In addition, All UM NOA correspondences for pre-service and concurrent denials, modifications, and adverse decisions sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer to allow for the Requesting Practitioner to request a reconsider of the UM Determination

14. Peer to Peer Review (Discussing a Denial with a Peer Reviewer)

All UM Notice of Action correspondences for pre-service and concurrent denials, (including modifications, terminations, and adverse decisions) sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer to allow the Requesting Practitioner the opportunity to discuss issues or concerns regarding the decision. If a denial is being considered by the Peer Reviewer, a practitioner can discuss the decision by calling or writing to supply additional information for discussion with the Peer Reviewer. The Peer Reviewer will make himself/herself available for discussion of the denial decision within one business day of the receipt of the provider telephone call or written request. If the discussion does not result in a fully reversed denial determination, the practitioner can initiate an expedited or standard appeal, as

appropriate.

15. Required Internal Reporting for UM Staff

- 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 their UM Manager

16. UM Documents

In addition to this program description, other documents important in communicating UM policies and procedures include:

- The Provider Manual, available on the Alliance web site and on a CD, 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.

- The Provider Bulletin is a periodic newsletter distributed to all contracted provider sites and delegated groups on topics relevant to the provider community and may include UM policies, procedures, and activities.
- The Member Alert is a periodic newsletter distributed to members in all lines of business. Each issue covers different topics of interest and importance to members about their health may include information about UM policies and procedures.

- Evidence of Coverage (EOC) documents are distributed to members based on their product line. Members have the 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.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the UM Program information is available on the Alliance website.

H. Continuity of Care for Medical and Behavioral Health Services

Continuity of care can be defined as 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 must provide continuity of care with an out-of-network provider when:

- 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 beneficiary has seen an out-of-network primary care provider (PCP) 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.
- 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 MediCal 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.

The Alliance is not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protections does not extend to the following providers: durable medical equipment, transportation, other ancillary services, and carved-out services.

The UM staff works with the member and the member's current treating physician and/or PCP to assist the member in continuity of care. Every effort is made to maintain continuity of care for the member during the transition process. If the current treating physician is not affiliated with any of the existing Provider Groups, (PGs,) or with the member's PG selection, the UM staff works with the PGs 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 PG. The UM staff notifies each PG of its membership qualifying for continuity of care assistance.

When members are identified as possibly benefiting from coordination of care, both within and outside of the network, the case is referred to Case Management for further intervention. The Case Management actively 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.

Continuity of care is also evaluated when members are referred from primary care physicians and specialists, including behavioral health specialists, or when a member is transferred or admitted to another level of care, such as a transfer or admittance to a skilled nursing facility (SNF), rehabilitation, chemical dependency, or mental health facility, where member follow through is a risk.

The Alliance documents all requests for assistance with continuity of care and is responsible for monitoring and oversight of the activities. A full description of the various programs is listed in the applicable policies and procedures.

1. *New Enrollees*

The Alliance recognizes that a strong doctor-patient relationship, particularly for members with serious medical conditions, may enhance the healing process. Maintaining continuity of care as new enrollees change physicians and health plans are an important aspect of this relationship. Each newly enrolled Medi-Cal member are placed in a transition group for up to 30 days, during which time they select their Alliance, PG, and PCP.

For a newly enrolled SPD members, the Alliance must honor any active MediCal FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by the Alliance. A new assessment is considered completed by the Alliance if the beneficiary has been seen by an Alliance -contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The FFS TAR must be honored as outlined above without a request by the beneficiary or the Provider.

2. *Terminated Practitioners (Both PCPs and Specialists)*

The Alliance's contracts with delegates establish a mechanism to continue appropriate and timely care for members whose physicians are terminating from the PG. This process includes notification from practitioners of intent to terminate, in accordance with the laws applicable to the line of business. Members under current care, and those with approved prior authorizations, not yet utilized, are identified, so that their care can be managed and coordinated with the receiving entity or with the Alliance physicians. Members, such as those undergoing cancer treatments of chemotherapy or radiation therapy, that are dialysis-dependent, awaiting transplants, in late-term pregnancies, have pending surgeries, or those awaiting transfer or admittance to a skilled nursing facility (SNF), rehabilitation, chemical dependency, or mental health facility, and any other members who might have their ongoing care negatively impacted by the termination of the group are identified.

The Alliance will notify members affected by the termination of a practitioner or practice group in general, family, or internal medicine of pediatrics, at least 30 calendar days prior

to the effective termination date, and help them select a new practitioner.

For members undergoing active treatment for a chronic or acute medical condition, care may be continued through the current period of active treatment or up to 90 calendar days, whichever is less.

3. ***Pregnant and Post- Partum Members***

Pregnant and post-partum Medi-Cal beneficiaries who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into the Alliance have the right to request out-of-network provider continuity of care for up to 12 months in accordance with the Alliance contracts and the general requirements listed in the regulatory guidance. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of regulatory guidance.

For Alliance Group Care, continuation of care extends through the postpartum period for members in their second or third trimester of pregnancy.

4. ***Medical Exemption Requests***

A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into the Alliance only until the Medi-Cal beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer to an Alliance provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from the Alliance enrollment that only applies to beneficiaries transitioning from Medi-Cal FFS to the Alliance. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. The Alliance is required to consider MERs that have been denied as an automatic continuity of care request to allow the beneficiary to complete a course of treatment with a Medi-Cal FFS provider in accordance with the most recent regulatory guidance.

5. ***Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder***

The Alliance is responsible for providing Early and Periodic Screening, Diagnosis, and Treatment 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 beneficiaries diagnosed with 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.

I. Behavioral Health Management

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. In 2021, the Alliance implemented the requirements of All Plan Letter (APL) 21-002 – Implementation of SB 855, Mental Health and Substance Use Disorder Coverage for the Group Care Line of Business. Medi-Cal members receive services for mild to moderate behavioral health services. The provision of treatment for moderate to severe behavioral health services for Medi-Cal members is managed under a Memorandum of Understanding with Alameda County Behavioral Health Care Services, as described below.

The Alliance ensures services are provided in a culturally and linguistically appropriate manner.

1. 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.

2. Behavioral Health

The Alliance contracts with a Managed Behavioral Health Organization (MBHO) NCQA accredited delegate for the provision of behavioral health and substance abuse services not covered through ACBHCS, and for behavioral health and substance abuse services benefits for of all other lines of business. The Alliance delegates behavioral health utilization management activities and the maintenance of the provider network for behavioral health and substance abuse services.

All services are based on a member's benefit plan and the functions delegated to the MBHO by the Alliance. 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 bases services, free-standing and hospital-based programs, residential treatment programs and facility based acute care treatment units. The MBHO uses information provided by the Alliance to determine member-specific benefit coverage, including plan-specific Evidence of Coverage documents, web-based member eligibility verification systems and direct download of member eligibility information via 834 files exchanges. Medical necessity is determined by applying level of care criteria, while the clinical appropriateness of services are evaluated using

Clinical Practice Guidelines. Member specific clinical information is obtained from the member and/or family member or other legal representative, behavioral health medical providers (through verbal case review and/or submission of medical records). Program processes include triage and referral; prospective; concurrent; post-service review and care coordination. Services include education to members and providers, coordination of care with primary care physicians, linkage and coordination with state and community agencies.

The Alliance reviews and approves the MBHO's LOC criteria through the HCQC. The Alliance reviews the criteria to ensure its clinical criteria for both medical and behavioral health services are aligned. MBHO's Level of Care criteria (LOC), as adopted by the UMC, were developed from the comparison of national, scientific and evidence-based criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM.)

The MBHO uses the LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. LOC criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular LOC. However, the individual's needs and characteristics of the local service delivery system are taken into consideration prior to the making of UM decisions.

3. Alameda Alliance Triage and Referral

The Alliance arranges for triage and screening services available by telephone to members 24 hours per day, 7 days per week. The Alliance ensures that the telephone triage or screening services are provided in a timely manner appropriate for the requesting member's condition.

The Alliance is contingent on its contracted provider network to provide 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 Plan provides members the Plan's nurse advice line to call 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.

4. Monitoring Over and Under Utilization of Medical and Behavioral Health Services

The CMO or its physician designee monitors patterns of over and under-utilization.

Data is reviewed at the UMC and HCQC and when a pattern of under or over utilization is identified an analysis of barriers is conducted and potential interventions are identified. Data is then re-evaluated to determine the efficacy of the interventions.

When a concern over potential over or under-utilization for a specific member is identified, the clinical team including the Primary Care Physician, under the direction of the UM Medical Director, develops a plan to address the utilization issue which may include referral to Behavioral Health Case Management and/or the Alliance's Case Management or Disease Management programs, physician peer to peer with the inpatient attending physician, referral to the Alameda county mental health authority for additional services and supports.

5. Behavioral Health Integration

Members may contact their appropriate behavioral health organization directly 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 HCQC meetings to support, advise, and coordinate behavioral healthcare aspects into UM Program policies, procedures and processes.
- 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 receives clinical reports from its Behavioral Health provider network which are reviewed by the Chief Medical Officer, the Senior Director of Health Care Services, the Senior Director of Quality Improvement, and the Director, Compliance, or designees.
- The Alliance participates in quarterly operational meetings with the Behavioral Health provider network delegate to review and coordinate administrative, clinical, and operational activities.

J. Pharmacy Management

Starting in 2022, much of the pharmacy benefit for MediCal members is carved out to the DHCS Medi-Cal Rx program. For those pharmacy benefits not carved out and for the commercial LOB, the Alliance ensures the provision of pharmacy management to a

pharmacy benefit manager (PBM), PerformRx. 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 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 the regulatory requirement. Pharmacy UM decision monitoring is reported through the UM Committee.

K. Linked and Carved Out Services

For linked and carved out services the Alliance provides linkages with community 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 special programs, such as the Alliance Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the California Children's Services, Alameda County Behavioral Health Care Services, and the Regional Center of the East Bay (RCEB). The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate State 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 with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

A full description of program the identification and referral process as well as the care coordination activities is maintained in the UM department policies and procedures.

Section IV. 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, whether MediCal or Group Care. 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.
Medi-Cal Members are covered for all medically necessary organ transplants:

a) As of 2022, the Alliance is responsible for all Major Organ Transplants/Bone Marrow Transplants. (MOT/BMT,) in addition to the kidney and corneal transplants previously covered.
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 the CCS-eligible member to the transplant Special Care Center, (SCC.) for adjudication of the request and follow-up.
c) Major Organ transplant evaluations are referred to one of the MediCal facilities noted as Center of Excellence (CoE) on the most recent DHCS CoE list of facilities for evaluation. The Alliance will authorize the request for the transplant after the transplant program confirms the transplant candidacy of the member. Once the transplant program confirms that the member is a suitable transplant candidate, the Alliance will authorize the request for the transplant.
d) Kidney and corneal transplants are provided through Alliance-approved practitioners.
e) 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.

Group Care (IHSS) Members are covered for all medically necessary organ transplants. This coverage is provided by Alliance-approved practitioners and facilities.

A full description of the program, including the identification and referral process as well as the care coordination activities is maintained in the department policies and procedures.

B. Transportation Services

Transportation services are covered benefits. Transportation benefits include:

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

Benefits are administered based on the guidance of the Alliance product line. Those products include:

- MediCal

- IHSS

For the administration of the benefit:

- For Members enrolled with Kaiser, the Alliance delegates the responsibility for the provision of transportation services to the contracted Plan Partner.
- For the administration of MediCal Direct and IHSS, the Alliance is responsible for the provision of transportation services.

The Alliance contracts with a vendor, Modivcare, (formerly called Logisticare,) to provide the various modes of transportation. The vendor's UM Department is delegated for the utilization review process to determine medical necessity when required; the vendor is not delegated for potential denials. All potential denials are referred to the Alliance UM Medical Director for final determination. Utilization review is performed using the transportation guidance for the product, and as needed, a Physician Certification Statement (PCS). A full description of the process is defined the most recent policies on transportation services.

C. Transportation Access to Early and Periodic Screening, Diagnostic and Treatment Services

The Alliance is responsible for the provision of medical and non-medical transportation to eligible children under the age of 21 to access Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The Alliance is required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation, 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 MediCal Members Under the Age of 21.

D. Long Term Services and Supports

The UM program includes oversight of the UM clinical decision-making review and authorizations for access to Long Term Service and Support benefits including Long Term Care (LTC) and Community Based Adult Services (CBAS). LTSS is responsible for the programmatic management of the LTSS programs. The Alliance administers the LTC and CBAS program elements as defined by the most recent DHCS contract, MMCD letter, or APL.

1. Long Term Care

The Long-Term Care (LTC) UM activities includes long term skilled care authorizations for the following facilities: skilled nursing, intermediate care, sub-acute care, intermediate care; developmentally disabled, intermediate care–developmentally disabled—

habilitative, and intermediate care–developmentally disabled—nursing, residential care facilities, board and care, and assisted living facilities. LTC excludes Institutes for Mental Disease and special behavioral health treatment programs. Authorizations are provided based on member's meeting criteria the eligibility and nursing facility admission criteria.

For Medi-Cal members: Long Term Care (LTC) services for eligible MediCal members. The Alliance is responsible for the provision of LTC services for the month of admission plus the following month. The UM Department is responsible for providing the following activities:

- If a Member requires LTC in the facility for longer than the regulatory timeframe for admission, the Alliance shall submit a disenrollment request for the member to DHCS, for approval.
- The Alliance shall provide all Medically Necessary Covered Services to the Member until the disenrollment is effective. For these Members, an approved disenrollment request will become effective the first day of the eligible month, provided Contractor submitted the disenrollment request at least 30 calendar days prior in the appropriate timeframe. If the Alliance submitted the disenrollment request less than 30 calendar days prior to that date, disenrollment will be effective the first day of the month that begins at least 30 calendar days after submission of the disenrollment request. Prior to the disenrollment effective date, the Alliance shall ensure the Member's orderly transfer from the Alliance's Provider to the Medi-Cal Fee-For-Service program. This includes notifying the Member and his or her family or guardian of the disenrollment; assuring the appropriate transfer of medical records or copies from the Alliance's Provider to the Medi-Cal fee-for-service provider; assuring that continuity of care is not interrupted; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Members.
- Admission to a nursing facility of a MediCal Member who has elected hospice services does not affect the Member's eligibility for Enrollment. Hospice services are Covered Services under and are not long-term care services regardless of the Member's expected or actual length of stay in a nursing facility.

2. CBAS

The Alliance administers the CBAS program elements as defined by the most recent DHCS contract, MMCD letter, or APL. The Alliance maintains procedures, processes, and mechanisms for administering assessments and re-assessments for CBAS services. For providers delegated to perform the CBAS assessments, the Alliance provides the necessary delegation oversight and monitoring activities. The Alliance develops mechanisms to generate and distribute the required reports to the identified DHCS departments.

E. 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 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 authorization, such as physician assessments and care plans.

The Alliance informs and educates its providers regarding availability of the palliative care benefit through its website and education materials.

The Alliance identifies members eligible for palliative care by the following:

- Screening for palliative care eligibility in Complex Case Management referrals
- Referrals from network providers, including through case management, concurrent review, and the general authorization process.
- Analysis of member data

Palliative care services follow the general authorization process is outlined in the UM policy and procedures. 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.

Section V. Quality Improvement Integration

The UM Program includes a wide variety of quality assurance activities to support positive member outcomes and continuous quality improvement. The CMO guides these activities in collaboration with the Senior Director of Health Care Services, the Administrative Director of Quality and the Director of Accreditation, and oversight of the HCQC. Performance results are analyzed and reviewed with opportunities for improvement identified for intervention and performance management. The following quality activities are included in the UM Program:

- Monitoring Under and Over Utilization, including Out of Network and Provider Capacity monitoring.
- Monitoring of Member Experience with the UM process.
- Monitoring UM Appeals for UM Decision Making.
- Potential quality issue referrals.
- Provider Preventable Condition identification and referral.
- Inter-rater reliability assessments.
- Delegation oversight including Corrective Action Plan completion and process improvements if audit findings occur.

The UM data sources, and information used for quality monitoring and improvement activities 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.

A. Monitoring Over and Under Utilization

The Alliance regularly monitors member service utilization using industry standard utilization measures. Medi-Cal contracts require that plans report rates to detect over and under-utilization. Rates for these measures vary based on the relative health of each population. For instance, usage rates for Non-SPD Medi-Cal members tend to be significantly lower than those for SPD Medi-Cal and IHSS members because the former populations are generally younger and healthier. Monitoring reports include changes in membership totals for each line of business in the last 12 months. National and regional benchmarks are not available for every line of business. In the absence of such benchmarks, the Alliance closely monitors monthly, quarterly, and annual data for significant changes and trends, reports the results quarterly to the UMC and HCQC, and acts when indicated.

UM data elements are reviewed to assess over/under utilization of services for either medical and/or behavioral health include but are not limited to the following:

- Ambulatory Services – e.g. Outpatient encounters per enrollee per year primary care visits, specialist visits, preventive health care.
- Out of Network Specialty Referrals, e.g. specialists, behavioral health care.
- Acute Hospital Services

  - Emergency room visit rates.
  - Hospital admit rates.
  - Bed days rates.
  - Length of Stay.
  - Re-admission rates.
- Behavioral health utilization data.
- Pharmacy utilization rates.
- HEDIS measures for use of services
- Complaint reports (Grievance & Appeals) that reflect barriers for access to care or delivery of care.

Because of these clinical data analyses, the Alliance identifies opportunities for improvement through root cause analysis, action plans and the continuous improvement cycle ensure the actions taken are improving performance. When appropriate, feedback is provided to both entities and individual practitioners allowing their input into the improvement activities. The Alliance continues to monitor the action plans to ensure the activities improvements in the care delivery process.

B. Experience with Utilization Management

Annually Alliance members and providers are surveyed to assess their experience with the plan's utilization management processes and services. Data is collected and analyzed to identify improvement opportunities. For identified opportunities, Alliance takes actions designed to improve the experience based on the data.

1. Member

Alliance uses survey data to assess the member experience with the UM process. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by mail to Alliance Medi-Cal members. Among the composite measures are member ratings for: 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. The CAHPS summary rate results are compared to Medicaid benchmarks. The UM department participates on the member satisfaction team and develops action plans to improve member satisfaction.

2. Provider

Annually, the Alliance surveys its providers for their experience with the plan's utilization management processes and services. 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:

- Access to knowledgeable UM staff.
- Procedures for obtaining prior authorization information.
- Timeliness for obtaining prior authorization information.

- The Plan's facilitation/support of appropriate clinical care for patients.
- Degree to which the Plan covers and encourages preventive care and wellness. Alliance provider survey responses are benchmarked against other Medi-Cal/Medicaid plans that use the same vendor's survey.

Alliance conducts quantitative and qualitative analysis to identify areas for improvement. Outcomes of the assessments are presented to the UMC and HCQC to assist in identifying opportunities for improvement. If the analysis indicates that there are opportunities to improve experience with UM, Alliance UM Department participates on the provider satisfaction team. Activities identified to improve the member and provider experience with UM are used to update the following years UM Program.

C. 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 Nurses and Physicians. Trending data for clinical appeals and fair hearings is reported to the UMC for the identification and recommendations of opportunities to improve the UM experience for members and providers. On a quarterly basis, the UM Department will review and analyze grievance data. The evaluation is reported to the UMC.

Appeal decisions are made by a practitioner who was not involved in the initial decision unless the case is overturned. A same-or similar specialist review is required for all appeals of medical necessity decisions. The details of the appeal process are outlined in the Alliance Appeals Policy and Procedure.

D. Potential Quality of Care/ Provider Preventable Reportable Conditions

At any time during an UM review, staff identify a condition or situation that appears to deviate from the professional standard of care or identified by regulatory guidance as a Potential Quality of Care or Provider Preventable Reportable Condition, are referred to the Quality Improvement Department to be evaluated per policy and procedure.

E. UM Delegation Activities

The Alliance delegates UM 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 finding are summarized at HCQC 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 pertaining to 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.

F. Inter-Rater Reliability Testing

Inter-Rater Reliability (IRR) Testing is a method used at the Alliance to assess the degree of agreement among personnel who make utilization management decisions. It provides a score of how much homogeneity or consensus there is in responses to utilization management cases. The purpose is for the Alliance to provide consistency and accuracy of review criteria applied by all reviewers - physicians and non-physicians and to act on improvement opportunities identified through this testing. This report provides an analysis of the Alliance’s testing for each year and fulfills regulatory, contractual and accreditation requirements associated with ensuring the consistency in applying UM criteria and acting on identified improvement opportunities.

IRR testing is conducted following the Alliance internal policy (QI-133 Inter-Rater Reliability—Testing for Clinical Decision Making) for UM, QM and Pharmacy staff that participates in the Health Services medical necessity decision making process. IRR test results are collated and reviewed by management.

Reports on IRR test results are reviewed and approved by the HCQC. The IRR process and reports are reviewed for delegated entities during the annual auditing process.

G. UM Department – Internal Quality Review

To ensure the oversight of the internal UM process, Alliance UM Department conducts ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. Alliance UM Department has implemented a monitoring program for the early identification of potential compliance risks. In addition, the program includes an opportunity to provide quality oversight of the current UM processes. This is accomplished by internal monitoring of UM authorization

files on a routine and/or periodic basis.

1. UM File Review

UM will complete file reviews using a defined methodology for the file selection. Files will be assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement. The process outcomes will also be utilized for staff performance. 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, and appropriate referral to physician reviewers as needed. For cases that are denied or modified, the file will assess the NOA requirements for communication to the member and provider.

2. Audit of Authorization Processing Turn-Around-Time (TAT)

An authorization aging report is used to monitor TATs for authorizations. Any opened authorization without a final determination will appear in this report. The UM Manager or designee will work this report daily to ensure all authorization determinations are compliant with UM will complete file reviews using a defined methodology for the file selection. Files will be assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement.

H. Annual UM Workplan

Each year, the Alliance establishes objectives and priorities and outlines a strategic UM Workplan for the coming year. The UM Workplan incorporates anticipated timeframes, responsible parties, and status of activities. The UM Workplan is submitted to the UM Committee for approval annually. See Attachment B – 2022 UM Workplan.

I. Annual UM Evaluation

Members of the UM Program management team annually evaluate and update the UM Program to ensure the overall effectiveness of UM Program objectives, structure, scope.
and processes. 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; and
- Recommendations for program revisions and modifications

The UM Program management team presents a written program evaluation to the UMC and HCQC. The UMC and HCQC reviews and approves the UM Program evaluation on an annual basis. The review and revision of the UM program description may be conducted more frequently as deemed appropriate by the UMC, HCQC, CMO, CEO, or BOG.

The HCQC's recommendations for revision are incorporated into the UM Program description, as appropriate, which is reviewed and approved by the BOG and submitted to DHCS on an annual basis.

UM Program Recommendations for 2022

As a result of internal performance monitoring performed in 2021, opportunities for improvement were identified and will be incorporated into the 2022 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Improve monitoring of network utilization (over/under), including out of network authorization requests particularly focus on the Stanford analysis.
- Continued monitoring of Specialty Referrals.
- Collaboration with the Alliance Compliance Department on the full implementation of the UM process for internal performance monitoring of UM decisions.
- Strengthen programs around oversight of clinical decision making, both internally and for Delegates.
- Continue the Transition of Care program in partnership with Highland Hospital and expansion to other hospitals, with attention to readmission risk screening and disease management
-
- Continue using the analysis of hospital data to work with hospital partners on individual hospital strategies for management of members for appropriate length of stay and timely discharge planning.
- Tighten concurrent reviews for progression of care and early discharge planning, increased internal oversight and identification of catastrophic stays, and escalating complex discharge barriers.
- Provide leadership to the initiative on Major Organ Transplant carve in, including expanding staffing to manage this vulnerable population, in collaboration with all relevant Alliance departments.
- Evaluate the options to develop and refine the ADT feed coming from contracted hospitals to enhance communication, coordination of care, and automation of UM Case creation in TruCare.
- Explore Quality initiatives with the Quality Department around PQIs, HEDIS measures, and PPCs.
- Work with the Alliance Case Management Department and all relevant Alliance departments to engage on UM aspects of CalAIM for ECM and CS in 2022.
- Provider leadership to the initiative for enhanced care coordination for high-risk hemodialysis members with DaVita.
- Analyze the opportunity and implement the process to increase the number of authorizations that are appropriate for automatic approval.
- Improve reporting and analysis of grievance and appeals activities related to UM decision making and analysis for member and provider experience with UM.
- Continue implementation for tracking and intervening with unused Authorizations to ensure that members receive appropriate care and follow up.

- Enhance collaboration opportunities with California Children's Service to ensure coordination of care for members carved out to CCS care.
- Fully implement the carve in of all Major Organ Transplants to the plan.
- Continue to monitor and enhance the use of the Palliative Care benefit for members in collaboration with outside partners.
- Continue the development for the Stanford Oncology program, including streamlining authorizations and coordination with Case Management.
- Continue the analysis of hospital data and develop an individual hospital strategy for management of members for appropriate length of stay.
- Hardwire the standardized work and training for the UM department staff to ensure regulatory compliance.
- Enhanced IRR training and educational enrichment for UM staff.
- Hardwire a standard process for policy review and revision that ensures UM processes maintain operational and regulatory compliance.

Attachment A

2022 The Alliance Delegated Network or Vendor Relationships

Delegate	Provider Type		Delegated Activity - UM	Delegated Activity – Grievance and Appeals	Exceptions
Kaiser	HMO		X	X	
Alameda Health System	Delivery System			NA	
CHCN	Medical Group		X	NA	
CFMG	Medical Group		X	NA	
California Home Medical Equipment (CHME)	Vendor DME		X*	NA	* Not delegated for denials
Beacon/College Health IPA (CHIPA)	MBHO		X	NA	
ModivCare	Vendor -		NA	NA	* Not

	Transportation				delegated for denials
March Vision	Vendor – Vision Services		NA	NA	

Attachment B – 2022 UM Work Plan

See attached document.

ALAMEDA ALLIANCE FOR HEALTH
QUALITY IMPROVEMENT – PROGRAM EVALUATION 2021

ALAMEDA Alliance FOR HEALTH

2021
Quality Improvement Program Evaluation Signature Page

Stephanie Wakefield, RN Senior Director of Quality	Date
Sanjay Bhatt, M.D. Senior Medical Director Vice Chair, Health Care Quality Committee	Date
Steve O'Brien, M.D. Chief Medical Officer Chair, Health Care Quality Committee	Date
Scott Coffin Chief Executive Officer	Date
Evan Seevak, M.D. Board Chair	Date

ALAMEDA Alliance FOR HEALTH

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 295,151 children and adults through its programs.

Under the leadership and strategic direction established by the Board of Governors (BOG), senior management and the Health Care Quality Committee (HCQC), the Health Care Services 2021 Quality Improvement (QI) Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2021 through December 31, 2021.

Mission, Vision, and Values

Mission

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

Vision

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

Values

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

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

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

ALAMEDA
Alliance
FOR HEALTH

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

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

Purpose

The purpose of the Alliance 2021 Annual QI Program Evaluation is to access and evaluate the overall quality and effectiveness of the QI Program in meeting the goals and objectives of the QI Program and Work Plan and covers Medi-Cal and Group Care lines of business. The QI Department leads the evaluation assessment in collaboration with cross function departments utilizing data and reports from committees, content experts, data analysts, work plans outcomes, Plan-Do-Study-Act studies, Performance Improvement and QI Projects to perform qualitative and quantitative analysis of initiatives and activities outcomes, identify barriers to established goals and objectives, best practices, next steps, and other improvement opportunities. The Alliance uses the annual evaluation to identify new and ongoing goals, objectives, and activities for the QI Program in the coming year.

This evaluation assesses the following elements:

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

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

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

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

Membership and Provider Network

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

Coordinated Care Initiative (CCI). For dually eligible Medi-Cal and Medicare beneficiaries,

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

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

Table 1: 2021 Trended Enrollment by Network and Aid Category

Current Membership by Network By Category of Aid							
Category of Aid	**Nov 2021**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	42,623	15%	9,085	8,900	658	16,232	7,748
Child	97,935	34%	9,163	8,746	29,410	32,796	17,820
SPD	26,427	9%	8,330	4,093	1,079	10,916	2,009
ACA OE	101, 508	35%	16,220	33,202	1,118	37,722	13,246
Duals	20,832	7%	8,168	2,230	1	7,465	2,968
Medi-Cal	289,325		50,966	57,171	32,266	105,131	43,791
Group Care	5,826		2,472	902	-	2,452	-
Total	**275,589**	**100%**	**53,438**	**58,073**	**32,266**	**107,583**	**43,791**
Medi-Cal %	98.0%		95.4%	98.4%	100.0%	97.7%	100.0%
Group Care %	2.0%		4.6%	1.6%	0.0%	2.3%	0.0%
Network Distribution			*18.1%*	*19.7%*	*10.9%*	*36.5%*	*14.8%*
			% Direct:	**38%**		**% Delegated:**	**62%**

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Table 2: 2021 Trended Categories of Aid, Distribution and Growth/Loss

Category of Aid Trend	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Nov 2019	Nov 2020	Oct 2021	Nov 2021	Nov 2019	Nov 2020	Oct 2021	Nov 2021	Nov 2019 to Nov 2020	Nov 2020 to Nov 2021	Oct 2021 to Nov 2021
Adults	32,357	37,638	42,177	42,623	12.9%	13.8%	14.4%	14.4%	16.3%	13.2%	1.1%
Child	89,711	94,620	97,636	97,935	35.8%	34.6%	33.3%	33.2%	5.5%	3.5%	0.3%
SPD	25,691	26,314	26,366	26,427	10.2%	9.6%	9.0%	9.0%	2.4%	0.4%	0.2%
ACA OE	79,104	89,752	100,844	101,508	31.6%	32.8%	34.3%	34.4%	13.5%	13.1%	0.7%
Duals	17,779	18,990	20,692	20,832	7.1%	6.9%	7.0%	7.1%	6.8%	9.7%	0.7%
Medi-Cal Total	244,642	267,314	287,715	289,325	97.6%	97.8%	98.0%	98.0%	9.3%	8.2%	0.6%
Group Care	6,056	5,982	5,880	5,826	2.4%	2.2%	2.0%	2.0%	-1.2%	-2.6%	-0.9%
Total	**250,698**	**273,296**	**293,595**	**295,151**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.0%**	**8.0%**	**0.5%**

Table 3:2021 Trend Enrollment by Age Category

	Members				% of Total (Distribution)				% Growth (Loss)		
Age Category	**Nov 2019**	**Nov 2020**	**Oct 2021**	**Nov 2021**	**Nov 2019**	**Nov 2020**	**Oct 2021**	**Nov 2021**	**Nov 2019 to Nov 2020**	**Nov 2020 to Dec 2021**	**Oct 2021 to Nov 2021**
Under 19	92,318	97,068	99,912	100,206	37%	36%	34%	34%	5%	3%	0%
19 - 44	79,016	91,897	103,423	104,239	32%	34%	35%	35%	16%	13%	1%
45 - 64	54,703	57,413	60,392	60,571	22%	22%	21%	21%	5%	6%	0%
65+	24,661	26,918	29,868	30,135	10%	10%	10%	10%	9%	12%	1%
Total	**250,698**	**273,296**	**293,595**	**295,151**	**100%**	**100%**	**100%**	**100%**	**9%**	**8%**	**1%**

In November of 2021, the Alliance annual membership increased by 8.0% from November 2020 . The Alliance experienced membership growth in all age categories from 2020 to 2021 with a **3.0%** membership growth for ages under 19, **13%** growth (largest growth category) in the 19-44 age category, **6.0%** growth for 45-64 age category and **12%** growth for the 65+ age category. Percent of total distribution by age category remained stable from 2020 -2021.

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A driver of the increase in membership was the economic downturn related to the 2020 – 2021 pandemic and the lack of member dis-enrollments from health plans by the state.

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

Table 4: 2021 Provider Network by Type, Enrollment and Percentage

PROVIDER NETWORK	PROVIDER TYPE	MEMBERS (ENROLLMENT)	% OF ENROLLMENT IN NETWORK
Direct-Contracted Network	Independent	52,288	17.6 %
Alameda Health System (AHS)	Managed Care Organization	58,590	19.7%
Children First Medical Group (CFMG)	Medical Group	32,573	11%
Community Health Clinic Network (CHCN)	Medical Group	109,059	36.8%
Kaiser Permanente	HMO	44,218	14.9%
	TOTAL	**275,589**	**100%**

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

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

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

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

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

The Alliance provider network includes:

Table 5: Alliance Ancillary Network

ANCILLARY TYPE	COUNT
Behavioral Health Network	1
DME Vendor	1 Capitated, 12 Non-Capitated
Health Centers (FQHCs and non-FQHCs)	68
Hospitals	17
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200
Skilled Nursing Facilities	65
Transportation Vendor	1 individual vendor with 380 individual transportation providers

Alliance members may choose from a network of over 590 primary care practitioners (PCPs), more than 7000 specialists, 17 hospitals, 68 health centers, 6 nursing facilities and more than 200 pharmacies throughout Alameda County. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our first priority.

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

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QI Structure and Resources

A. QI Structure

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

B. Governing Committee

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

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

The HCQC:

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

The HCQC met a total of 6 times in 2020:

- January 21, 2021
- March 18, 2021
- May 20, 2021
- July 15, 2021
- September 16, 2021
- November 18, 2021

The 2021 QI Program Description was reviewed and approved at the March 18, 2021, HCQC meeting and unanimously approved. The 2020 QI Program Evaluation and the 2021 QI Work Plan were presented at the May 20, 2021, HCQC meeting and unanimously approved.

C. Committee Structure

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

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

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

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

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

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

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

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

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

During 2021, Dr. Aaron Chapman, a psychiatrist and CMO of Alameda County Behavioral Health Care (ACBH), actively participated in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications.

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

E. Program Structure and Operations

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

2021 QI Program activities included, but were not limited to the following:

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

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

F. QI Resources

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

The QI program moved forward in providing quality improvement guidance enterprise-wide meeting regulatory and accreditation standards and promoting positive health outcomes for the Alliance membership. In late October 2020 the QI Department experienced a vacancy in the Access to Care Manager position due to employee resignation and this position remained vacant through 2021 despite aggressive recruitment and use of temporary to hire staff. The Senior Director of Quality provided direction and oversight of Access and Availability unit during 2021. Health Care Services continues to evaluate staff turn-over and strives to provide a positive work environment while creating a stable work force.

Throughout 2021, vendor partnerships were a part of the QI resource strategy. The QI department continued to augmented QI resources via consultants and analytic expertise for the HEDIS program.

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

In 2021 SPH supported the QI Department work with implementation, analysis, and reporting on the following surveys:

- Afterhours and Emergency Instruction Survey

- Member Satisfaction Survey (CAHPS 5.0, CG CAHPS)
- Provider Satisfaction Survey

Overall Program Effectiveness

The Alliance's quality improvement efforts strive to impact the safety and quality of care and service provided to our members and providers. Review of the Alliance's 2021 QI activities as described herein demonstrates the Alliance's QI department ability (in collaboration with internal and external entities) to successfully assess, design, implement, and evaluate an effective QI Program including but, not limited to, the following:

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

1. Maintained a targeted focus on the analysis of key drivers, barriers, and best practices to improve access to care.
2. Expanded staff knowledge of health disparities and equity within the Alliance membership through population data collection, analysis, and segmentation and targeted quality improvement activities as part of Population Health Management Program
3. Promoted the awareness and concepts of inter-departmental QI initiatives and activities, including Plan-Do-Study-Act (PDSA), and Inter-Rater Reliability (IRR), to:
    - identify, investigate, and resolve Potential Quality Issues (PQIs)
    - identify and address service over-and-under utilization
    - promote patient safety
    - remove barriers to access to timely care and services
4. Invested in quality measurement analysis expertise.
5. Identified Potential Quality Issues (PQIs) operations gaps and root cause analysis to identify and overcome barriers, as well as best practices resulting in internal workflow improvements and staff retraining.
6. Exhibited improvement in HEDIS measures' performance including CIS-Combo 10, IMA-Combo 2, PPC, AMR, CCS and AMM.
7. Ensured timely Facility Site Review (FSR/Medical Record Review (MRR) audits and Physical Accessibility Review Surveys (PARS) in person and virtually within a PHE environment.
8. Targeted QI initiatives to improve direct and delegate provider engagement in access to care efforts to improve rates of preventive care and services, screenings, and referrals for members

9. Targeted partnerships with community-based county agencies and delegate providers to improve referral and resources triage and management through technology collaboration and support.
10. Promoted healthcare access and safety education for members and providers through targeted pharmacy substance use programs.
11. Improved engagement with interpreter services vendors and Alliance network providers to ensure quality interpreter services at all points of healthcare service contact.
12. Enhanced engagement with Behavioral Health delegate for improved and timely access to care.
13. Collaborated with First 5 of Alameda County and delegate provider networks to improve WCV and EPSDT service utilization for pediatric and adolescent members.

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

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Serving Members with Complex Conditions

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

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

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

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

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

Provider Outreach and Engagement

During 2021, the Provider Services department provided continued outreach to all PCP, Specialists and Ancillary provider offices via the use of fax blasts. In-person visits continue to be suspended due to the Shelter-in-Place orders went into effect in March 2020 and since Alameda Alliance employees are currently working from home. Subsequently, outreach and engagement with providers resumed through alternative modalities of virtual meetings, email, telephone, 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, Rx Safety Guidelines and updates, Blood Lead Screening information, DHCS Medi-Cal Rx updates, Immunizations, provider network updates, outpatient authorization updates and reminders, Secondary Claim notice, Annual Healthcare Effectiveness Data and Information Set® (HEDIS) medical record data retrieval notice, Fraud, Waste and Abuse information, Cultural Sensitivity Training, Telehealth Survey information, Timely Access Standards Reminders, Pay-for-Performance program, provider contracting updates, and COVID-19 Vaccine information.

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

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

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

Overall, there were over 500 quarterly packets mailed to providers with updates as mentioned above. Additionally, 2,870 outreach occurrences conducted during the 2021 calendar year. The Provider Services department plans to continue our robust provider outreach and engagement strategies in 2022.

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 provider 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 on a quarterly basis. The following internal standards and goals are used to evaluate access to 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 %

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

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Table 6: 2021 Quarterly Call Center Metrics

ALLIANCE MEMBER SERVICES STAFF	Q1	Q2	Q3	Q4
Incoming Calls	35400	37357	38568	33282
Answered Calls	33287	33412	30002	27725
Abandoned Rate	6%	10%	22%	17%
Average Speed to Answer (ASA)	01:13	01:42	04:46	03:40
Calls Answered in 30 Seconds (All)	65%	54%	26%	38%
Average Talk Time	07:56	07:22	08:01	08:10
Calls Answered in 10 Minutes (goal: 100%)	100.0%	100.0%	87%	90%
Recordings/Voicemails	Q1	Q2	Q3	Q4
Incoming Calls (R/V)	5413	5422	5854	5084
Answered Calls (R/V)	5413	5422	5854	5084
Abandoned Rate (R/V)	0%	0%	0%	0%
Calls Answered in 30 Seconds (R/V)	100%	100%	100%	100%
Blended Results	Q1	Q2	Q3	Q4
Incoming Calls (R/V)	40813	42779	44422	38366
Answered Calls (R/V)	38700	38834	35856	32809
Abandoned Rate (R/V)	5%	9%	19%	14%
Average Speed to Answer (ASA)	01:03	01:27	03:59	03:05
Calls Answered in 30 Seconds (R/V)	72%	61%	38%	48%

The pandemic presented many challenges that impacted our call volumes, abandonment rate; talk times and service levels. Increased level of member emotion and anxiety in service calls contributed to increase in talk time averages. Staffing challenges due to the pandemic had a tremendous impact on the call center. Member Services implemented various changes to help meet the needs of our members, including the re-design of its call tree menus to offer additional self-service options to improve member experience and satisfaction. The Department continues to monitor and track call center operations to ensure compliance and quality standards are met.

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Member Advisory Committee (MAC)

In 2021, the Member Advisory Committee (MAC) functioned to provide information, advice, and recommendations to the Alliance on member educational and operational issues in respect to the administration of the Alliance's cultural and linguistic services. These advisory functions include but are not limited to, providing input on the following:

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

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

The MAC met four times in 2021:

- March 18, 2021
- June 17, 2021
- September 16, 20201
- December 2, 2021

Some of the key topics discussed in 2021 included:

- Alameda Alliance for Health Strategic Plan
- COVID-19
- Cultural and Linguistics Work Plan and Report
- Grievances & Appeals
- Communications & Outreach collateral, events, and activities
- Member Health Programs such as Transition of Care, Stanford Cancer Program, Enhanced Care Management, Major Organ Transplant and Community Supports

- Pharmacy Updates
- Pediatric Care Pilot – EPSDT Services
- Population Needs Assessment
- Questions & Answers for member concerns
- Timely Access Report

Member Newsletter

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

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

Safety of Clinical Care

In 2021, the Alliance continued its organizational focus on maintaining safety of clinical care for its membership.

A. Substance Use Disorder

In 2020 the Alliance partnered with our network providers and other local leaders to develop a Substance Use Disorder Program and have continued the work through 2021.

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

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

In 2021, the Alliance sent out quarterly educational mailings that is pertinent to members and providers. The mailings included:

1. Lists of identified members who are chronic users, high risk members on becoming chronic users, concurrent chronic opioid/benzodiazepine usage and members presenting to ED for opioid/benzodiazepine overdose
2. Provider Opioid and Benzodiazepine Tapering Tools
3. Opioid Safety guide for members and caregivers
4. Non-opioid formulary alternatives
5. Treatment for opioid dependence

Table 7: Escalation Process based on opioid use

Day	Member	Provider
1	Original mailing gets sent out	Original mailing gets sent out.
45	Repeat mailing. Refer to case management if member is on greater than 300 MME.	Repeat mailing.
90	Check if member transition to buprenorphine or received appropriate pain treatment.	Receive letters from medical director. Submit a PQI.
120	N/A	Include operations and peer review committee to decide whether to keep in-network.

B. Opioids Stewardship Report

Progress in 2021

August 2021: Mailings to 13 high-risk members with prescriptions of greater than 300 MME 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
- Map of providers in member's area

November 2021: Mailings to 63 rising risk members with prescriptions between 50 to 89 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

December 2021: Mailings to providers with members who were on any of the following lists:

- Opioid and Benzodiazepine Co-use list (68 members)
- Rising risk list: 50-89 MME for 3 consecutive months (64 members)
- High risk list: 300+ MME for 3 consecutive months (11 members)
- Opioid and Benzodiazepine ER list (137 members)

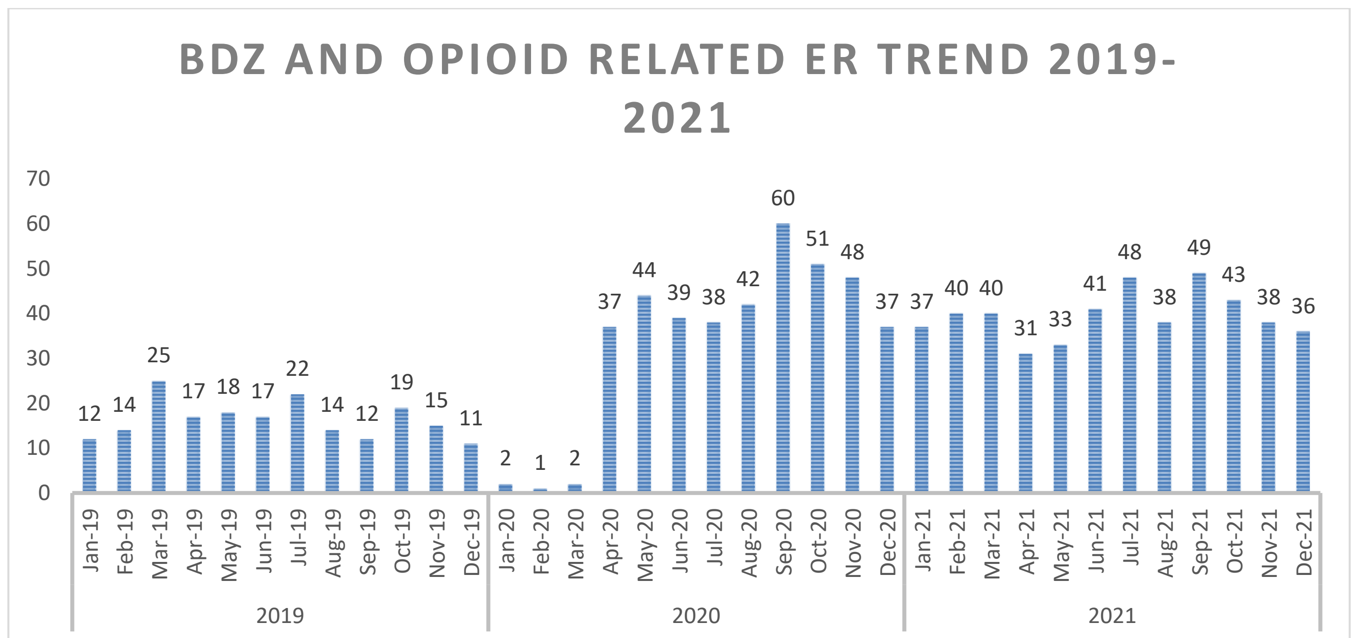
The Alliance developed a Provider packet featuring Tapering Tool, shared data for providers/delegates/committees and had the health education materials, maps, and member facing materials approved

Opioid and Benzodiazepine ER Reporting

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

- The Alliance will continue to improve our opioid stewardship program. Below are results of our interventions.

Table 8: 2019-2021 Opioid/Benzodiazepine related ER Visits



The Alliance has been tracking members' ER visits related to benzodiazepines and opioids since 2019. This data is shared with clinic partners.

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Table 9: Members on SAO, LAO, and both SAO and LAO for 2021

2021	SAO	LAO	BOTH
Q1	300	91	39
Q2	345	94	42
Q3	340	116	80
Q4	280	98	62

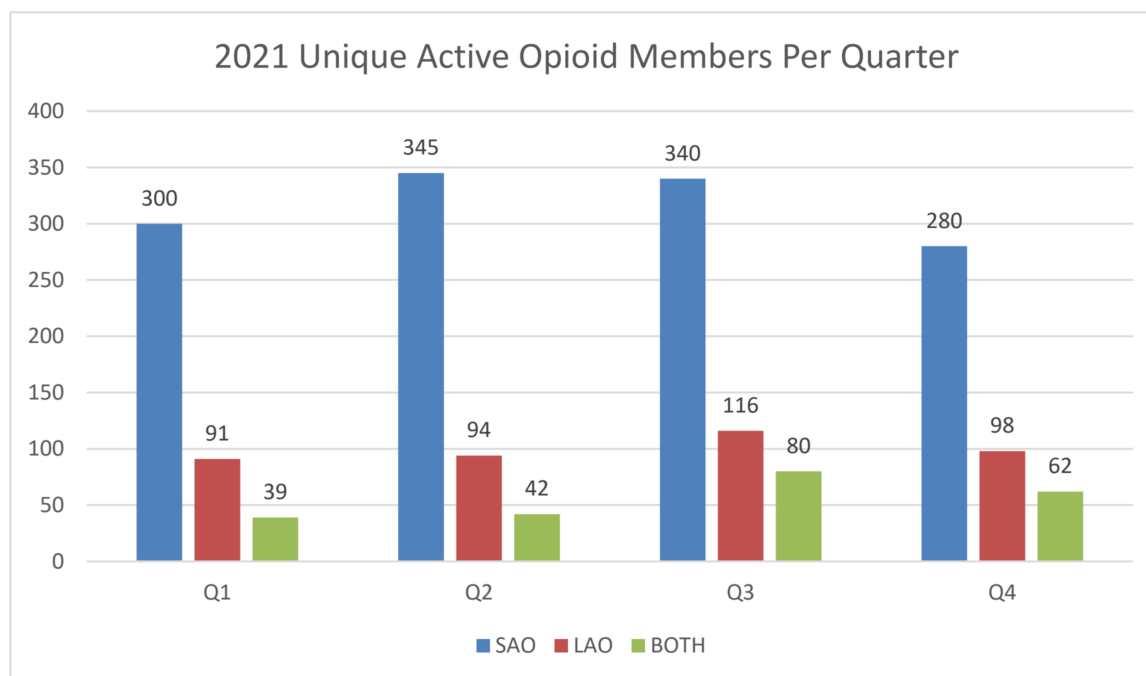
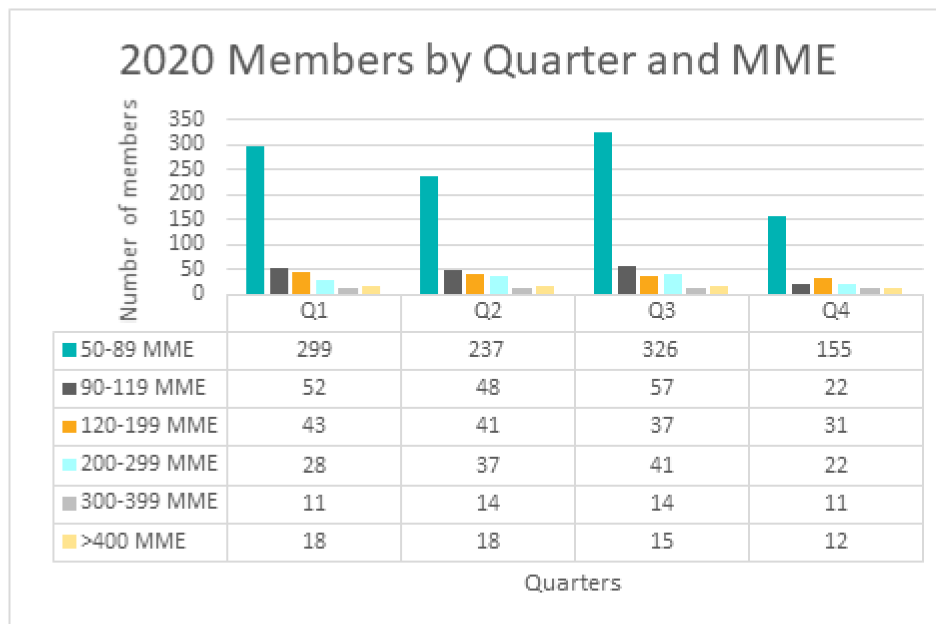
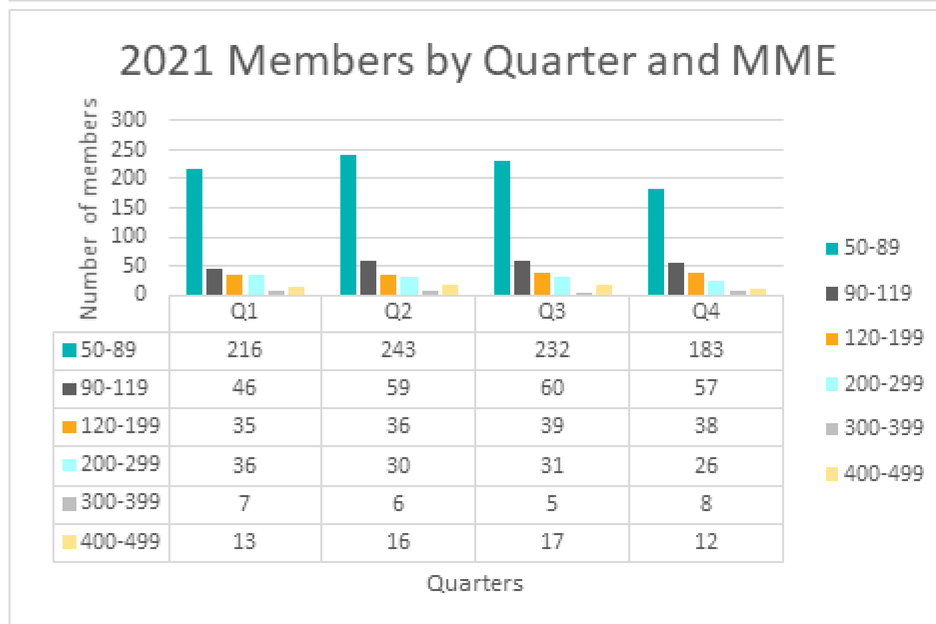


Table 10: 2021 Members per quarter on >50MME

MME (MORPHINE MILLIGRAM EQUIVALENTS)						
Month	**50-89**	**90-119**	**120-199**	**200-299**	**300-399**	**>400**
Q1	216	46	35	36	7	13
Q2	243	59	36	30	6	16
Q3	232	60	39	31	5	17
Q4	183	57	38	26	8	12



	Q1	Q2	Q3	Q4
50-89 MME	299	237	326	155
90-119 MME	52	48	57	22
120-199 MME	43	41	37	31
200-299 MME	28	37	41	22
300-399 MME	11	14	14	11
>400 MME	18	18	15	12



	Q1	Q2	Q3	Q4
50-89	216	243	232	183
90-119	46	59	60	57
120-199	35	36	39	38
200-299	36	30	31	26
300-399	7	6	5	8
400-499	13	16	17	12

Above is a table that lists the number of members on greater than 50 MME opioids. Within 2021, this table shows a 18% (216 to 183 members from Q1 to Q4) decrease in members utilizing 50- 89 MME, 19.2% (46 to 57 members) increase in members utilizing 90-119 MME, 7.9% (35 to 38 members) decrease in members utilizing 120-199 MME, 38.4% (36 to 26 members) decrease in members utilizing 200-299 MME, no change for member utilizing 300-399 MME, and greater than 400 MME.

Below is a graph depicting how many unique providers prescribing opioids categorized by ascending MME. There is a general decrease in prescribing trend as the MME go up. In 2021, 40 providers each wrote 1 prescription for 300-399 MME and 147 providers each wrote 1 prescription greater than 400 MME. In addition, at least 8 providers wrote at least 6 prescriptions greater than 400 MME—majority are cancer providers. There is 1 internal medicine doctor that prescribed 10 prescriptions over 400 MME.

Drug Recalls

The Pharmacy Department monitors all drug recalls. In 2021, pharmacy recall information is as below:

Table 11: 2021 Pharmacy Recalls

RECALL TYPE	QUANTITY
Total number of safety notices/recalls	**78**
Total number of withdrawals	0
The number of notifications where PBM completed a claims data review	3

In 2021, there were 78 recalls. Recalls were monitored for adversely affected members. The number of notifications where the PBM completed a claims data review were 3.

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

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Potential Quality Issues (PQIs)

Potential Quality Issues (PQIs) are defined as: A individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether a quality issue exists. PQI cases are classified as, **Quality of Access (QOA)**, **Quality of Care (QOC),** or **Quality of Service (QOS)** issues. **Quality of Language (QOL)** was added as a separate PQI classification as an improvement opportunity to better capture, track, trend, investigate and resolve potential quality issues related to member grievances regarding language. The Alliance QI Department investigates all PQIs referred 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 Quality Improvement (QI) Department through a secure electronic feed or entered manually into the PQI application, for evaluation, investigation, resolution, and tracking.

Quality Review Nurses investigate PQIs and summarize their findings. QOA, and QOS cases that do not contain a clinical component are investigated and closed by the review nurse. QOL cases are reviewed and investigated by the Cultural and Linguistic Manager. 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).

Table 12: 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

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Alameda Alliance for Health's Quality Department received 3051 Potential Quality Issues (PQIs), during measurement year 2021, which is a 44.0% increase from 2020. Of the 3051 PQIs received in 2021, 13%, or 389, of the PQIs were classified as a QOC. PQI monthly and quarterly totals are listed below:

Table 13: 2021 All PQI Type Monthly Totals

PQI Type	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	TOTAL	%
All Types of PQIs	143	192	275	287	230	276	179	329	396	300	220	224	**3051**	
QOA	48	70	88	80	62	91	59	125	158	112	57	74	**1024**	**34%**
QOC	14	26	53	45	24	26	26	43	48	30	30	24	**389**	**13%**
QOS	81	89	119	142	128	141	81	134	178	135	117	112	**1457**	**48%**
QOL*	0	4	11	16	13	12	8	22	12	21	13	12	**144**	**4.7%**
Other**	0	3	4	4	3	6	5	5	0	2	3	2	**37**	**1.2%**

*As of 2/2021
**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.

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Table 14: 2021 OQC PQI Quarterly Totals

INDICATOR	Q1	Q2	Q3	Q4
Indicator 1: QOC PQIs	Denominator: **614** Numerator: **94** Rate: **15.3%**	Denominator: **792** Numerator: **95** Rate: **11.9%**	Denominator: **894** Numerator: **109** Rate: **12.2%**	Denominator: **660** Numerator: **47** Rate: **7.1%**
Indicator 2: QOC PQIs leveled at severity C2-4	Denominator: **94** Numerator: **15** Rate: **15.9%**	Denominator: **95** Numerator: **10** Rate: **10.5%**	Denominator: **109** Numerator: **13** Rate: **11.9%**	Denominator: **47** Numerator: **5** Rate: **10.6%**

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 2021 there was an increase from 30 PQI exempt grievance case file reviews per quarter to 50 case reviews with an overall performance rate of 99.5 which exceeds the established performance metric of 90%.

	Q4 2020	Q1 2021	Q2 2021	Q3
Numerator	30	50	50	49
Denominator	30	50	50	50
Performance Rate	100%	100%	100%	98%
Gap to Goal	N/A	NA	N/A	NA
Universe (n)	3954	3781	3528	3687

The Alliance IT department continues to provide support with workflow enhancements to the PQI application. The PQI application remains a robust and responsive system allowing for timely and accurate reporting, documentation, tracking, and adjudication of PQIs.

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

A. Consistency in Application of Criteria in (IRR)

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

Table 15: Inter-rater Reliability (IRR) Thresholds

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 Director of Health Services and the Chief Medical Officer. • If staff fails to pass the IRR test a third time, the case will be escalated to Human Resources which may result in possible further disciplinary action.

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

For 2021, IRR testing was performed with QI clinical staff to evaluate consistency in classification, investigation and leveling of PQIs. All QI Review Nurse and Medical Director Reviewers passed the IRR testing with scores of 100%.

Facility Site Review (FSR)

Facility Site Review (FSR) and Medical Record Review (MRR) audits are mandated for each Health Plan under DHCS Plan Letter 14-004 to occur every three (3) years. FSRs are another way the Alliance ensures member quality of care and safety within the provider office environment. Interim monitoring and follow-up of FSR and MRR occurs between each regularly scheduled full scope reviews. Corrective Action Plans (CAPs) for non-compliance are required depending on the site FSR and MRR scores and critical element failures.

Due to public health emergency in 2020, DHCS issued APL 20-011 Governor's Executive Order N-55-20 in Response to COVID-19 allowing Alliance to temporarily suspend contractual requirement for in-person site reviews, encouraged alternative reviews, flexibilities with CAPs, and suspended APL 20-006 FSR and MRR. Although implementation of APL 20-006 has been suspended, Alliance also utilized the new FSR/MRR standards as a teaching opportunity during reviews. Providers are trained on the current AAP and USPSTF Recommendation A and B.

In July 8, 2021, APL 20-011 was updated to terminate the flexibilities effective July 1, 2021. Alliance started to conduct in-person FSRs in July 2021 and continued with virtual reviews as requested by providers. Starting January 2022, MCPs will fully resume all FSR activities in person.

In August 2021, Alliance submitted to DHCS a written plan to address FSR backlogs and projected timelines. It was provisionally approved by DHCS on August 17, 2021, and quarterly updates were submitted. In addition, the bi-annual DHCS reports were submitted to DHCS.

In 2021, there were 100 site reviews. The total number and types of audits are detailed in the table below.

Table 16: 2021 Facility Site Reviews

TYPE	Q1	Q2	Q3	Q4	TOTAL
FSR/MRR: Full Scope	2	5	4	10	**21**
Initial FSR	1	1	1	0	**3**
Initial MRR	1	2	1	1	**5**
Initial FSR/MRR	1	0	0	0	**1**
MRR: Focused	0	0	0	1	**1**
Interim Monitoring	12	7	3	1	**23**
Periodic Annual	0	0	0	0	**0**
Periodic FSR	3	2	7	13	**25**
Periodic MRR	0	3	8	10	**21**
Total Reviews	**20**	**20**	**24**	**36**	**100**

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

Additionally, a critical element CAP is issued for deficiencies in any of the 9 critical elements in the FSR that identify the potential for adverse effects on patient health or safety and must be corrected within 10 business days of the site review. Alliance allowed extension on CAP submission due to reduce office hours and staffing during public health emergency according to APL 20-011. FSR staff continued to work with providers in getting CAP submission. In 2021, there were 59 CAPs issued and 2 CAPs remain open for more than 120 days.

Table 17: FSR/MRR CAPs issued in 2021

TYPE	Q1	Q2	Q3	Q4	TOTAL
Total CAPs Issued	**8**	**11**	**15**	**25**	**59**
Open	0	0	1	13	14
Open >120 days	*NA*	*0*	*1*	*1*	*2*
Closed	8	11	14	12	45

Per DHCS regulation, failed periodic reviews are reported bi-annually. In 2021, the Alliance had one provider with non-passing scores below 80%. A corrective action plan was provided to DHCS.

Table 18: 2021 Audits with Non-Passing Scores

QUARTER	AUDIT DATE	FSR SCORE	MRR SCORE
Q1	N/A	N/A	N/A
Q2	N/A	N/A	N/A
Q3	N/A	N/A	N/A
Q4	12/16/2021	N/A	76.69%

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

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

Alliance continued to review records for IHA for members who were enrolled prior to December 1, 2019. IHA was also reviewed for newly enrolled members in 2021 who presented for well care visit at the providers office and where an IHEBA was completed. In 2021, medical records at 46 sites were reviewed for the presence of an IHA. Table 24 lists the results of these reviews. The 22 total non-compliant providers received CAP and re-education/training on IHA and IHEBA compliance.

Table 19: 2021 MRR Results

TYPE	Q1	Q2	Q3	Q4	TOTAL
# of MRRs with Compliant* IHAs	0 (0%)	3 (30%)	6 (50%)	13 (65%)	22
# of MRRs with Non-Compliant IHAs (CAPs)	4	7	3	7	21
Total IHAs Audited via FSR	4	10	12	20	46

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

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Peer Review and Credentialing Committee (PRCC)

In 2021, 34 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 2021. All grievances, complaints, and PQIs that required investigation were forwarded to this committee for review. In 2021, 87 practitioner grievances, complaints, or PQIs were investigated by the committee. There were no practitioners that required reporting to National Practitioner Data Bank (NPDB) by the Alliance.

In 2021, the PRCC granted one-year reappointment for one practitioner for grievances filed regarding office procedures and granted two-year reappointment for two practitioners for grievances filed regarding office procedures. The table below shows evidence of practitioner review by the PRCC prior to credentialing and re-credentialing decisions.

Table 20: Count of Practitioners Reviewed for Quality Issues at PRCC in 2021

Count of Practitioners Reviewed for Quality Issues At PRCC in 2021										
PRCC Date	**PRC**	**NPDB**	**Attestation**	**Malpractice (pending/dismissed)**	**Facility Site Review**	**Grievance, Complaints, PQI**	**License Action**	**Board Certification**	**CAP**	**Total**
January		4		1		5		7	2	19
February				2		8		1	3	14
March						9		1	3	13
April		2				7	1		1	11
May	1	2				7	1			11
June				1		6	1	1	1	10
July		2		1		6		1		10
August No Committee Meeting										0
September	1	4				7		3	1	16
October		1		3		9		9	1	23
November	1					15		8	1	25
December		5				8		3	2	18
Total	**3**	**20**	**0**	**8**	**0**	**87**	**3**	**34**	**15**	**170**

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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 California Department of Health Care Services (DHCS); California Department of Managed Health Care (DMHC), and the National Committee for Quality Assurance (NCQA) regulations. Audit results are reported to the Delegation Oversight Committee, which is an underreporting committee of the Compliance Committee.

In Calendar Year 2021, the Alliance conducted annual delegation oversight audits for the entities included in Table 26.

To supplement its approach to Compliance, the Alliance holds quarterly Joint Operations Meetings (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 Community Health Center Network (CHCN) and Alameda Health Systems.

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Table 21: Alameda Alliance Delegated Entities Compliance

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

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

Population Health Strategy

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

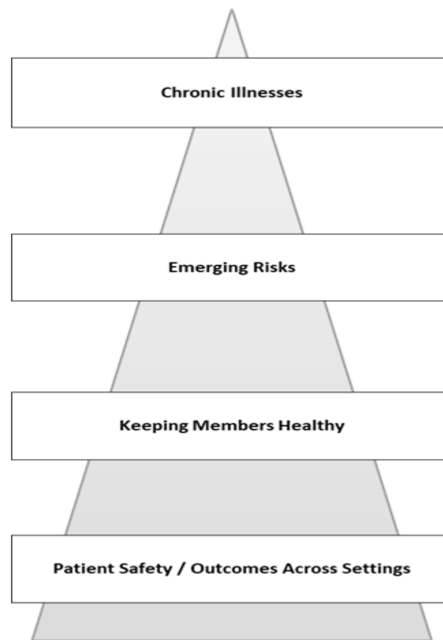
The Population Health Program aims to influence the health outcomes of the Alameda Alliance membership. The program oversees the health management system by ensuing that the system caters to the health needs of the enrolled member population. The goal of the Alliance Population Health Program is to improve health outcomes of the Alliance membership across the continuum of care, close gaps between identified disparities, and address SDOH that cause those disparities.

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

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

The 4 areas of focus are:

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



The 2021 Population Health Program objectives centered on the 4 areas of focus:

Multiple Chronic Illnesses: Multiple Chronic Illnesses were addressed through our Complex Case Management, Transitions of Care and Health Homes programs. Our Health Homes program was successful in decreasing admits (-16.1%), average length of stay -.05 days), and emergency room visits (-22.4%), while experiencing a modest increase in readmits (1.7%). Outcomes for CCM and TOC programs need improved tracking mechanisms to monitor goals. The Health Homes program in particular experienced challenges in building trust with members and maintaining regular contact.

Rising Risk: Programs that addressed Alliance members with rising risk included a pediatric asthma case management program, Asthma Start, and equity project, Asthma Affinity, focused on improving the asthma medication ratio for black adults ages 19-64. that reached its objectives of reducing ER visits from pre to post services (61% reduction). Our goal of increasing engagement for our Latino and Black pediatric members with asthma was not met due to an overall reduction in services due to COVID.

The Alliance also launched successful collaborative to address hypertension among our Asian and Pacific Islander members with hypertension. 150 members received blood pressure cuffs and hypertension self-management education through our community clinic partner, Asian Health Services. We began groundwork for Pediatric obesity education objectives, completing a new childhood exercise and nutrition book. Covid-19 also negatively impacted our school-based nutrition collaboration. The program closed while schools were meeting remotely.

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Keeping Members Healthy: Initiatives for cancer screenings and well child visits were a focus for 2021, including cervical cancer screening, breast cancer screening, and well child visits ages 3 - 21. Groundwork was laid in 2021 with clinics to begin education and incentive programs in 2022. Outcomes will be measured in 2022. Pregnant members were also a continued focus for the Alliance, where as 100% of members identified as pregnant or recently giving birth received pregnancy and baby care resources and referrals. All members enjoyed access to a comprehensive system of health education program and educational resources supporting healthy lifestyles and disease management topics ranging from diabetes to injury prevention.

Patient Safety/Outcomes Across Settings: The Alliance launched a substance use intervention for chronic users. All identified high risk and rising risk members and their providers received a packet with education on safe practices, and alternative pain management provider referrals. This initiative was successfully implemented and 75 members and their providers received resources.

Additional information can be found in the plans population health management strategy and effectiveness report.

Quality Improvement Projects

Improve Compliance Rate for WCV through HEDIS Crunch 2021

In September 2021, the Plan decided to continue the HEDIS Crunch initiative that was started in 2019 to improve well-child compliance rates for WCV for members 3-21 years of age. 20 pediatric providers within the CFMG network agreed to provide $25 member incentive at the completion of a well-child visit that is completed prior to December 31, 2021. A total of 1,511 gift cards were provided this year, which is an increase of 1,502 gift cards from 2020. CFMG network provider scores increased 9.34% from baseline MY2020 48.01%.

Improve Compliance Rate for African American Males Colon Cancer Screening Rates

July 2021, AAH partnered with a Federally Qualified Health Center, West Oakland Health Council (WOHC), to improve colon cancer screening rates in African American men between the ages of 45-75 years of age. AAH developed a two tired approach to engage the target population by offering a $10 member incentive to be given at the completion of an office visit with their assigned PCP at WOHC to discuss the importance of receiving screening for a colorectal cancer screening and a $50 member incentive when the FIT-DNA test has been completed. The goal of this project was to increase colon cancer screening rates in African American males at WOHC from 22.79 to 37.10%.

As of December 2021, 72 Alameda Alliance members completed a FIT-DNA test for colorectal cancer, of which 6 members had a positive result.

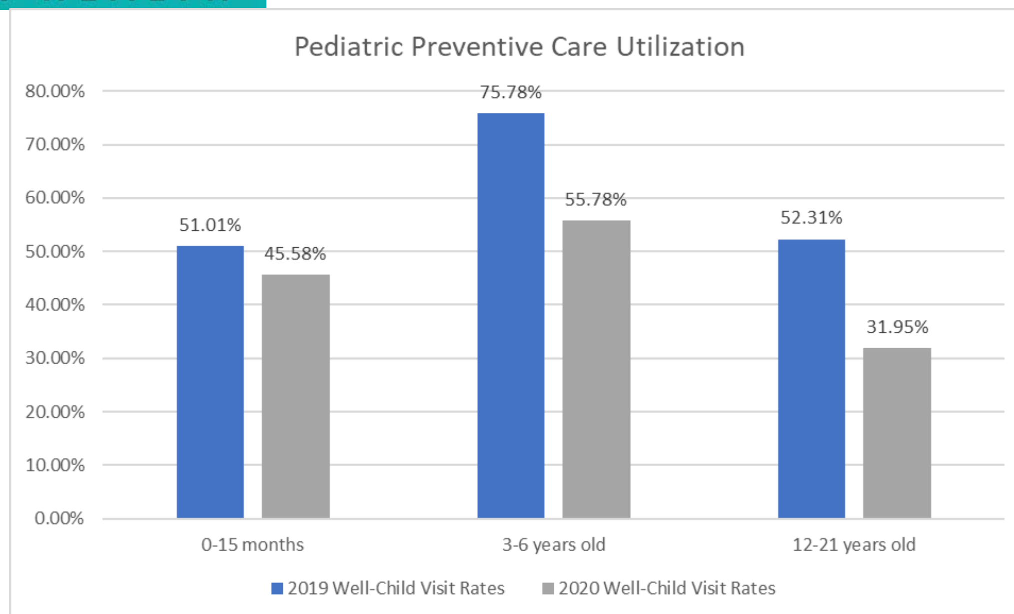
DHCS PDSA WCV

In California, it has been identified that children are not accessing comprehensive pediatric services consistently. The California State Auditor Report identified that, "an annual average of 2.4 million children enrolled in Medi-Cal do not receive all required preventive services."[1] Additionally, this report confirms utilization rates for children in Medi-Cal have remained below 50 percent. As a result, Alameda Alliance for Health (the Alliance), had a targeted focus on increasing pediatric access through its Pediatric Care Coordination Project. The goal of the pilot is to engage the Alliance's pediatric members to seek regular check-ups at age-appropriate intervals that follows the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule and anticipatory guidance with increased screenings and referrals to improve member health functional status and/or care satisfaction. This includes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for Medical, Dental, Vision, Hearing, and Mental Health, Substance Use Disorders, Developmental and Specialty Services for pediatric population less than 21 years of age.

The intervention focused on the HEDIS measure: WCV -- the percentage of members 3–21 years of age who had one or more well-child visits with a PCP during the measurement year. Well-child visits provide a critical opportunity for screening, referrals, and counseling as children develop physical activity, social, nutritional, and behavioral habits that often continue into adulthood. With these visits, providers conduct comprehensive physicals, connect patients to important EPSDT services, provide vaccinations and medications, as well as help answer any health-related questions patients and their families may have.

Alameda Alliance for Health (AAH) selected the MCAS WCV measure because the Plan has identified an opportunity for improvement based on administrative results for measurement year 2020. Given the Public Health COVID-19 emergency, the Plan saw a decrease in pediatric utilization of preventive care services. Below is a graph that illustrates the decline in children receiving the appropriate preventive well-child exams by different age bands.

[1] California Department of Health Care Services. (2020, December). 2020 preventive services report. Retrieved from www.dhcs.ca.gov/Documents/MCQMD/2020-Preventive-Services-Report.pdf.



For children ages 3-6 and 12-21, the Alliance has seen a 20% decrease in utilization of preventive care in 2020 due to COVID-19.

In partnership with Osita, a low performing provider, the Alliance tested member outreach by sending out postcards. The postcard served as a method to gently, and unobtrusively, remind members to visit their PCP for preventive care services. The postcards were sent out to members (parents) between the ages of 3-21 years old. The goal for this project was:

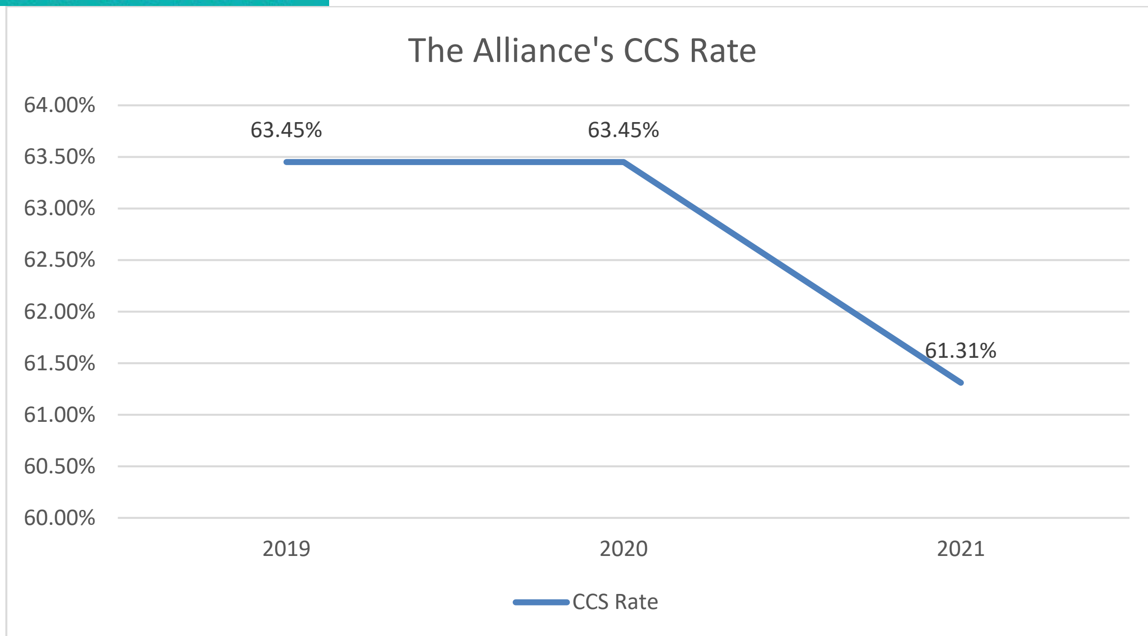
- By December 31, 2021, increase Well-Child Visits (WCV) for noncompliant Osita members ages 3 to 21 from 6.08% as of September 2021 to 16% through the implementation of color-coded postcards mailed to identified members.

The Alliance did not meet the SMART Aim goal of raising the WCV rate to 16% by 12/31/2021. A major barrier encountered included the continuous strain COVID put on healthcare systems, including shortage in staffing. As a result, providers ability to outreach and communicate with members about preventive measures was limited. The Alliance ran a 2nd PDSA with Osita; the 2nd cycle included outreach phone calls to 20 members to understand if they received the postcard and to serve as a second reminder to visit their provider. The data does not show evidence of improvement and therefore both interventions are abandoned.

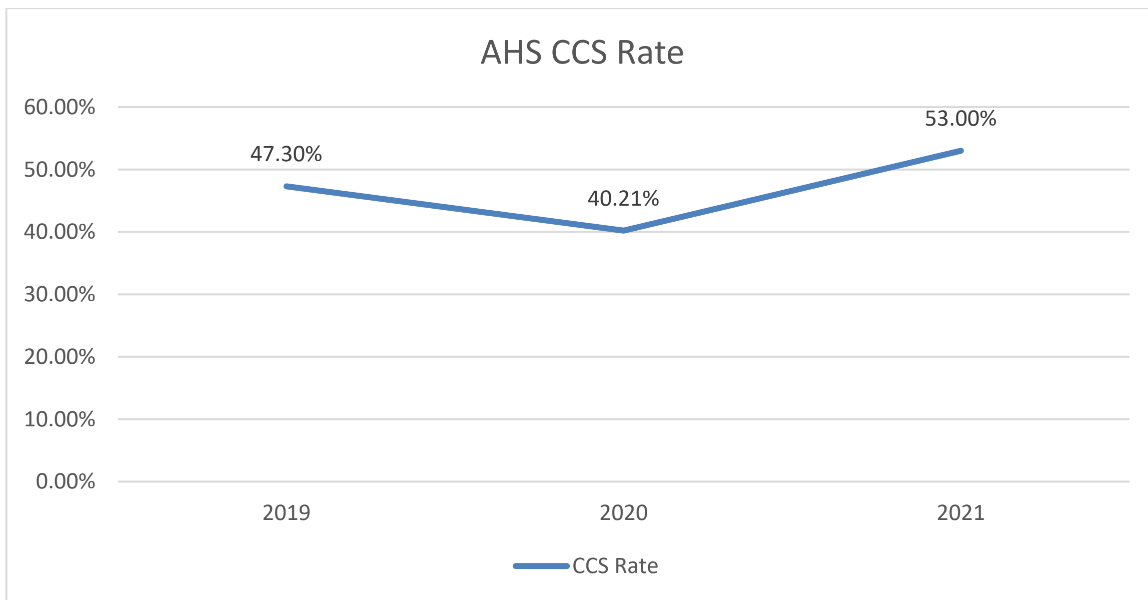
DHCS PDSA

Cervical cancer screening is recommended for all women aged 21 to 65 years old for early detection and treatment of cervical cancer. Regular cervical cancer screening is associated with a 67% reduction in cervical cancer and a 70% reduction in deaths from the disease.

The graph below illustrates the Alliance's reported hybrid CCS rates from RY2019 – 2021. CCS rates saw over a 2% decrease during the COVID-19 public health emergency.



The graph below illustrates Alameda Health System's (AHS) hybrid CCS rates from RY2019 – 2021.



Historically, Alameda Health System (AHS) has fallen below national benchmarks and comparable health systems' rates for cervical cancer screening. This has further been exacerbated by the COVID-19 pandemic and transition from a predominately in-person model of care to a telehealth model that prevented the completion of in-person services such as cervical cancer screening. As a result, The Alliance identified an opportunity to partner with AHS to improve CCS rates for MY2021/RY2022.

The SMART aim goal for this project was: by December 31, 2021, Alameda Alliance for Health will increase its delegate, Alameda Health System's (AHS), Cervical Cancer Screening rates among their 16,340 eligible female members ages 21 to 64 from 23.50% (3,840/16,340 members) as of September 2021, to 31.43% (5,136/16,340 members) through the development of Pap focused clinic days across all four of AHS' ambulatory clinic locations.

The intervention the Alliance tested was to offer Pap clinic days that focused on completing cervical cancer screenings. Pap Clinic days had the potential to increase AHS CCS compliance rates by adding 12 additional appointment slots per month at each clinic location. By offering pap focused clinic days, it increased the appointment availability for cervical cancer screening visits at Alameda Health System (AHS), which we predicted it would increase AHS' CCS rate.

This intervention was a multi-pronged approach to increase capacity to complete CCS screenings, create awareness among identified members through AHS' outreach through calls and text messaging, and create motivation to complete the preventive exam by offering a member incentive. To meet cervical cancer screening targets, AHS opened clinics dedicated only to cervical cancer screening. These pap smear clinics were offered at all four of AHS' ambulatory sites. AHS used text messaging outreach campaigns and telephone outreach by their community health workers (CHWs). At the completion of the cervical cancer screening, the member received a $25 incentive by AHS staff.

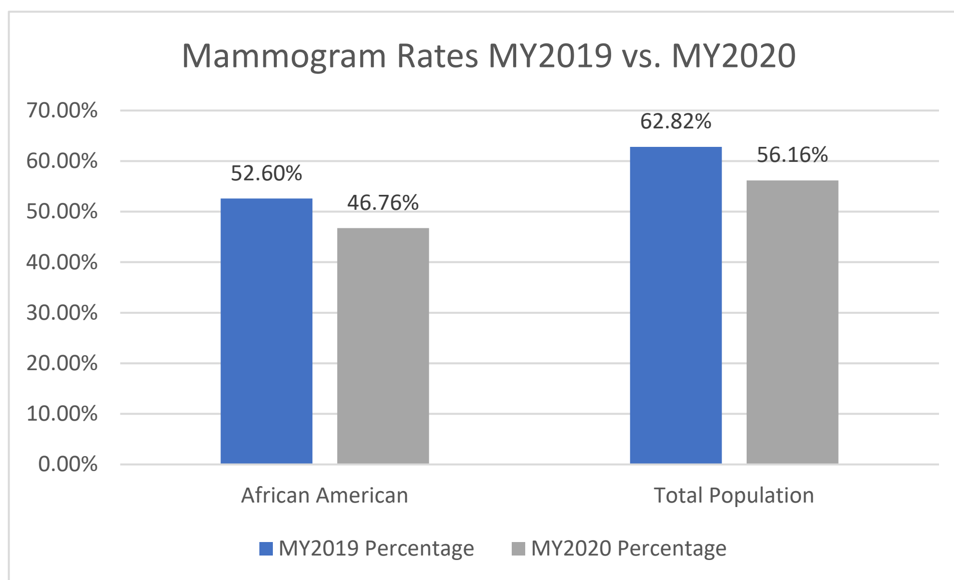
The goal of increasing AHS' rate to 40.39% by 12/31/2021 was not met. Not every slot was filled due to COVID hesitancies, and staff shortages made outreach and data collection difficult for AHS during the months of September through December 2021. While there was a slight increase in rates, it is difficult to correlate the increase to this intervention (see rates below). The intervention was promising however, external factors created unforeseen challenges. This intervention will be abandoned and perhaps tested later when staffing is at full capacity for both the Alliance and AHS.

Clinic	Sep-21	Oct-21	Nov-21	Dec-21
Eastmont Wellness Center	35.22%	35.97%	37.23%	38.19%
Hayward Wellness Center	31.45%	32.03%	33.15%	34.31%
Highland Wellness Center	34.22%	35.52%	36.30%	37.72%
Newark Health Center	28.01%	28.71%	29.65%	30.64%
AHS	32.46%	33.31%	34.34%	35.51%
Goal	40.39%	40.39%	40.39%	40.39%

Improve Compliance Rate for the African American Female Population for BCS – DHCS Equity PIP

According to an American Cancer Society 2019-2020 report, approximately 1 in 8 women (13%) will be diagnosed with invasive breast cancer in their lifetime. The report also highlights and reinforces the disparities felt by African American women when it comes to receiving timely and accessible preventive care such as mammograms. African American women have the highest breast cancer death rate of 28.4 deaths per 100,000.[2] They also have higher incidence rates than non-Hispanic Whites before the age of 40 and are more likely to die from breast cancer at every age. Early detection of breast cancer is the number one way to decrease mortality rates, therefore, Alameda Alliance for Health (AAH) focused on increasing breast cancer screening rates among our members with a narrowed focus on African American women.

AAH has selected the MCAS BCS measure because there has been identified opportunities for improvement based on MY 2020 data for MY 2021. AAH has seen a decrease in breast cancer screening services as depicted in the chart below comparing MY 2019 and MY 2020 admin rates for African American women and all other eligible women for the MCAS BCS measure.



There was a 5.84% decrease in mammogram rates among African American women, and a 6.66% decrease in mammogram rates among all Alliance female members that qualified for the BCS measure.

[2] https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/breast-cancer-facts-and-figures/breast-cancer-facts-and-figures-2019-2020.pdf

Increasing breast cancer screening rates among AAH's African American female members is the narrowed focus of this PIP. The MY2020 admin rate for AAH was 56.16%, and among African American women it was 46.76%.

This intervention allows AAH to strengthen outreach initiatives surrounding breast cancer screening and improve access to mammograms along with other barriers members may help identify. AAH strives to increase member awareness of their rights to access preventive care in 2021/2022 and to encourage a safe return to clinics.

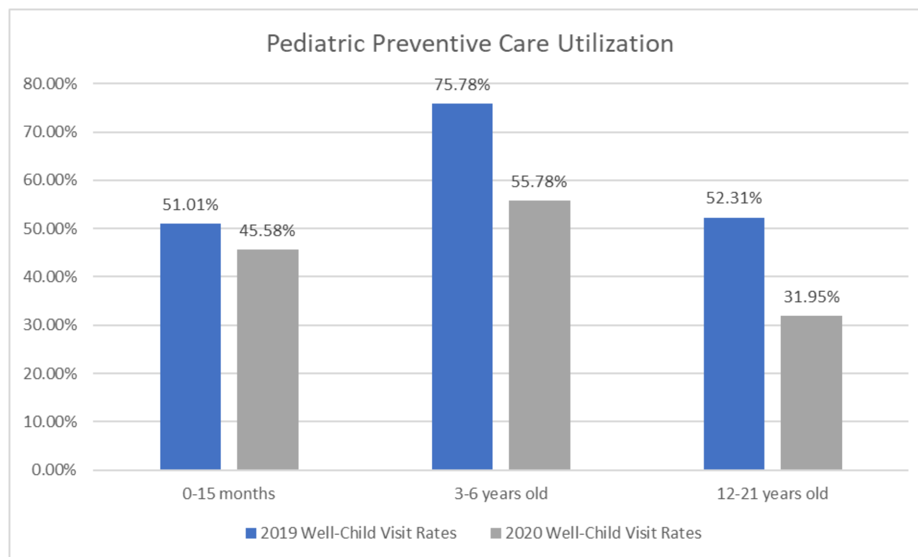
In partnership with Lifelong, a high volume, low performing provider, AAH is piloting an outreach and incentive project to encourage women to complete their mammography screening.

ALAMEDA Alliance FOR HEALTH

Increase Well-Child visits among members ages 3-21– DHCS Priority PIP

The intervention focuses on the HEDIS measure: MCAS WCV -- the percentage of members 3–21 years of age who had one or more well-child visits with a PCP during the measurement year. Well-child visits provide a critical opportunity for screening, referrals, and counseling as children develop physical activity, social, nutritional, and behavioral habits that often continue into adulthood. During these visits, providers conduct comprehensive physicals, connect patients to important EPSDT services, important vaccinations, and medications, as well as help answer any health-related questions patients and their families may have.

Alameda Alliance for Health (AAH) selected the MCAS WCV measure because the Plan identified an opportunity for improvement based on its current administrative results for measurement year 2020. Given the COVID-19 pandemic, the Plan has seen a decrease in pediatric utilization of preventive care services. Below is a graph that illustrates the decline in children receiving the appropriate preventive well-child exams in different age bands.



For children ages 3-6 and 12-21, the Alliance has seen a 20% decrease in utilization of preventive care in 2020 due to COVID-19.

WCV admin rates for direct providers within the AAH network is the narrowed focus of this PIP. The MY2020 admin rate for the Alliance was 38.93% and for directs, it was 38.22%.

After looking at AAH MY2020 WCV admin data, we established a threshold to identify providers with patient panels greater than 650, a compliance rate less than 55%, and have expressed interest in partnering with the Alliance to be included into this PIP. Based on this threshold, we identified one provider

Specifically, the target population for this initiative will be members ages 3-21 assigned to one direct

Alliance provider:

1. Rhodora De La Cruz MD (3-21 years of age with a denominator of 1160)

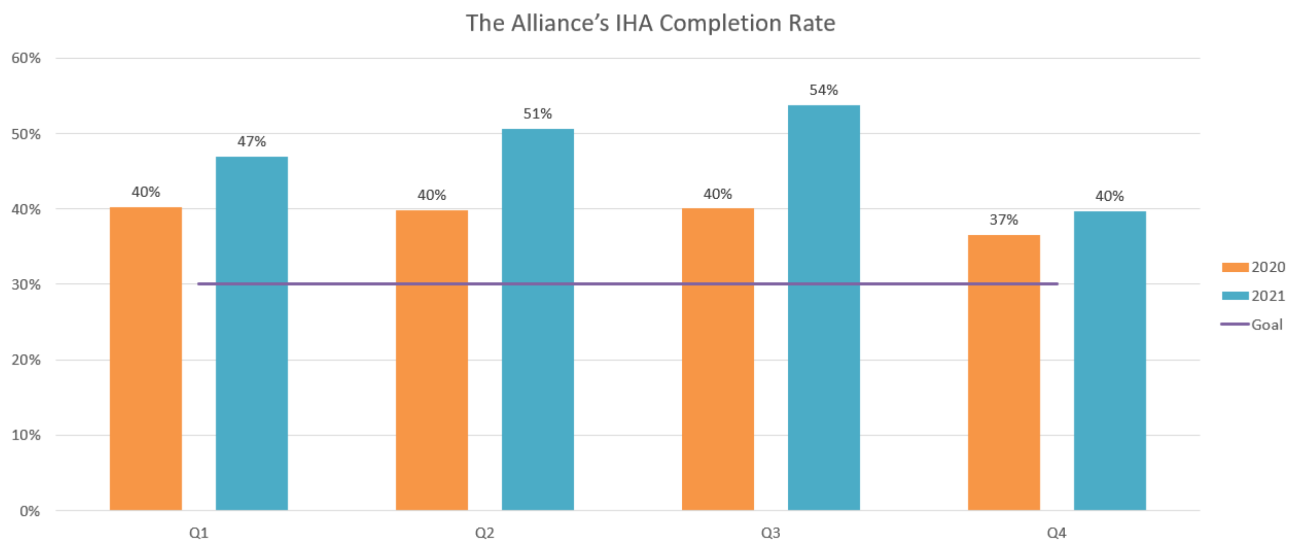
The SMART aim goal for this PIP is by December 31, 2022, use key driver diagram interventions to increase the percentage of WCV admin visit rate for Dr. Rhodora De La Cruz from 40.94% to 45%. The intervention AAH plans to implement is outreach and incentive using a birthday card mailer. The birthday card will serve as a reminder to members (parents) to make an appointment with their provider. AAH is in the process of finalizing the mailers to be sent out to members assigned to Dr. Rhodora De La Cruz.

Improving Initial Health Assessment (IHA) Rates

The past 1 year of IHA rates is outlined below.

Table 22: 2021 IHA Completion Rates – Medi-Cal

Total	New Enrollee	Re-Enrollee
Denominator: 41,944 Numerator: 1,5787 Rate: 37.6% Goal: 30% Gap to goal: Goal Met	Denominator: 25,588 Numerator: 9,491 Rate: 37.1% Goal: 30% Gap to goal: Goal Met	Denominator: 16,356 Numerator: 6,296 Rate: 38.5% Goal: 30% Gap to goal: Goal Met



Annually AAH conducts an audit of the Initial Health Assessment (IHA). A random sample of 90 members are selected and medical records are requested to review if the six elements of the IHA has been completed, including:

1. Patient history
2. Review of organ systems
3. Physical and mental examination
4. Preventive care
5. Diagnoses and plan of care
6. Staying Healthy Assessment (SHA)

In 2021, 90 charts were requested, 37 received. In all 51 components of the IHA was missing, with the Staying Healthy Assessment (SHA) missed most often. As a response to COVID-19, DHCS implemented APL 20-004, which suspended the requirement to complete an IHA in 120 days for newly enrolled members between December 1, 2019 – September 1, 2021. As a results AAH did not issue caps in 2021 however, the plan sent out educational letters to providers who were missing elements of the IHA.

To improve IHA compliance rates, the Alliance is working to:

- Ensure member education – through mailings and member orientation
- Improve provider education – through faxes, the PR team and provider handbook.
- Improve data sharing – by sharing gaps in care lists with our delegates and providers
- Monitor records to ensure compliance with all components of the IHA
- Given the 6 month claims lag, data will be reviewed and analyzed in Q3 – Q4 of 2022.

Pediatric Care Coordination Pilot

In 2018 CA State Auditor Report cited the following:

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

The Pediatric Care Coordination Pilot launched October of 2019

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

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

In 2021, the Alliance continued to address the important issue of under-utilization and improve pediatric access to care for preventive health services. Health Care Services (HCS) QI department developed deployed strategies for enhanced integration of pediatric health care services for the children and adolescent population enrolled in the Alameda Alliance (AA) for Heath Medi-Cal program. The Alliance sought to constructively influence and impact care delivery for this identified population in three (3) ways:

- Quality Initiatives
- Clinical Initiatives
- Pediatric Care Management Program

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

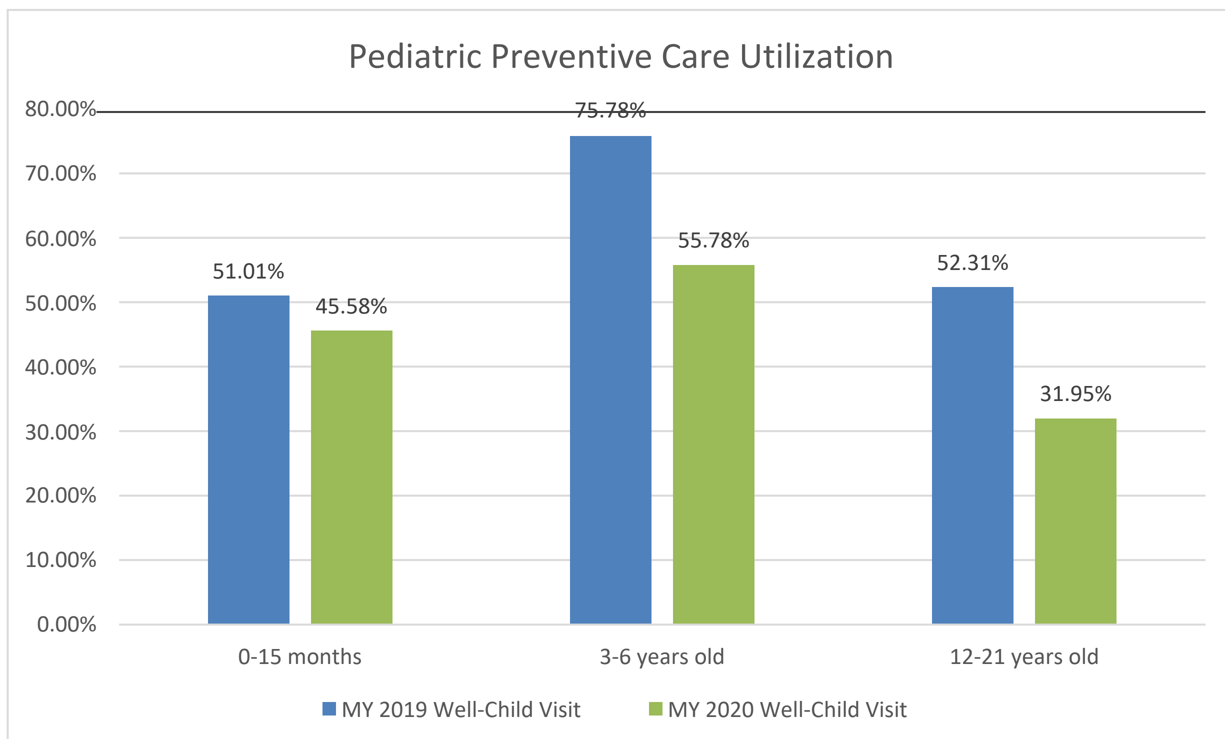
- Improved screening and referrals as part of Medi-Cal Early and Periodic Screening, and Diagnostic and Treatment (EPSDT) supplement benefit
- Reporting via data segmentation and visualization
- Member and provider incentives
- Community based program funding
- Provider P4P
- Health Education engagement
- QI Initiatives
- DHCS Performance Improvement Initiatives
- Direct Provider collaboration
- Delegate Provider collaboration

o Children's First Medical Group (29K Pediatric Members)
o Community Health Care Network (31K Pediatric Members)

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

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

Table 23: Pediatric Preventive Care Utilization



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

- WCV – Well Child-Visits for Children 3 – 21 years of age
    - Alliance focused on well care visit (WCV) for ages 3-21 members to complete a comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner and receive member incentive upon completion of visit before December

31, 2021. Starting in September, Providers started outreaching to members to schedule appointments and provide member incentives at completion of well-care visit. The Alliance partnered with 20 provider sites, resulting in a 9.34% increase from baseline 48.01. As a result of this initiative, Alliance will be discussing the option of moving to start outreach in the summer because it is a good time for children to get well-care visit before school starts. Provider Groups mentioned that cancellations of visits happen during the holiday season.

First 5 Alameda Integrated Pediatric Care – Well Child Visit 0 – 5 years

Alameda Alliance for Health established a partnership with First 5 Alameda in July 2021. 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, ACES, and social determinants of health; and
- Coordinate family-centered access to well-child care, 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.

While the project will continue through June 2022, mid-year results shows that 753 members between the ages of 0-5 years were contacted successfully and 69% of those members completed or showed pending appointments for well visits exam.

ALAMEDA Alliance FOR HEALTH

Clinical Improvement Trends: HEDIS

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

Note: 2021 rates are preliminary as of April 2022. Final rates will be available July 2022.

Table 24: Medicaid Administrative HEDIS Rates

NCQA Acronym	Measure	Admin Final MY2020	2021 April Admin	2021 April Hybrid	MY2021 MPL
CBP	Controlling High Blood Pressure	25.57%	33.91%	54.47%	55.35%
CCS	Cervical Cancer Screening	58.32%	55.55%	61.02%	59.12%
CDC	HbA1c Poor Control (>9.0%)	42.87%	37.30%	32.85%	43.19%
CIS	Combo 10	46.81%	44.31%	47.15%	38.20%
IMA	Combo 2	50.04%	45.14%	46.72%	36.74%
PPC	Timeliness of Prenatal Care	86.91%	86.33%	92.00%	85.89%
PPC	Postpartum Care	78.95%	78.98%	83.60%	76.40%
WCC	BMI Percentile	34.89%	63.74%	86.61%	76.64%
WCC	Counseling for Nutrition	35.09%	48.72%	84.97%	70.11%
WCC	Counseling for Physical Activity	33.23%	46.36%	83.88%	66.18%
BCS	Breast Cancer Screening	56.19%	53.02%		53.93%
CHL	Chlamydia Screening in Women - Total	59.09%	63.46%		54.91%
W30	Well Child Visits in the First 15 Months	45.64%	44.08%		54.92%
W30	Well Child Visits for age 15 Months- 30 Months	69.34%	63.73%		70.67%
WCV	Child and Adolescent Well-Care Visit	39.47%	51.64%		45.31%

ALAMEDA Alliance FOR HEALTH

Analysis Of HEDIS MEDICAID Managed Care Accountability Set (MCA)

The above tables represent the Medicaid HEDIS measures for the DHCS' Managed Care Accountability Set. Of the trended measures 12 out of the 15 measures met the Minimum Performance Level (MPL). Furthermore, of the reported HEDIS measures in table 34 there is an increase in rates over MY2020 for 11 of the 15 measures. There is significant improvement in HEDIS rates over MY2020 however, there are three measures we are performing under the MPL, Breast Cancer Screening, Well Child Visits in the first 15 months and Well Child Visits 15 – 30 months.

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

Based on the HEDIS data presented, potential focus areas for 2022 include the following:

- BCS – Breast Cancer Screening
- CCS – Cervical Cancer Screening
- CBP – Controlling High Blood Pressure
- WCV – Well-Child Visits in the First 15 months
- WCV – Well-Child Visits for ages 15 months – 30 months

Quality of Service

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

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

Member Experience Survey

The Medi-Cal and Commercial Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by the National Committee for Quality Assurance (NCQA) a certified Health Effectives Data and Information Set (HEDIS) survey vendor. SPH Analytics was selected by the Alliance to conduct the 2020 CAHPS 5.1 survey. NCQA is used a new 5.1 version of the CAHPS survey for 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) are surveyed separately. The table below shows the survey response rates. As of 11/30/2021, the Alliance had a total of 295,151 members.

The breakdown of member enrollment by network is as follows:

- Alameda Health Systems (AHS) 19.7%
- Alliance 17.6%
- Community Health Center Network (CHCN) 36.8%
- Children First Medical Group (CFMG) 11%,
- Kaiser 14.5%

Table 25: Survey Response Rates by Line of Business

	Medi-Cal Adult	Medi-Cal Child	Commercial Adult
2021	15.9%	18.2%	23.7%
2020	14.7%	16.5%	23.5%
2019	21.3%	21.3%	28.3%

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 2021 that provides for an aggregate or national summary.

In respect to benchmark scores, Red signifies that the current year 2021 score is significantly lower than the 2020 score. Green indicates that the current year 2021 score is significantly higher than the2020 score.

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Table 26: Medi-Cal Child Trended Survey Results

Summary Rate Scores: Medi-Cal Child				
Composite	**2021**	**Previous Year Comparison**	**2020**	**2019**
Getting Needed Care	82.2%	↑	81.0%	83.5%

Summary Rate Scores: Medi-Cal Child				
Composite	**2021**	**Previous Year Comparison**	**2020**	**2019**
Getting Care Quickly	78.8%	↓	82.0%	85.4%
How Well Doctors Communicate	93.2%	↑	92.7%	93.7%
Customer Service	90.2%	↑	84.0%	86.1%
Rating of Health Care (8-10)	89.1%	↑	87.3%	89.8%
Rating of Personal Doctor (8-10)	91.0%	↓	91.2%	93.6%
Rating of Specialist (8-10)	87.2%	↓	90.6%	85.5%
Rating of Health Plan (8-10)	88.1%	↑	87.5%	88.9%
Coordination of Care	73.8%	↓	82.4%	86.0%

Table 27: Medi-Cal Adult Trended Survey Results

Summary Rate Scores: Medi-Cal Adult				
Composite	**2021**	**Previous Year Comparison**	**2020**	**2019**
Getting Needed Care	79.0%	↓	82.6%	76.0%
Getting Care Quickly	72.4%	↑	71.7%	74.5%
How Well Doctors Communicate	83.5%	↓	95.7%	88.4%
Customer Service	84.1%	↓	88.8%	80.7%
Rating of Health Care (8-10)	73.1%	↓	75.4%	73.6%
Rating of Personal Doctor (8-10)	81.3%	↓	84.7%	77.1%
Rating of Specialist (8-10)	78.9%	↓	91.7%	74.5%
Rating of Health Plan (8-10)	74.9%	↓	78.4%	73.4%
Coordination of Care	83.0%	↑	80.3%	70.4%

Table 28: Commercial Adult Trended Survey Results

Summary Rate Scores: Commercial Adult				
Composite	**2021**	**Previous Year Comparison**	**2020**	**2019**
Getting Needed Care	75.2%	↑	65.6%	72.8%
Getting Care Quickly	71.1%	↑	68.7%	70.9%
How Well Doctors Communicate	87.7%	↓	90.0%	87.6%
Customer Service	77.3%	↓	80.3%	82.8%
Rating of Health Care (8-10)	70.1%	↑	66.1%	68.2%
Rating of Personal Doctor (8-10)	77.4%	↓	77.6%	80.4%
Rating of Specialist (8-10)	82.9%	↑	80.2%	75.5%
Rating of Health Plan (8-10)	67.1%	↓	68.5%	64.5%
Coordination of Care	76.8%	↓	83.5%	83.7%

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

Table 29: Medi-Cal Child Trended Survey Results – Delegates

		AHS			Alliance			CFMG			CHCN			Kaiser		
	2021 Plan Total	**2021**	**2020**	**Year Over Year Trend**	2021	**2020**	**Year Over Year Trend**	**2021**	**2020**	**Year Over Year Trend**	**2021**	**2020**	**Year Over Year Trend**	**2021**	**2020**	**Year Over Year Trend**
Total Respondents	**373**	**31**			**31**			**115**			**139**			**57**		
Getting Needed Care	**82.2%**	80.0%	84.0%	↓	95.5%	59.4%	↑	71.7%	91.7%	↓	92.6%	73.7%	↑	94.2 %	89.6%	↑
Getting Care Quickly	**78.8%**	69.2%	77.1%	↓	58.3%	75.0%	↓	75.6%	87.4%	↓	86.5%	74.4%	↑	89.7 %	90.2%	↓
How Well Doctors Communicate	**93.2%**	89.7%	90.1%	↓	90.6%	83.3%	↑	95.9%	95.9%	↔	91.4%	90.3%	↑	95.0 %	96.3%	↓
Rating of Health Care (8-10)	**89.1%**	90.9%	94.1%	↓	83.3%	75.0%	↑	89.1%	95.0%	↓	86.9%	80.8%	↑	96.2 %	89.5%	↑
Rating of Personal Doctor (8-10)	**91.0%**	92.0%	100%	↓	91.3%	85.0%	↑	92.4%	96.2%	↓	86.6%	85.2%	↑	96.1 %	90.7%	↑
Rating of Specialist (8-10)	**87.2%**	75.0%	100%	↓	100%	80.0%	↑	81.0%	100%	↓	91.7%	84.2%	↑	100%	91.7%	↑
Rating of Health Plan (8-10)	**88.1%**	89.7%	90.9%	↓	83.3%	76.2%	↑	89.3%	93.8%	↓	86.8%	79.7%	↑	90.9 %	94.9%	↓
Coordination of Care	**73.8%**	66.7%	50.0%	↑	62.5%	87.5%	↓	70.0%	95.5%	↓	76.2%	73.1%	↑	88.9%	93.8%	↓

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Table 30: Medi-Cal Adult Trended Survey Results – Delegates

		AHS			Alliance			CHCN			KAISER		
	2021 Total Plan	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend
Total Respondents	**210**	48			52			71			36		
Getting Needed Care	**79.0%**	72.5%	88.3%	↓	82.3%	78.6%	↑	79.7%	82.7%	↓	80.4%	79.5%	↑
Getting Care Quickly	**72.4%**	81.3%	72.2%	↑	61.5%	79.0%	↓	62.1%	96.1%	↓	87.5%	70.3%	↑
How Well Doctors Communicate	**83.5%**	73.8%	98.1%	↓	86.6%	96.4%	↓	87.9%	95.3%	↓	80.9%	94.2%	↓
Rating of Health Care (8-10)	**73.1%**	80.0%	81.0%	↓	65.5%	95.8%	↓	72.2%	73.0%	↓	76.2%	80.0%	↓
Rating of Personal Doctor (8-10)	**81.3%**	88.2%	84.2%	↑	73.0%	73.9%	↓	80.9%	89.3%	↓	82.8%	79.2%	↑
Rating of Specialist (8-10)	**78.9%**	**87.5%**	**90.9%**	↓	**64.3%**	**76.9%**	↓	**94.7%**	**93.8%**	↑	**50.0%**	**100%**	↓
Rating of Health Plan(8-10)	**74.9%**	**76.1%**	**80.0%**	↓	**68.0%**	**80.0%**	↓	**75.4%**	**78.0%**	↓	**81.3%**	**84.0%**	↓
Coordination of Care	**83.0%**	73.3%	100%	↓	83.3%	78.6%	↑	87.5%	75.8%	↑	88.9%	90.0%	↓

ALAMEDA Alliance FOR HEALTH

Table 31: Commercial Adult Trended Survey Results – Delegated Network

		Alliance			CHCN			AHS		
	2021 Plan Total	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend	2021	2020	Year Over Year Trend
Total Respondents	**250**	**117**			**108**			**25**		
Getting Needed Care	**75.2%**	76.2%	59.8%	↑	74.7%	72.5%	↑	72.6%	52.8%	↑
Getting Care Quickly	**71.1%**	75.2%	63.5%	↑	70.5%	73.3%	↓	56.4%	68.9%	↓
How Well Doctors Communicate	**87.7%**	93.2%	86.9%	↑	84.1%	91.7%	↓	75.0%	93.5%	↓
Rating of Health Care (8-10)	**70.1%**	73.9%	62.5%	↑	69.8%	67.4%	↑	53.3%	75.0%	↓
Rating of Personal Doctor (8-10)	**77.4%**	76.4%	72.1%	↑	79.3%	81.9%	↓	73.3%	76.2%	↓
Rating of Specialist (8-10)	**82.9%**	91.5%	74.2%	↑	73.3%	89.4%	↓	60.0%	50.0%	↑
Rating of Health Plan (8-10)	**67.1%**	72.1%	66.3%	↑	62.6%	70.8%	↓	63.6%	65.5%	↓
Care Coordination	**76.8%**	78.8%	81.6%	↓	75.6%	86.3%	↓	75.0%	75.0%	↔

CAHPS Survey Qualitative and Quantitative Analysis

The 2021 CAHPS survey results year-over-year trends show variation within the **Alliance** business lines. Across LOBs, the Medi-Cal Child population had the highest composite summary rate scores in 2021. The Medi-Cal Adult population had the highest overall decrease composite summary rate scores in six (6) of nine (9) composites.

ALAMEDA Alliance FOR HEALTH

MY 2021 – 2020 Alliance and Delegate Comparative Findings

Medi-Cal Child

AHS show that seven (7) of eight (8) composites rate scores increased.

Alliance show that six (6) of eight (8) composites rate scores increased.

CFMG show that seven (7) of the eight (8) composite rate scores decreased.

CHCN show that eight (8) of eight (8) composites rate scores increased.

Kaiser shows that four (4) of eight (8) composites rate scores decreased. However, there is a noted significant increase in Rating of Personal Doctor from 2020.

Quantitative Trends:

- No overall consistent trends noted in composite scores in 2021 compared to 2020.

Medi-Cal Adult

AHS scored lower in six (6) of eight (8) composites with a significant decrease noted in Care Coordination

Alliance scored lower in six (6) of eight (8) composites

CHCN scored lower in five (5) of eight (8) composites

Kaiser scored lower in five (5) of eight (8) composites

Quantitative Trends:

- Decrease score trends noted in composite scores in 2021 compared to 2020 for all networks in:
    - How well Doctor's Communicate
    - Rating of Health Care 8-10
    - Rating of Health Plan

Commercial Adult

AHS scores increased in seven (7) of eight (8) composites.

Alliance scores increased in seven (7) of eight (8) composites.

CHCN scored decreased in six (6) of eight (8) composites.

Quantitative Trends:

- All networks showed an increase in composite scores in 2021 compared to 2020 in:
    - Getting Needed Care

Alameda Alliance for Health

Table 32: Composite Measures

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

One (1) composite

- Getting Care Quickly is identified for all networks as a lower scoring composite provide providing opportunities for improvement via RCA as part of the QI Work Plan for 2022.

Table 33: Composites and Key Drivers

Composite	Key Driver
Rating of Health Plan	Customer Service Providing Information and Help
	Getting Needed Care
Rating of Health Care	Health Plan Overall Rating
	Doctors Spending Enough Time with Patients
Rating of Personal Doctor	How Well Doctors Communicate
	Getting Needed Care

Next Steps

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

Care coordination across direct and delegate networks show an opportunity for improvement. Improvement strategies for 2022 will be a part of the QI and UM Work Plan and include but not limited to:

Inform, support, remind specialty providers about coordination of care expectations, timely notification requirements, and standards of care for post-visit follow up to all PCPs. Explore options to encourage and support communications between specialists and PCPs.

- Assess the status and consistency of coordination of patient care, communication, and information shared within and across provider networks. Assure prompt feedback, standards.
- Explore potential of aligning information flow/EHRs to better integrate, support or facilitate patient care, care coordination and vital medical and personal information among providers.

Quality Of Access

A. Standards and Provider Education

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

Table 34: Primary Care Physician (PCP) Appointment

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

Table 35: Specialty/Other Appointment

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

Table 36: All Provider Wait Time/Telephone/Language Practices

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

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

PA = Prior Authorization

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

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

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

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

Table 37: Primary Care Physician (PCP) Appointment

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

Table 38: Specialty/Other Appointment

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

Table 39: All Provider Wait Time/Telephone/Language Practices

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

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

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

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

B. Provider Capacity

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

C. Geo Access

The geographic access reports are reviewed quarterly to ensure that the plan is meeting the geographic access standards for provided services in Alameda County. For PCPs, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. For specialists, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. During 2021, the Alliance continued its cross functional quarterly meeting to review access issues and concerns.

In 2021, the rural areas near Livermore were the only areas in which the plan faced geographic access issues for Primary Care Provider (PCP) services. Although, there were some deficiencies in the Livermore area for PCP services for distance, the Alliance was able to demonstrate

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

D. Provider Appointment Availability Survey (PAAS)

The Alliance's annual Provider Appointment Availability Survey (PAAS) for MY2021 was used to review appointment wait times for the following provider types:

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

The Alliance reviewed the results of its annual PAAS for MY2021 to identify areas of deficiency and areas for potential improvement. The Alliance defines *deficiency* as a provider group scoring less than a seventy-five percent (75%) compliance rate on any survey question related to appointment wait times.

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

Table 40: MY 2021 Compliance Rates by Appointment Type across All Provider Types

Ancillary		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	Not applicable	94%
MCL	Not applicable	94%
PCPs		
LOB	**Urgent Appt**	**Routine Appt**
IHSS	78.5%	84.9%
MCL	78.9%	87.8%
NPMH		

LOB	Urgent Appt	Routine Appt
IHSS	81.4%	85.6%
MCL	73.1%	77.7%
Psychiatrists		
LOB	Urgent Appt	Routine Appt
IHSS	63.2%	82.5%
MCL	58.6%	80.5%
Specialists		
LOB	Urgent Appt	Routine Appt
IHSS	46.0%	56.5%
MCL	45.6%	56.0%

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 2019, 2020, and 2021. As a result of COVID-19 PHE office visits (face-to-face and telehealth) dramatically declined. The Alliance will continue engaging in provider/delegate re-education around the timely access standards, to increase its efforts around compliance with the urgent appointment standard through the following ways:

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

Table 41: Percentage of Ineligible Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2021	40%	26%	34%	31%	21%
2020	41%	17%	29%	36%	18%

Across all provider types, Psychiatrists had the highest percentage of ineligible providers, followed by Ancillary providers, Specialists, and NPMH, with PCPs providers having the lowest percentage of ineligible providers. Results of the MY2020 PAAS also show Psychiatrists as having the highest percentage of ineligible providers. Psychiatrists, and Ancillary providers showed a decrease in percentage of ineligible providers from MY2020 to MY2021. While PCPs, Specialists, and NPMH providers show an increase in eligible 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 increasing the overall percentage of ineligible providers to 75%.

Table 42: Percentage of Non-Responsive Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2021	19%	8%	30%	19%	27%
2020	30%	6%	33%	12%	28%

Across all provider types, Specialists had the highest percentage of non-responsive providers, followed by NPMH providers, Psychiatrists and Ancillary and providers, with PCPs having the lowest percentages of non-responsive providers in MY 2021(see table above). The Alliance will increase its level of provider/delegate education around survey completion and purpose, including a focus on the development of provider/delegate improvement plans, with the overall goal of lessening and/or removing barriers for non-responsiveness. These efforts will include a focus on Specialists, given they had the highest level of survey non-responsiveness across provider types year-on-year.

E. Year-Over-Year Analysis

All provider types did not show improvement in compliance rates in either appointment types for both LOBs. Specialist providers showed the biggest decrease in compliance rates for both appointment standards for both LOBs, followed by Psychiatrists and NPMH providers.

Alameda Health System

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

CFMG

For the PCP provider type, CFMG providers maintained a stable rate of compliance with both appointment standards for LOBs. For the Specialist provider types, CFMG providers showed a significant decrease in compliance for both appointment standards for cardiology appointments. However, CFMG providers demonstrated zero compliance with endocrinology and gastroenterology appointments, providing opportunity for improvements.

CHCN

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

ICP

For the PCP provider type, ICPs showed a decrease in compliance with urgent appointments but maintained 100% compliance with routines appointments for both LOBs. For cardiology and gastroenterology, ICPs demonstrated best practice by maintaining 100% compliance with both appointment standards for both LOBs. ICPs maintained 100% compliance with urgent appointments for IHSS LOB. However, ICPs showed a significant decrease in routine appointments for both LOBs and MCL urgent appointment. This represents a significant negative change from their previous year's improvements. For the Adult NPMH provider type, ICPs showed overall decrease in compliance for both appointment standards for both LOBs, anther negative change from their previous year's improvements.

F. Provider-Focused Improvement Activities

As part of the Quality Improvement strategy for 2022, 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, by the end of Q2 2022 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 MY2021 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 MY2021 PAAS at the Q2 2022 Access and Availability Sub-Committee for feedback and recommendations, as well as, in the Q3 Health Care Quality Committee (HCQC), which is comprised of Chief Officer leadership from delegated networks, offering additional opportunities for discussion of best practice and improvement opportunities.

G. After Hours Survey

The Alliance contracted with SPH Analytics (SPH) to conduct the annual Provider After-Hours Survey for MY2021, which measures providers' compliance with the after-hours emergency instructions standard. The MY2021 After-Hours Survey was conducted from September to October2021. SPH followed a phone-only protocol to administer the survey to the eligible provider population during closed office hours. A total of 451 Alliance providers and/or their staff were surveyed, and included 82 primary care physicians (PCPs), 222 specialists, and 147 behavioral health (BH) providers. The survey assesses for the presence of instructions for a caller with an emergency situation, either via a recording or auto-attendant, or a live person.

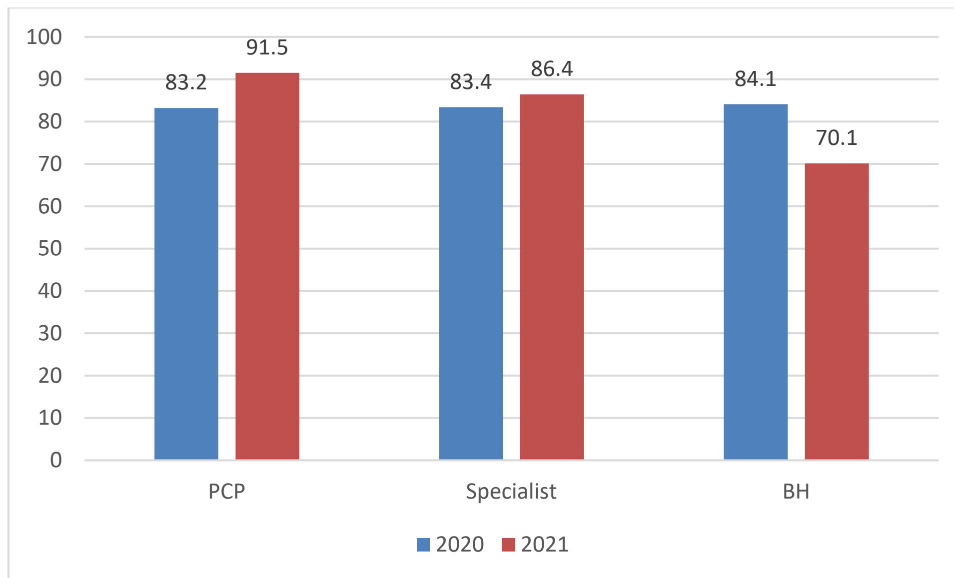
The table below presents the compliance rates for the providers surveyed in the After-Hours Survey:

Table 43: Compliance Rates for After Hours Survey

	Emergency Instructions		
Provider Type	**Total Compliant**	**Total Non-Compliant**	**Compliance Rate**
PCP	75	7	91.5%
Specialist	192	30	86.4%
BH	103	44	70.1%
Total	**370**	**81**	

A total of 58 providers (7 PCPs, 30 Specialists,44 BH) were found to be non-compliant with the emergency instructions standard as a result of the After-Hours Survey. BH providers had the highest non-compliance rate in 2021 up from 7 in 2020followed by Specialists, then PCP providers.

Table 44: After Hours Emergency Instruction and Access to Physician Compliance Rate Comparison (2020 v 2021)



The figure below presents the response rate across provider types:

Table 45: Response Rate by Provider Type

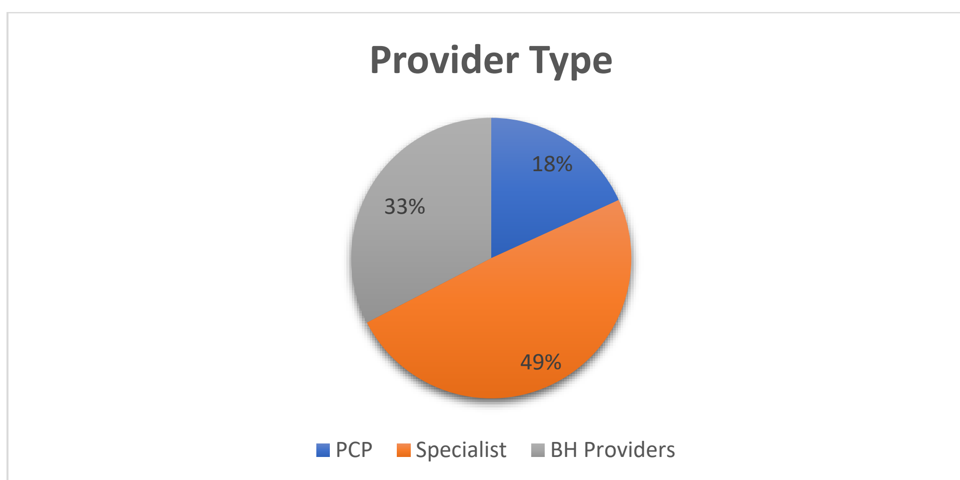


Table 46: After Hours Emergency Instruction and Access to Provider Survey Response Rate Comparison (2020 v 2021)

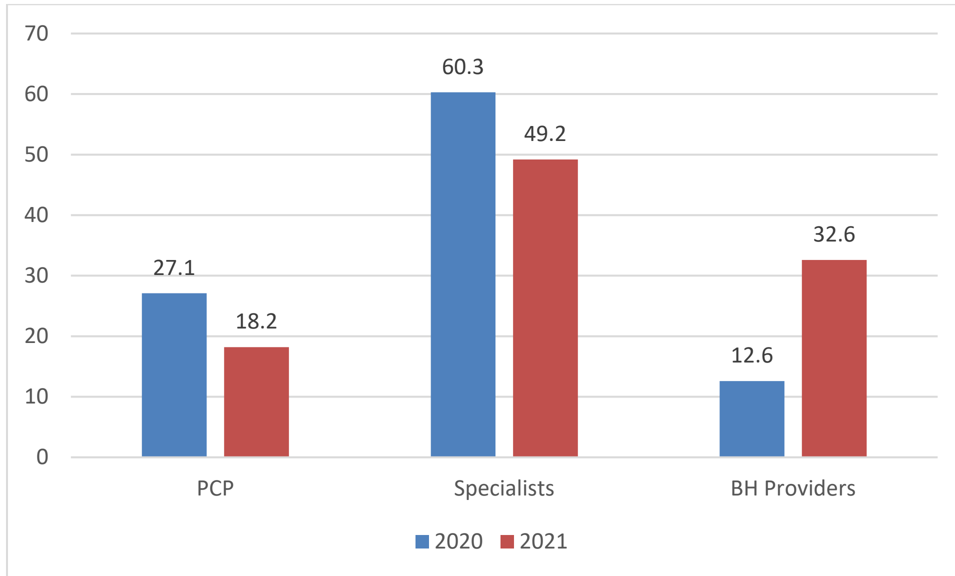
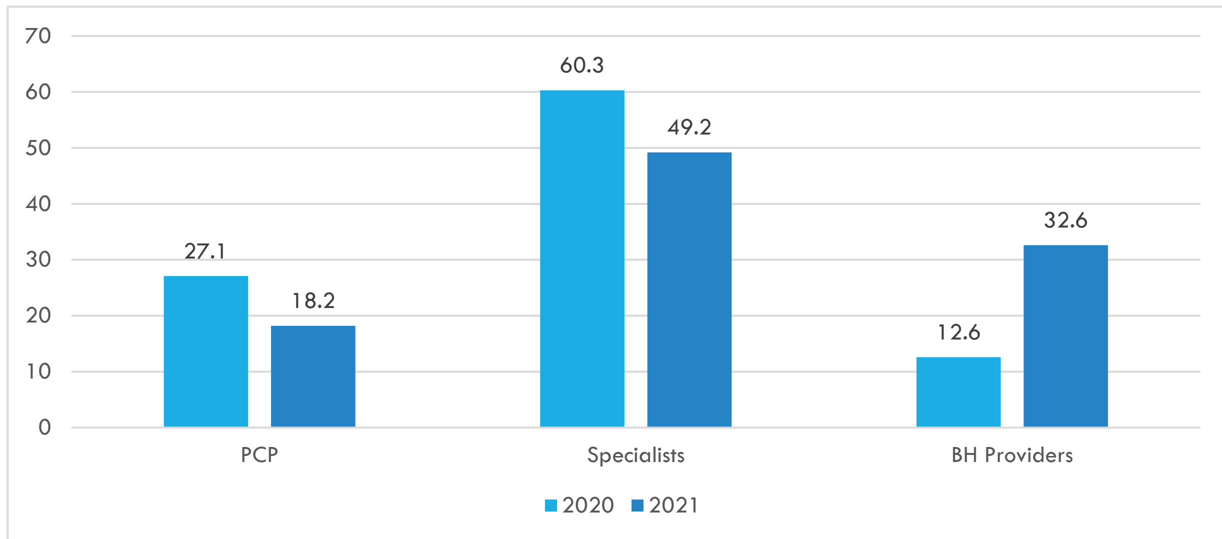


Table 47: 2020 After Hours Emergency Response Rates for 2021 when compared to 2020



- Number of survey respondents in 2020 = 350
- Number of survey respondents in 2021 = 451
- Year-over-Year Specialist providers have had the highest response rate to the survey
- BH providers response rate increased in 2021 from 2020 by 20%
- PCPs and Specialist providers response rates in 2021 decreased from 2020 by 8.9% and 11.1% respectively.

COVID-19 PHE appears to have had a negative impact on After Hours Emergency Instruction compliance for both PCPs and Specialists. Results of survey were presented at Q1 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

H. First Prenatal Visit Survey

The Alliance conducted the annual First Prenatal Visit Survey for MY2021, which measures providers' compliance with the first prenatal visit standard. The survey was conducted in September – November of 2021 and was administered to a random sample of eligible Alliance Obstetrics and Gynecology (OB/GYN) providers. The table below shows results of the survey.

Table 48: First Prenatal Visit Survey

Appointment Within 2 Weeks	75% Target Goal Met	Percent of Ineligibles	Precent of Non-Responsive
73.2%	No	44.4%	18.8%

The First Prenatal Visit 2021 survey results shows a compliance rate is 4.3% percentage points higher than the 2020 (68.9%) compliance rate, although the goal of 75% was not met. Corrective Action Plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2022.

Plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2022. Additionally, the Alliance's QI Department will continue: 1) between survey monitoring of First Prenatal Visit compliance via Quality of Access PQIs 2) ongoing provider education and discussions at delegate Joint Operations Meetings (JOMs) regarding timely access standards; 3) collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.

I. Oncology Survey

The Alliance conducted the annual Oncology Survey for MY2021, which measures providers' compliance with the urgent and non-urgent appointment standards for specialists. The survey was conducted from September – November of 2021 and was administered to a random sample of eligible Alliance oncology providers. The table below shows results of the survey.

Table 49: Oncology Survey

Urgent Appt	75% Target Goal Met	Non-Urgent Appt	75% Target Goal Met	Percent of Ineligibles	Percent of Non-Responsive
84.2%	Yes	78.9%	Yes	32.8%	34.4%

In 2021 the compliance rate for non-urgent appointments decreased from 90% in 2020 by 11.1 percentage points, as did the compliance rate for urgent appointments by 2.5 percentage points in 2020 down from 86.7%. Time-sensitive corrective action plans (CAPs) will be issued to all non-responding and non-compliant providers within Q2 2022. Additionally, the Alliance's QI Department will:

1) its ongoing provider education and discussions at delegate Joint Operations Meetings (JOMs) regarding timely access standards
2) collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.

J. CG-CAHPS SURVEY

The Alliance contracted with SPH Analytics (SPH) to conduct its quarterly Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey within 2021, 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 2021. In 2019 the Alliance was given approval by DHCS to modified the CG-CAHPS survey. Per approval from DHCS, the in-office wait time standard changed from within 30 minutes to within 60 minutes. Also, the call return time standard changed from within 30 minutes

to within one business day. The time to answer call standard remained the same (within 10 minutes). SPH followed a mixed methodology of mail and phone to administer the survey to a randomized selection of eligible members who had accessed care with their PCP within the previous six months.

The table below presents the compliance rates across the three metrics for the CG-CAHPS surveys that were conducted in 2021 within each quarter.

Table 50: CG-CAHPS Survey Results 2021

Metric	Compliance Goal	Q1 2021	Q2 2021	Q3 2021	Q4 2021
In-Office Wait Time (Within 60 minutes)	80%	92.4%	91.7%	92.7%	91.8%
Call Return Time (Within 1 Business Day)	80%	76.2%	76.6%	75.9%	82.2%
Time To Answer Call (Within 10 minutes)	80%	78.5%	77.7%	71.1%	75.0%

The target compliance goal for each of the three metrics is 80%. In-office Wait Time compliance goals were met throughout 2021. Call Return Time and Time to Answer Call compliance rates trended slightly below the compliance goal of 80% ranging from 75.9% - 82.2% and 71.1% - 78.5%.

Possible Barriers:	• **6 month delay in survey fielding from date of encounter. Results are based on *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-compliance 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

	• Outreach to other HP to solicit compliance rates for comparison • Consider validity/reset of our compliance goal of 80% based on findings

Provider Satisfaction Survey Overview

The Alliance contracted with its NCQA certified vendor, SPH, to conduct a Provider Satisfaction Survey for measurement year 2021. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Alliance provided SPH with a database of Primary Care Physicians (PCPs), Specialists (SPCs) and Behavioral Health (BH) providers who were part of the Alliance network. Duplicate provider names or NPIs were removed from the databased prior to submitting to survey vendor. From the database of unique providers, a sample of 815 records was drawn. A total of 114 surveys were completed between September - December 2021 (71 mail, 26 internet, 17 phone).

The table below contains the survey response rates, survey respondents, and role of survey respondents for 2021 compared to 2020.

Table 51: Survey Response Rates: 2021 vs. 2020

	Mail/Internet	Phone
2021	12%	2%
2020	15%	8%

Table 52: Survey Respondents 2021 vs. 2020

	PCPs	BH Providers	SPCs
2021	51.3%	10%	38.8%
2020	32.9%	19.3%	56.0%

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Year to Year Trend Comparisons

The table below contains the trended survey results across composites.

Table 53: Trended Survey Results Across Composites

Summary Rate Scores					
Composite / Attribute	**MY 2021**	**Variance Compared to Previous Year**	**Variance Compared to SPH Commercial Benchmark BoB**	**2020**	**2019**
Overall Satisfaction with the Alliance	**77.3%**	Lower	Higher	85.0 %	67.8%
All Other Plans (Comparative Rating)	**50.0%**	Lower	Significantly Higher	55.6 %	43.8%
Finance Issues	**44.5%**	Stable	Higher	45.0%	36.2%
Utilization and Quality Management	**45.3%**	Lower	Significantly Higher	50.9%	48.2%
Network Coord. of Care	**37.6%**	Lower	Higher	39.1%	36.6%
Pharmacy	**35.1%**	Higher	Higher	33.0%	34.1%
Health Plan Call	**54.0%**	Stable	Significantly Higher	53.9%	44.5%
Provider Relations	**63.5%**	Higher	Significantly Higher	61.5%	57.3%

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The Alliance identified significant higher composite scores in 4 of 8 composites in 2021 compared to 8 of 8 composite scores being significantly higher in 2020.

SPH Alliance POWER List:

Promote and Leverage Strengths (Top 5 Listed)

1. Overall satisfaction with the Alliance call center
2. Ease of reaching the Alliance staff over the phone
3. Helpfulness of call center staff in assisting with the referral process or referral network
4. Ability to speak with an Alliance medical director about a prior authorization
5. Variety of different formulary options

Best Practice

Below are the performance results for the past three years, for provider care coordination. AAH has exceeded the SPH Aggregate BoB value all three years. For 2022 the Alliance will consider establishing an improvement goal that is > 35% as a push goal

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

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

Cultural and Linguistic Needs Of Members

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

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

The Alliance strives to ensure members have access to a PCP who can speak their language or to appropriate interpreters. For members who have not chosen a PCP upon enrollment, the Alliance will assign a member to a PCP based on characteristics, including language. In 2021, the Alliance identified the following threshold languages.

Table 54: 2021 Threshold Languages

Total by Plan	Threshold Languages		
Medi-Cal 291,257	English	182,678	62.72%
	Spanish	58,154	19.97%
	Chinese	26,257	9.02%
	Vietnamese	8,531	2.93%
	Tagalog	1,870	0.64%

Total by Plan	Threshold Languages		
Group Care **5,824**	English	3,465	59.50%
	Chinese	1,390	23.87%
	Spanish	281	4.82%

Source: Alliance Monthly Membership Report December 2021

Table 55: Member Ethnicity – Medi-Cal

MEDI-CAL	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2020	Jan - Dec 2021	% YTD Membership in Jan - Dec 2021 (minus) % of Membership in Jan - Dec 2020	Dec 2021	Dec 2021 %
Hispanic (Latino)	27.80%	28.00%	0.19%	81,788	28.08%
Other	20.69%	21.81%	1.12%	64,535	22.16%
Black (African American)	16.88%	16.12%	-0.76%	46,317	15.90%
Chinese	10.49%	10.19%	-0.31%	29,394	10.09%
White	9.12%	9.10%	-0.01%	26,389	9.06%
Other Asian / Pacific Islander	7.38%	7.20%	-0.18%	20,701	7.11%
Vietnamese	4.09%	3.89%	-0.20%	11,081	3.80%
Filipino	2.78%	2.89%	0.11%	8,461	2.90%
Unknown	0.55%	0.59%	0.04%	1,966	0.68%
American Indian Or Alaskan Native	0.22%	0.21%	-0.00%	625	0.21%
Total Members				**291,257**	

Source: Alliance Monthly Membership Report December 2021

Medi-Cal Ethnicity Discussion: 2021 saw an overall increase in membership, but only slight changes in ethnicities as a percent of the Medi-Cal membership with the greatest increase in “Other” ethnicity. Hispanic (Latino) members make up almost 30%, all Asian members combined make up almost 25%, and Black (African American) members 16% of Medi-Cal membership.

Table 56: Member Ethnicity – Group Care

GROUP CARE	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY ETHNICITY	Jan - Dec 2020	Jan - Dec 2021	% YTD Membership in Jan - Dec 2021 (minus) % of Membership in Jan - Dec 2020	Dec 2021	Dec 2021 %
Other Asian / Pacific Islander	27.35%	29.47%	2.12%	1,765	30.31%
Unknown	30.28%	28.52%	-1.76%	1,613	27.70%
Chinese	13.21%	13.26%	0.04%	785	13.48%
Black (African American)	11.33%	11.11%	-0.22%	643	11.04%
Other	7.93%	7.60%	-0.34%	451	7.74%
Hispanic (Latino)	3.66%	3.80%	0.15%	215	3.69%
Vietnamese	3.03%	3.02%	-0.00%	177	3.04%
White	2.09%	1.99%	-0.10%	107	1.84%
Filipino	1.00%	1.11%	0.11%	62	1.06%
American Indian Or Alaskan Native	0.11%	0.11%	-0.00%	6	0.10%
Total Members				**5,824**	

Source: Alliance Monthly Membership Report December 2021

Group Care Ethnicity Discussion: The largest group who identified their ethnicity was the Other Asian/Pacific Islander, representing over 30% of the Group Care membership. These are mostly Asian Indian (27.47% of Group Care membership). The percent of Group Care members with unknown ethnicity continues to decline, although still higher than desired.

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Table 57: Member Languages Spoken – Medi-Cal

MEDI-CAL	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2020	Jan - Dec 2021	% YTD Membership in Jan - Dec 2021 (minus) % of Membership in Jan - Dec 2020	Dec 2021	Dec 2021 %
English	61.89%	62.65%	0.76%	182,678	62.72%
Spanish	19.68%	19.84%	0.16%	58,154	19.97%
Chinese	9.56%	9.12%	-0.45%	26,257	9.02%
Vietnamese	3.21%	3.01%	-0.20%	8,531	2.93%
Unknown	2.60%	2.47%	-0.13%	7,235	2.48%
Other Non-English	2.39%	2.26%	-0.12%	6,532	2.24%
Tagalog	0.67%	0.65%	-0.02%	1,870	0.64%
Total Members				**291,257**	

Source: Alliance Monthly Membership Report December 2021

Medi-Cal Language Discussion: Medi-Cal members are approximately 63% English-speaking, 20% Spanish-speaking, 9% Chinese-speaking, and 3% Vietnamese-speaking. Less than 1% speak Tagalog. There are no significant changes from last year.

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Table 58: Member Languages Spoken – Group Care

GROUP CARE	Prior Year	YTD	% Change	Current Month	
ALAMEDA ALLIANCE FOR HEALTH MEMBERSHIP BY PRIMARY LANGUAGE	Jan - Dec 2020	Jan - Dec 2021	% YTD Membership in Jan - Dec 2021 (minus) % of Membership in Jan - Dec 2020	Dec 2021	Dec 2021 %
English	59.80%	59.66%	-0.14%	3,465	59.50%
Chinese	23.50%	23.60%	0.10%	1,390	23.87%
Spanish	4.92%	4.81%	-0.11%	281	4.82%
Other Non-English	4.05%	4.11%	0.06%	234	4.02%
Vietnamese	3.71%	3.70%	-0.02%	216	3.71%
Unknown	3.58%	3.60%	0.02%	209	3.59%
Tagalog	0.43%	0.52%	0.09%	29	0.50%
Total Members				**5,824**	

Source: Alliance Monthly Membership Report December 2021

Group Care Language Discussion: Group Care members continue to speak predominately English (60%), followed by Chinese (almost 25%) and Spanish-speaking (5%).

A. Practitioner Language Capacity

During 2021, the Alliance's Provider Relations staff conducted in-person surveys during provider office visits to verify languages spoken by providers. The chart below is a comparison of identified languages spoken by the Plan's members to its provider network at the end of Quarter 4 2021.

Table 59: Medi-Cal Provider Network vs. Members Comparison of Identified Languages

	2020Q4			2021 Q4			Change			
Language	**PCPs**	**Members**	**Members per PCP**	**PCPs**	**Members**	**Members per PCP**	**# PCPs**	**% PCPs**	**# Members**	**% Members**
English	519	137,496	264	648	148,043	228	129	25%	10,547	8%
Spanish	121	48,715	402	139	52,449	377	18	15%	3,734	8%
Chinese	68	23,110	339	81	23,774	293	13	19%	664	3%
Vietnamese	16	8,088	505	18	8,125	451	2	13%	37	0%
Tagalog*	N/A	N/A	N/A	16	1,680	105	N/A	N/A	N/A	N/A
Arabic	6	2,203	367	6	2,257	376	0	0%	54	2%
Farsi	6	1,498	249	6	1,544	257	0	0%	46	3%
Total**	**910**	**231,656**		**1,094**	**246,684**		184	20%	15,028	6%

Source: Q4 2020 and Q4 2021 Provider Language Access Reports

*Tagalog was not tracked in 2020.
**Total also includes unknown and other languages. A number of PCPs do not have a primary language designated in the data we receive. Also, multilingual providers are counted for each language they speak. Kaiser members are not included.

Table 60: Medi-Cal PCPs & Members by Language

	2020Q4	2021Q4	Change
Language	**Members per PCP**	**Members per PCP**	**Difference**
English	264	228	Improvement ↓36
Spanish	402	377	Improvement ↓25
Chinese	339	293	Improvement ↓46
Vietnamese	505	451	Improvement ↓54
Tagalog	N/A	105	N/A
Arabic	367	376	Decline ↑9
Farsi	249	257	Decline ↑8

Source: Q4 2020 and Q4 2021 Provider Language Access Reports

In 2021 the Plan experienced overall slight improvements in Medi-Cal members per PCP for threshold languages due to an increase in the number of PCPs.

Table 61: Group Care Provider Network vs. Members Comparison of Identified Languages

	2020 Q4			2021 Q4			Change			
Language	**PCPs**	**Members**	**Members per PCP**	**PCPs**	**Members**	**Members per PCP**	**# PCPs**	**% PCPs**	**# Members**	**% Members**
English	402	3,545	8	526	3,465	6	124	31%	-80	-2%
Chinese	60	1,383	23	72	1,391	19	12	20%	8	1%
Spanish	93	295	3	110	283	2	17	18%	-12	-4%
Vietnamese	14	215	15	16	216	13	2	14%	1	0%
Tagalog*	N/A	N/A	N/A	15	29	1	N/A	N/A	N/A	N/A
Arabic	6	9	1	6	6	1	0	0%	-3	-33%
Farsi	5	98	19	5	92	18	0	0%	-6	-6%
Total**	**722**	**5,953**		**896**	**5,823**		174	24%	-130	-2%

Source: Q4 2020 and Q4 2021 Provider Language Access Reports

Table 62: Group Care PCPs & Members by Language

	2020Q4	2021Q4	Change
Language	**Members per PCP**	**Members per PCP**	**Difference**
English	8	6	Improvement ↓ 2
Chinese	23	19	Improvement ↓ 4
Spanish	3	2	Improvement ↓ 1
Vietnamese	15	13	Improvement ↓ 2
Tagalog	N/A	1	N/A
Arabic	1	1	No change
Farsi	19	18	Improvement ↓ 1

Source: Q4 2020 and Q4 2021 Provider Language Access Reports

Group Care members, while being a significantly smaller population, have access to most of our extensive Medi-Cal network of providers. As a result, all languages have at least 1 PCP per 19 members.

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

- Review of grievances related to provider language capacity
- Monitoring of interpreter services provided

In the absence of a practitioner who speaks a member's preferred language, the Alliance ensures the provision of interpreter services at the time of appointment. In 2021, the Alliance provided almost 50,000 interpreter services. The interpreter services delivery mode in 2021 was approximately 50% pre-scheduled phone or video, 38% telephonic, and 11% in-person. The fulfillment rate for interpreter services was 99%.

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Analysis Of 2021 Quality Program Evaluation and Effectiveness

The Alliance has identified the challenges and barriers to improvement throughout the 2021 QI Evaluation measurement year. Both challenges and achievements helped to inform our 2021 QI Work Plan. The COVID-19 pandemic and PHE brought unexpectant challenges that impacted our members, provider partners and staff. 2021 brought an abundance of opportunities for improvement in ensuring that our members have high quality, safe, timely, effective, efficient, equitable, patient centered care. Recommended activities and interventions for the upcoming year consider these challenges and barriers in working toward success and achievement of the Alliance's goals in 2022.

Challenges and barriers to achieving objectives encountered within the 2021 program year included but are not limited to:

- COVID-19 pandemic and PHE shelter in place resulted in multiple quality initiatives and activities paused due to PHE
- COVID-19 changes to interpreter needs from in-person to telephonic and video.
- COVID-19 caused IHA Audits to be impacted because of a delay in provider responses to medical record requests.
- Because of COVID-19, all Facility Site Reviews were halted until further notice.
- Drop in health education program participation due to pandemic and move to virtual formats for classes.
- HEDIS measurement results impeded deployment of optimal strategic rapid cycle PDSA implementation for quality improvement activities
- Member Services call center "call abandonment" rate negatively impacted by staffing challenges
- QI leadership staffing challenges in hiring a qualified Access to Care Manager

Program major accomplishments with objectives met for 2021 include but are not limited to:

- Adequate QI program resources to carry out roles, functions, and responsibilities
- A consistent and stable QI committee and program structure
- Successful administration of all timely access surveys within the expected timeframes, allowing for timely analysis and implementation of next steps with providers and within the Alliance

- Maintenance of favorable Provider Satisfaction Survey scores
- HCQC meetings held 6 times within 2021 and remains active in ensuring requirements of the QI Program were met despite PHE
- Stable and consistent Senior Level Physician involvement and Appropriate External and Internal Leadership
- Improved HEDIS performance rates for measures; above the MPL for all accountable HEDIS metrics
- Deployment of a Pediatric Care Management Program to promote access to care and EPSDT service utilization in partnership 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 Care (QOL) PQIs segmentation for tracking and trending
- Ongoing Member 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.

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT PROGRAM DESCRIPTION 2022

2022 Quality Improvement Program Description
Signature Page

Stephanie Wakefield, RN Senior Director of Quality	Date
Sanjay Bhatt, M.D. Senior Medical Director, Vice Chair, Health Care Quality Committee	Date
Steve O'Brien, M.D. Chief Medical Officer Chair, Health Care Quality Committee	Date
Scott Coffin Chief Executive Officer	Date
Evan Seevak, M.D. Board Chair	Date

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 295,151 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 thorough one of several Medi-Cal programs, e.g., TANF, SPD, Medi-Cal Expansion and Dually Eligible Medi-Cal members 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.

Alameda Alliance for Health's (Alliance) Quality Improvement (QI) Program strives to ensure that members have access to quality and safe health care services. The QI 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.

The Alliance QI Program is applicable to all product lines and is designed to assess, measure, evaluate and improve the quality and safety of care that members receive. Participation of all Alliance departments and staff in quality improvement activities is essential to the organization achieving our QI 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 physically disability, sex, gender, gender identity, or sexual orientation, medical condition, genetic condition, or marital status. The Alliance QI 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

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

QI PROGRAM SCOPE AND GOALS

The purpose of the Alliance QI Program is to objectively monitor and evaluate the quality, safety, appropriateness, and outcome of care and services delivered to members of the Alliance. The overall goal of the QI Program is to ensure that members have access to quality medical and behavioral health care services that are safe, effective, and meet their needs. The QI program is structured to continuously pursue opportunities for improvement and problem resolution. The QI program is organized to meet overall program objectives as described below and as directed each year by the QI and UM Work Plan. Improvement priorities are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

Although not limited to, the goals of the QI 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 QI 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 QI 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 service 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 QI program is comprehensive and encompasses the following:

1. Timely access and availability to quality and safe medical and behavioral 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
7. Tracking of service utilization trends, including over-and under-utilization
8. Clinical practice guideline development, adoption, distribution, and monitoring
9. Targeted focus on acute, chronic, and preventive care services for children and adults
10. Member and provider education
11. Prenatal, primary, specialty, emergency, inpatient, and ancillary care
12. Case review, investigation, and corrective actions of potential quality issues
13. Credentialing and re-credentialing activities
14. Delegation oversight and monitoring
15. Delegate performance improvement project collaborations
16. Targeted support of special needs populations including Seniors and Persons with Disabilities and persons with chronic conditions
17. Population Health Management Integration
18. Health care diversity and equity

ORGANIZATIONAL STRUCTURE AND SUPPORT COMMITTEES' RESPONSIBILITY

A. Overview

The Alliance Board of Governors (BOG) appoints and oversees the Health Care Quality Committee (HCQC), Pharmacy & Therapeutics (P&T) Committee, Peer Review/Credentialing Committee (PRCC), Member Advisory Committee, and Compliance Committee which in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QI Program.

The organizational chart in **Appendix A** displays the reporting relationships for key staff responsible for QI activities at the Alliance. **Appendix B** displays the committee reporting relationship and organizational bodies.

B. Board of Governors

The Alliance BOG is appointed by the Alameda County Board of Supervisors and consists of up to 15 members who represent member, provider, and community partner stakeholders. The BOG is the final decision-making authority for the Alliance QI program. Its duties include:

- Reviewing annually, updating, and approving the QI program description, defining the scope, objectives, activities, and structure of the program.
- Reviewing and approval of the annual QI report and evaluation of QI studies, activities, and data on utilization and quality of services.
- Assessing QI program's effectiveness and direct modification of operations as indicated.
- Defining the roles and responsibilities of HCQC.
- Designating a physician member of senior management with the authority and responsibility for the overall operation of the quality management program, who serves on HCQC.
- Appointing and approving the roles of the Chief Medical Officer (CMO) and other management staff in the QI program.
- Receiving a report from the CMO on the agenda and actions of HCQC.

C. Health Care Quality Committee (HCQC)

The HCQC 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 HCQC is responsible for the implementation, oversight, and monitoring of the QI Program and Utilization Management (UM) Program. As it relates to the QI Program, the HCQC recommends policy decisions, analyzes, and evaluates the QI work plan activities, and assesses the overall effectiveness of the QI program. The HCQC reviews results and outcomes for all QI 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 HCQC meetings. The HCQC oversees and reviews all QI delegation summaries reports and evaluates delegate quality program descriptions, program evaluations, and work plan activities. The HCQC presents to the Board the annual QI program description, work plan and prior year evaluation. Signed and dated minutes that summarize committee activities and decisions are maintained. The Annual QI Program, Work Plan, Evaluation and minutes from the HCQC are submitted to the California Department of Health Care Services (DHCS).

Responsibilities include but are not limited to:

- Approve, select, design, and schedule studies and improvement activities.
- Review results of performance measures, improvement activities and other studies.
- 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 developing 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 of the Plan's process for monitoring delegated providers.
- Oversee of the Plan's UM Program.
- Review advances in health care technology and recommend incorporation of new technology into delivery of services as appropriate.
- Provide guidance to staff on quality improvement activities.
- Monitor progress in meeting QI goals.
- Evaluate annually the effectiveness of the QI and Population Health Management program.
- Oversee the Plan's complex case management and disease management programs.
- Review and approve annual QI and UM Program Descriptions, Work Plans, and Evaluations.
- Recommends and approves resource allocation for the QI Department Program. The HCQC 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 Seniors and Persons with Disabilities (SPD) and chronic conditions. The HCQC 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)
  - Medical Director or designee from each delegated medical group (i.e., Community Health Center Network, Children First Medical Group, Kaiser)
  - 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 QI Director

A quorum is established when the majority of the voting membership is present at the meeting. The Chief Executive Officer does not count in the determination of a quorum.

D. Pharmacy and Therapeutics Committee (P&T)

The P&T Committee assists the HCQC 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 and pharmacy updates are shared at the HCQC 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).

E. 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

F. Internal Quality Improvement Committee (IQIC)

The IQIC assists the HCQC 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 targets, and report results to the HCQC. 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 in order 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 HCQC for review.

Committee Responsibilities include but are not limited to:

- Develop, approve, and monitor a dashboard of key performance and QI indicators compared to organizational goals and industry benchmarks.
- Oversee and evaluate the effectiveness of AAH's Performance Improvement and Quality Plans.
- Review reports from other sub-committees and, if acceptable, forward for review at the next scheduled HCQC.
- Reviewing plan and delegate corrective plans regarding negative variances and serious errors.
- Oversee compliance with NCQA accreditation standards.
- Make recommendations to the HCQC 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 of Quality
- Quality Improvement Manager
- Access to Care Manager
- Health Education (Cultural & Linguistics) Manager
- Members from Provider Relations, Member Services, Business Analytics and Health Education, and Compliance, Grievance and Appeals.

G. 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 Program, UM Policies/Procedures, UM Criteria
  - Other pertinent UM documents such as the UM, Evaluation and UM Workplan, UM Notice of Action Templates
  - Case/Care Management (CM) and Health Homes (HH) Programs Policies/Procedures,
  - Health Risk Assessment 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 analysis of utilization data for the identification of trends.
- Recommend actions to the Quality Oversight 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, 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.

H. 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
- Medical Directors
- Quality Director
- Access to Care Manager
- Quality Improvement Manager
- Health Education (Cultural & Linguistics) Manager
- Quality Assurance
- Grievance and Appeals Management
- 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 capacity levels
- Geographic accessibility
- Appointment availability
- High volume and high impact specialists
- Grievances and appeals related to access
- Potential quality issues related to access
- Triage and screening services related to access
- Member and provider satisfaction survey
- After hours care

I. Cultural and Linguistic Services Committee

The Cultural and Linguistic Services Committee (CLSC) reports demographic changes in the Alliance membership, language services offered, grievances related to discrimination, sensitivity and language services and overall execution of the Alliance's Cultural and Linguistic Services Program to HCQC. Its primary role is to ensure members receive culturally and linguistically appropriate health care services regardless of language, ethnicity, gender identity, sexual orientation, age, or disability. The CLSC reports results to the HCQC.

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 Cultural and Linguistic Services program description and work plan.
- Review input from the Member Advisory Committee on cultural and linguistic services and consider how it may inform Alliance's programs, policies, and procedures.
- Identify issues related to access to and provision of culturally and linguistically appropriate services and develops corrective actions to correct deficiencies found.
- Review plan and delegate corrective action plans.

The CLSC is composed of the following voting members:

- Chief Medical Officer
- Senior Director of Quality
- 1 Representative from Compliance
- 1 Representative from Communications and Outreach
- 1 Representative from Grievance and Appeals
- 1 Representative from Health Education
- 1 Representative from Medical Management
- 1 Representative from Member Services
- 1 Representative from Provider Services
- 1 Representative from Quality Improvement

J. 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 QI activities and includes these activities in the QI 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 HCQC meetings, as appropriate.

The Alliance currently delegates the following functions:

Table 1: Alameda Alliance Delegated Entities

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

QUALITY IMPROVEMENT PROGRAM RESOURCES

Responsibilities for QI 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 QI activities and monitoring the QI program. The QI Department participates in the accreditation process, manages the HEDIS and CAHPS data collection and improvement process, conducts facility site reviews (FSRs), 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 HCQC, 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 QI program.

The Alliance's commitment to the QI program extends throughout the organization and focuses on QI activities linked to service, access, continuity and coordination of care, and member and provider experience. The Director of Quality with direction from the Medical Director of Quality and CMO, coordinate the QI program. Titles, education and/or training for key positions within the Quality Department include:

A. Chief Medical Officer

The Alliance Chief Medical Officer (CMO) is a board-certified physician who holds a current unrestricted license to practice medicine in California. The CMO has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The CMO is responsible for and oversees the QI program. The CMO provides leadership to the QI program through oversight of QI study design, development, and implementation, and chairs the HCQC, 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.

B. Senior Medical Director

The Senior Medical Director is a board-certified physician trained in Emergency Medicine who holds a current unrestricted license to practice medicine in California. The Senior Medical Director has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management and holds a Medical Doctorate, Master of Medical Management, and Master of Science in Biomedical Investigations, over 16 years of clinical experience, and 12 years of QI experience. The Senior Medical Director is part of the medical team and is responsible for strategic direction of the Quality and Program Improvement programs. The Medical Director also forms a dyad partner with the Sr. Director of Quality and will serve 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.

C. Senior Director of Quality

The Sr. Director of Quality is responsible for the strategic direction of the Quality Improvement Program. The Sr. Director of Quality holds a Master’s in Public Administration in Health Care, with 23 years of QI and UM management and experience. The Sr. Director of Quality is a Registered

Nurse who holds an active license to practice in California. This position has direct responsibility for the development, implementation, and evaluation of HEDIS and CAHPS. 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., EAS/MCAS measures, QI Standards) as well as managing, tracking, analyzing, and reporting member experience/satisfaction 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 assists with setting the priorities of the Health Education program and ensures Health Education and Cultural and Linguistic Services are incorporated into the Quality program. The Sr. Director of Quality is a dyad partner with the QI Medical Director and reports to the CMO.

D. Senior Director of Behavioral Health

The Senior Director of Behavioral Health is a licensed psychologist with an active license to practice in California. 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.

E. Quality Improvement Manager

The Quality Improvement Manager is a non-clinical/licensed staff member who holds a Master's in Business Administration degree and has 7 years of Medicaid Health Plan experience and holds certification as a Project Management Professional. The QI Manger is responsible for the day-to-day management of the QI department, 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 Manager also acts as liaison between the Alliance's physician leadership and community practitioners/providers of care across all specialties and delegates. The Manager is also responsible for creating report cards and assessing gaps in care. The QI manager works collaboratively throughout the organization to lead and establish appropriate performance management/quality improvement systems including PDSA. The Quality Improvement Manager reports to the Sr. Director of Quality.

F. Access to Care Manager

The Access to Care Manager is a non-clinical/licensed staff member who holds a bachelor's degree in Media and Technology and has 8 years of community health and provider network experience. The Access to Care Manager is responsible for day-to-day management of access to care activities throughout the organization and to lead and establish 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, and daily operations related to Facility Site Reviews (FSRs). The Access to Care Manager reports to the Sr. Director of Quality.

G. Quality Improvement Nurse Supervisor

The QI Nurse Supervisor is a Registered Nurse who holds an active license to practice in California and has 10 years of managed care experience.

The Quality Improvement Nurse Supervisor works collaboratively throughout the organization to ensure appropriate oversight of the 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 Facility Site Reviews (FSR) and participation in HEDIS activities. The QI Nurse Supervisor reports to the Sr. Director of Quality.

H. Quality Improvement Review Nurse (3)

The QI Review Nurse is a Registered Nurse who holds an active license to practice in California and has at least 3 years of managed healthcare experience. Under the direct supervision of the Quality Improvement Nurse Supervisor, the Quality Review Nurse is 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, Facility Site Review (FSR) evaluations, 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.

I. Senior Quality Improvement Nurse Specialist (1)

The QI Review Nurse is a Registered Nurse who holds an active license to practice in California and has at least 13 years of managed healthcare experience. Under the direct supervision of the Quality Improvement Nurse Supervisor, the Sr. Quality Improvement (QI) Nurse Specialist 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.

The Senior QI Nurse Specialist identifies, investigates, and reports on Potential Quality Issues (PQIs) and Provider Preventable Conditions (PPCs) as appropriate from FSR findings. The QI Nurse Specialist prepares cases and presents quality of care issues to the Medical and Sr. Director of Quality Improvement for review and determination.

J. Quality Improvement Project Specialist (5)

QI Project Specialist (QIPS) are Bachelor's prepared non-clinical support staff responsible for providing support for quality assessment and performance improvement activities including quality monitoring, accreditation, access, and availability monitoring, evaluation, and facilitation of performance improvement projects. The QI Project Specialist reports directly to either the Quality Improvement or Access to Care Manager. The QIPS acts as a liaison between the Alliance and the survey vendors, assist with accreditation needs, collaborate on HEDIS interventions, and perform regular assessments of access surveys, provider surveys, CAHPS and grievances. The QIPS ensures accuracy of DHCS performance improvement projects, internal subcommittees and HCQC and subcommittee meeting facilitation. The QIPS have experience in managed care as well as other highly regulated organizations.

K. Facility Site Review QI Coordinator (1)

The Facility Site Review Coordinator (FSRC) has years of training and experience within the managed healthcare industry. The FSRC reports to the Access to Care Manager and 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 trainings, HEDIS data collection, disease specific outreach, and preparation for accreditation and compliance surveys by external agencies such as DHCS, DMHC and NCQA.

L. Quality Program Coordinator (2)

The Quality Program Coordinator (QPC) is a Bachelor's prepared non-clinical support staff. Under the general direction of the Quality Improvement Manager, the QPC is responsible for helping to plan, organize, and implement Alliance quality programs. Responsibilities include coordination of quality projects including PQI case tracking, conducting reminder calls/mailings to targeted members or providers participating in quality improvement initiatives or activities, represents the Alliance at community meetings/events, create/runs periodic departmental reports, and maintains departmental worksheets.

ANCILLARY SUPPORT SERVICES FOR THE QI PROGRAM

A. Health Education

The Health Education Department consists of a Health Educator Manager and Disease Management Health Educator, a Health Programs Coordinator, and a Health Education Specialist, and Interpreter Services Coordinator. The Health Education department is a component of the QI Department. The Health Education staff supports 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 Health Education Department also manages and monitors the Cultural and Linguistic programs for the Alliance. The Health Education and Cultural and Linguistic Programs are outlined in a separate document.

B. Healthcare Analytics Services

The Healthcare Analytics Department performs data analyses involving clinical, financial, provider and member data in support of the Quality department with improvement activities and initiatives. The Health Care Analysts are available to the QI department allotting at least 25% of their time to direct QI analysis. They collect and summarize QI data, and work in conjunction with the Information Technology (IT) Department and the QI department to produce analytics and reporting for various QI activities projects including HEDIS. Additionally, some quality analytics and reporting are produced by outside vendors under contract with the Alliance.

C. Quality Assurance

The Director, Quality Assurance is responsible for the operations management of the Alliance Quality Assurance Program under the direction of the Chief Medical Officer. The Director is responsible for Health Care Services internal monitoring activities as well as clinical components of delegation oversight auditing and performance monitoring. The Director is responsible for ensuring Health Care Service's overall regulatory compliance with Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) 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 to coordinate 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.

D. 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 HCQC is able to 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 includes persons with complex health conditions. The UM Program Description defines how UM decisions are made in a fair and consistent manner. There is also a Case Management (CM) and Complex Case Management Program Description. These programs address serving members with complex health needs, such as, seniors and people with physical or developmental disabilities (SPDs) and/or multiple chronic conditions in addition to case management for high-risk members identified through the disease management program. Responsibilities include conducting outreach and care coordination activities for members in the programs to ensure the improvement of member outcomes and overall member satisfaction. The staff will also assist the QI department in QI activities through conducting member outreach calls and mailings.

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 Program Description is approved by the UMC and HCQC. For additional information, refer to the UM and CM/Complex CM Program Descriptions.

E. Pharmacy Services

The Pharmacy Department and QI Department work collaboratively on various QI 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 HCQC.

F. Network Management/Provider Relations

The Network Management/Provider Relations Department is the primary point of contact for network providers. They assist the QI Department on various QI activities with network providers as appropriate as well as disseminating QI information to practitioners. The Department is responsible for assessing provider satisfaction with Alliance processes and monitoring availability and accessibility standards at physician offices, including after-hours coverage. Provider Services staff also assists the QI Department with practitioners who do not comply with requests from QI including scheduling HEDIS abstraction visits.

G. 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.

H. Member Services

The Member Services staff fields all member inquiries regarding eligibility, benefits, claims, programs, and access to care. The staff conducts welcome calls to members to educate new members about the health plan benefits. Member Services staff also works 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 Member Services Department may conduct reminder calls to members to get HEDIS services completed.

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 2022.

METHODS AND PROCESSES FOR QUALITY IMPROVEMENT

The QI 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 QI 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 QI 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 and others are identified through surveys and dialogue with our member and provider communities (e.g., CAHPS, provider satisfaction and Group Needs Assessment). Particular attention is paid to those areas in which members are high risk, high volume, high cost, or problem prone.

DATA COLLECTION AND DATA SOURCES

The Alliance uses internal resources and capabilities to design sound studies of clinical and service quality that produce meaningful and actionable information.

Much of the data relevant to QI activities are maintained in a confidential and secure data warehouse named Verscend. Data integrity is validated annually through the HEDIS reporting audit process, and through adherence to the Alameda Alliance data analysis plan.

Data sources to support the QI program include, but are not limited to the following:

- Data Warehouse (HAL): Houses legacy data from previous system (Diamond).
- ODS (Operational Data Store): This is the main database and the primary source for all data including member, eligibility, encounter, provider, pharmacy data, lab data, vision, encounters, etc. and claims. This database is used for abstracting data required for quality reporting.
- HealthSuite: a platform for integrating data from Providers, Members, Medical Records, Encounters, and claims.
- 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 data storage software.
- HEDIS: Preventive, chronic care, and access measures run through NCQA-certified HEDIS software vendor (Cotiviti).
- CAHPS 5.1H and CG-CAHPS: Member experience survey via SPH vendor support
- California Immunization Registry (CAIR): Immunization registry information.
- Laboratory supplemental data sources from: Quest, Foundation, Sorian, Epic, NextGen and Novius.
- Credentialing via Cactus, a 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 databases (e.g., asthma and diabetes).
- Provider Appointment Availability Survey (PAAS), as well as after hour access and emergency instructions.
  - Other clinical or administrative data.

EVALUATION

Health care analysts collect and summarize quality data. 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. Particular subsets of our membership may also 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, actual file creation for HEDIS vendors, mapping proprietary data to vendor and NCQA specifications, data quality review and data clean-up). These activities

involve both 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., Kaiser Permanente, Quest Diagnostics, and the California Immunization Registry).

Aggregated reports are forwarded to the HCQC. Status and final reports are submitted to regulatory agencies as contractually required. Evaluation is documented in committee minutes and attachments.

ACTIONS TAKEN AS RESULT OF QUALITY IMPROVEMENT 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 QI 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 measurement, with an analysis of statistical significance when indicated.

Based on the HEDIS data presented, areas of focus for 2022 include but are not limited to the following:

- Childhood Immunizations: Combo 10
- Immunizations for Adolescents: Combo 2
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in members 3-15 Months of Life
- Child & Adolescent:
  - BMI Percentiles
  - Counseling for Nutrition
  - Counseling for Physical Activity
  - Well Child Visit
- Asthma Medication Ratio
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women
- HbA1c Testing for Diabetics

Other Non-HEDIS related measures of focus will include but not be limited to:

- Initial Health Assessment
- 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

A. 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.

B. Consumer Assessment of Health Plan Survey (CAHPS 5.1H and CG-CAHPS)

The Alliance evaluates member experience periodically. The Consumer Assessment of Health Plan Survey (CAHPS) is conducted by third party vendors. 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 HCQC 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 QI evaluation and used to identify opportunities to improve health care and service for our members.

C. 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 an Under/Over-Utilization Monitoring Measure Set.

D. 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 QI Program Description, an evaluation of the prior year's QI Work Plan and a QI Work Plan for the next year. The QI Work Plan is updated throughout the year as QI activities are designed, implemented and re-assessed.

The Alliance complies with the requirements described in regulatory All Plan Letters.

E. Monitoring Satisfaction

The QI 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, and other data as available. These data sets are presented to the HCQC and BOG at quarterly and annual intervals. The plan may administer topic specific satisfaction surveys depending on findings of other QI studies and activities.

F. Health Education Activities

The Health Education Program at the Alliance operates as part of the Health Care Services 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 disease self-care and management. The primary goal of Health Education is to provide the means and opportunities for Alameda Alliance members to maintain and support their health.

Health education programs include individual, provider, and community-focused health education activities which cluster around several topic areas. The Alliance also collaborates on community projects to develop and distribute important health education messages for at risk populations.

G. Cultural and Linguistic Activities

The Alliance Cultural and Linguistic 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". The program 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.
- Identify, inform, and assist Limited English Proficiency 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 program through cultural competency training.
- Integrate community input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.

The objectives for cultural and linguistic activities are addressed in the Cultural and Linguistic Services work plan which is updated annually.

H. Disease Surveillance

The Alliance has executed a Memoranda of Understanding with DMHC and 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 Public Health Department contact phone and fax numbers.

I. 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 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.
- 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.

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 initial health assessments
- Standing referrals to HIV/AIDS specialists
- Sexually transmitted disease services
- Minor's consent services
- Pregnant women services
- Chronic pain management specialists.

The QI program collaborates with the Provider Relations 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, appointment availability. The HCQC 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 and periodic fax blasts inform practitioners of these standards.

The HCQC 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 involves a senior behavioral healthcare physician in quarterly HCQC meetings to monitor, support, and improve behavioral healthcare aspects of QI.

Behavioral Health Services are delegated to Beacon Health Strategies, an NCQA Accredited MBHO, except for Specialty Behavioral Health for Medi-Cal members, 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).
While mild to moderate behavioral health is delegated, some primary care physicians may choose to treat mild mental health conditions.

The Alliance includes the involvement of a Senior Director of Behavioral Health and a designated behavioral health physician in program oversight and implementation as discussed in Beacon's QI Program Description. The Alliance annually reviews Beacon's QI Program Description, Work Plan, and Annual Evaluation. The Alliance reviews Beacon behavioral health quality, utilization, and member satisfaction quarterly reports in a Joint Operations Meeting (JOM) to ensure members obtain necessary and appropriate behavioral health services. Insourcing of Behavioral Health into the Alliance form Beacon will take place Q4 2022.

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 Department 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 Assessment (IHA) within 120 days of their enrollment with the plan. The IHA includes an age-appropriate health education and behavioral assessment (IHEBA). 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, 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 PROGRAM

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; 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 objectives of the complex case management program 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, and Manager of Case and Disease Management develop and monitor the objectives. The HCQC 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 HCQC for review and feedback. The HCQC makes recommendations for improvement and interventions to improve program performance, as appropriate. The Director of Clinical Services is responsible for implementing the interventions under the oversight of the Chief Medical Officer.

DISEASE MANAGEMENT PROGRAM

The Alliance makes available to 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, to those members at high risk to making educational materials and care coordination available for those members who may have gaps in care. The components of the Alliance disease management program include member identification and risk stratification; provision of case management services, chronic condition monitoring; identification of gaps in care, and education.

Program structure is designed to promote quality condition management, client satisfaction and cost efficiency using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

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 HCQC

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.

POPULATION HEALTH MANAGEMENT (PMH) PROGRAM

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

The Population Health Program aims to influence the health outcomes of the Alameda Alliance membership. The program oversees the health management system by ensuing that the system caters to the health needs of the enrolled member population. A key priority is to ensure that the new and ongoing programs target and close the gaps between identified disparities and the social determinants of health (SDOH) that cause those disparities. The PHM Program is monitored via the Population Health work group, which is comprised of representatives from Quality Improvement, Utilization Management, Case Management, Pharmacy and Quality Assurance. In addition, overall outcomes and finding from the population health strategy are presented, reviewed, and approved by the Internal Quality Improvement Committee (ICQIC.

The Population Health Program is used to:

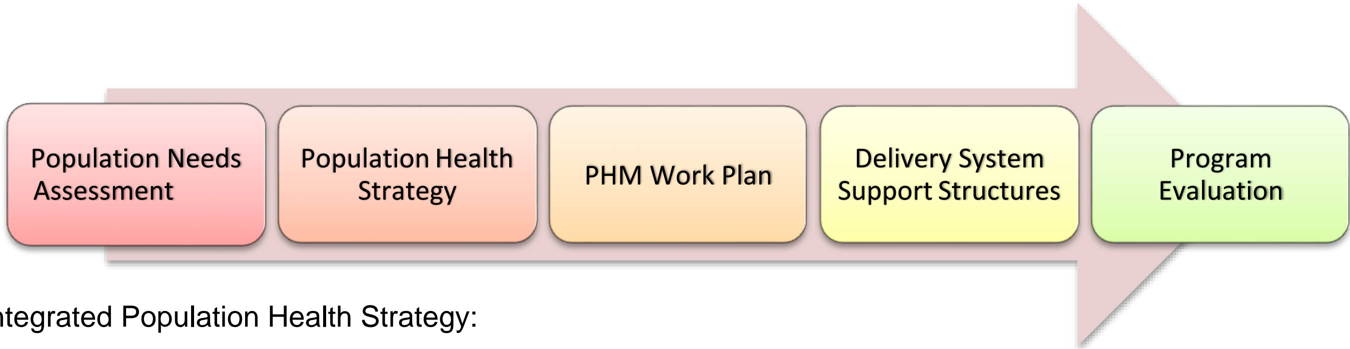
- Enhance Case Management Department and program
- Inform Quality Improvement Performance Projects
- Guide Health Education Materials and Programs
- Guide the Population Needs Assessment (PNA)

Additionally, the program may be used to better understand the patterns of cost, utilization and identify high-risk members with high-risk disease processes. Alameda Alliance for Health has developed a basic framework to support a cohesive plan of action for addressing member needs across the continuum of care. This continuum includes the community setting, through participation, engagements, and targeted interventions for a defined population.

The framework of this strategy is designed to address the 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 4 areas of focus are:

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



Integrated Population Health Strategy:

The Alliance has a comprehensive strategy for population health management that includes but is not limited to the following four areas of focus:

Four Areas of Focus

Keeping Members Healthy

Managing Members with Emerging Risk

Outcomes Across Setting

Managing Multiple Chronic Conditions

Keeping All Members Healthy
Primary & Preventive Care Wellness Services
Explanation of Benefits
Health Education
Community Activities

Managing Members with Emerging Risk
Chronic Care Management Disease Management Behavioral Health Support
Community Support Groups

Outcomes Across Setting (Safe Care Coordination)
Managing Acute Care Admission
LOS Effective & Safe Transitions of Care
Patient Centered Discharge Education Health Homes
End of Life Care Support
Community Resources Linkages

Managing Multiple Chronic Conditions
Complex Care Management
Individualized Care Planning
Behavioral Health Care Coordination Robust Social Support
Community Resources Linkages

3. PMH Work Plan:
   - Case Identification
   - Aligning Services with Member needs as identified
   - Delivery Systems/Provider Support Structures:
   - Sharing Data – provider measures, informing members
   - 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
   - Program Evaluation/Outcomes Data
   - HEDIS Performance Measures
   - Complex Case Management
   - Transitions of Care
   - Health Homes
   - Member Experience
   - Population Needs Re-Assessment

The Alliance Population Health Program and services are designed to improve the health and wellbeing of members and is committed to ongoing rigorous evaluation of our program that continuously looks for ways to improve our program and revise services as needed.

SENIORS AND PERSONS WITH DISABILITY (SPD)

The Alliance categories all new SPD members as high risk. High risk members are contacted for a 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 a 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 QI activities. Contract language specifically addresses:

- Provider cooperation with QI 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 involvement in the QI program occurs through membership in standing and ad-hoc committees, and attendance at BOG and HCQC meetings. Providers and members may request copies of the QI program description, work plan, and annual evaluation. Provider participation is essential to the success of QI studies including HEDIS and those that focus on improving aspects of member care. Additionally, provider feedback on surveys and questionnaires is encouraged as a means of continuously improving the QI program.

Providers have an opportunity to review the findings of the QI program through a variety of mechanisms. The HCQC reports findings from QI 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 QI 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 QUALITY IMPROVEMENT PROGRAM (SEPARATE DOCUMENT)

The HCQC reviews, makes recommendations, and approves a written evaluation of the overall effectiveness of the QI 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 QI activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or opportunities.
- Recommendations for goals, targets, activities, or priorities in subsequent QI Work Plan.

The review and revision of the program may be conducted more frequently as deemed appropriate by the HCQC, CMO, CEO, or BOG. The HCQC's recommendations for revision are incorporated into the QI Program Description, as appropriate, which is reviewed by the BOG and submitted to DHCS on an annual basis.

ANNUAL QI WORK PLAN (SEPARATE DOCUMENT)

A QI Work Plan is received and approved annually by the HCQC. The work plan describes the QI 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 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

- 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 QI program

Progress on completion of activities in the QI work plan is reported to the HCQC quarterly. A summary of this progress will be reported by the CMO to the BOG.

QI 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 QI 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 QI 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 QI 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 QI 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 HCQC or any of its subcommittees, or other QI 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 HCQC meetings will sign a confidentiality agreement.

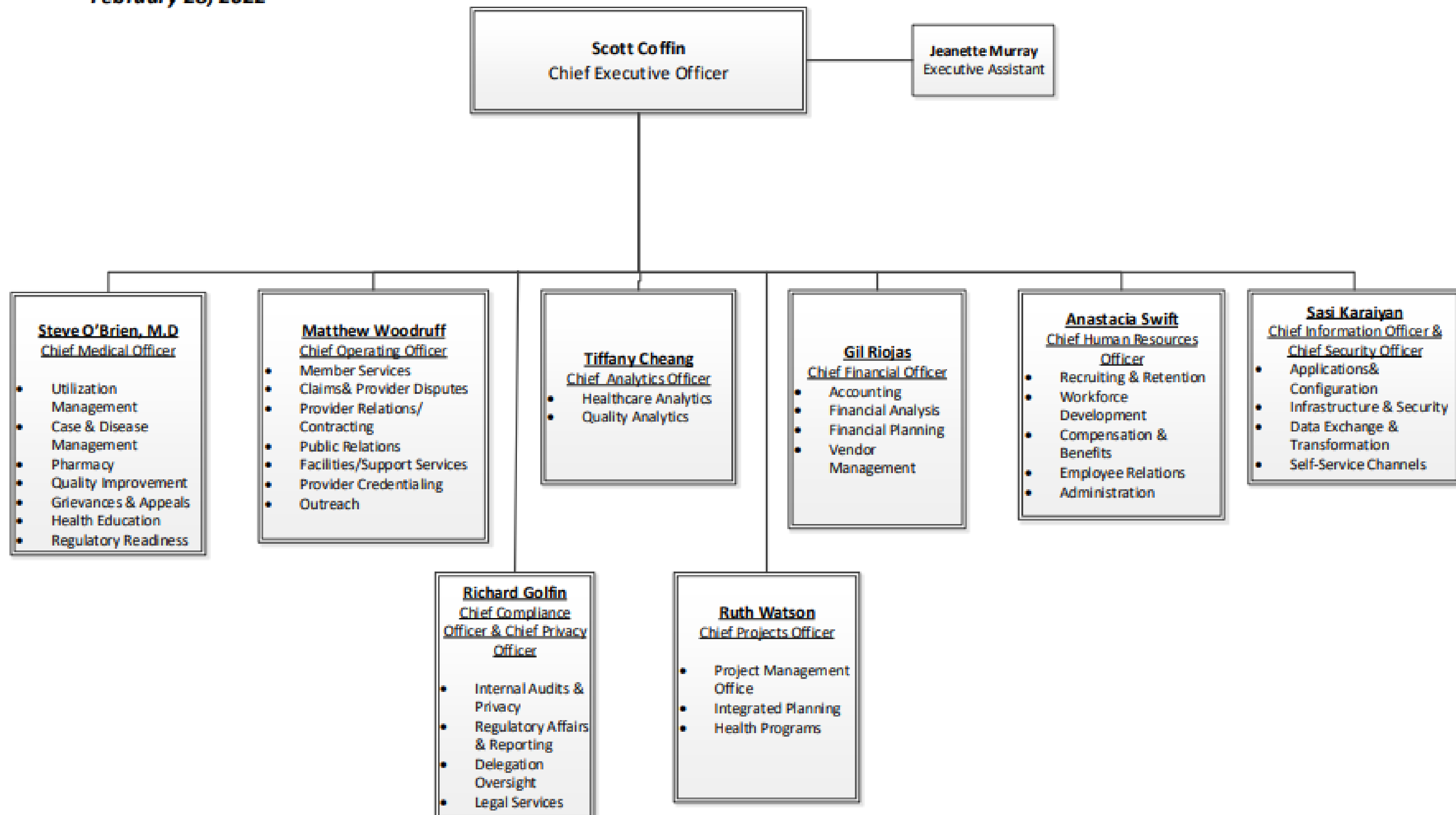
Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

All QI meeting materials and minutes are marked with the statement "Confidential". Copies of QI meeting documents and other QI data are maintained separately and secured to ensure strict confidentiality.

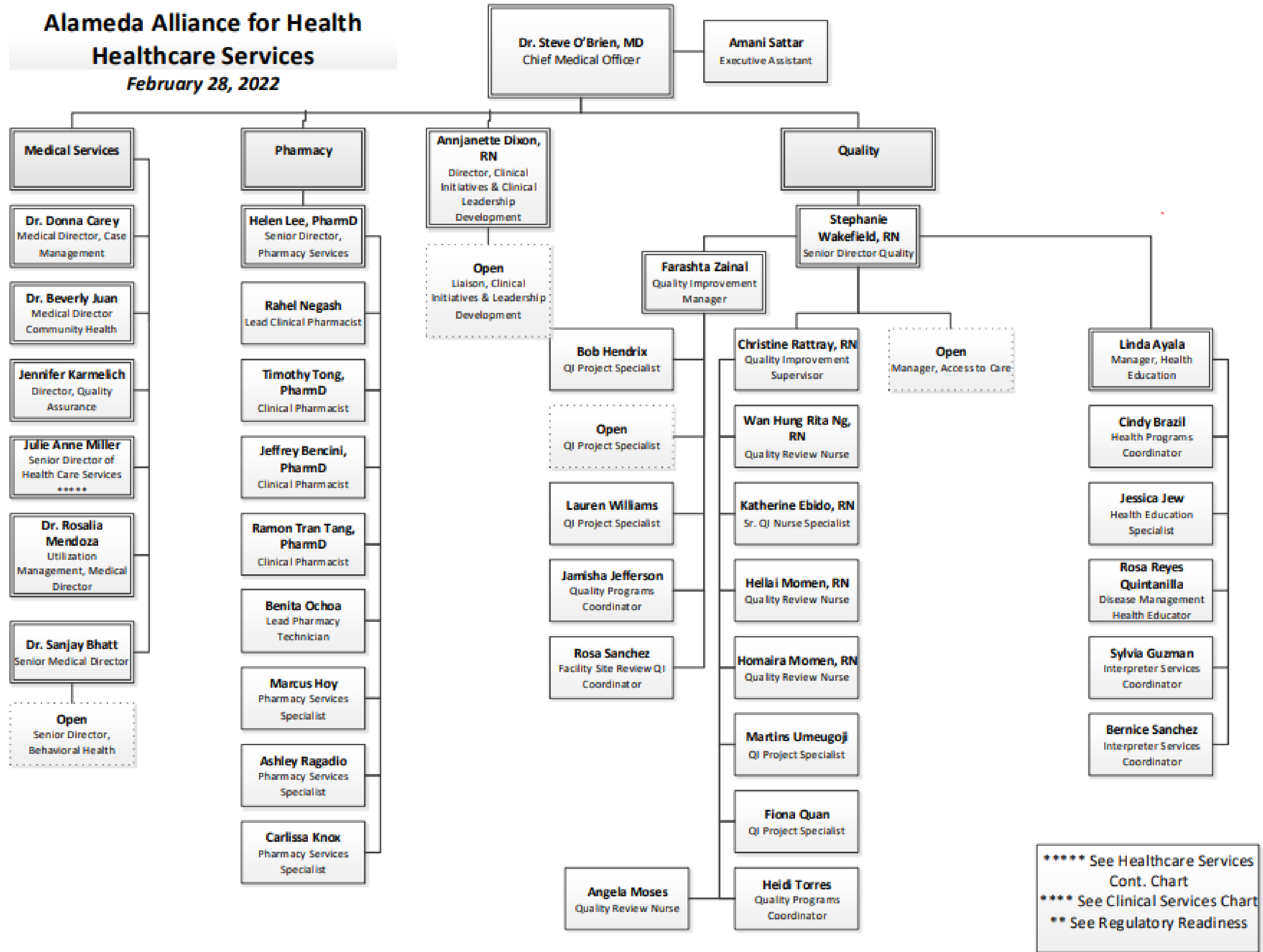
Organizational charts are as follows:

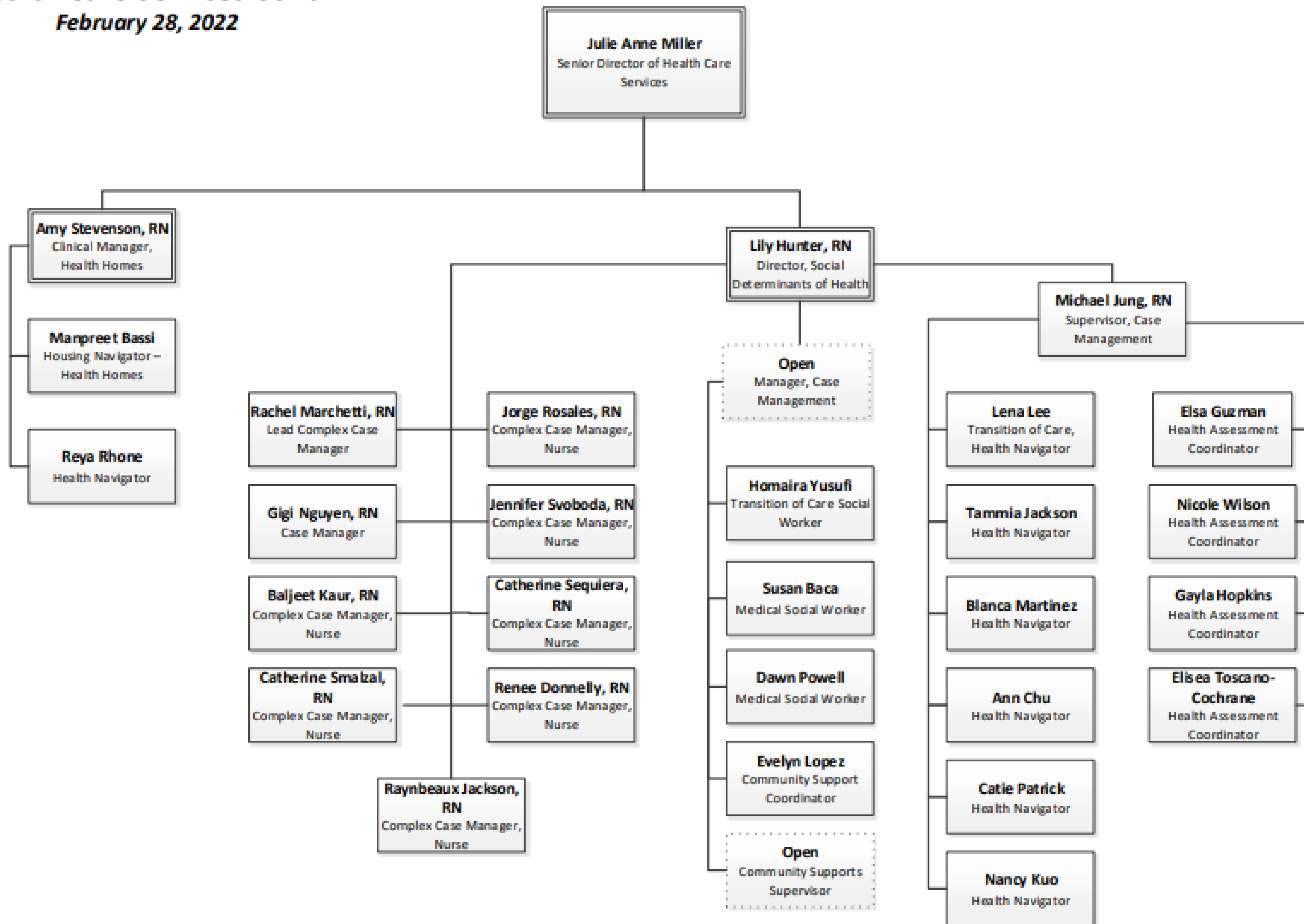
APPENDIX A

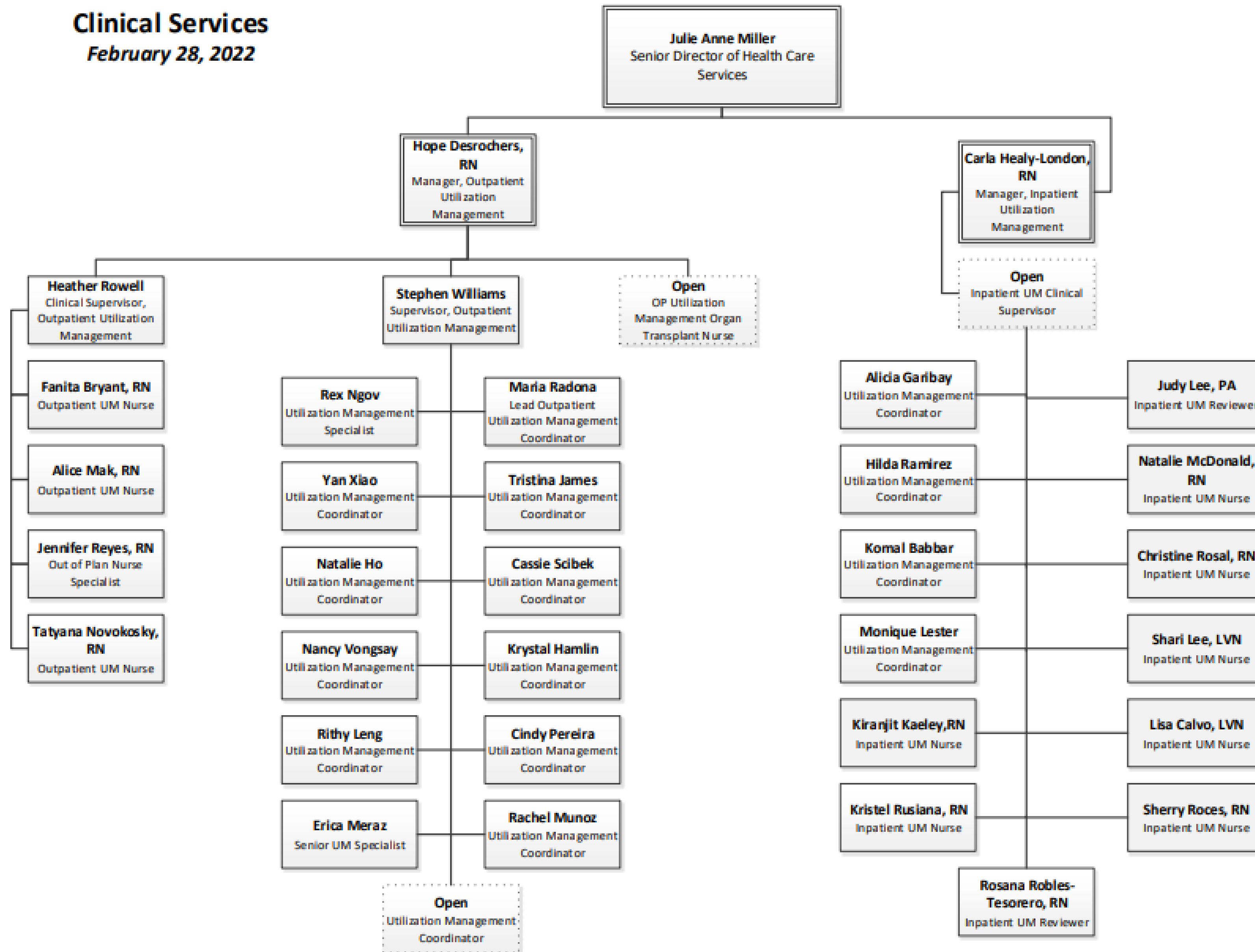
- Senior Management –



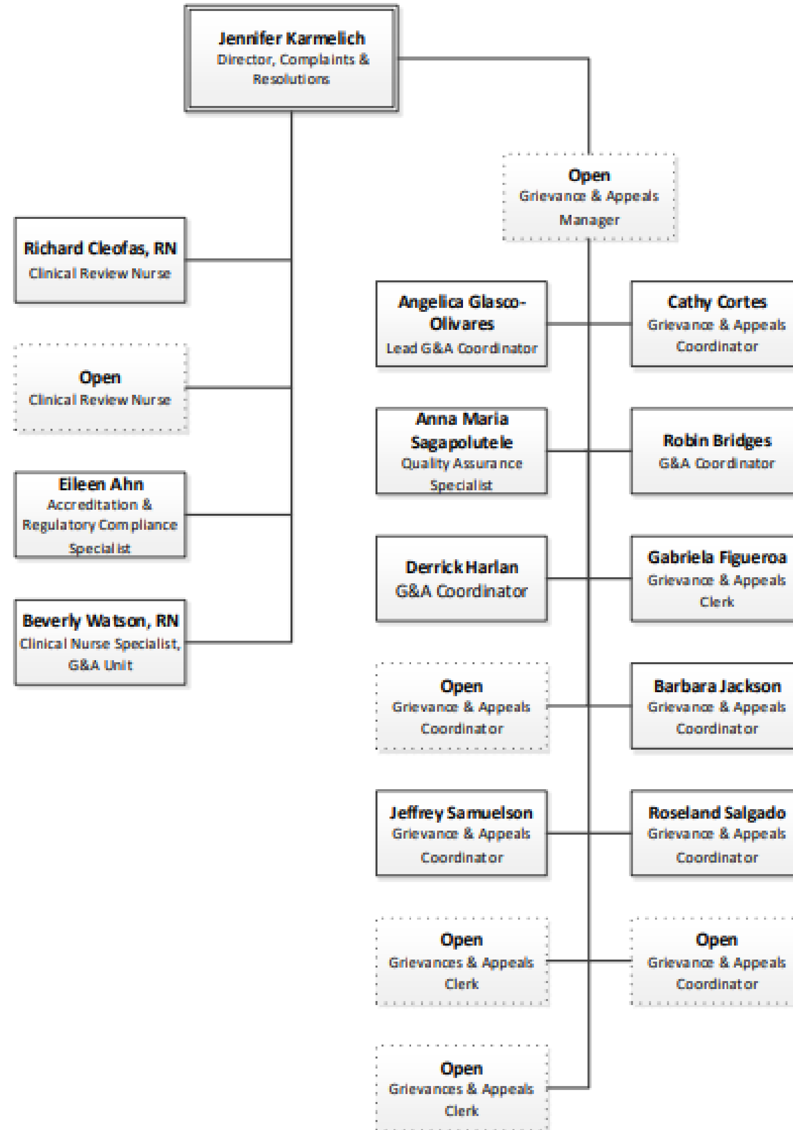
- Health Care Services –




Alameda Alliance for Health
Health Care Services Cont.
February 28, 2022
Julie Anne Miller
Senior Director of Health Care Services
Amy Stevenson, RN
Clinical Manager, Health Homes
Manpreet Bassi
Housing Navigator – Health Homes
Reya Rhone
Health Navigator
Lily Hunter, RN
Director, Social Determinants of Health
Rachel Marchetti, RN
Lead Complex Case Manager
Gigi Nguyen, RN
Case Manager
Baljeet Kaur, RN
Complex Case Manager, Nurse
Catherine Smalzal, RN
Complex Case Manager, Nurse
Jorge Rosales, RN
Complex Case Manager, Nurse
Jennifer Svoboda, RN
Complex Case Manager, Nurse
Catherine Sequiera, RN
Complex Case Manager, Nurse
Renee Donnelly, RN
Complex Case Manager, Nurse
Raynbeaux Jackson, RN
Complex Case Manager, Nurse
Open
Manager, Case Management
Homaira Yusufi
Transition of Care Social Worker
Susan Baca
Medical Social Worker
Dawn Powell
Medical Social Worker
Evelyn Lopez
Community Support Coordinator
Open
Community Supports Supervisor
Michael Jung, RN
Supervisor, Case Management
Lena Lee
Transition of Care, Health Navigator
Tammia Jackson
Health Navigator
Blanca Martinez
Health Navigator
Ann Chu
Health Navigator
Catie Patrick
Health Navigator
Nancy Kuo
Health Navigator
Elsa Guzman
Health Assessment Coordinator
Nicole Wilson
Health Assessment Coordinator
Gayla Hopkins
Health Assessment Coordinator
Elisea Toscano-Cochrane
Health Assessment Coordinator


Alameda Alliance for Health
Clinical Services
February 28, 2022
Julie Anne Miller
Senior Director of Health Care Services
Hope Desrochers, RN
Manager, Outpatient Utilization Management
Carla Healy-London, RN
Manager, Inpatient Utilization Management
Heather Rowell
Clinical Supervisor, Outpatient Utilization Management
Stephen Williams
Supervisor, Outpatient Utilization Management
Open
OP Utilization Management Organ Transplant Nurse
Open
Inpatient UM Clinical Supervisor
Fanita Bryant, RN
Outpatient UM Nurse
Alice Mak, RN
Outpatient UM Nurse
Jennifer Reyes, RN
Out of Plan Nurse Specialist
Tatyana Novokosky, RN
Outpatient UM Nurse
Rex Ngov
Utilization Management Specialist
Maria Radona
Lead Outpatient Utilization Management Coordinator
Yan Xiao
Utilization Management Coordinator
Tristina James
Utilization Management Coordinator
Natalie Ho
Utilization Management Coordinator
Cassie Scibek
Utilization Management Coordinator
Nancy Vongsay
Utilization Management Coordinator
Krystal Hamlin
Utilization Management Coordinator
Rithy Leng
Utilization Management Coordinator
Cindy Pereira
Utilization Management Coordinator
Erica Meraz
Senior UM Specialist
Rachel Munoz
Utilization Management Coordinator
Open
Utilization Management Coordinator
Alicia Garibay
Utilization Management Coordinator
Judy Lee, PA
Inpatient UM Reviewer
Hilda Ramirez
Utilization Management Coordinator
Natalie McDonald, RN
Inpatient UM Nurse
Komal Babbar
Utilization Management Coordinator
Christine Rosal, RN
Inpatient UM Nurse
Monique Lester
Utilization Management Coordinator
Shari Lee, LVN
Inpatient UM Nurse
Kiranjit Kaeley, RN
Inpatient UM Nurse
Lisa Calvo, LVN
Inpatient UM Nurse
Kristel Rusiana, RN
Inpatient UM Nurse
Sherry Roces, RN
Inpatient UM Nurse
Rosana Robles-Tesorero, RN
Inpatient UM Reviewer

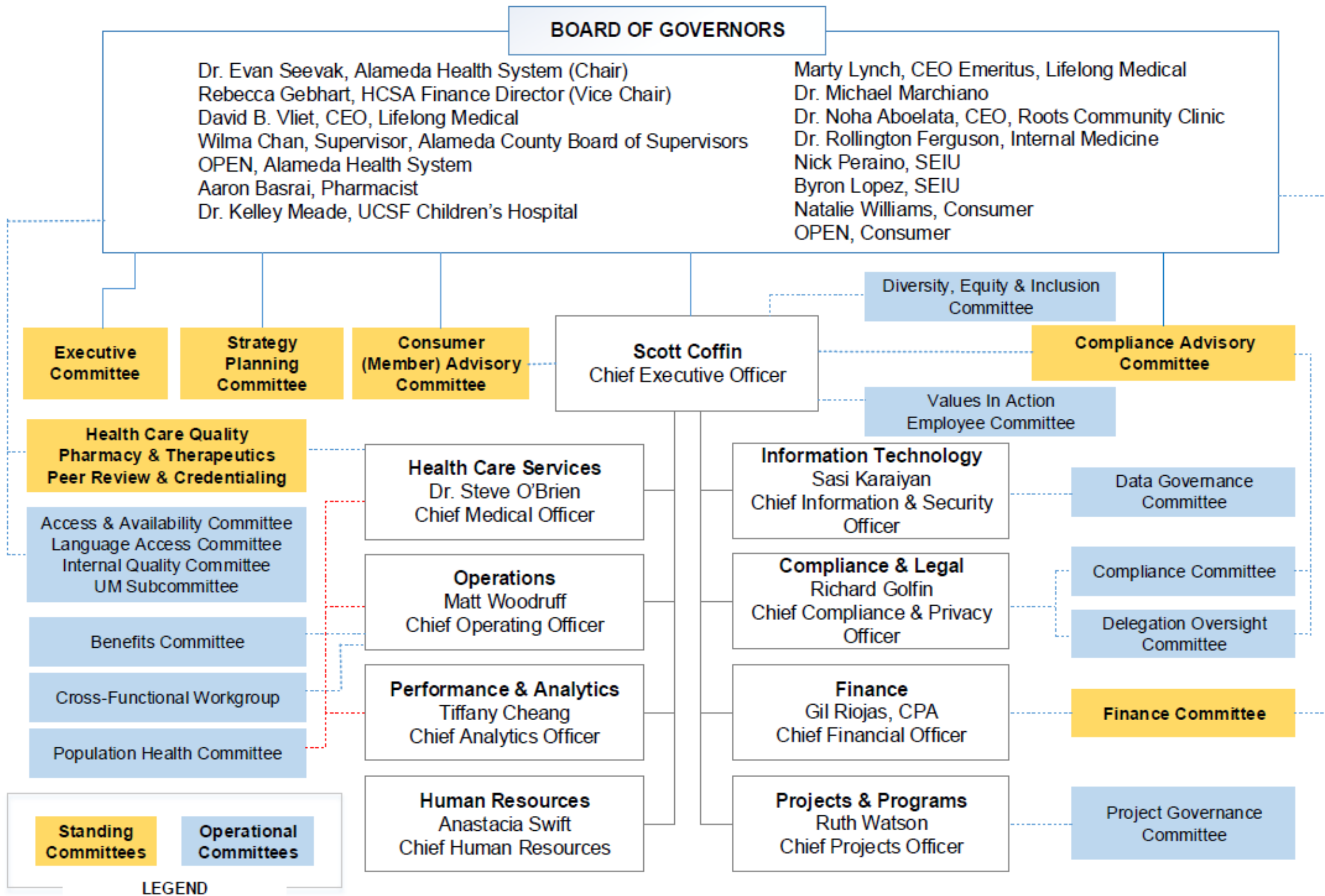
Alameda Alliance for Health
Regulatory Readiness
February 28, 2022

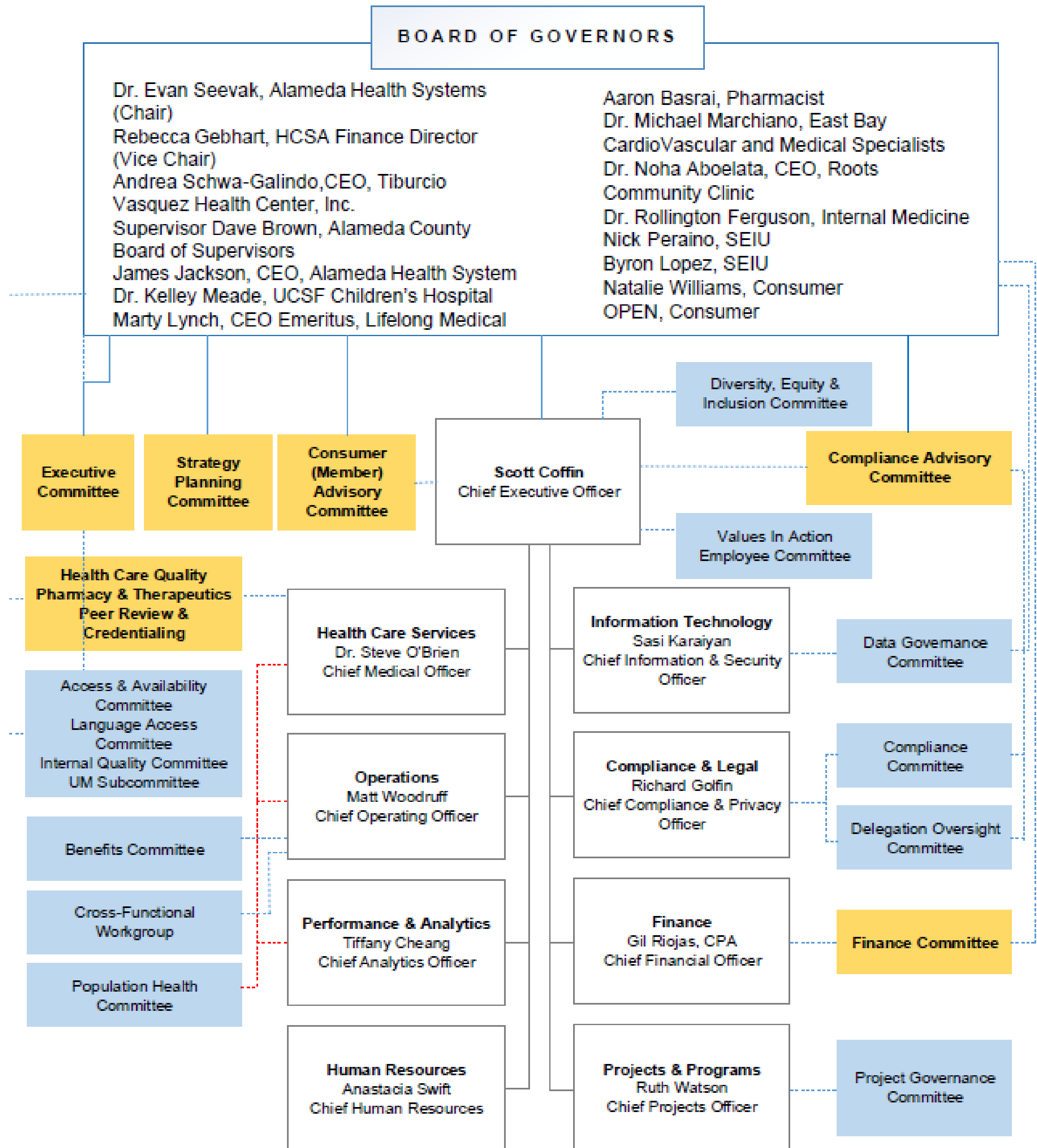


APPENDIX B

- ALAMEDA ALLIANCE COMMITTEES

November 2021




Alameda Alliance for Health
STANDING COMMITTEES & OPERATIONS COMMITTEES
BOARD OF GOVERNORS
Dr. Evan Seevak, Alameda Health Systems (Chair)
Rebecca Gebhart, HCSA Finance Director (Vice Chair)
Andrea Schwa-Galindo,CEO, Tiburcio Vasquez Health Center, Inc.
Supervisor Dave Brown, Alameda County Board of Supervisors
James Jackson, CEO, Alameda Health System
Dr. Kelley Meade, UCSF Children's Hospital
Marty Lynch, CEO Emeritus, Lifelong Medical
Aaron Basrai, Pharmacist
Dr. Michael Marchiano, East Bay CardioVascular and Medical Specialists
Dr. Noha Aboelata, CEO, Roots Community Clinic
Dr. Rollington Ferguson, Internal Medicine
Nick Peraino, SEIU
Byron Lopez, SEIU
Natalie Williams, Consumer
OPEN, Consumer
Executive Committee
Strategy Planning Committee
Consumer (Member) Advisory Committee
Scott Coffin
Chief Executive Officer
Diversity, Equity & Inclusion Committee
Compliance Advisory Committee
Values In Action Employee Committee
Health Care Quality
Pharmacy & Therapeutics
Peer Review & Credentialing
Access & Availability Committee
Language Access Committee
Internal Quality Committee
UM Subcommittee
Benefits Committee
Cross-Functional Workgroup
Population Health Committee
Health Care Services
Dr. Steve O'Brien
Chief Medical Officer
Operations
Matt Woodruff
Chief Operating Officer
Performance & Analytics
Tiffany Cheang
Chief Analytics Officer
Human Resources
Anastacia Swift
Chief Human Resources
Information Technology
Sasi Karaiyan
Chief Information & Security Officer
Compliance & Legal
Richard Golfin
Chief Compliance & Privacy Officer
Finance
Gil Riojas, CPA
Chief Financial Officer
Projects & Programs
Ruth Watson
Chief Projects Officer
Data Governance Committee
Compliance Committee
Delegation Oversight Committee
Finance Committee
Project Governance Committee

Cultural and Linguistic Program Description

2022

2022 Cultural and Linguistic Services Program
Description Signature Page

Date ________________ ______________________________

Sanjay Bhatt, M.D.
Medical Director, Quality Improvement
Vice Chair, Health Care Quality Committee

Date ________________ ______________________________

Steve O'Brien, M.D.
Chief Medical Officer, Medical Management
Chair, Health Care Quality Committee

Date ______________________________

Scott Coffin
Chief Executive Officer

Date ______________________________

Evan Seevak, M.D.
Board Chair

Alameda Alliance for Health
Cultural and Linguistic Services
Program Description 2022

Overview

The Alameda Alliance for Health (Alliance) is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible Medi-Cal and Group Care members. The Alliance's Cultural and Linguistic Services Program complies with Title VI of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80), the Patient Protection and Affordable Care Act, Section 1557, Senate Bill (SB) 223 (Atkins, Chapter 771, Statutes of 2017), 3 and SB 1423 (Hernandez, Chapter 568, Statutes of 2018) and with the Cultural and Linguistic Services requirements of the Alliance's contracts with the Department of Health Care Services (DHCS), (Exhibit A, Attachment 9. 12), and the Centers for Medicare and Medicaid Services.

The goal of the Cultural and Linguistic Services (C & L) Program is to ensure that all members receive equal access to high quality health care services that are culturally and linguistically appropriate. This includes ensuring culturally appropriate services and access for members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56.

Program objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer its members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic program through cultural competency training.
- Identify, inform, and assist limited English proficiency (LEP) members in accessing quality interpretation services.
- Ensure that Alliance health care providers follow the Alliance C & L Services Program.
- Integrate community input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.

The Work Plan for the C & L Program in Appendix A includes a timetable for implementation of activities related to meeting the program goal and objectives.

The Organizational Chart in Appendix B displays reporting relationships for the Alliance organization and identifies key staff with overall responsibility for the operation of the Cultural and Linguistic Services Program.

Departmental Roles

The **Quality Improvement Department** is responsible for developing, implementing and evaluating the Alliance's Cultural and Linguistic Services Program in coordination with other Alliance departments including Provider Services, Human Resources, Analytics and Performance, Member Services, Communications and Outreach, Quality Assurance, Vendor Management and Compliance. The Cultural and Linguistic Program is led by the Manager of Health Education. All participating persons/departments report ultimately to the Chief Executive Officer.

Health Education is a part of the Alliance's Quality Improvement Department. The Health Education Manager, in collaboration with the aforementioned departments, develops the Cultural and Linguistic Services Program work plan and integrates information and resources on cultural competency into the Alliance's programs and services. The Health Education Manager also facilitates the Cultural and Linguistic Services Subcommittee (CLSS) of the Health Care Quality Committee, which in turn reports to the Alliance Board of Governors.

Health Education staff also ensure that members have access to qualified interpreters and make health education materials available to members and providers. These materials meet the literacy, cultural, linguistic, clinical, and regulatory standards.

The Health Education Manager and the Communications and Outreach Manager are responsible for supporting the Alliance Member Advisory Committee (see below for description) in accordance with Title 22, CCR, Section 53876 (c). There is administrative support staff, the Health Education Coordinator, as well assigned to the Member Advisory Committee.

Quality Improvement Specialists conduct member and provider surveys, and Quality Nurses conduct medical record and facility site reviews that monitor C&L requirement implementation at the provider office level and issue corrective action plans as needed.

The **Provider Services** department is responsible for ensuring that the Alliance provider network composition continuously meets members' cultural and linguistic needs. Provider Services also trains providers on the Alliance Cultural and Linguistic program requirements. Language capabilities of clinicians and other provider office staff are identified during the credentialing process and providers update language capacity with the Alliance regularly.

The **Member Services** department assesses member cultural and linguistic needs at each contact by identifying and verifying language preferences, reported ethnicity and preference for use of interpreter services. Members are informed that they can access no cost oral interpretation in their preferred language and written materials translated into Alliance threshold languages or provided in alternative formats. Member Services also monitors call quality for Member Services Representatives ability to follow cultural and linguistic protocols.

The **Communications and Outreach** department is responsible for ensuring that marketing practices for eligible beneficiaries or potential enrollees do not discriminate due to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. In addition, they take into consideration results from member surveys and assessments, community feedback and other C&L monitoring activities when producing member materials. The department is also responsible for quality translations of member written materials and communications and assists all departments in sending the appropriate non-discrimination and language assistance service notices to members.

Human Resources department is responsible for bilingual assessment of new staff

who will use their bilingual skills with members. They maintain a listing of Alliance bilingual staff and ensure quality monitoring of bilingual staff not monitored through the Member Services quality assurance program.

The **Quality Assurance** department supports the C&L program through monitoring and reporting of grievances related to C&L services.

Compliance is responsible for conducting audits of the Alliance Cultural and Linguistic Services program, monitoring delegated C&L responsibilities, and ensuring that all state and federal regulations are followed.

Vendor Management supports compliance oversight of language services vendors and implements corrective action plans as needed.

Community Advisory Committee

The **Community Advisory Committee** at the Alliance is known as the Member Advisory Committee (MAC). The MAC is supported by the Communications and Outreach Manager and Health Education Manager and their respective departments. The purpose of the Member Advisory Committee (MAC) is to provide a link between the Alliance and the community. The MAC advises the Alliance on the development and implementation of its cultural and linguistic accessibility standards and procedures. The committee's responsibilities include advising on cultural competency issues, and educational and operational issues affecting members, including seniors, people who speak a primary language other than English, and persons with disabilities. The MAC is comprised of Alliance members, community advocates, safety net providers, and at least one traditional provider.

The MAC provides input about members' cultural and linguistic needs and the Alliance cultural and linguistic access standards (CLAS) and procedures. The MAC enables the Alliance to maintain community partnerships with consumers, community advocates and traditional and safety net providers regarding CLAS. Alliance procedures ensure MAC involvement in policy decisions related to educational, operational, and cultural competency decisions affecting groups that speak a primary language other than English.

Standards and Performance Requirements

The Alliance's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. The Alliance has systems and processes to:

- Provide members access to no cost language assistance services at all points of contact, 24 hours a day, 7 days a week. Educate members and providers about the availability of language services and how to access them.

- Identify, assess, and track linguistic capability of interpreters, bilingual employees and contracted staff in medical and non-medical settings.

- Conduct a Population Needs Assessment (PNA) according to the DHCS timeline to:
    - Identify member health needs and health disparities;

- Evaluate health education, C&L, and quality improvement (QI) activities and available resources to address identified concerns; and
- Implement targeted strategies for health education, C&L, and QI programs and services.

- Provide cultural sensitivity and diversity training for staff, providers, and subcontractors at key points of contact. Training will cover accessing language services, the Alliance cultural and linguistic program, importance of culturally sensitive care as well as working with identified cultural groups within the Alliance service areas including:
  - Members with limited English proficiency;
  - Diverse cultural and ethnic backgrounds;
  - Seniors and persons with disabilities;
  - Gender, sexual orientation and gender identities.

- Monitor and evaluate the Cultural and Linguistic Services Program and the performance of individuals providing linguistics services.

The program meets the standards detailed in the following Alliance Policies and Procedures:

- CLS-001 Cultural and Linguistic Services Program Description
- CLS-002 Cultural and Linguistic Services Program - Member Advisory Committee
- CLS-003 Cultural and Linguistic Services Program – Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
- CLS-008 Cultural and Linguistic Services Program - Member Assessment of Cultural and Linguistic NeedsCLS-009 Cultural and Linguistic Services Program – Contracted Providers
- CLS-010 Cultural and Linguistic Services Program - Staff Training and Assessment
- CLS-011 Cultural and Linguistic Services Program – Compliance Monitoring

Alameda Alliance for Health
Cultural and Linguistic Services Program Work Plan 2022
Appendix A

Program	**Member Cultural and Linguistic Assessment**	
Goal	Assess the cultural and linguistic needs of plan enrollees.	
Rationale	**Alliance Membership Report:** From 2020 - 2021 there were no significant changes in demographics in the Alliance population; however, the total membership increased by 8% from December 2020 – December 2021, and the largest increases were in "Other" ethnicity, a decrease in the "Under 19" and increase in "19 – 44" age ranges.	
Lead Responsibility	Health Education Manager	
Performance Measure	Objective	
Complete quarterly CLSS reports	Create and review reports on Cultural and Linguistic needs of members at quarterly Cultural and Linguistic Subcommittee (CLSS).	
Major Activities	**Timeline**	**Responsible Party**
Collect member demographic information and track over time. Report on trends, discuss at the CLSS and Health Care Quality Committee (HCQC) of the Alliance Board of Governors and take action as needed.	By end of January, April, July, October 2022	Health Education Manager

Program	**Language Assistance Services**	
Goal	**Inform and assist Limited English Proficiency members in accessing quality interpretation services and translated written informing materials.**	
Rationale	**Alliance Membership Report, January 2022:** 37% of members prefer to communicate with the plan in a non-English language. Of those, 87% speak threshold languages. **For 2021, the fill rate for interpreter services** was 98.6% **Interpreter services delivery mode in 2021** was 50% pre-scheduled phone or video, 38% telephonic, and 11% in-person.	
Lead Responsibility	Health Education Manager	
Performance Measure	Objective	
Fulfillment rate in Quarterly Cultural and linguistic Reports.	Reach an average fulfillment rate of ninety-five percent (95%) or more for in-person, video and telephonic interpreter services.	
Major Activities	**Timeline**	**Responsible Party(s)**
Make available to Alliance providers an online option for pre-scheduling in-person and 3-way video interpreter services.	By June 30, 2022.	Health Education Manager

Supporting Activities	Timeline	Responsible Party(s)
Inform members at all points of contact of availability of no cost Language Assistance Services (LAS) through newsletters, Evidence of Coverage (EOC), website, non-discrimination statements, significant communications/ publications, letters, and flyers.	Ongoing	Health Education Manager; Director, Provider Relations

Program	**Provider Language Capacity**		
Goal	Ensure that Alliance health care providers follow the Alliance C & L Services Program and ensure interpreter access.		
Rationale	**Q4 2021 Provider Language Capacity report:** All ratios were stayed within the expected range. Highest ratio was Vietnamese (1:451) compared to 1:228 for English for Medi-Cal and Chinese (1:19) compared to 1:6 for English for Group Care. **Q1-Q3 2021 CG CAHPS Survey:** Adult responses to the question "Were you able to communicate with your doctor and clinic staff in your preferred language?" were 81.1% favorable for receiving a qualified interpreter through their doctor's office or health plan, child responses were 92.4% favorable.		
Lead Responsibility	Health Education Manager		
Performance Measure	Objective		
CG-CAHPS Survey	81% of adult members and 88% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.		
Provider Language Capacity Report	Note: Per Cultural and Linguistics Services Subcommittee we do not have a specific objective but will monitor trends.		

Major Activities	Timeline	Responsible Party(s)
See Language Access activities for ensuring access to language services during telehealth visits.		
Supporting Activities	**Timeline**	**Responsible Party(s)**
Maintain language assistance program information in Provider Manual, New Provider Orientation, Member Handbook and member and provider webpages.	Ongoing	Health Education Manager; Communications and Outreach Manager
Monitor availability of providers who speak members' preferred languages at the Cultural and Linguistic Service Subcommittee.	By end of Jan, April, July, Oct 2022	Health Education Manager

Make available to providers up-to-date information on language needs of members through PCP member roster available on the Provider Portal.	Monthly update	Senior Business Analyst, IT
Maintain up-to-date information on provider language capacity in the on-line and printed provider directories.	Continual updates	Senior Business Analyst, IT

Program	**Staff and Provider Cultural Sensitivity Training**	
Goal	Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic program through cultural sensitivity training.	
Rationale	**Alliance Membership Report, January 2022:** 37% of members prefer to communicate with the plan in a non-English language. Of those, 87% speak threshold languages. **Annual Cultural Sensitivity Training AAH** Staff participation rate was 96% for 2020 (with 4% of staff out on leave) and new hire participation rate was 100%. 2021 Cultural Sensitivity Training was rolled out with staff December 2021-January 2022.	
Lead Responsibility	Health Education Manager	
Performance Measure	Objective	
Compliance tracking of AAH staff participation in Cultural Sensitivity Training.	96% of Alliance staff (by March 31, 2022) and 100% of new staff (within 90 days of hire) will participate in the Cultural Sensitivity training.	
Provider Relations tracking of new provider orientation completion.	90% of new Providers will complete the New Provider Orientation, including the Cultural Sensitivity training and C&L processes within 90 days of becoming an Alliance provider.	
Major Activities	Timeline	Responsible Party(s)
Offer the Cultural Sensitivity training via webinar to Alliance Staff within 90 days of hire and yearly thereafter. - Update training to enhance content on working with African American members	By 6/1/2020 (yearly renewal)	Health Education Manager; Compliance Coordinator
Supporting Activities	Timeline	Responsible Party(s)
Post a provider version of the training online and promote with providers.	By 12/31/2022	Health Education Manager

Program	**Member Advisory Committee**		
Goal	Integrate community input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.		
Rationale	**Member Advisory Meeting**– Member feedback requested more time to reflect on complex issues presented at the meeting and offer input.		
Rationale Category(s)	√ Contractual Topic ❒ GNA ❒ NCQA √ Quality Improvement		
Lead Responsibility	Health Education Manager		
Target Population	All Alliance staff		
Performance Measure	Objective		
MAC meeting minutes	Hold quarterly Member Advisory Committee meetings and provide opportunities for member input into C&L programs.		
Major Activities		Timeline	Responsible Party(s)
Recruit 3 new members (male, 19 – 44, Asian, Latinx, and African American are priorities) for the Member Advisory Committee.		By September 31, 2022.	Health Education Manager
Supporting Activities		Timeline	Responsible Party(s)
Hold quarterly meetings of the MAC to participate in the public policy of the health plan and provide input on the Alliance cultural and linguistic services		March, June, September and December 2022.	Health Education Manager & Communications and Outreach Manager

<table>
<tr><td>Program</td><td colspan="3">Monitoring of Cultural and Linguistic Services</td></tr>
<tr><td>Goal</td><td colspan="3">Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.</td></tr>
<tr><td>Rationale</td><td colspan="3">AAH Grievances Related C&L and Discrimination/Sensitivity Report Q1-Q3 2021: Lack of Language Accessibility grievances averaged 86 per quarter with a range of 80-92.</td></tr>
<tr><td>Rationale Category(s)</td><td colspan="3">√ Contractual Topic ❒ GNA ❒ NCQA √ Quality Improvement</td></tr>
<tr><td>Lead Responsibility</td><td colspan="3">Health Education Manager</td></tr>
<tr><td>Performance Measure</td><td colspan="3">Objective</td></tr>
<tr><td>CLSS Meeting Minutes</td><td colspan="3">Meet regulatory compliance for monitoring quality of language assistance services.</td></tr>
<tr><td colspan="2">Supporting Activities</td><td>Timeline</td><td>Responsible Party(s)</td></tr>
<tr><td colspan="2">Monitor grievances, exempt grievances and Potential Quality Issues to identify concerns and areas of improvement in Cultural and Linguistic Services for investigation and resolution. Forward data or concern to appropriate department, provider, vendor or Joint Operations Meeting.</td><td>By end of January, April, July and October, 2022.</td><td>Manager, Grievances and Appeals; Health Education Manager</td></tr>
<tr><td colspan="2">Maintain listing of assessed bilingual employees and linguistic, their capacity as medical or non-medical interpreter and perform at minimum yearly review of bilingual capacity.</td><td>October 31, 2022 – yearly renewal.</td><td>Executive Director, Human Resources; Health Education Manager; Director, Member Services</td></tr>
<tr><td colspan="2">Conduct facility site reviews re: C & L services including: 24-hour interpreter services, coverage of threshold services, documented capacity and training of bilingual medical and interpreter staff.</td><td>Complete review once every three years for Alliance PCPs.</td><td>Senior Facility Site Review Nurse</td></tr>
<tr><td colspan="2">Monitor contracts with interpreter services. Establish CAPs when necessary</td><td>Quarterly JOM meetings</td><td>Manager, Vendor Management; Health Education Manager</td></tr>
<tr><td colspan="2">Monitor vendors delegated for language services for quality of language services provided using the C&L Audit Tool.</td><td>Yearly review according to Compliance schedule.</td><td>Compliance Director and Health Education Manager</td></tr>
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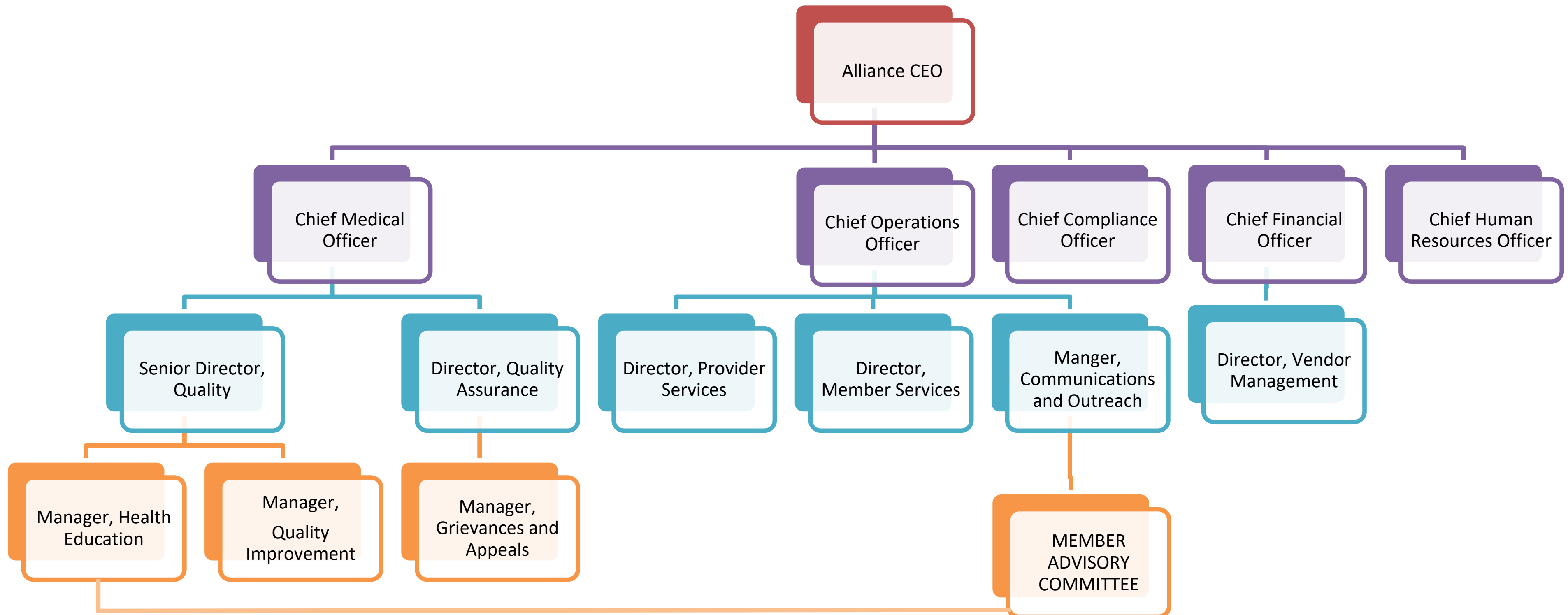
Alameda Alliance for Health Organizational Chart
Cultural and Linguistic Services

APPENDIX B



CEO Update

Scott Coffin

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

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

Date: **July 8th, 2022**

Subject: **CEO Report**

- **Financials:**

  - Revenue $99.4 million in May 2022, and $1.1 billion Year-to-Date (YTD).

    - Medical expenses for May were $89.1 million, and $1.0 billion year-to-date, representing the eleven months of the fiscal year, and 5.6% in administrative expenses.

  - Tangible Net Equity (TNE): Financial reserves are 594% above the regulatory requirement, representing $187.8 million in excess TNE.

  - Total enrollment 310,578 in May 2022, increasing by more than 2,000 Medi-Cal members as compared to April. Preliminary enrollment in the month of July exceeds 318,000 members.

  - Medi-Cal enrollment increases range from 1,200 to 2,100 members per month. Approximately 5,000 to 6,000 new Medi-Cal beneficiaries are projected to enroll in the months of July and August 2022 related to the transition of undocumented adults (age 50 and over) into Medi-Cal managed care; the population is currently enrolled in Alameda County's HealthPAC program.

  - The Public Health Emergency is approved through the month of July and is anticipated to be terminated by Governor Newsom in October; subsequently, the Medi-Cal re-determination process may resume by January 2023.

  - Net Operating Performance by Line of Business:

	May	YTD
Medi-Cal	$4.6M	$21.3M
Group Care	$0.5M	($1.0M)
Totals	$5.2M	$20.3M

- **Preliminary Budget – Fiscal Year (FY) 2023:**

  - Fiscal Year 2023 preliminary budget approved by the Board of Governors on June 10th, 2022.

  - DHCS has announced that final Medi-Cal rates will be issued two months later than normal this year (November vs. September).

  - First Quarter forecast to be presented in December 2022, and final budget will be presented in early Calendar Year 2023.

  - Total enrollment projected to exceed 320,000 by January 2023, and decline by more than 22,000 to 297,219 by June 2023. Enrollment reduction primarily in the Medi-Cal line of business due to the resumption of the re-determination process in January 2023 (6 months in fiscal year).

  - Combined FY2023 forecasted revenue, expense, and net operating results by line of business:

	Enrollment	Revenue	Expense	Net
Medi-Cal	291,391	$1.28B	$1.29B	($16.3M)
Group Care	5,828	$32M	$30.5M	$1.4M
Totals	**297,219**	**$1.31B**	**$1.33B**	**($14.9M)**

- **Key Performance Indicators:**

  - Regulatory Metrics:

    - 100% of regulatory metrics were met in the month of May 2022.

  - Non-Regulatory Metrics:

    - The Member Services call center received 12,793 inbound calls in May, approximately 3% higher than previous month. The average wait time to speak with a Member Services Representative was 3 minutes and 48 seconds, nearly 37% higher than previous month; abandonment rate also reduced by 13% for the month of May, 7% above the internal threshold.

        - The Human Resources Division is reporting 18% vacancy rate in the month of June due to the high volume of positions opened resulting from the approval of the FY2023 preliminary budget.

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

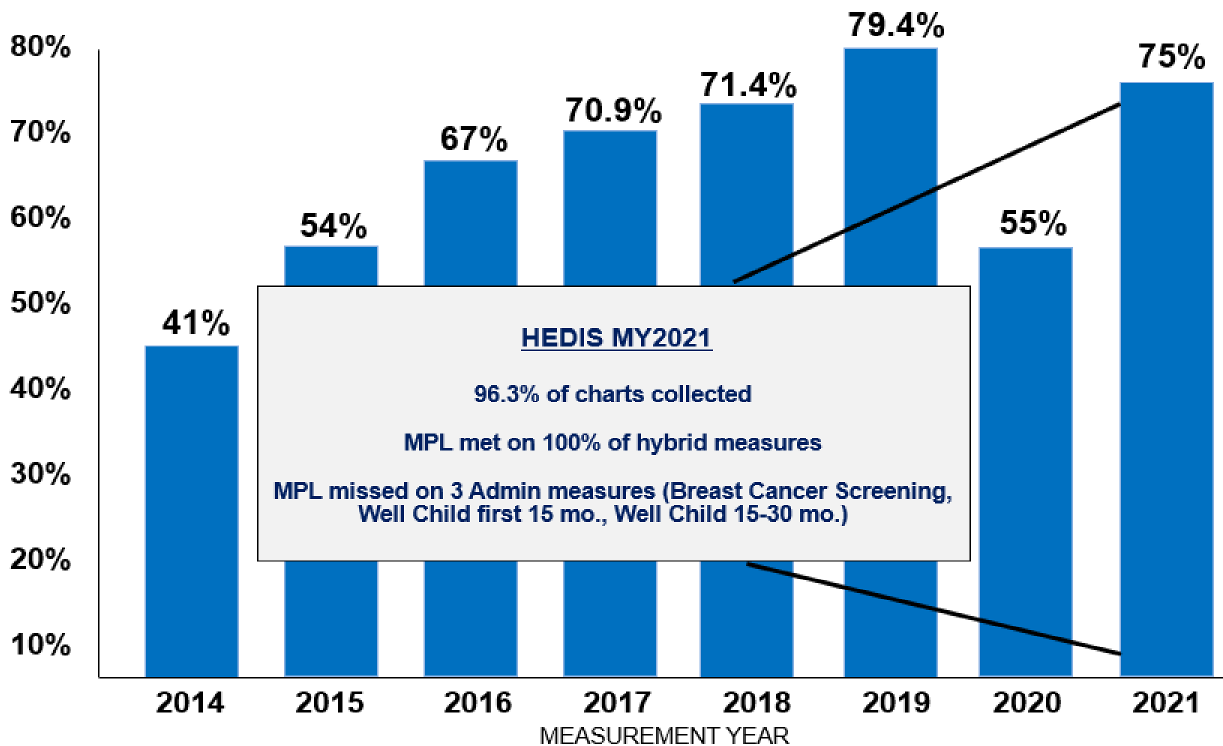
    - The following program implementations are currently in the operational readiness phase and being administered through the Alliance's Integrated Planning Division.

    - Medi-Cal and Group Care:
        - Insourcing of mental health & autism spectrum services on 11/1/2022

    - Medi-Cal Only:
        - CalAIM: Community Support (Recipe4Health) is scheduled for September 2022 go-live.
        - CalAIM: New ECM Populations of Focus phases in 2023.
        - CalAIM: Long-Term Care begins 1/1/23.
        - CalAIM: Justice Involved begins in Q3-2023 (policy changes announced by the DHCS).
        - CalAIM: Behavioral health in schools begins 12/31/22.
        - CalAIM: Population health begins 1/1/23.

- **Regulatory Audits & Accreditation:**

    - The NCQA re-accreditation survey is scheduled for July 2022, and the required documents have been delivered to the NCQA survey team. The re-accreditation applies to both lines of business for calendar years 2020 and 2021. A risk has been identified that may impact the accreditation status, and a mitigation plan is being developed to address the self-identified deficiencies. In addition, an internal audit is being conducted by an external agency in July and August to assess NCQA practices, and to identify opportunities for improvement.

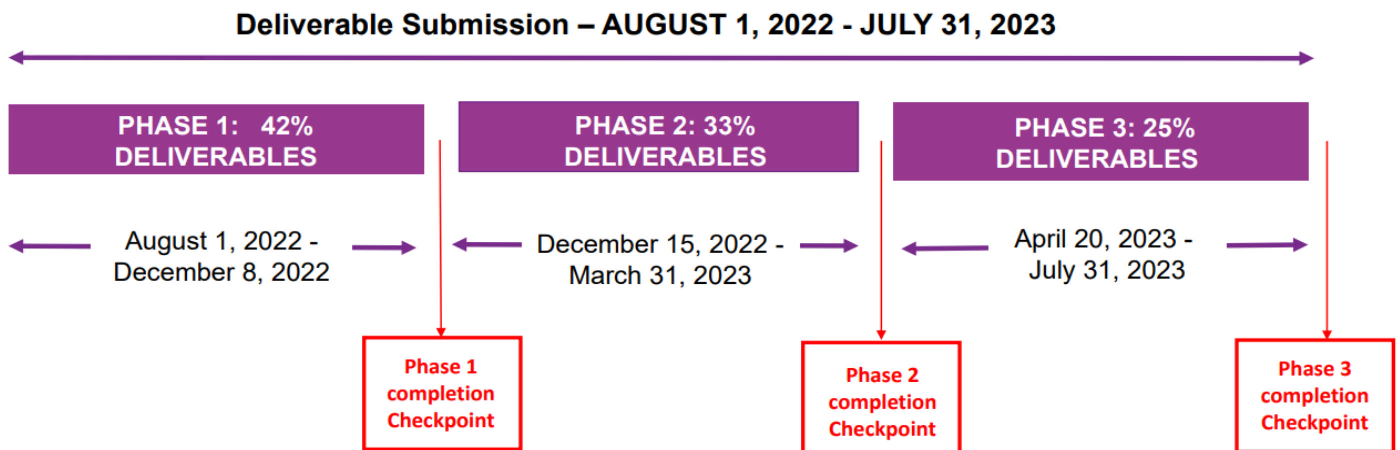


- The DMHC routine financial survey is scheduled for mid-August.

- The DMHC focused mental health parity audit is pending confirmation, and is expected to occur in calendar year 2022.

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

  - DHCS announced a Medi-Cal quality withhold that will be applied to base rates in calendar year 2023.
  - The quality withhold is based on a proposed set of 10-15 HEDIS measures, and uses actual HEDIS scores from calendar year 2021.
  - Weightings for each measure is applied to the calculation and includes achievement and improvement as part of the scoring component.
  - The following graph illustrates the Alliance's actual HEDIS scores for calendar years 2014 through 2020, and the projected HEDIS score for calendar year 2021:
    - *MPL is the minimum performance level for a HEDIS measure, defined by NCQA.



- **Single Plan Model:**
  - The California DHCS has issued a single plan transition timeline for calendar years 2022 and 2023.
  - First deliverable is August 12th, and second submission is March 31st, 2023, followed by a final submission in July 2023.
  - The Alliance's Integrated Planning & Compliance Divisions will be coordinating resources to meet the timeline.
  - Alameda County begins the single plan model for Medi-Cal managed care on January 1st, 2024.

- **CalAIM Incentives:**
  - The COVID-19 vaccine incentive program completed on February 28th, 2022.
  - The first wave of the CalAIM incentive funding completed in early July, resulting in defined allocation of $3.7 million to qualified applicants. A second wave of funding begins later in July and is forecasted to complete in the month of August.
  - The gap assessment for Student Behavioral Health incentive program is due to the DHCS by December 30th, 2022. The assessment will define the interventions that will be targeted.

Incentive Program	Duration	Maximum	Awarded	Approved
1) Behavioral Health Integration	2021-2022	$3.2M	$2.0M	$1.8M
2) COVID-19 Vaccine	2021-2022	$8.4M	$2.1M	$1.4M
3) CalAIM	2022-2024	$14.8M	$7.4M	$3.7M
4) Student Behavioral Health	2022-2024	$9.7M	$381K	Pending
5) Housing and Homelessness	2022-2023	$44.3M	Pending	Pending
Totals		**$80.4M**	**$11.9M**	**$6.9M**

- The initial submission for the Housing & Homelessness incentive program was delivered to the DHCS earlier this week, and the DHCS will be issuing further guidance following the review of the local housing plans.
- Alameda Alliance is forecasting administrative costs for each incentive program to oversee the management of the funding, and outcomes-based reporting, over the life of each incentive program.
- Listed above is a summary of the incentive dollar allocations, awards to community-based organizations, and funding durations between calendar years 2022-2024.

Executive Dashboard

OPERATIONS DASHBOARD JULY 2022

Alliance for Health

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Financials

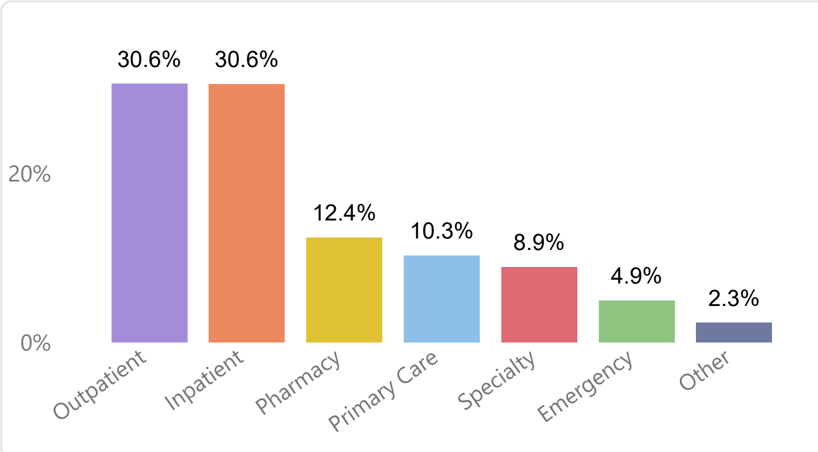
Income & Expenses

	MAY 2022	FISCAL YTD
REVENUE	$ 99.4 M	$ 1.1 B
MEDICAL EXPENSE	$ (89.1) M	$ (1.0) B
ADMIN EXPENSE	$ (5.6) M	$ (59.1) M
OTHER	$ 419 K	$ (446) K
NET INCOME	$ 5.2 M	$ 20.3 M

Gross Margin %

7.3%

Medical Expenses



Liquid Reserves

MLR Net %

92.7%

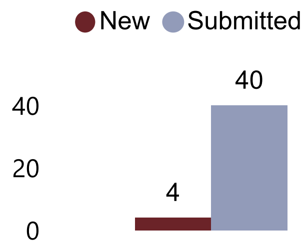
TNE %

594.5%

TNE $

$225.8M

Reinsurance Cases



Balance Sheet

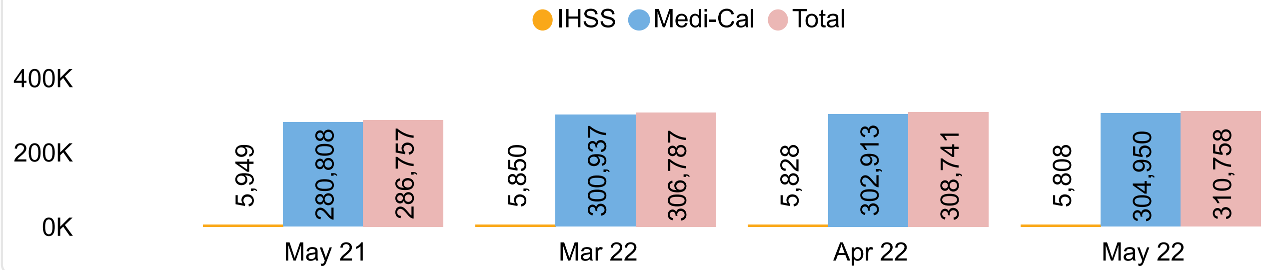
Cash Equivalents	$297.9M
Pass-Through Liabilities	$101.2M
Uncommitted Cash	$196.8M
Working Capital	$184.4M

Current Ratio %

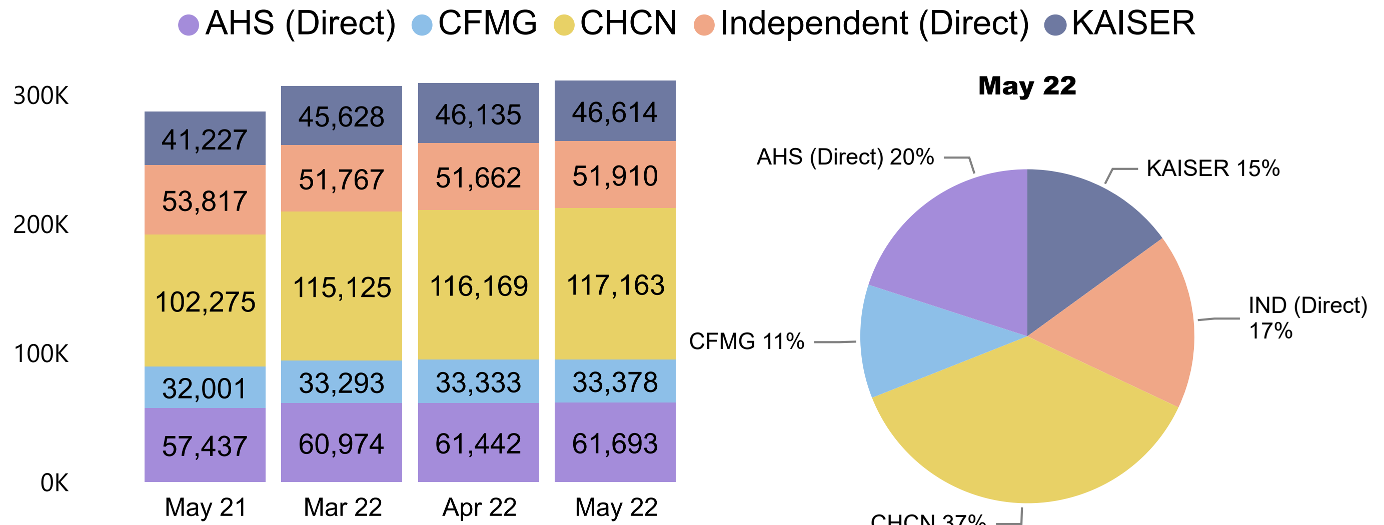
171.5%

Membership

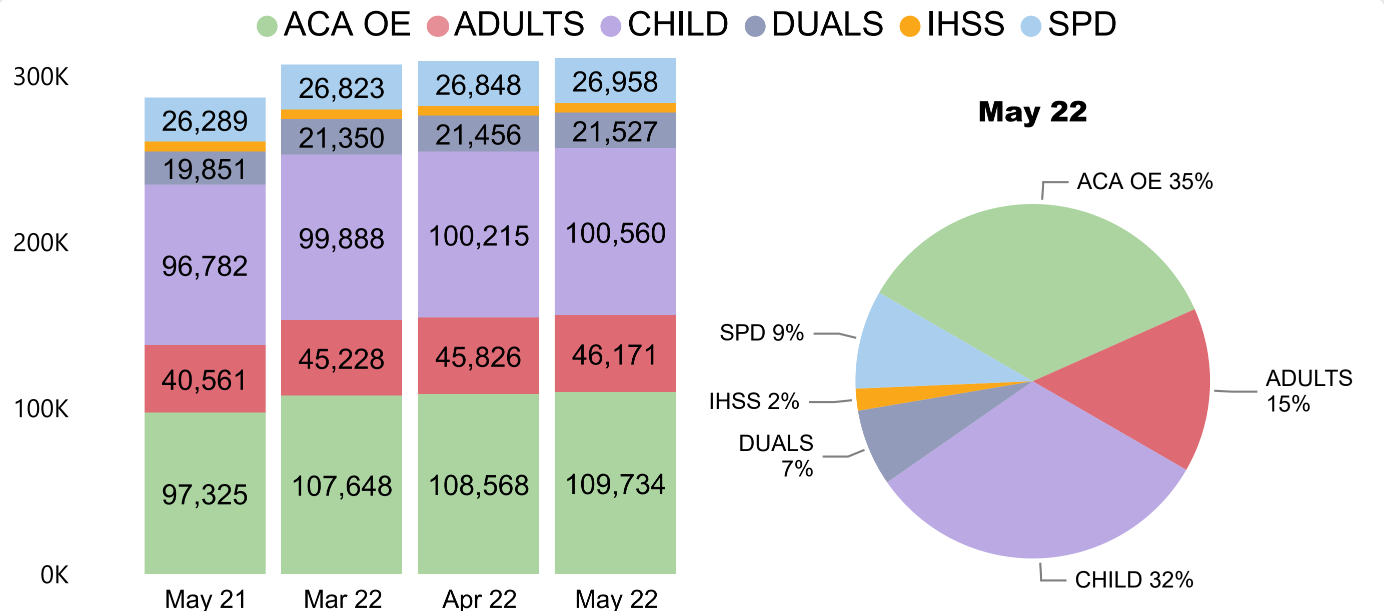
By Plan



By Network



By Category



Alliance **OPERATIONS DASHBOARD** **JULY 2022**

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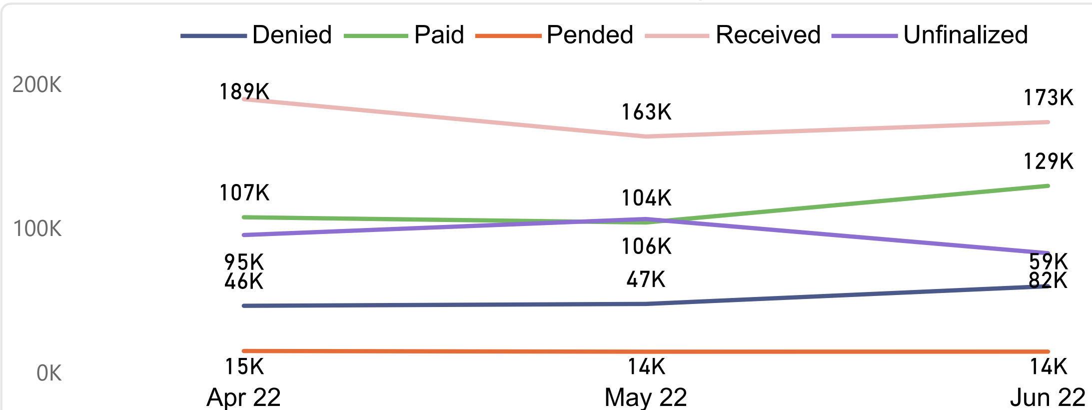
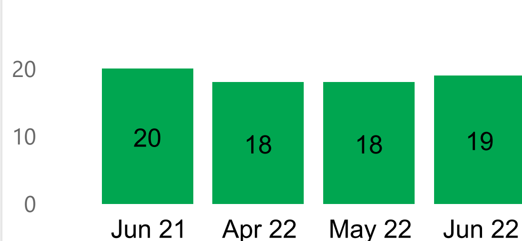
Claims

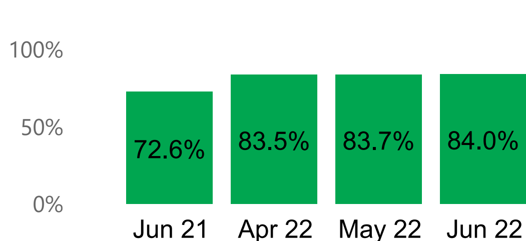
Claims Processing



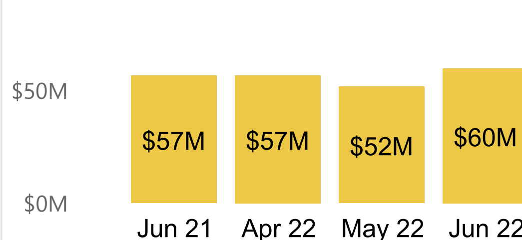
Average Payment TAT (Days)



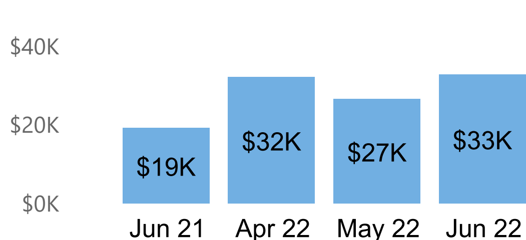
Auto Adjudication Rate (%)



Claims Paid ($)

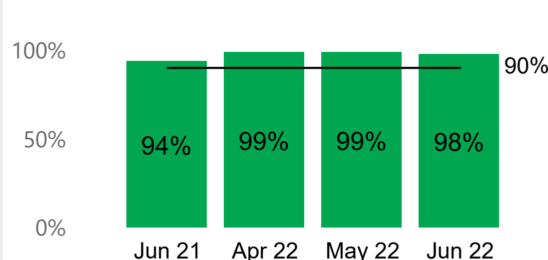


Interest Paid ($)

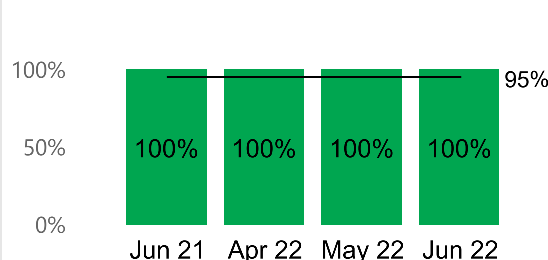


Claims Compliance

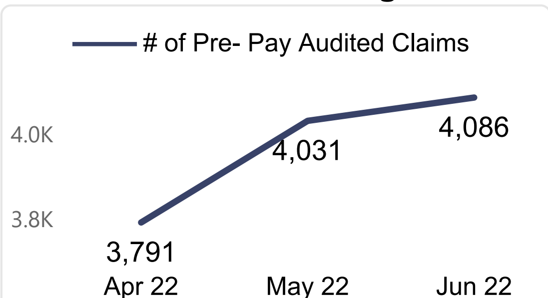
Processed 30 Cal Days (%)



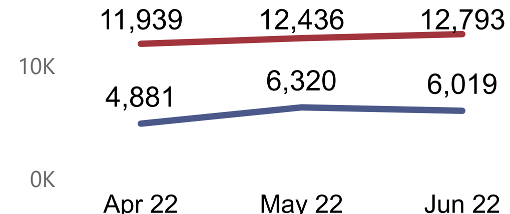
Processed 45 Work Days (%)



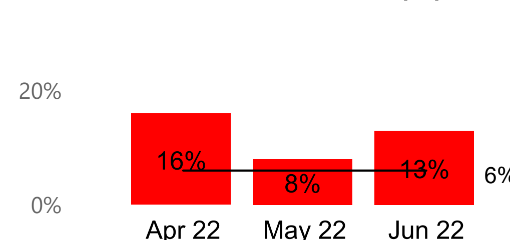
Claims Auditing



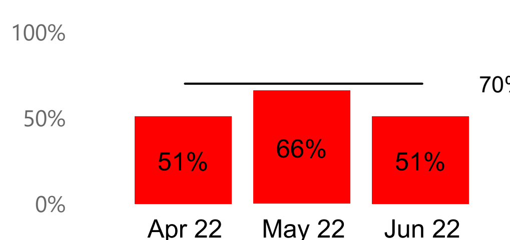
Member Services



Abandoned Call Rate (%)

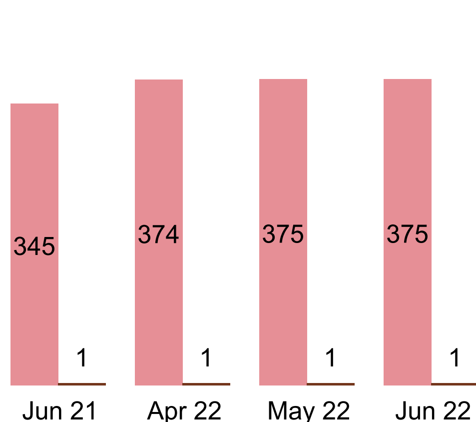


Calls Answered in 60 Seconds (%)

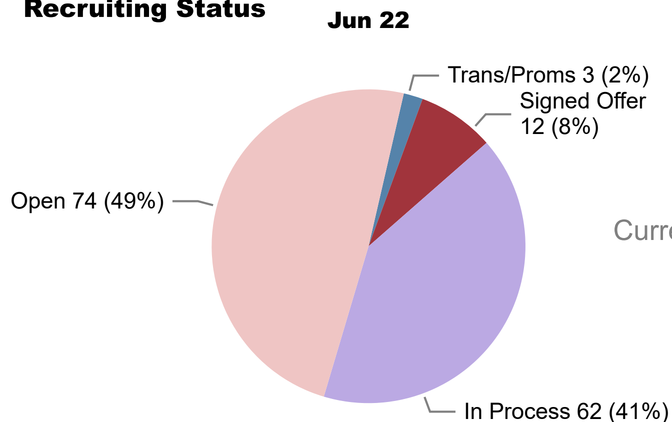


Average Call Times	Apr 22	May 22	Jun 22
Wait Time	04:30	02:20	03:48
Call Duration	06:58	06:30	06:53

Human Resources

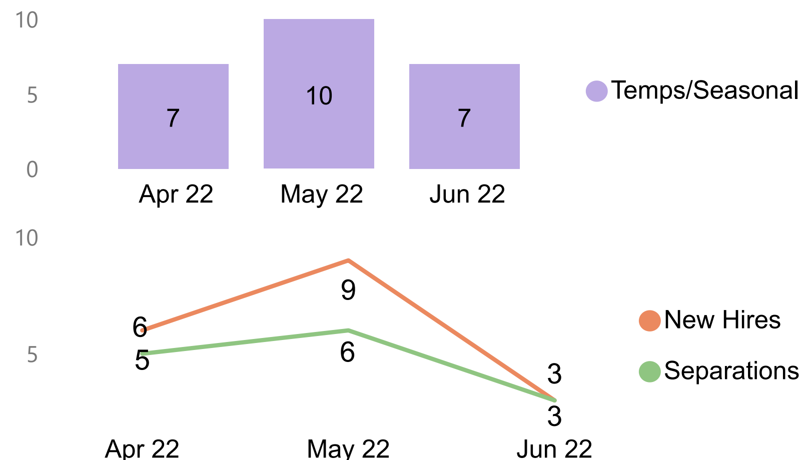


Recruiting Status



Current Vacancy

18%



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Provider Services

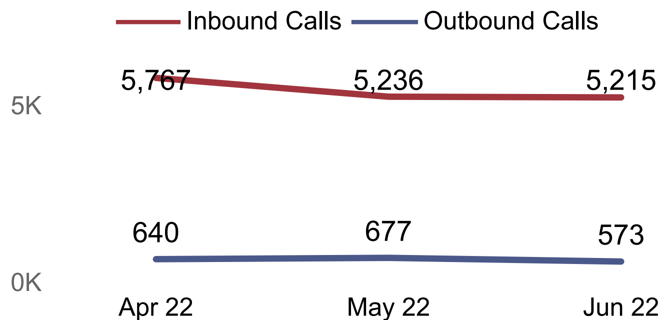
Provider Network

Hospital	17
Specialist	8,566
Primary Care Physician	733
Skilled Nursing Facility	66
Urgent Care	9
Health Centers (FQHCs and Non-FQHCs)	68
Transportation	380
TOTAL	**9,839**

Provider Credentialing

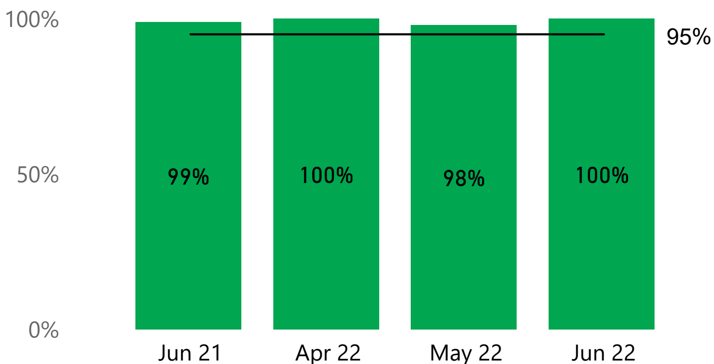
1,401

Provider Call Center



Provider Disputes & Resolutions

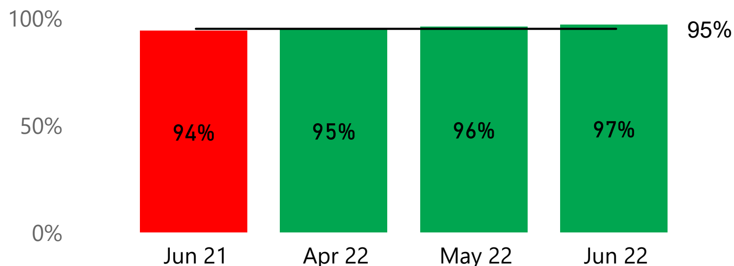
Turnaround Compliance (45 business days)



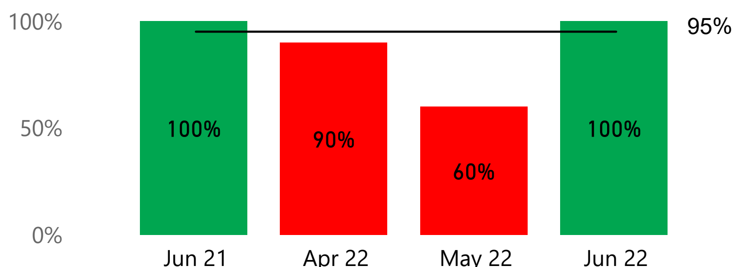
Compliance

Member Grievances

Standard (30 calendar days)

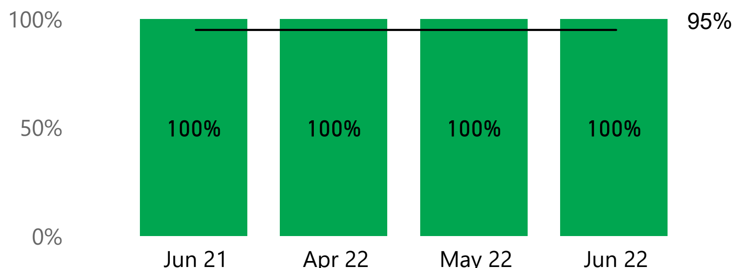


Expedited (3 calendar days)

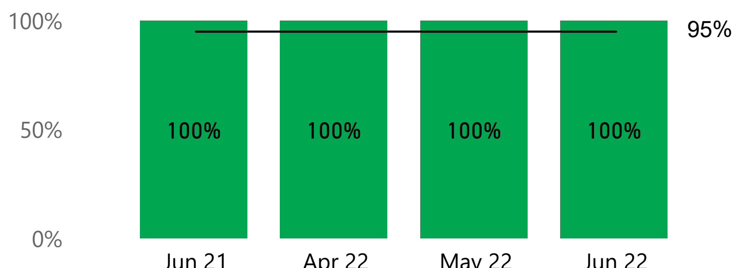


Member Appeals

Standard (30 calendar days)

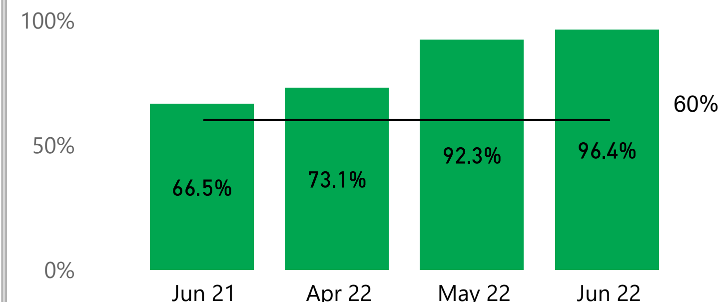


Expedited (3 calendar days)

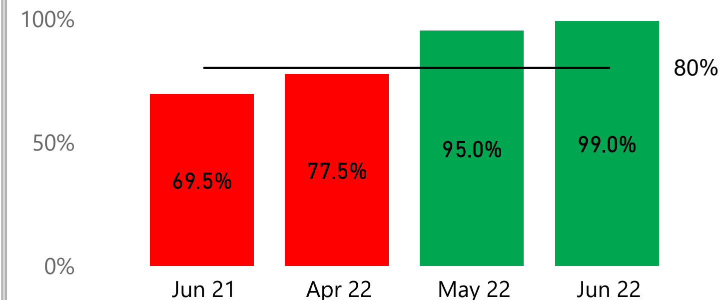


Encounter Data

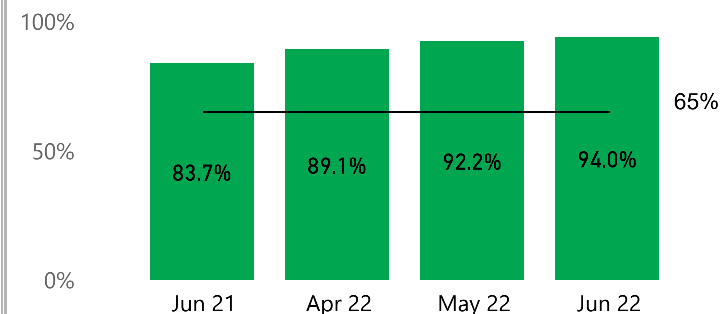
Institutional 0-90 days



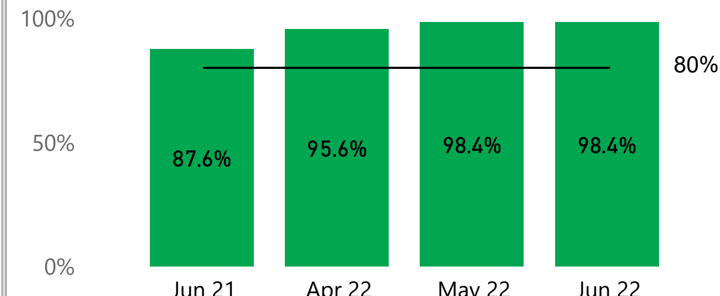
Institutional 0-180 days



Professional 0-90 days



Professional 0-180 days



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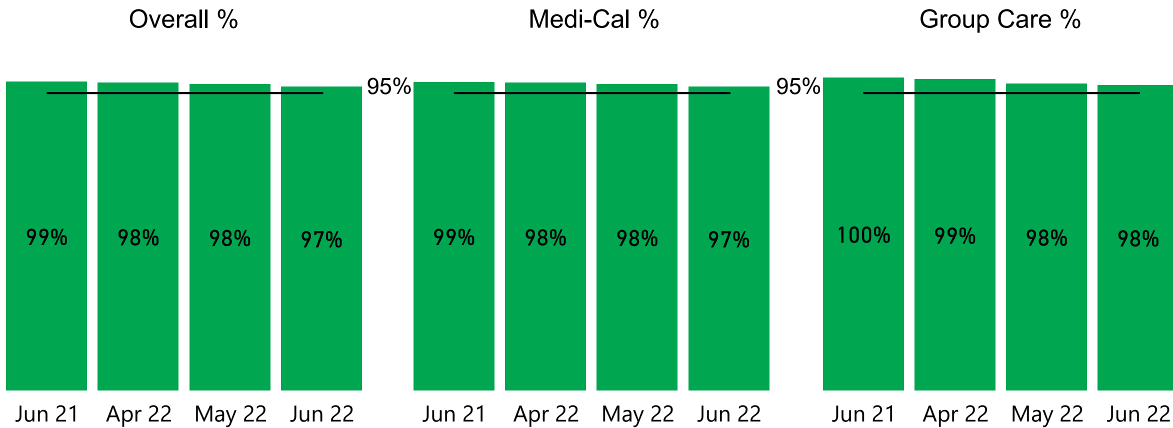
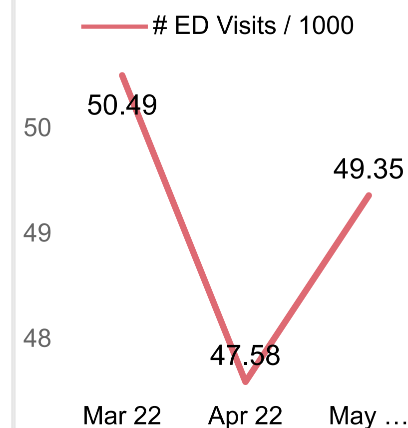
Health Care Services

Authorization Turnaround

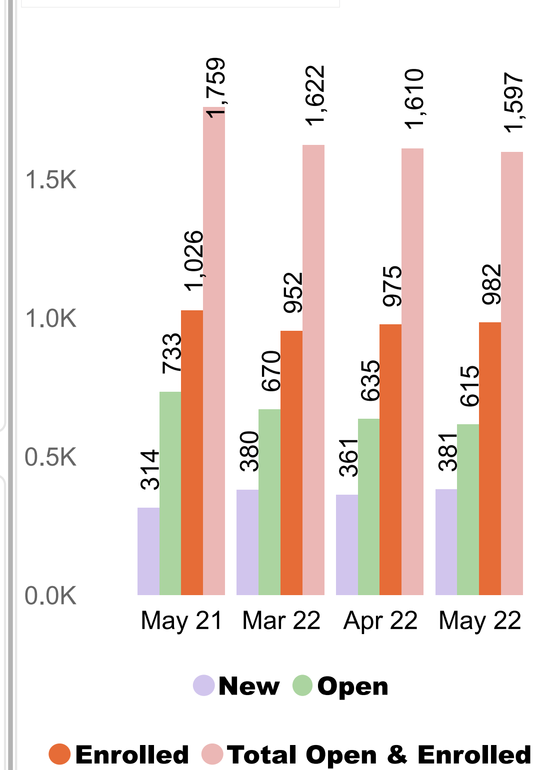


ED Utilization

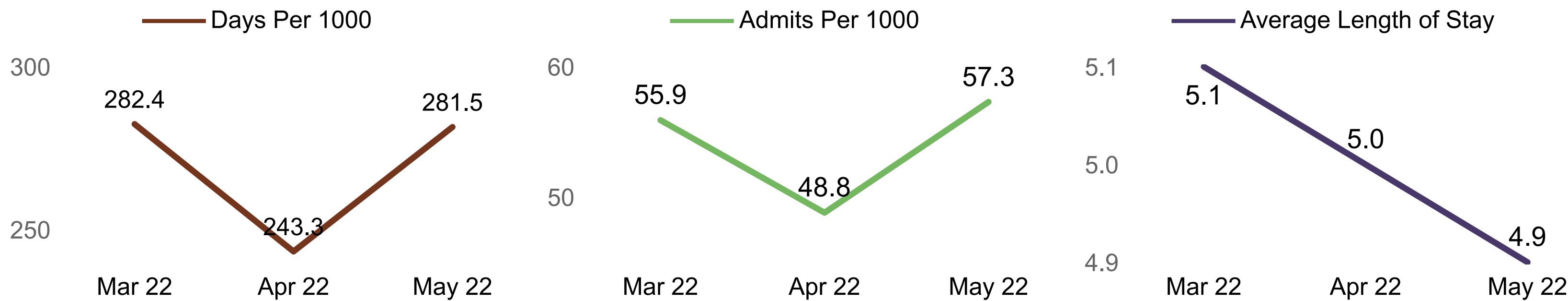


Case Management

Total Cases^



Inpatient Utilization

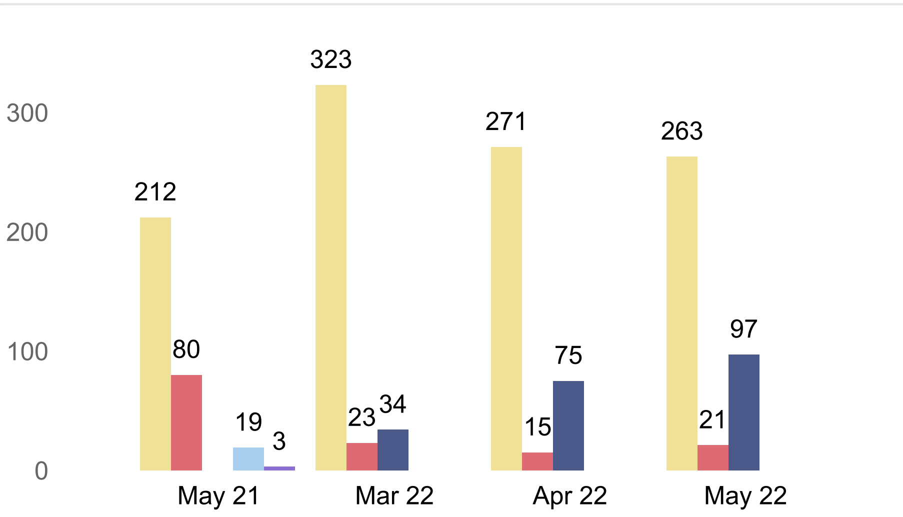


Case Management^

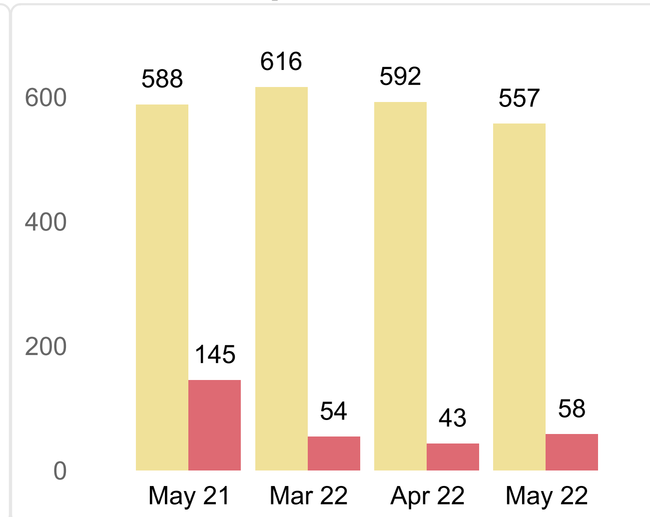
Care Coordination Complex Cases Health Homes Whole Person Care Enhanced Case Management

^ ECM Metrics since 2022

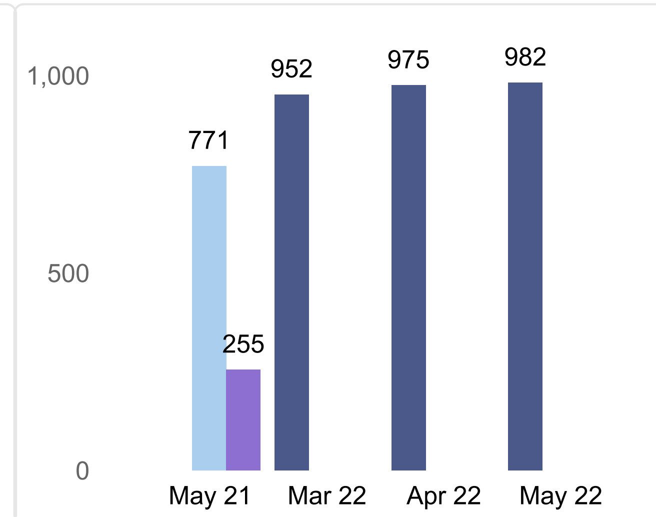
New Cases



Open Cases



Enrolled Cases



Technology (Business Availability)

Applications	Jun 21	Apr 22	May 22	Jun 22
HEALTHsuite System	100.0%	100.0%	100.0%	100.0%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Jun 21	Apr 22	May 22	Jun 22
Denial Rate Excluding Partial Denials (%)	4.3%	4.1%	3.6%	3.0%
Overall Denial Rate (%)	4.4%	4.6%	4.1%	3.4%
Partial Denial Rate (%)	0.1%	0.6%	0.5%	0.4%

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

Pharmacy Authorizations

Authorizations	Jun 21	Apr 22	May 22	Jun 22
Approved Prior Authorizations	826	19	20	18
Closed Prior Authorizations	559	67	20	26
Denied Prior Authorizations	693	33	27	33
Total Prior Authorizations	2,078	119	67	77

Legislative Tracking

ALAMEDA
Alliance
FOR HEALTH

2022 Legislative Tracking List

The following is a list of state bills tracked by the Public Affairs Department that were introduced during the 2021 and 2022 Legislative Sessions. This list includes 2-year bills introduced in 2021 that did not make it through the legislature and have moved through the legislature in 2022, as well as bills introduced in 2022. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership. **The bills on this list are updated as of 7/5/2022.**

May 27th was the last day for each house to pass bills introduced in that house. Bills that were not moved for action in the second house failed to make it through the legislative process.

Medi-Cal (Medicaid)

- **AB 1355 (Levine – D) Medi-Cal: Independent Medical Review System**
  - **Introduced:** 2/19/2021
  - **Status:** 6/27/2022-In committee: Referred to suspense file.
  - **Summary:** Current law authorizes the State Department of Health Care Services to enter into various types of contracts for the provision of services to beneficiaries, including contracts with a managed care plan. Current law generally requires Medi-Cal managed care plan contractors to be licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The act provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. The act requires the Department of Managed Health Care to establish the Independent Medical Review System, which generally serves to address grievances involving disputed health care services based on whether the service is medically necessary. This bill would require the State Department of Health Care Services to establish the Independent Medical Review System (IMRS) for the Medi-Cal program, commencing on January 1st, 2023, which generally models the above-described requirements of the Knox-Keene Health Care Service Plan Act. The bill would provide that any Medi-Cal beneficiary appeal involving a disputed health care service is eligible for review under the IMRS if certain requirements are met, and would define "disputed health care service" as any service covered under the Medi-Cal program that has been denied, modified, or delayed by a decision of the department, or by one of its contractors that makes a final decision, in whole or in part, due to a finding that the service is not medically necessary.

- **AB 1859 (Levine – D) Mental Health Services**
  - **Introduced:** 2/8/2022
  - **Status:** 6/27/2022-Read second time and amended. Re-referred to Com. on APPR.
  - **Summary:** Would require a health care service plan or a health insurance policy issued, amended, or renewed on or after July 1st, 2023, that includes coverage for mental health services to, among other things, approve the provision of mental health services for persons who are screened, evaluated, and detained for treatment and evaluation under the Lanterman-Petris-Short Act and to ensure a follow up appointment with a licensed mental health professional is covered and scheduled as part of a discharge plan, as specified. The bill would prohibit a noncontracting provider of covered mental health services from billing the previously described enrollee or insured more than the cost-sharing amount the enrollee or insured would pay to a contracting provider for those services. Because a willful violation of the bill's requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **AB 1880 (Arambula – D) Prior Authorization and Step Therapy**
  - **Introduced:** 1/24/2022
  - **Status:** 6/27/2022-In committee: Referred to suspense file.
  - **Summary:** Current law permits a health care provider or prescribing provider to appeal a denial of a step therapy exception request for coverage of a nonformulary drug, a prior authorization request, or a step therapy exception request, consistent with the current utilization management processes of the health care service plan or health insurer. Current law also permits an enrollee or insured, or the enrollee's or insured's designee or guardian, to appeal a denial of a step therapy exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing a grievance under a specified provision. This bill would require health care service plan's or health insurer's utilization management process to ensure that an appeal of a denial of an exception request is reviewed by a clinical peer of the health care provider or prescribing provider, as specified. The bill would define the term "clinical peer" for these purposes.

- **AB 1892 (Flora - R) Medi-Cal: orthotic and prosthetic appliances**
  - **Introduced:** 2/9/2022
  - **Status:** 6/20/2022-In committee: Referred to suspense file.
  - **Summary:** Under the Medi-Cal program, current law requires the State Department of Health Care Services to establish a list of covered services and maximum allowable reimbursement rates for prosthetic and orthotic appliances and requires that the list be published in provider manuals. Current law prohibits reimbursement for prosthetic and orthotic appliances from exceeding 80% of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar services. This bill would instead require reimbursement for these appliances to be set at least at 80% of the lowest maximum allowance for California established by the federal Medicare Program, and would require that reimbursement to be adjusted annually, as specified.

- **AB 1900 (Arambula – D): Medi-Cal: income level for maintenance**
  - **Introduced:** 2/9/2022
  - **Status:** 6/20/2022-In committee: Referred to suspense file.
  - **Summary:** Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, and under which qualified low-income individuals receive health care services. Current law requires the department to establish income levels for maintenance at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. Under current law, for a single individual, the amount of the income level for maintenance per month is based on a calculation of 80% of the highest amount that would ordinarily be paid to a family of 2 persons, without any income or resources, under specified cash assistance provisions, multiplied by the federal financial participation rate, adjusted as specified. To the extent that any necessary federal authorization is obtained, and effective no sooner than January 1st, 2024, this bill would increase the above-described income level for maintenance per month to be equal to the income limit for Medi-Cal without a share of cost for individuals who are 65 years of age or older or are disabled, generally totaling 138% of the federal poverty level. The bill would require the department to seek any necessary federal authorization for maintaining that income level for maintenance and would make conforming changes to related provisions. The bill would authorize the department to implement those provisions by various means, including all-county letters, and would require the department to implement those changes by regulatory action within 2 years of the operation of the above-described increase.

- **AB 1929 (Gabriel - D) Medi-Cal: violence preventive services**
    - **Introduced:** 2/10/2022
    - **Status:** 6/28/2022-Read second time. Ordered to third reading.
    - **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. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law establishes a schedule of benefits under the Medi-Cal program, including various mental health services. Current federal law authorizes, at the option of the state, preventive services, as defined, that are recommended by a physician or other licensed practitioner of the healing arts. This bill would add violence prevention services, as defined, as a covered benefit under Medi-Cal, subject to medical necessity and utilization controls. The bill would authorize the department to implement, interpret, or make specific that provision by means of all-county letters, plan letters, or plan or provider bulletins, or similar instructions until regulations are adopted. The bill would limit its implementation only to the extent that any necessary federal approvals are obtained, and federal financial participation is not otherwise jeopardized. The bill would require the department to post on its internet website the date upon which violence prevention services may be provided and billed.

- **AB 1930 (Arambula - D) Medi-Cal: comprehensive perinatal services**
    - **Introduced:** 2/10/2022
    - **Status:** 6/27/2022-In committee: Referred to suspense file.
    - **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual’s pregnancy. This bill, during the one-year post pregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27th, 2021, during pregnancy and the initial 60-day post pregnancy period in effect on that date. The bill would require the department to collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered.

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

authorize the department to implement the above-described provisions through all-county or plan letters, or similar instructions, and would require regulatory action no later than January 1st, 2026.

- **AB 1944 (Lee – D) Local governments: open and public meetings**
  - **Introduced:** 1/24/2022
  - **Status:** 6/22/2022-In committee: Set, first hearing. Hearing canceled at the request of author. In committee: Hearing postponed by committee.
  - **Summary:** The Ralph M. Brown Act requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act contains specified provisions regarding the timelines for posting an agenda and providing for the ability of the public to observe and provide comment. The act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. This bill would require the agenda to identify any member of the legislative body that will participate in the meeting remotely.

- **AB 1995 (Arambula - D) Medi-Cal: premiums, contributions or copayments**
  - **Introduced:** 1/24/2022
  - **Status:** 6/27/2022-In committee: Referred to suspense file.
  - **Summary:** Current law requires that Medi-Cal benefits be provided to optional targeted low-income children, as defined, based on a certain income eligibility threshold. Current law also establishes the Medi-Cal Access Program, which provides health care services to a woman who is pregnant or in her postpartum period and whose household income is between certain thresholds, and to a child under 2 years of age who is delivered by a mother enrolled in the program, as specified. Current law also establishes a program under which certain employed persons with disabilities are eligible for Medi-Cal benefits based on income and other criteria. Existing law requires the department to exercise the option, available to the state under federal law, to impose specified monthly premiums, based on income level, for the above-described children and employed persons with disabilities. Existing law requires the department to determine schedules for subscriber contribution amounts for persons enrolled in the Medi-Cal Access Program. This bill would eliminate the premiums and subscriber contributions for the above-described populations.

- **AB 2007 (Valladares – R) Health care language assistance services**
  - **Introduced:** 2/14/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/24/2022)
  - **Summary:** The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Current law requires the Department of Managed Health Care to adopt regulations establishing standards and requirements for health care service plans to provide enrollees with appropriate access to language assistance in obtaining health care services. Current law requires the department to report biennially to, among others, the Legislature, regarding plan compliance with the standards. This bill would instead require the department to provide that report 3 times a year.

- **AB 2024 (Friedman - D) Health care coverage: diagnostic imaging**
  - **Introduced:** 2/14/2022
  - **Status:** 6/30/2022-From committee: Amend and do pass as amended and re-refer to Com. on APPR. (Ayes 10. Noes 0.) (June 29th).
  - **Summary:** Would require a health care service plan contract, health insurance policy, or self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1st, 2023, to provide coverage for screening mammography, medically necessary diagnostic, or supplemental breast examinations, or testing for screening or diagnostic purposes upon referral by specified professionals. The bill would prohibit a health care service plan contract, health insurance policy, or self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1st, 2023, from imposing cost sharing for screening mammography, medically necessary or supplemental breast examinations, or testing, unless the contract or policy is a high deductible health plan, and the deductible has not been satisfied for the year.

- **AB 2029 (Wicks - D) Health care coverage: treatment for infertility**
  - **Introduced:** 2/14/2022
  - **Status:** 5/20/2022-Failed Deadline pursuant to Rule 61(b)(8). (Last location was A. APPR. SUSPENSE FILE on 5/18/2022)
  - **Summary:** Would require a health care service plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1st, 2023, to provide coverage for the diagnosis and treatment of infertility and fertility services, as specified, up to a lifetime maximum benefit of $75,000. The bill would except specialty health care service plan contracts and disability insurance policies from that requirement. The bill also would require a small group health care service plan contract or disability insurance policy, except a specialized contract or policy, which is issued, amended, or renewed on or after January 1st, 2023, to offer coverage for the treatment of infertility, as specified. The bill would revise the definition of infertility and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and health insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contract holders and policyholders and prospective group contract holders and policyholders. With respect to a health care service plan, the bill would not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services for the delivery of health care services pursuant to specified provisions.

- **AB 2077 (Calderon - D) Medi-Cal: monthly maintenance amount: personal and incidental needs**
  - **Introduced:** 2/14/2022
  - **Status:** 6/20/2022-In committee: Referred to suspense file.
  - **Summary:** Current law requires the State Department of Health Care Services to establish income levels for maintenance needs at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Existing law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $80.

- **AB 2117 (Gipson – D) Mobile stroke units**
  - **Introduced:** 2/14/2022
  - **Status:** 6/23/2022-From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 9. Noes 0.) (June 22). Re-referred to Com. on APPR.
  - **Summary:** Current law provides for the licensure and regulation of health facilities by the State Department of Public Health and defines various types of health facilities for those purposes. This bill would define "mobile stroke unit" to mean a multijurisdictional mobile facility that serves as an emergency response critical care ambulance under the direction and approval of a local emergency medical services (EMS) agency, and as a diagnostic, evaluation, and treatment unit, providing radiographic imaging, laboratory testing, and medical treatment under the supervision of a physician in person or by telehealth, for patients with symptoms of a stroke, to the extent consistent with any federal definition of a mobile stroke unit, as specified.

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

- **AB 2304 (Bonta – D) Nutrition Assistance: "Food as Medicine"**
  - **Introduced:** 2/16/2022
  - **Status:** 5/6/22 Failed Deadline pursuant to Rule 61(b)(6). (Last location was A. PRINT on 2/16/2022)
  - **Summary:** Current law provides for the California Health and Human Services Agency, which includes the State Department of Health Care Services, the State Department of Public Health, and the State Department of Social Services. Current law establishes various programs and services under those departments, including the Medi-Cal program, under which qualified low-income individuals receive health care services, such as enteral nutrition products, the California Special Supplemental Nutrition Program for Women, Infants, and Children, which is administered by the State Department of Public Health and counties and under which nutrition and other assistance are provided to eligible individuals who have been determined to be at nutritional risk, and the CalFresh program, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county. This bill would declare the intent of the Legislature to enact the Wilma Chan Food as Medicine Act of 2022.

- **AB 2352 (Nazarian - D) Prescription drug coverage**
  - **Introduced:** 2/16/2022
  - **Status:** 6/27/2022-In committee: Referred to suspense file.
  - **Summary:** Would require a health care service plan or health insurer that provides prescription drug benefits and maintains one or more drug formularies to furnish specified information about

a prescription drug upon request by an enrollee or insured, or their prescribing provider. The bill would require the plan or insurer to respond in real time to that request and ensure the information is current no later than one business day after a change is made. The bill would prohibit a health care service plan or health insurer from, among other things, restricting a prescribing provider from sharing the information furnished about the prescription drug or penalizing a provider for prescribing a lower cost drug. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **AB 2402 (Rubio, Blanca - D) Medi-Cal: continuous eligibility**
  - **Introduced:** 2/17/2022
  - **Status:** 6/27/2022-Read second time and amended. Re-referred to Com. on APPR.
  - **Summary:** Would prohibit the redetermination of Medi-Cal eligibility before the child reaches 5 years of age, unless the department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and, except as specified, on the availability of federal financial participation.

- **AB 2449 (Rubio, Blanca – D) Open meetings: local agencies: teleconferences**
  - **Introduced:** 1/24/2022
  - **Status:** 6/30/2022-Read second time and amended. Re-referred to Com. on APPR.
  - **Summary:** Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act contains specified provisions regarding the timelines for posting an agenda and providing for the ability of the public to observe and provide comment. The act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. This bill would revise and recast those teleconferencing provisions and, until January 1st, 2026, would authorize a local agency to use teleconferencing without complying with the teleconferencing requirements that each teleconference location be identified in the notice and agenda and that each teleconference location be accessible to the public if at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda that is open to the public and situated within the local agency's jurisdiction. This bill contains other related provisions and other existing laws.

- **AB 2458 (Weber – D) California Children's Services: reimbursement rates.**
  - **Introduced:** 2/17/2022
  - **Status:** 5/20/22 Failed Deadline pursuant to Rule 61(b)(8). (Last location was A. APPR. SUSPENSE FILE on 4/6/2022)
  - **Summary:** Would make legislative findings relating to the need for an increase in the reimbursement rates for physician services provided under the California Children's Services (CCS) Program. Under the bill, subject to an appropriation, and commencing January 1st, 2023, those reimbursement rates would be increased by adding at least 25% to the above-described augmentation percentage relative to the applicable Medi-Cal rates. The bill would make the rate

increase applicable only if the services are provided by a physician in a practice in which at least 30% of the practice's pediatric patients are Medi-Cal beneficiaries.

- **AB 2539 (Choi - R) Public health: COVID-19 vaccination: proof of status**
  - **Introduced:** 2/17/2022
  - **Status:** 4/29/22 Failed Deadline pursuant to Rule 61(b)(5). (Last location was PRINT on 2/17/2022)
  - **Summary:** Would require a public or private entity that requires a member of the public to provide documentation regarding the individual's vaccination status for any COVID-19 vaccine as a condition of receipt of any service or entrance to any place to accept a written medical record or government-issued digital medical record in satisfaction of the condition, as specified.

- **AB 2581 (Salas – D) Health Care Service Plans: Mental Health and Substance Use Disorders: Provider Credentials**
  - **Introduced:** 2/18/2022
  - **Status:** 6/27/22 In committee: Referred to suspense file.
  - **Summary:** Current law requires a health care service plan contract issued, amended, or renewed on or after January 1st, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. For provider contracts issued, amended, or renewed on and after January 1st, 2023, this bill would require a health care service plan that provides coverage for mental health and substance use disorders and credentials health care providers of those services for the health care service plan's networks, to assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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

- **AB 2680 (Arambula - D) Medi-Cal: Community Health Navigator Program**
  - **Introduced:** 2/19/2022

- **Status:** 6/30/2022-From committee: Amend and do pass as amended and re-refer to Com. on APPR. (Ayes 7. Noes 0.) (June 30th).
- **Summary:** Current law also authorizes a county to collaborate with a community-based organization to maintain up-to-date contact information in order to assist with the timely submission of annual reaffirmation forms, among others. This bill would require the State Department of Health Care Services to create the Community Health Navigator Program to make direct grants to qualified community-based organizations, as defined, to conduct targeted outreach, enrollment, retention, and access activities for Medi-Cal-eligible individuals and families. The bill would specify the basis for issuing a grant, including specified factors in the applicant's service area. The bill would require the department to contract with a private foundation to administer the grant application and allocation process. The bill would require the department to contract with specified providers to furnish training and technical assistance to grant recipients. The bill would also require the department to coordinate and partner with Covered California and counties that elect to participate, on an approach for outreach, enrollment, retention, and access activities for marketing to eligible individuals, including the development of a joint application tracker system to allow specified persons and entities to track application and referrals between commercial and Medi-Cal enrollment progress and facilitation of quarterly meetings on enrollment and access barriers and solutions, among other requirements.

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

- **AB 2727 (Wood – D) Medi-Cal Eligibility**
  - **Introduced:** 1/24/2022
  - **Status:** 6/2/2022-Read second time. Ordered to third reading.
  - **Summary:** Current law prohibits the use of resources, including property or other assets, to determine Medi-Cal eligibility for applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods, and requires the department to seek federal authority to disregard all resources as authorized by the flexibilities provided under federal law. Current law conditions implementation of that provision on the Director of Health Care Services determining that systems have been programmed for those disregards and their communicating that determination in writing to the Department of Finance, no sooner than January 1st, 2024. Current law also conditions implementation of that provision on receipt of any necessary federal approvals and the availability of federal financial participation. Current law states the intent of the Legislature to provide, to the extent practicable, through the Medi-Cal program, for health care for those aged and other persons, including family persons who lack sufficient annual income to meet the costs

of health care, and whose other assets are so limited that their application toward the costs of that care would jeopardize the person or family's future minimum self-maintenance and security. This bill would, commencing on the date that the resource disregards are implemented, remove from that statement of legislative intent the above-described assets as an eligibility criterion.

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

- **AB 2833 (Irwin – D) COVID-19 testing capacity**
  - **Introduced:** 2/18/2022
  - **Status:** 6/1/22 Referred to Com. on HEALTH.
  - **Summary:** Current law sets forth various provisions specific to COVID-19 testing, including, among others, provisions relating to health care coverage for testing and certain programs or requirements for the workplace or educational setting. This bill would require the State Department of Public Health to make plans to ensure that the laboratory infrastructure in the state is sufficient and prepared for COVID-19 testing capacity to be scaled, within a period of 2 calendar weeks, to 500,000 tests per day, and for results of at least 90% of those COVID-19 tests to be returned to the individuals tested and to the department within 24 hours of collection of the testing samples. The bill would require the department, for purposes of making these plans, to prioritize local public health laboratories and the state laboratory and to consider sufficient staffing.

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

- **AB 2516 (Aguiar-Curry - D) Health care coverage: human papillomavirus**
  - **Introduced:** 2/17/2022
  - **Status:** 6/30/22 From committee: Do pass and re-refer to Com. on APPR. (Ayes 8. Noes 1.) (June 29th). Re-referred to Com. on APPR.

  - **Summary:** Current law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2002, to provide coverage for an annual cervical cancer screening test, including a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA). Current law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law also establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department, under which comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level, and who is eligible to receive these services. This bill would expand the coverage requirement for an annual cervical cancer screening test to disability insurance policies that provide coverage for hospital, medical, or surgical benefits and would require a health care service plan contract or disability insurance policy that provides coverage for hospital, medical, or surgical benefits issued, amended, or renewed on or after January 1st, 2023, to provide coverage without cost sharing for the HPV vaccine for persons for whom the vaccine is FDA approved.

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

- **SB 853 (Wiener – D) Prescription drug coverage**
  - **Introduced:** 1/19/2022
  - **Status:** 6/29/2022-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (June 28th). Re-referred to Com. on APPR.
  - **Summary:** Current law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law prohibits a health care service plan contract that covers prescription drug benefits or a specified health insurance policy from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which it was approved by the federal Food and Drug Administration if specified conditions are met. Current law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for

coverage if an enrollee continues to be prescribed that drug, as specified. This bill would expand the above-described prohibitions to prohibit limiting or excluding coverage of a drug, dose, or dosage form, and would apply the prohibition to blanket disability insurance policies and certificates. The bill would prohibit a health care service plan or disability insurer that provides coverage for prescription drugs from limiting or declining to cover a drug or dose of a drug as prescribed or imposing additional cost sharing for covering a drug as prescribed if specified criteria apply.

- **SB 858 (Wiener – D) Health care service plans: discipline: civil penalties.**
  - **Introduced:** 1/19/2022
  - **Status:** 6/30/2022-Read second time and amended. Re-referred to Com. on APPR.
  - **Summary:** Current law authorizes the Director of the Department of Managed Health Care to take disciplinary measures, including the imposition of civil penalties, against a licensee when the director determines that the licensee has committed an act or omission constituting grounds for disciplinary action, as specified. Under current law, a person who violates the act, or a rule or order adopted or issued under the act, is generally liable for a civil penalty not to exceed $2,500 per violation. Current law also includes various provisions that assess specific civil and administrative penalties for certain violations. Fines and penalties under the act are deposited into the Managed Care Administrative Fines and Penalties Fund, and used, upon appropriation by the Legislature, for designated purposes. This bill would increase the base amount of the civil penalty from $2,500 per violation to not more than $25,000 per violation, and would authorize a lower, proportionate penalty for specialized dental and vision health care service plans. Under the bill, the civil penalty base amount would be adjusted annually commencing January 1st, 2024, as specified.

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

- **SB 912 (Limon – D) Biomarker testing**
  - **Introduced:** 2/3/2022
  - **Status:** 6/22/2022-From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (June 21st). Re-referred to Com. on APPR.

- **Summary:** Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1st, 2023, to provide coverage for biomarker testing, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition if the test is supported by medical and scientific evidence, as prescribed. This bill would apply these provisions relating to biomarker testing to the Medi-Cal program, including Medi-Cal managed care plans, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

- **SB 923 (Wiener – D) Gender- affirming care**
  - **Introduced:** 1/25/2022
  - **Status:** 6/23/2022-Read second time and amended. Re-referred to Com. on APPR.
  - **Summary:** Would require a Medi-Cal managed care plan, a PACE organization, a health care service plan, or a health insurer, as specified, to require its staff to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for individuals who identify as transgender, gender diverse, or intersex (TGI). The bill would specify the required components of the training and would make use of any training curricula subject to approval by the respective departments. The bill would require an individual to complete a refresher course if a complaint has been filed, and a decision has been made in favor of the complainant, against that individual for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary.

- **SB 958 (Limon - D) Medication and Patient Safety Act of 2022**
  - **Introduced:** 2/09/2022
  - **Status:** 6/28/2022-June 28th set for first hearing canceled at the request of author.
  - **Summary:** Would prohibit a health care service plan or health insurer, or its designee, from requiring a vendor to dispense an infused or injected medication directly to a patient with the intent that the patient will transport the medication to a health care provider for administration. The bill would authorize a plan or insurer, or its designee, to arrange for an infused or injected medication to be administered in an enrollee's or insured's home when the treating health care provider and patient determine home administration is in the best interest of the patient. The bill would prohibit a plan or insurer, or its designee, from requiring an infused or injected medication to be supplied by a vendor specified by the plan or insurer, or its designee, as a condition of coverage, unless specified criteria are met.

- **SB 966 (Limon – D) Federally qualified health centers and rural health clinics**
  - **Introduced:** 2/09/2022
  - **Status:** 6/15/22 From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 13. Noes 0.) (June 14th). Re-referred to Com. on APPR.
  - **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. "Visit" is defined as a face-to-face encounter between an FQHC or RHC patient and any of specified health care professionals, including a physician, a licensed clinical social worker, or a marriage and family therapist. This bill would also include, within the definition of a visit, a face-to-face encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when supervised by a licensed behavioral health practitioner as required by the Board of Behavioral Sciences, as specified. The bill would make this provision operative 60 days after the termination of the national emergency declared on March 13th, 2020.

- **SB 974 (Portantino - D) Health care coverage: diagnostic imaging**
  - **Introduced:** 2/10/2022
  - **Status:** 6/29/2022-From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (June 28th). Re-referred to Com. on APPR.
  - **Summary:** Would require a health care service plan contract, an individual or group policy of disability insurance that provides hospital, medical, or surgical coverage, or a self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1st, 2023, to provide coverage without imposing cost sharing for screening mammography and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee or insured indicated to have a risk factor associated with breast cancer.

- **SB 987 (Portantino – D) California Cancer Care Equity Act**
  - **Introduced:** 2/14/2022
  - **Status:** 6/30/2022-Read second time and amended. Re-referred to Com. on APPR.
  - **Summary:** Would require a Medi-Cal managed care plan to make a good-faith effort to include in its contracted provider network at least one National Cancer Institute (NCI)-designated comprehensive cancer center, site affiliated with the NCI Community Oncology Research Program (NCORP), or qualifying academic cancer center, as defined, located within the beneficiary's county of residence or as otherwise specified, and ensure that any beneficiary diagnosed with a complex cancer diagnosis, as defined, is eligible to request a referral to any of those centers within 15 business days of the diagnosis, unless the beneficiary selects a different cancer treatment provider.

- **SB 1019 (Gonzalez – D) Medi-Ca managed care plans: mental health benefits**
  - **Introduced:** 2/14/2022
  - **Status:** 6/23/2022-Read second time and amended. Re-referred to Com. on APPR.
  - **Summary:** Would require a Medi-Cal managed care plan to conduct annual outreach and education for its enrollees, based on an annual plan that the Medi-Cal managed care plan develops and submits to the State Department of Health Care Services, regarding the mental health benefits that are covered by the Medi-Cal managed care plan, and to also develop an annual outreach and education plan to inform primary care providers regarding those mental health benefits.

- **SB 1033 (Pan – D) Health care coverage**
  - **Introduced:** 2/15/2022
  - **Status:** 6/29/2022-From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 2.) (June 28th). Re-referred to Com. on APPR.
  - **Summary:** Current law requires the Department of Managed Health Care and the commissioner to develop and adopt regulations establishing standards and requirements to provide enrollees and insureds with appropriate access to language assistance in obtaining health care services and covered benefits. Current law requires the Department of Managed Health Care and the Insurance Commissioner, in developing the regulations, to require health care service plans and health insurers to assess the linguistic needs of the enrollee and insured population, and to provide for translation and interpretation for medical services, as indicated. Current law requires the regulations to include, among other things, requirements for conducting assessments of the enrollees and insured groups. This bill would require the Department of Managed Health Care and the commissioner to revise these regulations and develop and adopt regulations establishing demographic data collection standards, no later than July 1st, 2024. The bill would require health care service plans and health insurers to assess the individual cultural, linguistic, and health-

related social needs of enrollees and insureds for the purpose of identifying and addressing health disparities, improving health care quality and outcomes, and addressing population health.

- **SB 1089 (Walk – R) Medi-Cal Eyeglasses: Prison Industry Authority**
  - **Introduced:** 1/24/2022
  - **Status:** 6/28/2022-From committee: Do pass and re-refer to Com. on APPR. (Ayes 7. Noes 0.) (June 28). Re-referred to Com. on APPR.
  - **Summary:** Would, for purposes of Medi-Cal reimbursement for covered optometric services, authorize a provider to obtain eyeglasses from a private entity, as an alternative to a purchase of eyeglasses from the Prison Industry Authority. The bill would condition implementation of this provision on the availability of federal financial participation.

- **SB 1180 (Pan – D) Medi-Cal: time and distance standards for managed care services**
  - **Introduced:** 2/17/2022
  - **Status:** 6/29/2022-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 15. Noes 0.) (June 28th). Re-referred to Com. on APPR.
  - **Summary:** Current law establishes, until January 1st, 2023, certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. This bill would extend the operation of those standards to January 1st, 2026, and would require the department to seek input from stakeholders, as specified, prior to January 1st, 2025, to determine what changes are needed to these provisions.

- **SB 1184 (Cortese - D) Confidentiality of Medical Information Act: school-linked services coordinators**
  - **Introduced:** 2/17/2022
  - **Status:** 6/30/2022-Read second time. Ordered to third reading.
  - **Summary:** The Confidentiality of Medical Information Act prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information, as defined, regarding a patient of the provider of health care or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as prescribed. The act authorizes a provider of health care or a health care service plan to disclose medical information in certain circumstances, including by authorizing disclosure to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient. This bill would additionally authorize a provider of health care or a health care service plan to disclose medical information to a school-linked services coordinator, as prescribed. The bill would define the term "school-linked services coordinator" as an individual located on a school campus or under contract by a county behavioral health provider agency for the treatment and health care operations and referrals of students and their families that holds any of certain credentials, including a services credential with a specialization in pupil personnel services, as specified.

- **SB 1207 (Portantino – D) Health care coverage: maternal and pandemic-related mental health conditions**
  - **Introduced:** 2/17/2022
  - **Status:** 6/22/2022-From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (June 21st). Re-referred to Com. on APPR.

- **Summary:** Current law requires health care service plans and health insurers to provide specified mental health and substance use disorder coverage, and requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1st, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. Current law requires health care service plans and health insurers, by July 1st, 2019, to develop, consistent with sound clinical principles and processes, a maternal mental health program designed to promote quality and cost-effective outcomes, as specified. This bill would make findings and declarations relating to the effect of the COVID-19 pandemic on mental health in California and the importance of outreach, education, and access to quality mental health treatment. The bill would extend the deadline for establishment of the maternal mental health program to July 1st, 2023.

- **SB 1298 (Ochoa Bogh - R) Behavioral Health Continuum Infrastructure Program**
  - **Introduced:** 2/18/2022
  - **Status:** 5/19/22 May 19th hearing: Held in committee and under submission.
  - **Summary:** Current law authorizes the State Department of Health Care Services to, subject to an appropriation, establish a Behavioral Health Continuum Infrastructure Program. Current law authorizes the department, pursuant to this program, to award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources to build or expand the capacity of various treatment and rehabilitation options for persons with behavioral health disorders, as specified. This bill would authorize the department, in awarding the above-described grants, to give preference to qualified entities that are intending to place their projects in specified facilities or properties.

- **SB 1361 (Kamlager - D) Prescription drugs: cost sharing: pharmacy benefit managers**
  - **Introduced:** 2/18/2022
  - **Status:** 5/20/2022-Failed Deadline pursuant to Rule 61(b)(8). (Last location was S. APPR. SUSPENSE FILE on 5/16/2022)
  - **Summary:** Current law provides for the regulation of health insurers by the Department of Insurance under the authority of the Insurance Commissioner. Current law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price. This bill, commencing no later than January 1st, 2024, would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would require a health care service plan or health insurer to, among other things, pass through to each enrollee or insured at the point of sale a good faith estimate of the enrollee's or insured's decrease in cost sharing. The bill would require a health care service plan or health insurer to calculate an enrollee's or insured's defined cost sharing and provide that information to the dispensing pharmacy, as specified.

- **SB 1379 (Ochoa Bogh - R) Pharmacy: remote services**
  - **Introduced:** 2/18/2022
  - **Status:** 4/29/2022 Failed Deadline pursuant to Rule 61(b)(5). (Last location was B., P. & E.D. on 3/9/2022)
  - **Summary:** The Controlled Substances Act regulates, among other matters, the dispensing by prescription of controlled substances, which are classified into schedules, and the Pharmacy Law regulates, among other matters, the dispensing by prescription of dangerous drugs and

dangerous devices, which also include controlled substances. Current law authorizes a prescriber, a prescriber's authorized agent, or a pharmacist to electronically enter a prescription or order from outside of a pharmacy or hospital, as specified, except for prescriptions for controlled substances classified in Schedules II, III, IV, or V. Under current law, a violation of these provisions is a crime. This bill would extend the authority to remotely enter a prescription or order to include prescriptions for controlled substances classified in Schedules II, III, IV, or V. The bill would also authorize a pharmacist to perform various services remotely, as specified, on behalf of a pharmacy located in California and under the written authorization of a pharmacist-in-charge.

Board Business

Finance

Gil Riojas

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: July 8th, 2022

Subject: Finance Report – May 2022

Executive Summary

- For the month ended May 31st, 2022, the Alliance had enrollment of 310,758 members, a Net Income of $5.2 million and 594% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$99,423	$1,090,424
Medical Expense	89,078	1,010,546
Admin. Expense	5,596	59,089
Other Inc. / (Exp.)	419	(446)
Net Income	**$5,168**	**$20,343**

Net Income by Program:

	Month	YTD
Medi-Cal	$4,636	$21,282
Group Care	531	(938)
	$5,168	**$20,343**

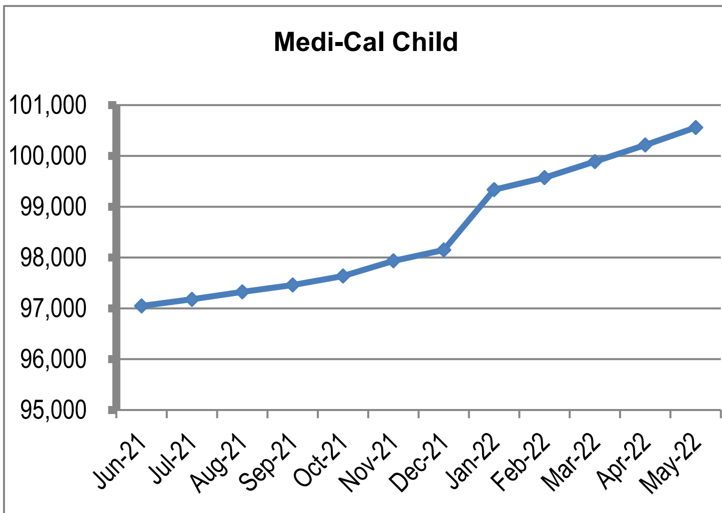
Enrollment

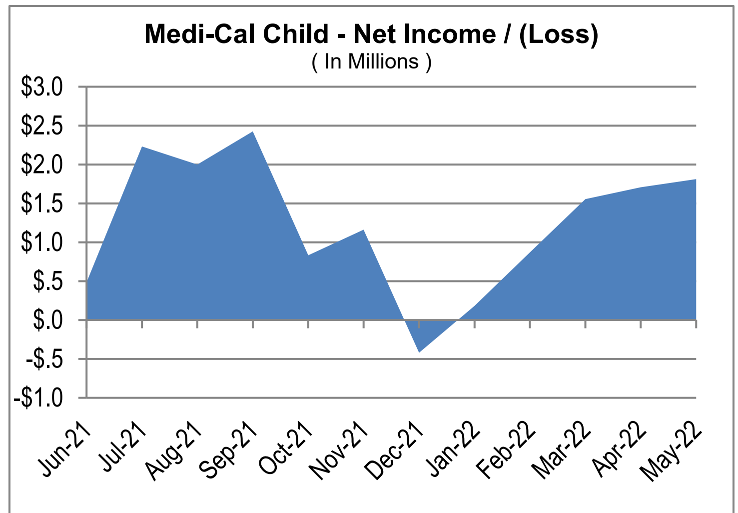
- Total enrollment increased by 2,017 members since April 2022.
- Total enrollment increased by 22,204 members since June 2021.
- Higher enrollment compared to Budget is due to the extension of the Public Health Emergency.

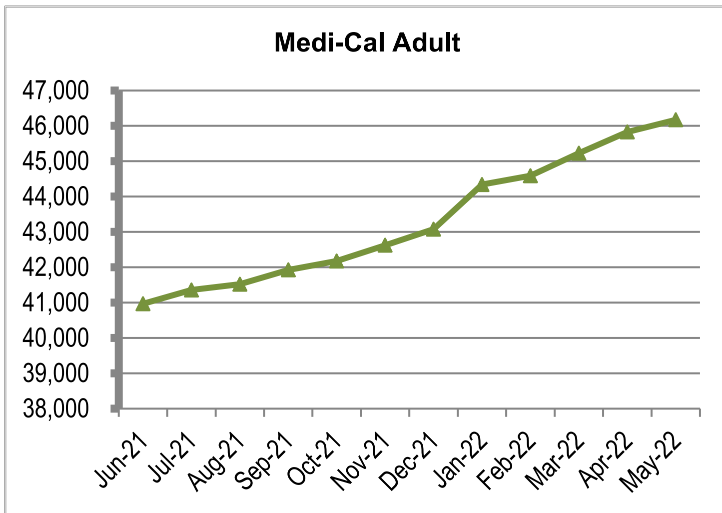
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

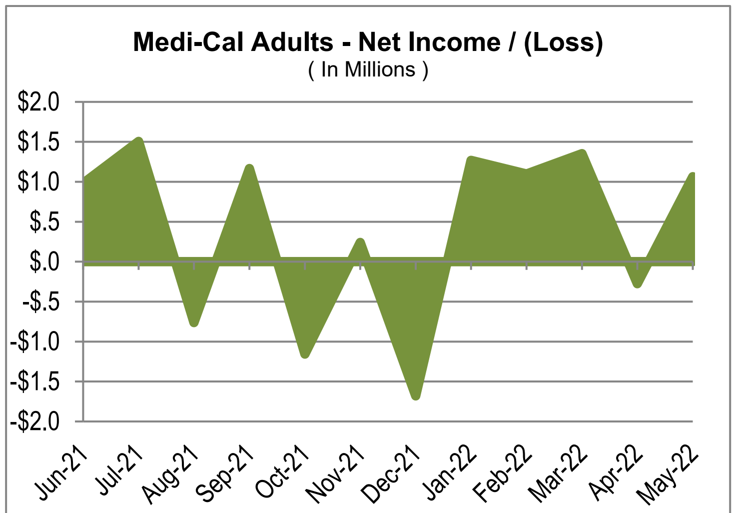
Enrollment					Member Months			
May-2022					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
46,171	41,482	4,689	11.3%	Adult	478,830	463,678	15,152	3.3%
100,560	95,743	4,817	5.0%	Child	1,085,258	1,073,725	11,533	1.1%
26,958	26,997	(39)	-0.1%	SPD	292,143	289,566	2,577	0.9%
21,527	19,976	1,551	7.8%	Duals	230,311	225,584	4,727	2.1%
109,734	104,404	5,330	5.1%	ACA OE	1,142,377	1,108,953	33,424	3.0%
304,950	**288,602**	**16,348**	**5.7%**	**Medi-Cal Total**	**3,228,919**	**3,161,506**	**67,413**	**2.1%**
5,808	5,852	(44)	-0.8%	Group Care	64,396	64,581	(185)	-0.3%
310,758	**294,454**	**16,304**	**5.5%**	**Total**	**3,293,315**	**3,226,087**	**67,228**	**2.1%**

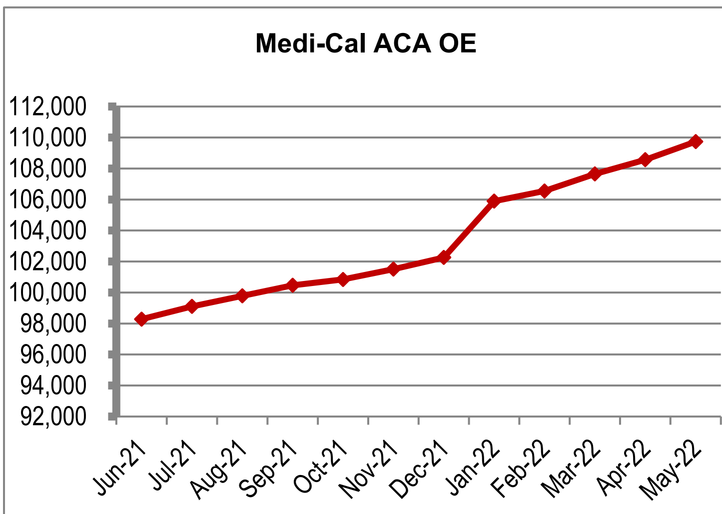
Enrollment and Profitability by Program and Category of Aid

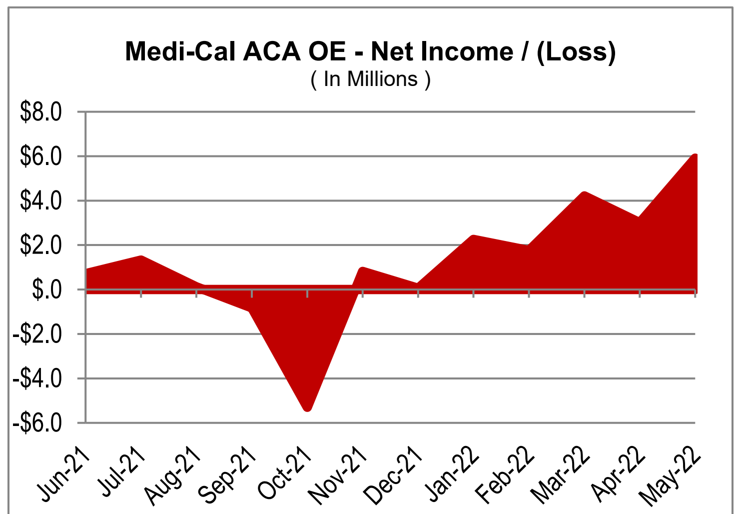




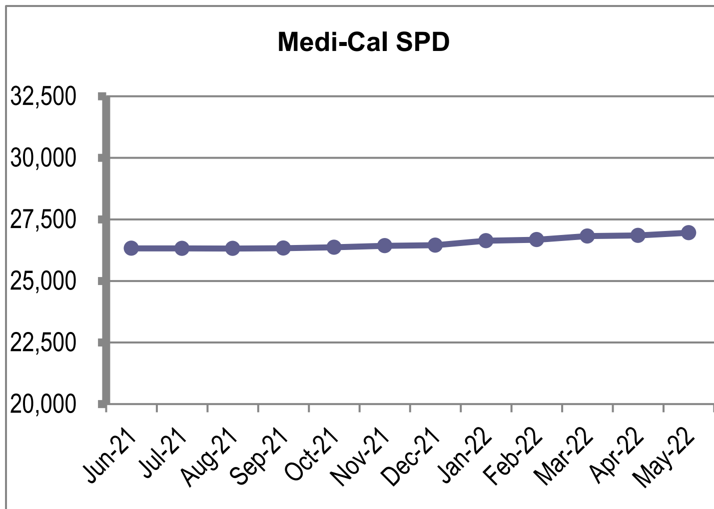


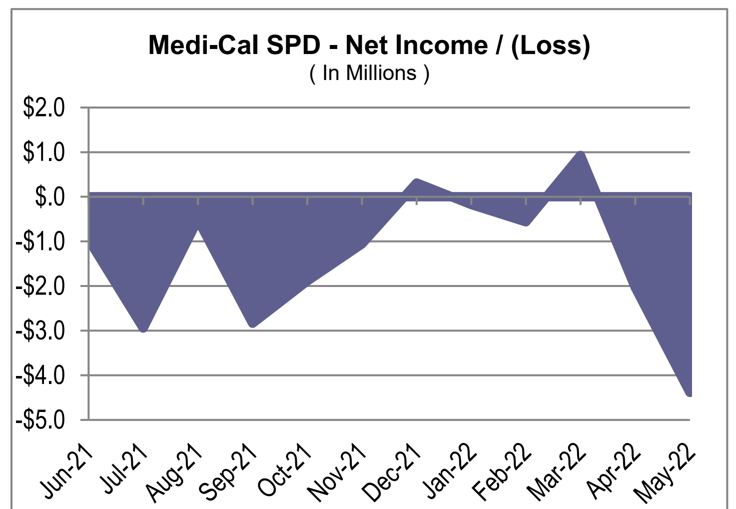


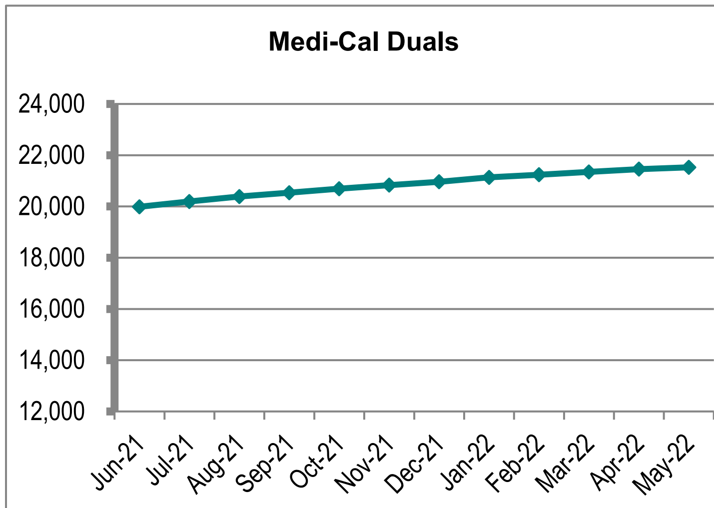


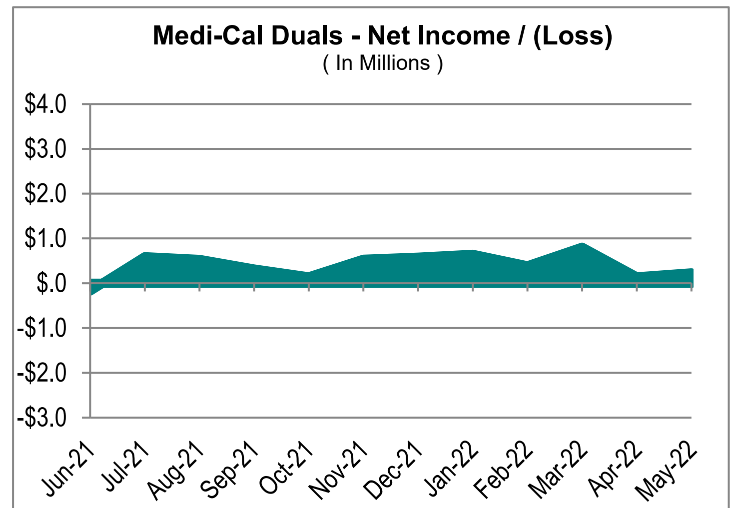


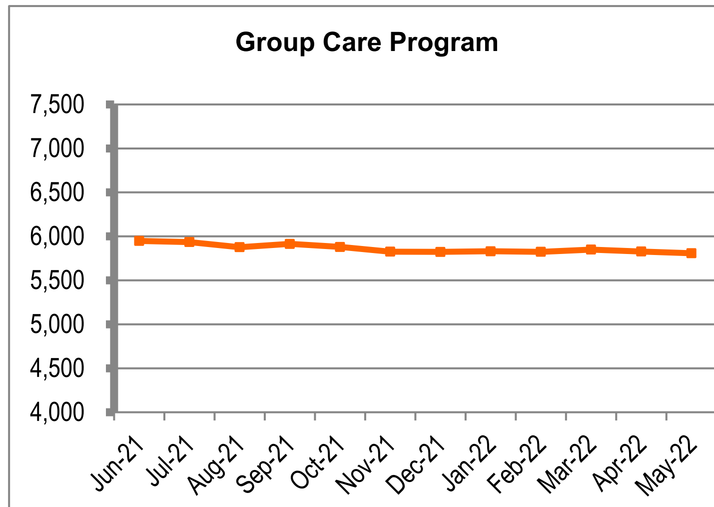
Enrollment and Profitability by Program and Category of Aid

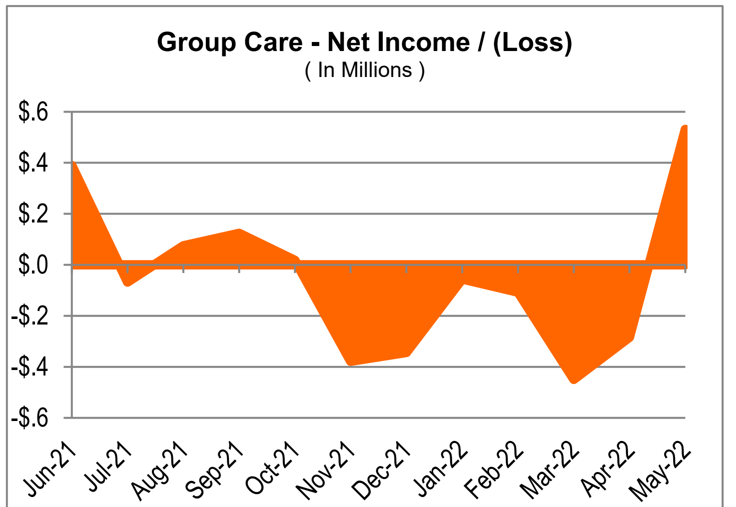




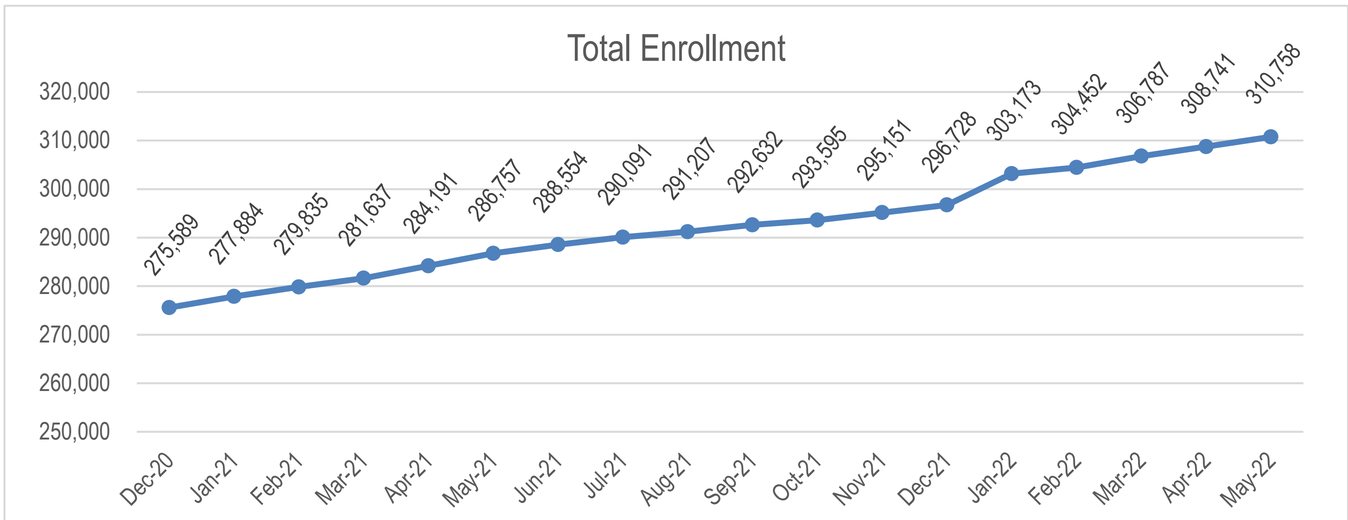


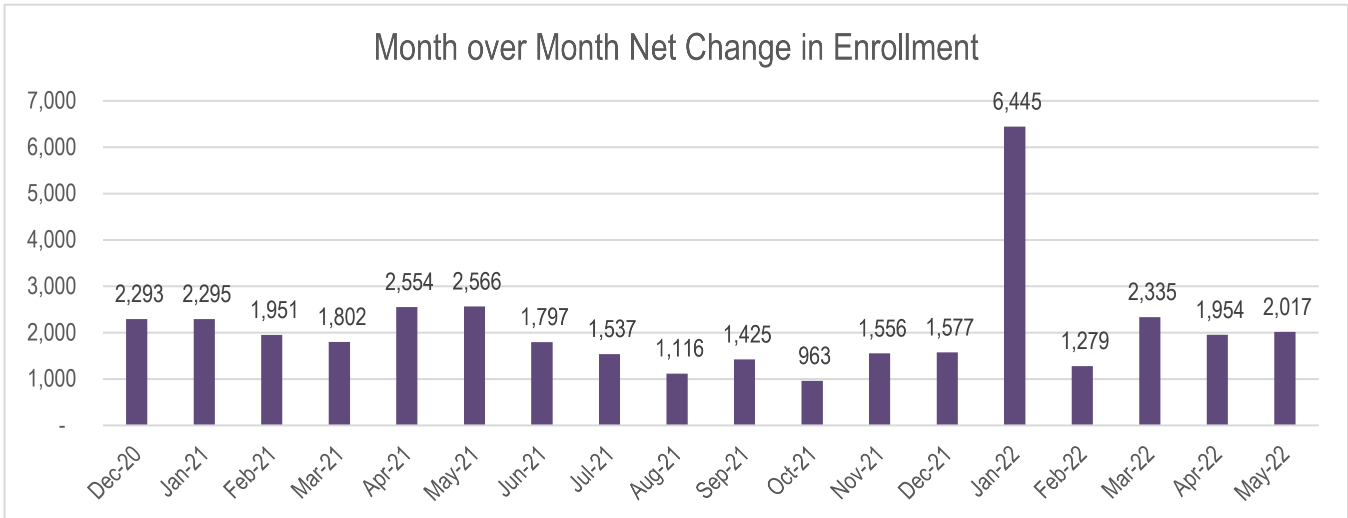






Net Change in Enrollment



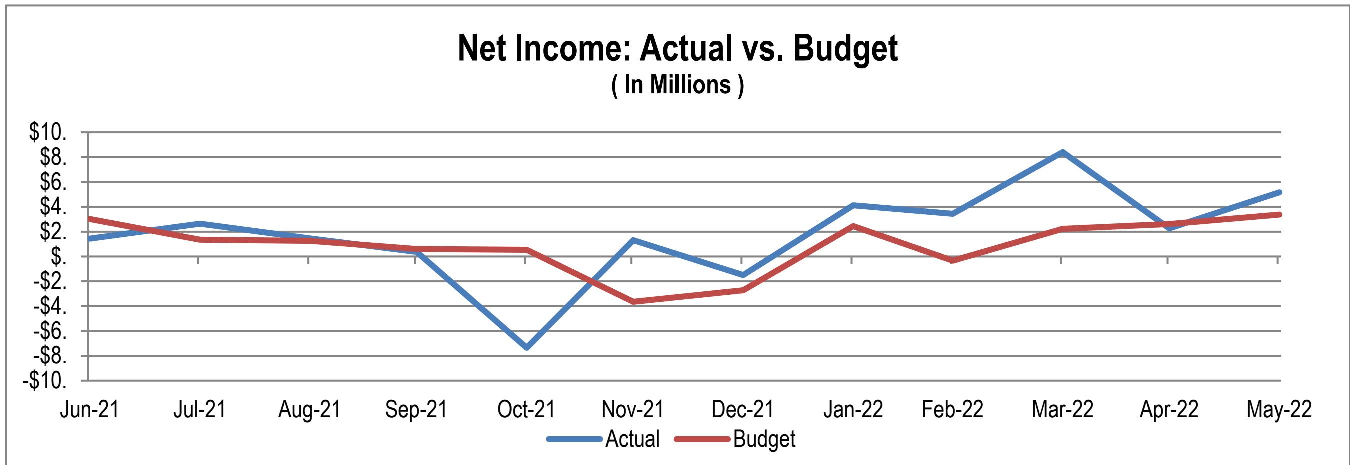


- Total monthly enrollment is projected to continue to increase for the rest of the Fiscal Year. The Public Health Emergency (PHE) is currently expected to be extended through October 2022.

Net Income

- For the month ended May 31st, 2022:
  - Actual Net Income: $5.2 million.
  - Budgeted Net Income: $3.4 million.

- For the fiscal YTD ended May 31st, 2022:
  - Actual Net Income: $20.3 million.
  - Budgeted Net Income: $1.1 million.

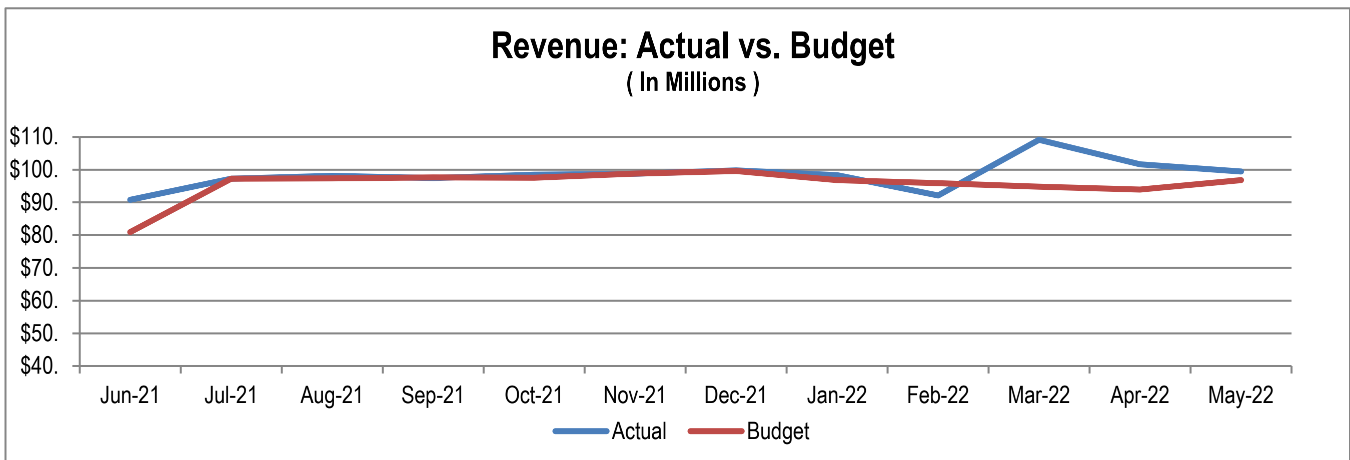


- The favorable variance of $1.8 million in the current month is primarily due to:
  - Favorable $2.6 million higher than anticipated Revenue.
  - Unfavorable $2.3 million higher than anticipated Medical Expense.
  - Favorable $1.1 million lower than anticipated Administrative Expense.
  - Favorable $410,000 higher than anticipated Total Other Income.

Revenue

- For the month ended May 31st, 2022:
  - Actual Revenue: $99.4 million.
  - Budgeted Revenue: $96.8 million.

- For the fiscal YTD ended May 31st, 2022:
  - Actual Revenue: $1.1 billion.
  - Budgeted Revenue: $1.1 billion.

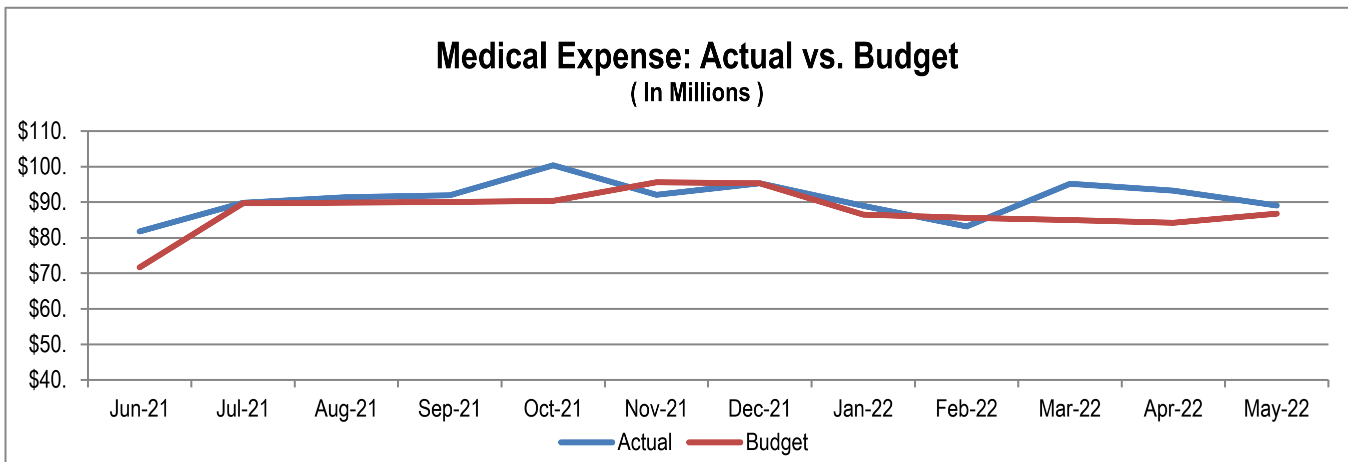


- For the month ended May 31st, 2022, the favorable revenue variance of $2.6 million is largely due to favorable $1.5 million CalAIM Incentive Revenue, favorable$470,000 Medi-Cal Base Capitation Revenue, and favorable $381,000 Student Behavioral Incentive Revenue, offset by unfavorable $378,000 Behavioral Health Supplemental Revenue. The favorable Medi-Cal Base Capitation Revenue variance of $470,000 is net of unfavorable $1.4 million DHCS recoupment resulting from Date of Death Audit.

Medical Expense

- For the month ended May 31st, 2022:
  - Actual Medical Expense: $89.1 million.
  - Budgeted Medical Expense: $86.8 million.

- For the fiscal YTD ended May 31st, 2022:
  - Actual Medical Expense: $1.0 billion.
  - Budgeted Medical Expense: $992.4 million.



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

- For May, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $750,000. The estimate for prior years increased by $5.1 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	$247,178,206	$0	$247,178,206	$245,087,516	($2,090,689)	-0.9%
Primary Care FFS	49,089,811	$33,609	$49,123,420	49,541,535	$451,724	0.9%
Specialty Care FFS	51,466,857	$223,741	$51,690,598	51,354,626	($112,230)	-0.2%
Outpatient FFS	90,618,739	$577,338	$91,196,077	91,753,241	$1,134,502	1.2%
Ancillary FFS	63,614,909	$255,590	$63,870,499	57,735,691	($5,879,218)	-10.2%
Pharmacy FFS	123,575,227	$1,604,716	$125,179,942	119,800,139	($3,775,087)	-3.2%
ER Services FFS	49,728,684	$259,035	$49,987,720	48,867,596	($861,088)	-1.8%
Inpatient Hospital & SNF FFS	306,797,176	$2,186,740	$308,983,916	303,430,035	($3,367,141)	-1.1%
Other Benefits & Services	23,707,443	$0	$23,707,443	23,970,067	$262,624	1.1%
Net Reinsurance	(371,378)	$0	($371,378)	907,339	$1,278,717	140.9%
	$1,005,405,673	**$5,140,769**	**$1,010,546,443**	**$992,447,786**	**($12,957,888)**	**-1.3%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

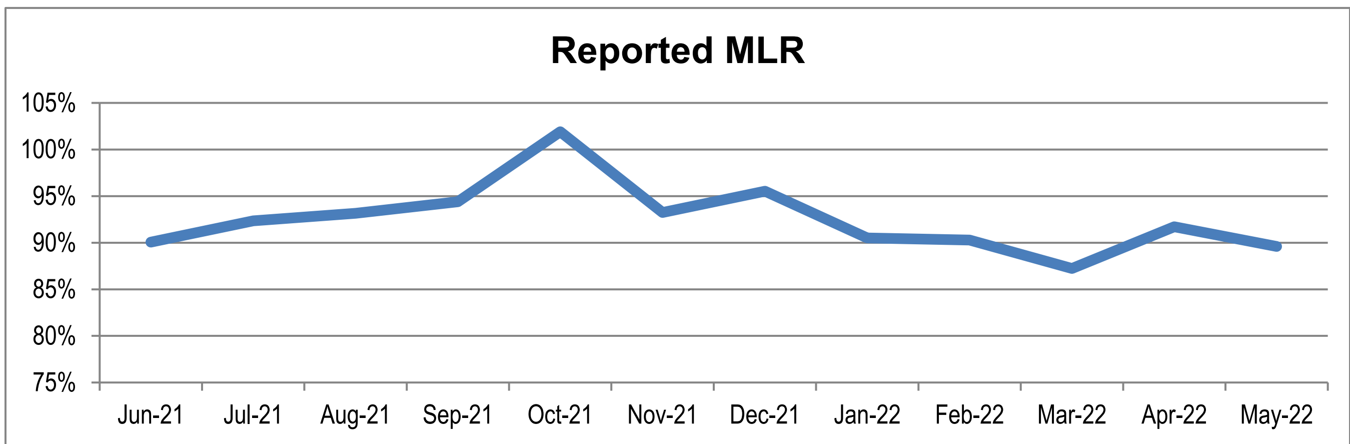
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$75.05	$0.00	$75.05	$75.97	$0.92	1.2%
Primary Care FFS	$14.91	$0.01	$14.92	$15.36	$0.45	2.9%
Specialty Care FFS	$15.63	$0.07	$15.70	$15.92	$0.29	1.8%
Outpatient FFS	$27.52	$0.18	$27.69	$28.44	$0.93	3.3%
Ancillary FFS	$19.32	$0.08	$19.39	$17.90	($1.42)	-7.9%
Pharmacy FFS	$37.52	$0.49	$38.01	$37.13	($0.39)	-1.0%
ER Services FFS	$15.10	$0.08	$15.18	$15.15	$0.05	0.3%
Inpatient Hospital & SNF FFS	$93.16	$0.66	$93.82	$94.06	$0.90	1.0%
Other Benefits & Services	$7.20	$0.00	$7.20	$7.43	$0.23	3.1%
Net Reinsurance	($0.11)	$0.00	($0.11)	$0.28	$0.39	140.1%
	$305.29	**$1.56**	**$306.85**	**$307.63**	**$2.35**	**0.8%**

- Excluding the effect of prior year estimates for IBNP, year-to-date medical expense variance is $13.0 million unfavorable to final budget, primarily due to higher enrollment. On a PMPM basis, medical expense is 0.8% favorable to budget. For per-member-per-month expense:
  - Capitated Expense overall is 1.2% under budget. Favorable Maternity Supplemental expense is partially offset by unfavorable global delegate expense and unfavorable BHT Supplemental Expense.

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

Medical Loss Ratio (MLR)

- The Medical Loss Ratio (total reported medical expense divided by operating revenue) was 89.6% for the month and 92.7% for the fiscal year-to-date.



Administrative Expense

- For the month ended May 31st, 2022:
  - Actual Administrative Expense: $5.6 million.
  - Budgeted Administrative Expense: $6.7 million.
- For the fiscal YTD ended May 31st, 2022:
  - Actual Administrative Expense: $59.1 million.
  - Budgeted Administrative Expense: $74.5 million.

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

Month					Year-to-Date			
Actual	**Budget**	**Variance $**	**Variance %**		**Actual**	**Budget**	**Variance $**	**Variance %**
$3,189,364	$3,653,516	$464,152	12.7%	Employee Expense	$33,305,779	$37,008,817	$3,703,038	10.0%
318,368	314,569	(3,799)	-1.2%	Medical Benefits Admin Expense	5,605,178	5,608,154	2,976	0.1%
997,818	1,523,211	525,393	34.5%	Purchased & Professional Services	8,056,852	14,577,970	6,521,118	44.7%
1,089,991	1,198,888	108,897	9.1%	Other Admin Expense	12,120,798	17,309,743	5,188,945	30.0%
$5,595,540	$6,690,184	$1,094,643	16.4%	Total Administrative Expense	$59,088,605	$74,504,684	$15,416,077	20.7%

The year-to-date variances include:

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

Administrative loss ratio (ALR) represented 5.6% of net revenue for the month and 5.4% of net revenue year-to-date.

Other Income / (Expense)

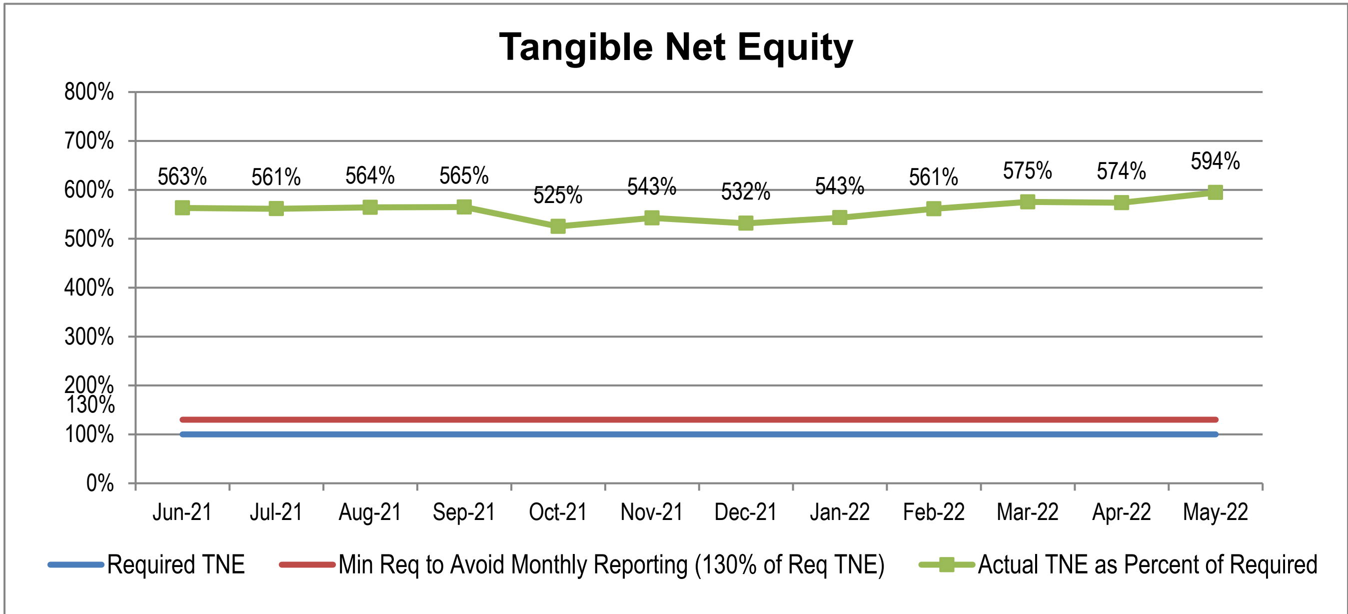
Other Income & Expense is comprised of investment income and claims interest.

- Fiscal year-to-date net investment revenue is $82,000 loss.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $363,000.

Tangible Net Equity (TNE)

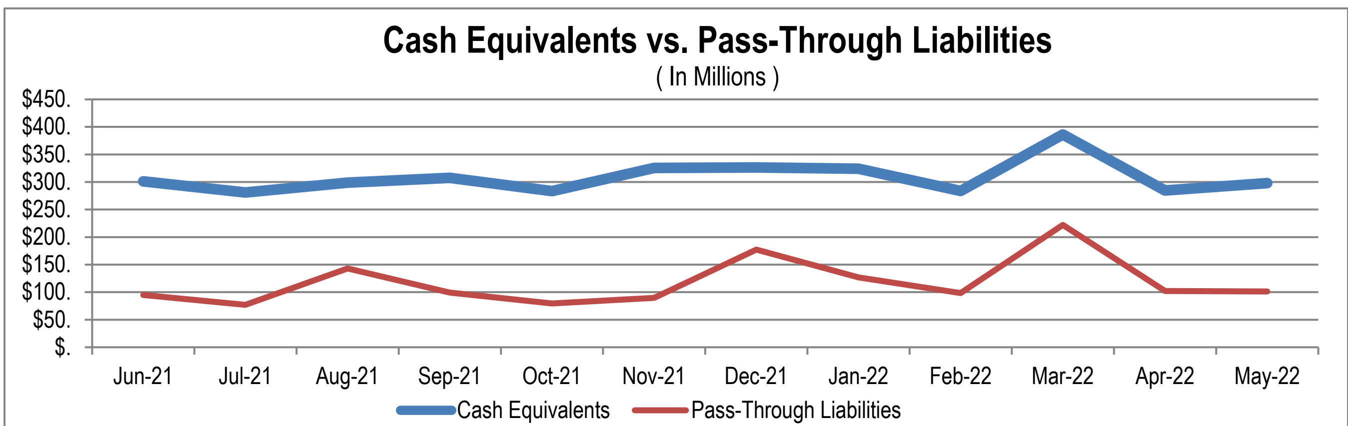
- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to consumers. TNE is a calculation of a company's total tangible assets minus the company's total liabilities. The Alliance exceeds DMHC's required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

- Required TNE $38.0 million
- Actual TNE $225.8 million
- Excess TNE $187.8 million
- TNE % of Required TNE 594%



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

- Key Metrics
  - Cash & Cash Equivalents $297.9 million
  - Pass-Through Liabilities $101.2million
  - Uncommitted Cash $196.7 million
  - Working Capital $184.4 million
  - Current Ratio 1.72 (regulatory minimum is 1.0)



Capital Investment

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

Caveats to Financial Statements

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

Finance

Supporting Documents

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
304,950	288,602	16,348	5.7%	1 - Medi-Cal	3,228,919	3,161,506	67,413	2.1%
5,808	5,852	(44)	(0.8%)	2 - Group Care	64,396	64,581	(185)	(0.3%)
310,758	**294,454**	**16,304**	**5.5%**	**3 - Total Member Months**	**3,293,315**	**3,226,087**	**67,228**	**2.1%**
				REVENUE				
$99,422,627	**$96,819,038**	**$2,603,589**	**2.7%**	**4 - TOTAL REVENUE**	**$1,090,424,168**	**$1,067,961,713**	**$22,462,455**	**2.1%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
23,014,289	22,343,843	(670,446)	(3.0%)	5 - Capitated Medical Expense	247,178,206	245,087,534	(2,090,672)	(0.9%)
				Fee for Service Medical Expenses:				
29,251,679	28,300,659	(951,020)	(3.4%)	6 - Inpatient Hospital & SNF FFS Expense	308,983,916	303,430,038	(5,553,878)	(1.8%)
4,556,681	4,594,759	38,078	0.8%	7 - Primary Care Physician FFS Expense	49,123,420	49,541,531	418,111	0.8%
4,693,649	4,755,058	61,409	1.3%	8 - Specialty Care Physician Expense	51,690,598	51,354,627	(335,971)	(0.7%)
6,775,650	6,451,702	(323,949)	(5.0%)	9 - Ancillary Medical Expense	63,870,499	57,735,689	(6,134,810)	(10.6%)
8,625,535	8,276,250	(349,285)	(4.2%)	10 - Outpatient Medical Expense	91,196,077	91,753,239	557,162	0.6%
4,420,205	4,379,328	(40,877)	(0.9%)	11 - Emergency Expense	49,987,720	48,867,597	(1,120,123)	(2.3%)
5,046,141	5,268,456	222,315	4.2%	12 - Pharmacy Expense	125,179,942	119,800,147	(5,379,795)	(4.5%)
63,369,540	62,026,212	(1,343,329)	(2.2%)	13 - Total Fee for Service Expense	740,032,173	722,482,868	(17,549,304)	(2.4%)
2,543,652	2,255,581	(288,071)	(12.8%)	14 - Other Benefits & Services	23,707,443	23,970,051	262,609	1.1%
150,912	138,158	(12,754)	(9.2%)	15 - Reinsurance Expense	(371,378)	907,339	1,278,717	140.9%
89,078,393	**86,763,794**	**(2,314,599)**	**(2.7%)**	**17 - TOTAL MEDICAL EXPENSES**	**1,010,546,443**	**992,447,793**	**(18,098,650)**	**(1.8%)**
10,344,234	**10,055,244**	**288,990**	**2.9%**	**18 - GROSS MARGIN**	**79,877,725**	**75,513,920**	**4,363,805**	**5.8%**
				ADMINISTRATIVE EXPENSES				
3,189,362	3,653,516	464,154	12.7%	19 - Personnel Expense	33,305,779	37,008,817	3,703,038	10.0%
318,368	314,569	(3,799)	(1.2%)	20 - Benefits Administration Expense	5,605,178	5,608,154	2,976	0.1%
997,817	1,523,211	525,394	34.5%	21 - Purchased & Professional Services	8,056,852	14,577,970	6,521,117	44.7%
1,089,993	1,198,888	108,895	9.1%	22 - Other Administrative Expense	12,120,797	17,309,743	5,188,946	30.0%
5,595,540	**6,690,184**	**1,094,644**	**16.4%**	**23 -Total Administrative Expense**	**59,088,607**	**74,504,684**	**15,416,077**	**20.7%**
4,748,694	**3,365,060**	**1,383,634**	**41.1%**	**24 - NET OPERATING INCOME / (LOSS)**	**20,789,119**	**1,009,237**	**19,779,882**	**1,959.9%**
				OTHER INCOME / EXPENSE				
418,813	**8,751**	**410,062**	**4,685.9%**	**25 - Total Other Income / (Expense)**	**(445,701)**	**58,942**	**(504,643)**	**(856.2%)**
$5,167,507	**$3,373,811**	**$1,793,696**	**53.2%**	**26 - NET INCOME / (LOSS)**	**$20,343,418**	**$1,068,179**	**$19,275,239**	**1,804.5%**
5.6%	6.9%	1.3%	18.6%	27 - Admin Exp % of Revenue	5.4%	7.0%	1.6%	22.3%

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

	May	April	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$35,616,120	$33,854,888	$1,761,232	5.20%
Short-Term Investments	262,319,385	250,838,515	11,480,870	4.58%
Interest Receivable	275,251	263,865	11,386	4.31%
Other Receivables - Net	136,544,658	137,909,180	(1,364,521)	-0.99%
Prepaid Expenses	4,617,782	5,248,674	(630,892)	-12.02%
Prepaid Inventoried Items	24,200	29,325	(5,125)	-17.48%
CalPERS Net Pension Asset	(1,665,176)	(1,665,176)	0	0.00%
Deferred CalPERS Outflow	4,501,849	4,501,849	0	0.00%
TOTAL CURRENT ASSETS	**442,234,069**	**430,981,119**	**11,252,949**	**2.61%**
OTHER ASSETS:				
Long-Term Investments	35,383,898	37,634,132	(2,250,234)	-5.98%
Restricted Assets	350,000	350,000	0	0.00%
TOTAL OTHER ASSETS	**35,733,898**	**37,984,132**	**(2,250,234)**	**-5.92%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	9,626,797	9,626,797	0	0.00%
Furniture And Equipment	11,540,223	11,540,223	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Construction in Process	275,666	275,666	0	0.00%
Internally-Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	37,169,134	37,169,134	0	0.00%
Less: Accumulated Depreciation	(31,549,532)	(31,483,040)	(66,491)	0.21%
NET PROPERTY AND EQUIPMENT	**5,619,602**	**5,686,094**	**(66,491)**	**-1.17%**
TOTAL ASSETS	**$483,587,569**	**$474,651,345**	**$8,936,224**	**1.88%**
CURRENT LIABILITIES:				
Accounts Payable	$1,822,944	$1,782,148	$40,795	2.29%
Pass-Through Liabilities	101,166,651	102,056,923	(890,272)	-0.87%
Claims Payable	21,722,991	23,348,554	(1,625,563)	-6.96%
IBNP Reserves	116,135,862	111,998,329	4,137,533	3.69%
Payroll Liabilities	6,303,657	5,657,433	646,224	11.42%
CalPERS Deferred Inflow	859,093	859,093	0	0.00%
Risk Sharing	8,124,932	8,124,932	0	0.00%
Provider Grants/ New Health Program	237,981	237,981	0	0.00%
Deferred Revenue	1,460,000	0	1,460,000	0.00%
TOTAL CURRENT LIABILITIES	**257,834,109**	**254,065,392**	**3,768,717**	**1.48%**
TOTAL LIABILITIES	**257,834,109**	**254,065,392**	**3,768,717**	**1.48%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	204,569,809	204,569,809	0	0.00%
Year-to Date Net Income / (Loss)	20,343,418	15,175,911	5,167,507	34.05%
TOTAL NET WORTH	**225,753,460**	**220,585,953**	**5,167,507**	**2.34%**
TOTAL LIABILITIES AND NET WORTH	**$483,587,569**	**$474,651,345**	**$8,936,224**	**1.88%**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,197,861	$6,566,149	$13,097,761	$24,141,358
Total	2,197,861	6,566,149	13,097,761	24,141,358
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	97,224,327	303,529,011	586,451,514	1,064,075,320
Allowance for Doubtful Accounts	0	0	0	0
Deferred Premium Revenue	1,460,000	1,460,000	1,460,000	1,460,000
Premium Receivable	1,777,331	(6,210,206)	(34,146,055)	(8,012,465)
Total	100,461,658	298,778,805	553,765,459	1,057,522,855
Investment & Other Income Cash Flows				
Other Revenue (Grants)	(29,962)	(2,799)	708,376	2,060,844
Interest Income	475,754	(22,683)	(75,578)	64,309
Interest Receivable	(11,386)	(1,898)	(255,843)	(265,680)
Total	434,406	(27,380)	376,955	1,859,473
Medical & Hospital Cash Flows				
Total Medical Expenses	(89,078,389)	(277,492,945)	(544,946,835)	(1,010,546,444)
Other Receivable	(412,810)	1,307,396	614,501	7,862,459
Claims Payable	(1,625,563)	5,556,620	2,048,742	(11,741,280)
IBNP Payable	4,137,533	(817,887)	4,265,404	17,495,304
Risk Share Payable	0	0	0	(2,224,917)
Health Program	0	(32,077)	(91,636)	(213,162)
Other Liabilities	0	0	0	0
Total	(86,979,229)	(271,478,893)	(538,109,824)	(999,368,040)
Administrative Cash Flows				
Total Administrative Expenses	(5,622,080)	(16,737,559)	(33,326,660)	(59,451,974)
Prepaid Expenses	636,017	791,827	1,002,864	1,532,144
CalPERS Pension Asset	0	0	0	0
CalPERS Deferred Outflow	0	0	0	0
Trade Accounts Payable	40,795	(1,151,198)	(1,822,197)	(2,476,196)
Other Accrued Liabilities	0	0	0	0
Payroll Liabilities	646,226	1,053,487	1,117,504	1,537,390
Depreciation Expense	66,491	202,002	433,066	886,191
Total	(4,232,551)	(15,841,441)	(32,595,423)	(57,972,445)
Interest Paid				
Debt Interest Expense	0	0	0	0
Total Cash Flows from Operating Activities	**11,882,145**	**17,997,240**	**(3,465,072)**	**26,183,201**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	2,250,234	(6,643,201)	(35,383,898)	(35,383,898)
	2,250,234	(6,643,201)	(35,383,898)	(35,383,898)
Restricted Cash & Other Asset Cash Flows				
Provider Pass-Thru-Liabilities	(890,270)	2,912,899	11,378,603	6,334,115
Restricted Cash	0	0	0	0
	(890,270)	2,912,899	11,378,603	6,334,115
Fixed Asset Cash Flows				
Depreciation expense	66,491	202,002	433,066	886,191
Fixed Asset Acquisitions	0	0	(121,291)	(233,657)
Change in A/D	(66,491)	(202,002)	(433,066)	(886,191)
	0	0	(121,291)	(233,657)
Total Cash Flows from Investing Activities	**1,359,964**	**(3,730,302)**	**(24,126,586)**	**(29,283,440)**
Financing Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Total Cash Flows	**13,242,109**	**14,266,938**	**(27,591,658)**	**(3,100,239)**
Rounding	(8)	3	10	7
Cash @ Beginning of Period	284,693,404	283,668,564	325,527,153	301,035,737
Cash @ End of Period	**$297,935,505**	**$297,935,505**	**$297,935,505**	**$297,935,505**
Difference (rounding)	0	0	0	0

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$5,167,502	$15,839,175	$21,908,594	$20,343,420
Add back: Depreciation	66,491	202,002	433,066	886,191
Receivables				
Premiums Receivable	1,777,331	(6,210,206)	(34,146,055)	(8,012,465)
First Care Receivable	0	0	0	0
Family Care Receivable	0	0	0	0
Healthy Kids Receivable	0	0	0	0
Interest Receivable	(11,386)	(1,898)	(255,843)	(265,680)
Other Receivable	(412,810)	1,307,396	614,501	7,862,459
FQHC Receivable	0	0	0	0
Allowance for Doubtful Accounts	0	0	0	0
Total	1,353,135	(4,904,708)	(33,787,397)	(415,686)
Prepaid Expenses	636,017	791,827	1,002,864	1,532,144
Trade Payables	40,795	(1,151,198)	(1,822,197)	(2,476,196)
Claims Payable, IBNR & Risk Share				
IBNP	4,137,533	(817,887)	4,265,404	17,495,304
Claims Payable	(1,625,563)	5,556,620	2,048,742	(11,741,280)
Risk Share Payable	0	0	0	(2,224,917)
Other Liabilities	0	0	0	0
Total	2,511,970	4,738,733	6,314,146	3,529,107
Unearned Revenue				
Total	1,460,000	1,460,000	1,460,000	1,460,000
Other Liabilities				
Accrued Expenses	0	0	0	0
Payroll Liabilities	646,226	1,053,487	1,117,504	1,537,390
Health Program	0	(32,077)	(91,636)	(213,162)
Accrued Sub Debt Interest	0	0	0	0
Total Change in Other Liabilities	646,226	1,021,410	1,025,868	1,324,228
Cash Flows from Operating Activities	**$11,882,136**	**$17,997,241**	**($3,465,056)**	**$26,183,208**
Difference (rounding)	(9)	1	16	7

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 5/31/2022

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received From:				
Capitation Received from State of CA	$100,461,658	$298,778,805	$553,765,459	$1,057,522,855
Commercial Premium Revenue	2,197,861	6,566,149	13,097,761	24,141,358
Other Income	(29,962)	(2,799)	708,376	2,060,844
Investment Income	464,368	(24,581)	(331,421)	(201,371)
Cash Paid To:				
Medical Expenses	(86,979,229)	(271,478,893)	(538,109,824)	(999,368,040)
Vendor & Employee Expenses	(4,232,551)	(15,841,441)	(32,595,423)	(57,972,445)
Interest Paid	0	0	0	0
Net Cash Provided By (Used In) Operating Activities	11,882,145	17,997,240	(3,465,072)	26,183,201
Cash Flows from Financing Activities:				
Purchases of Fixed Assets	0	0	(121,291)	(233,657)
Net Cash Provided By (Used In) Financing Activities	0	0	(121,291)	(233,657)
Cash Flows from Investing Activities:				
Changes in Investments	2,250,234	(6,643,201)	(35,383,898)	(35,383,898)
Restricted Cash	(890,270)	2,912,899	11,378,603	6,334,115
Net Cash Provided By (Used In) Investing Activities	1,359,964	(3,730,302)	(24,005,295)	(29,049,783)
Financial Cash Flows				
Subordinated Debt Proceeds	0	0	0	0
Net Change in Cash	**13,242,109**	**14,266,938**	**(27,591,658)**	**(3,100,239)**
Cash @ Beginning of Period	284,693,404	283,668,564	325,527,153	301,035,737
Subtotal	$297,935,513	$297,935,502	$297,935,495	$297,935,498
Rounding	(8)	3	10	7
Cash @ End of Period	**$297,935,505**	**$297,935,505**	**$297,935,505**	**$297,935,505**
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$5,167,502	$15,839,175	$21,908,594	$20,343,420
Depreciation	66,491	202,002	433,066	886,191
Net Change in Operating Assets & Liabilities:				
Premium & Other Receivables	1,353,135	(4,904,708)	(33,787,397)	(415,686)
Prepaid Expenses	636,017	791,827	1,002,864	1,532,144
Trade Payables	40,795	(1,151,198)	(1,822,197)	(2,476,196)
Claims payable & IBNP	2,511,970	4,738,733	6,314,146	3,529,107
Deferred Revenue	1,460,000	1,460,000	1,460,000	1,460,000
Accrued Interest	0	0	0	0
Other Liabilities	646,226	1,021,410	1,025,868	1,324,228
Subtotal	11,882,136	17,997,241	(3,465,056)	26,183,208
Rounding	9	(1)	(16)	(7)
Cash Flows from Operating Activities	**$11,882,145**	**$17,997,240**	**($3,465,072)**	**$26,183,201**
Rounding Difference	9	(1)	(16)	(7)

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF MAY 2022

	Child	Adult	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Enrollment	100,560	46,171	26,958	109,734	21,527	304,950	5,808	310,758
Net Revenue	$12,739,879	$14,987,823	$25,446,544	$39,855,094	$4,183,649	$97,212,988	$2,209,639	$99,422,627
Medical Expense	$10,504,226	$13,225,102	$28,023,968	$32,054,524	$3,780,117	$87,587,935	$1,490,458	$89,078,393
Gross Margin	$2,235,653	$1,762,721	($2,577,424)	$7,800,570	$403,532	$9,625,052	$719,181	$10,344,234
Administrative Expense	$454,610	$757,260	$1,955,899	$2,047,448	$178,457	$5,393,675	$201,865	$5,595,540
Operating Income / (Expense)	$1,781,042	$1,005,461	($4,533,323)	$5,753,123	$225,074	$4,231,378	$517,316	$4,748,694
Other Income / (Expense)	$30,339	$59,156	$149,441	$159,161	$6,975	$405,073	$13,740	$418,813
Net Income / (Loss)	$1,811,382	$1,064,618	($4,383,882)	$5,912,284	$232,050	$4,636,451	$531,056	$5,167,507
Revenue PMPM	$126.69	$324.62	$943.93	$363.20	$194.34	$318.78	$380.45	$319.94
Medical Expense PMPM	$104.46	$286.44	$1,039.54	$292.11	$175.60	$287.22	$256.62	$286.65
Gross Margin PMPM	$22.23	$38.18	($95.61)	$71.09	$18.75	$31.56	$123.83	$33.29
Administrative Expense PMPM	$4.52	$16.40	$72.55	$18.66	$8.29	$17.69	$34.76	$18.01
Operating Income / (Expense) PMPM	$17.71	$21.78	($168.16)	$52.43	$10.46	$13.88	$89.07	$15.28
Other Income / (Expense) PMPM	$0.30	$1.28	$5.54	$1.45	$0.32	$1.33	$2.37	$1.35
Net Income / (Loss) PMPM	$18.01	$23.06	($162.62)	$53.88	$10.78	$15.20	$91.44	$16.63
Medical Loss Ratio	82.5%	88.2%	110.1%	80.4%	90.4%	90.1%	67.5%	89.6%
Gross Margin Ratio	17.5%	11.8%	-10.1%	19.6%	9.6%	9.9%	32.5%	10.4%
Administrative Expense Ratio	3.6%	5.1%	7.7%	5.1%	4.3%	5.5%	9.1%	5.6%
Net Income Ratio	14.2%	7.1%	-17.2%	14.8%	5.5%	4.8%	24.0%	5.2%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE - MAY 2022

	Child	Adult	Medi-Cal SPD	ACA OE	Duals	Medi-Cal Total	Group Care	Grand Total
Member Months	1,085,258	478,830	292,143	1,142,377	230,311	3,228,919	64,396	3,293,315
Net Revenue	$138,825,092	$157,877,898	$300,761,800	$426,476,933	$42,328,088	$1,066,269,812	$24,154,357	$1,090,424,168
Medical Expense	$119,604,288	$145,962,467	$295,096,798	$391,305,774	$35,510,820	$987,480,147	$23,066,296	$1,010,546,443
Gross Margin	$19,220,804	$11,915,431	$5,665,002	$35,171,159	$6,817,268	$78,789,664	$1,088,061	$79,877,725
Administrative Expense	$4,838,008	$8,011,132	$20,657,473	$21,671,490	$1,894,947	$57,073,050	$2,015,557	$59,088,607
Operating Income / (Expense)	$14,382,796	$3,904,299	($14,992,471)	$13,499,669	$4,922,321	$21,716,614	($927,496)	$20,789,119
Other Income / (Expense)	($24,436)	($82,216)	($149,096)	($158,620)	($20,563)	($434,931)	($10,770)	($445,701)
Net Income / (Loss)	$14,358,360	$3,822,084	($15,141,567)	$13,341,049	$4,901,758	$21,281,684	($938,266)	$20,343,418
Revenue PMPM	$127.92	$329.72	$1,029.50	$373.32	$183.79	$330.23	$375.09	$331.10
Medical Expense PMPM	$110.21	$304.83	$1,010.11	$342.54	$154.19	$305.82	$358.19	$306.85
Gross Margin PMPM	$17.71	$24.88	$19.39	$30.79	$29.60	$24.40	$16.90	$24.25
Administrative Expense PMPM	$4.46	$16.73	$70.71	$18.97	$8.23	$17.68	$31.30	$17.94
Operating Income / (Expense) PMPM	$13.25	$8.15	($51.32)	$11.82	$21.37	$6.73	($14.40)	$6.31
Other Income / (Expense) PMPM	($0.02)	($0.17)	($0.51)	($0.14)	($0.09)	($0.13)	($0.17)	($0.14)
Net Income / (Loss) PMPM	$13.23	$7.98	($51.83)	$11.68	$21.28	$6.59	($14.57)	$6.18
Medical Loss Ratio	86.2%	92.5%	98.1%	91.8%	83.9%	92.6%	95.5%	92.7%
Gross Margin Ratio	13.8%	7.5%	1.9%	8.2%	16.1%	7.4%	4.5%	7.3%
Administrative Expense Ratio	3.5%	5.1%	6.9%	5.1%	4.5%	5.4%	8.3%	5.4%
Net Income Ratio	10.3%	2.4%	-5.0%	3.1%	11.6%	2.0%	-3.9%	1.9%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$3,189,362	$3,653,516	$464,154	12.7%	Personnel Expenses	$33,305,779	$37,008,817	$3,703,038	10.0%
318,368	314,569	(3,799)	(1.2%)	Benefits Administration Expense	5,605,178	5,608,154	2,976	0.1%
997,817	1,523,211	525,394	34.5%	Purchased & Professional Services	8,056,852	14,577,970	6,521,117	44.7%
247,580	272,901	25,321	9.3%	Occupancy	2,804,077	3,032,570	228,493	7.5%
333,838	228,996	(104,842)	(45.8%)	Printing Postage & Promotion	2,188,028	2,392,359	204,331	8.5%
495,423	666,985	171,562	25.7%	Licenses Insurance & Fees	5,502,011	7,005,052	1,503,041	21.5%
13,152	30,006	16,854	56.2%	Supplies & Other Expenses	1,626,681	4,879,762	3,253,081	66.7%
2,406,178	3,036,668	630,490	20.8%	Total Other Administrative Expense	25,782,828	37,495,867	11,713,039	31.2%
$5,595,540	**$6,690,184**	**$1,094,644**	**16.4%**	**Total Administrative Expenses**	**$59,088,607**	**$74,504,684**	**$15,416,077**	**20.7%**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
$2,155,648	$2,227,437	$71,789	3.2%	Salaries & Wages	$22,104,128	$22,865,691	$761,563	3.3%
212,872	246,124	33,252	13.5%	Paid Time Off	2,256,015	2,489,444	233,429	9.4%
1,450	3,645	2,195	60.2%	Incentives	20,608	30,338	9,730	32.1%
0	25,000	25,000	100.0%	Severance Pay	0	175,000	175,000	100.0%
34,176	36,489	2,313	6.3%	Payroll Taxes	435,237	557,679	122,442	22.0%
19,556	15,418	(4,138)	(26.8%)	Overtime	293,053	261,912	(31,141)	(11.9%)
179,221	189,003	9,782	5.2%	CalPERS ER Match	1,758,553	1,880,692	122,139	6.5%
0	0	0	0.0%	Mandated Covid -19 Supplemental Sick Leave	10,398	10,400	2	0.0%
520,275	711,011	190,736	26.8%	Employee Benefits	5,391,827	6,471,475	1,079,648	16.7%
10	0	(10)	0.0%	Personal Floating Holiday	103,731	112,983	9,252	8.2%
1,398	13,953	12,555	90.0%	Employee Relations	46,228	150,377	104,149	69.3%
7,590	9,601	2,011	20.9%	Work from Home Stipend	78,810	92,201	13,391	14.5%
53	4,152	4,099	98.7%	Transportation Reimbursement	882	16,906	16,024	94.8%
1,510	17,548	16,038	91.4%	Travel & Lodging	4,956	80,581	75,625	93.8%
41,485	52,543	11,058	21.0%	Temporary Help Services	575,881	885,032	309,151	34.9%
6,925	90,220	83,295	92.3%	Staff Development/Training	93,695	524,762	431,067	82.1%
7,195	11,372	4,177	36.7%	Staff Recruitment/Advertising	131,776	403,344	271,568	67.3%
3,189,362	**3,653,516**	**464,154**	**12.7%**	**Total Employee Expenses**	**33,305,779**	**37,008,817**	**3,703,038**	**10.0%**
				Benefit Administration Expense				
24,139	52,782	28,643	54.3%	RX Administration Expense	2,580,539	2,712,293	131,754	4.9%
275,752	245,199	(30,553)	(12.5%)	Behavioral Hlth Administration Fees	2,828,274	2,708,555	(119,719)	(4.4%)
18,477	16,588	(1,889)	(11.4%)	Telemedicine Admin Fees	196,366	187,306	(9,060)	(4.8%)
318,368	**314,569**	**(3,799)**	**(1.2%)**	**Total Employee Expenses**	**5,605,178**	**5,608,154**	**2,976**	**0.1%**
				Purchased & Professional Services				
73,051	366,140	293,089	80.0%	Consulting Services	2,723,810	4,801,008	2,077,198	43.3%
291,157	569,093	277,936	48.8%	Computer Support Services	3,129,364	5,433,714	2,304,350	42.4%
3,670	11,583	7,913	68.3%	Professional Fees-Accounting	135,536	131,405	(4,131)	(3.1%)
0	10	10	100.0%	Professional Fees-Medical	95	70	(25)	(36.1%)
49,130	302,733	253,603	83.8%	Other Purchased Services	501,182	1,799,264	1,298,082	72.1%
1,407	5,000	3,593	71.9%	Maint.& Repair-Office Equipment	9,103	56,809	47,706	84.0%
523,615	122,537	(401,078)	(327.3%)	HMS Recovery Fees	928,469	981,907	53,438	5.4%
0	0	0	0.0%	MIS Software (Non-Capital)	0	250,002	250,002	100.0%
1,798	28,695	26,897	93.7%	Hardware (Non-Capital)	206,768	376,813	170,045	45.1%
10,336	21,492	11,156	51.9%	Provider Relations-Credentialing	137,293	195,190	57,897	29.7%
43,652	95,928	52,276	54.5%	Legal Fees	285,232	551,788	266,556	48.3%
997,817	**1,523,211**	**525,394**	**34.5%**	**Total Purchased & Professional Services**	**8,056,852**	**14,577,970**	**6,521,117**	**44.7%**
				Occupancy				
66,491	92,073	25,582	27.8%	Depreciation	886,192	1,015,410	129,218	12.7%
69,890	70,286	396	0.6%	Building Lease	774,727	775,519	792	0.1%
3,818	2,006	(1,812)	(90.3%)	Leased and Rented Office Equipment	58,235	22,164	(36,071)	(162.7%)
12,402	13,545	1,143	8.4%	Utilities	137,276	157,102	19,826	12.6%
86,499	71,401	(15,098)	(21.1%)	Telephone	796,155	789,208	(6,947)	(0.9%)
8,478	23,590	15,112	64.1%	Building Maintenance	151,492	273,167	121,675	44.5%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	**Budget**	**$ Variance (Unfavorable)**	**% Variance (Unfavorable)**	**Account Description**	**Actual**	**Budget**	**$ Variance (Unfavorable)**	**% Variance (Unfavorable)**
$247,580	**$272,901**	**$25,321**	**9.3%**	**Total Occupancy**	**$2,804,077**	**$3,032,570**	**$228,493**	**7.5%**
				Printing Postage & Promotion				
43,355	32,821	(10,534)	(32.1%)	Postage	339,125	466,284	127,160	27.3%
3,655	7,000	3,345	47.8%	Design & Layout	29,690	90,888	61,198	67.3%
126,579	39,466	(87,113)	(220.7%)	Printing Services	683,129	586,460	(96,669)	(16.5%)
32,406	2,500	(29,906)	(1,196.3%)	Mailing Services	65,033	28,394	(36,639)	(129.0%)
4,974	3,225	(1,749)	(54.2%)	Courier/Delivery Service	46,046	38,803	(7,243)	(18.7%)
61	334	273	81.8%	Pre-Printed Materials and Publications	981	5,271	4,290	81.4%
0	2,500	2,500	100.0%	Promotional Products	0	5,000	5,000	100.0%
0	150	150	100.0%	Promotional Services	0	450	450	100.0%
117,071	132,500	15,430	11.6%	Community Relations	844,005	1,009,675	165,670	16.4%
0	0	0	0.0%	Health Education-Member	(67)	0	67	0.0%
5,737	8,500	2,763	32.5%	Translation - Non-Clinical	180,086	161,134	(18,952)	(11.8%)
333,838	**228,996**	**(104,842)**	**(45.8%)**	**Total Printing Postage & Promotion**	**2,188,028**	**2,392,359**	**204,331**	**8.5%**
				Licenses Insurance & Fees				
0	0	0	0.0%	Regulatory Penalties	0	250,001	250,001	100.0%
21,174	20,800	(374)	(1.8%)	Bank Fees	228,316	227,265	(1,051)	(0.5%)
61,920	61,377	(543)	(0.9%)	Insurance	678,405	675,145	(3,260)	(0.5%)
333,501	503,835	170,334	33.8%	Licenses, Permits and Fees	3,774,719	4,841,959	1,067,240	22.0%
78,828	80,973	2,145	2.6%	Subscriptions & Dues	820,571	1,010,682	190,111	18.8%
495,423	**666,985**	**171,562**	**25.7%**	**Total Licenses Insurance & Postage**	**5,502,011**	**7,005,052**	**1,503,041**	**21.5%**
				Supplies & Other Expenses				
3,732	15,666	11,934	76.2%	Office and Other Supplies	47,778	150,188	102,410	68.2%
2,270	2,251	(19)	(0.8%)	Ergonomic Supplies	24,571	63,930	39,359	61.6%
2,594	7,673	5,079	66.2%	Commissary-Food & Beverage	9,377	40,977	31,600	77.1%
0	0	0	0.0%	Miscellaneous Expense	534	0	(534)	0.0%
0	4,150	4,150	100.0%	Member Incentive Expense	4,850	35,950	31,100	86.5%
4,556	0	(4,556)	0.0%	Covid-19 Vaccination Incentive Expense	1,538,775	4,581,255	3,042,480	66.4%
0	100	100	100.0%	Covid-19 IT Expenses	0	700	700	100.0%
0	166	166	100.0%	Covid-19 Non IT Expenses	797	6,762	5,965	88.2%
13,152	**30,006**	**16,854**	**56.2%**	**Total Supplies & Other Expense**	**1,626,681**	**4,879,762**	**3,253,081**	**66.7%**
$5,595,540	**$6,690,184**	**$1,094,644**	**16.4%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$59,088,607**	**$74,504,684**	**$15,416,077**	**20.7%**

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

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Network Hardware	IT-FY22-07	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Cisco UCS Blade	IT-FY22-08	$ -		**$ -**	$ 100,000	$ 100,000
	Veeam Backup	IT-FY22-10	$ -		**$ -**	$ 60,000	$ 60,000
	Call Center Hardware	IT-FY22-11	$ -		**$ -**	$ 100,000	$ 100,000
	Network / AV Cabling	IT-FY22-13	$ -		**$ -**	$ 150,000	$ 150,000
Hardware Subtotal			**$ -**	**$ -**	**$ -**	**$ 560,000**	**$ 560,000**
2. Software:							
	Patch Management	AC-FY22-01	$ -		**$ -**	$ 20,000	$ 20,000
	Zerto Licenses (DR - Replication Orchestration)	AC-FY22-02	$ -		**$ -**	$ 50,000	$ 50,000
	Monitoring Software	AC-FY22-03	$ -		**$ -**	$ 40,000	$ 40,000
	Identity and Access Management (Security)	AC-FY22-04	$ -		**$ -**	$ 40,000	$ 40,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 150,000**	**$ 150,000**
3. Building Improvement:							
	1240 Emergency Generator (carryover from FY21)	FA-FY22-06	**$ 227,316**		**$ 227,316**	$ 360,800	$ 133,484
	1240 Electrical Requirements for EV Charging Stations (est.)	FA-FY22-07	$ -		**$ -**	$ 20,000	$ 20,000
	1240 EV Charging stations installation, fees (est. only)	FA-FY22-08	$ -		**$ -**	$ 50,000	$ 50,000
	1240 Seismic Improvements (carryover from FY21)	FA-FY22-09	$ -		**$ -**	$ 50,000	$ 50,000
	Contingency	FA-FY22-16	**$ 6,341**		**$ 6,341**	$ 100,000	$ 93,659
Building Improvement Subtotal			**$ 233,657**	**$ -**	**$ 233,657**	**$ 580,800**	**$ 347,143**
4. Furniture & Equipment:							
	Replace, reconfigure, re-design workstations/add barriers or plexiglass	FA-FY22-20	$ -		**$ -**	$ 125,000	$ 125,000
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ 125,000**	**$ 125,000**
GRAND TOTAL			**$ 233,657**	**$ -**	**$ 233,657**	**$ 1,415,800**	**$ 1,182,143**
5. Reconciliation to Balance Sheet:							
	Fixed Assets @ Cost - 5/31/22				**$ 37,169,134**		
	Fixed Assets @ Cost - 6/30/21				**$ 36,935,477**		
	Fixed Assets Acquired YTD				**$ 233,657**		

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

TANGIBLE NET EQUITY (TNE)

	Jul-21	Aug-21	QTR. END Sep-21	Oct-21	Nov-21	QTR. END Dec-21	Jan-22	Feb-22	QTR. END Mar-22	Apr-22	May-22
Current Month Net Income / (Loss)	$2,645,613	$1,455,041	$370,178	($7,350,897)	$1,314,900	($1,496,048)	$4,122,017	$3,443,438	$8,404,167	$2,267,503	$5,167,507
YTD Net Income / (Loss)	$2,645,613	$4,100,654	$4,470,832	($2,880,065)	($1,565,165)	($3,061,213)	$1,060,804	$4,504,242	$12,908,409	$15,175,912	$20,343,419
Actual TNE											
Net Assets	$208,055,654	$209,510,696	$209,880,873	$202,529,977	$203,844,876	$202,348,828	$206,470,845	$209,914,283	$218,318,450	$220,585,953	$225,753,460
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$208,055,654**	**$209,510,696**	**$209,880,873**	**$202,529,977**	**$203,844,876**	**$202,348,828**	**$206,470,845**	**$209,914,283**	**$218,318,450**	**$220,585,953**	**$225,753,460**
Increase/(Decrease) in Actual TNE	$3,467,237	$1,455,042	$370,177	($7,350,896)	$1,314,899	($1,496,048)	$4,122,017	$3,443,438	$8,404,167	$2,267,503	$5,167,507
Required TNE[(1)]	**$37,061,269**	**$37,134,762**	**$37,155,961**	**$38,560,140**	**$37,568,385**	**$38,067,278**	**$38,019,954**	**$37,402,476**	**$37,954,630**	**$38,456,012**	**$37,976,096**
Min. Req'd to Avoid Monthly Reporting (130% of Required TNE)	$48,179,650	$48,275,191	$48,302,749	$50,128,181	$48,838,900	$49,487,461	$49,425,940	$48,623,218	$49,341,019	$49,992,815	$49,368,925
TNE Excess / (Deficiency)	$170,994,385	$172,375,934	$172,724,912	$163,969,837	$166,276,491	$164,281,550	$168,450,891	$172,511,807	$180,363,820	$182,129,941	$187,777,364
Actual TNE as a Multiple of Required	**5.61**	**5.64**	**5.65**	**5.25**	**5.43**	**5.32**	**5.43**	**5.61**	**5.75**	**5.74**	**5.94**

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

LIQUID TANGIBLE NET EQUITY

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Net Assets	$208,055,654	$209,510,696	$209,880,873	$202,529,977	$203,844,876	$202,348,828	$206,470,845	$209,914,283	$218,318,450	$220,585,953	$225,753,460
Fixed Assets at Net Book Value	(6,161,088)	(6,073,778)	(6,093,339)	(6,013,994)	(5,931,375)	(5,851,942)	(5,774,186)	(5,821,605)	(5,753,060)	(5,686,094)	(5,619,604)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$201,544,566**	**$203,086,918**	**$203,437,534**	**$196,165,983**	**$197,563,501**	**$196,146,886**	**$200,346,659**	**$203,742,678**	**$212,215,390**	**$214,549,859**	**$219,783,856**
Liquid TNE as Multiple of Required	**5.44**	**5.47**	**5.48**	**5.09**	**5.26**	**5.15**	**5.27**	**5.45**	**5.59**	**5.58**	**5.79**

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

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

	Actual Jul-21	**Actual Aug-21**	**Actual Sep-21**	**Actual Oct-21**	**Actual Nov-21**	**Actual Dec-21**	**Actual Jan-22**	**Actual Feb-22**	**Actual Mar-22**	**Actual Apr-22**	**Actual May-22**	**Actual Jun-22**	**YTD Member Months**
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	97,179	97,324	97,460	97,636	97,935	98,150	99,337	99,573	99,889	100,215	100,560		1,085,258
Adult	41,358	41,519	41,924	42,177	42,623	43,077	44,340	44,588	45,227	45,826	46,171		478,830
SPD	26,320	26,316	26,330	26,366	26,427	26,450	26,633	26,675	26,820	26,848	26,958		292,143
ACA OE	99,105	99,783	100,469	100,844	101,508	102,264	105,897	106,553	107,652	108,568	109,734		1,142,377
Duals	20,194	20,388	20,535	20,692	20,832	20,964	21,135	21,239	21,349	21,456	21,527		230,311
Medi-Cal Program	284,156	285,330	286,718	287,715	289,325	290,905	297,342	298,628	300,937	302,913	304,950		3,228,919
Group Care Program	5,935	5,877	5,914	5,880	5,826	5,823	5,831	5,824	5,850	5,828	5,808		64,396
Total	**290,091**	**291,207**	**292,632**	**293,595**	**295,151**	**296,728**	**303,173**	**304,452**	**306,787**	**308,741**	**310,758**		**3,293,315**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	131	145	136	176	299	215	1,187	236	316	326	345		3,512
Adult	392	161	405	253	446	454	1,263	248	639	599	345		5,205
SPD	(3)	(4)	14	36	61	23	183	42	145	28	110		635
ACA OE	824	678	686	375	664	756	3,633	656	1,099	916	1,166		11,453
Duals	206	194	147	157	140	132	171	104	110	107	71		1,539
Medi-Cal Program	1,550	1,174	1,388	997	1,610	1,580	6,437	1,286	2,309	1,976	2,037		22,344
Group Care Program	(13)	(58)	37	(34)	(54)	(3)	8	(7)	26	(22)	(20)		(140)
Total	**1,537**	**1,116**	**1,425**	**963**	**1,556**	**1,577**	**6,445**	**1,279**	**2,335**	**1,954**	**2,017**		**22,204**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	34.2%	34.1%	34.0%	33.9%	33.8%	33.7%	33.4%	33.3%	33.2%	33.1%	33.0%		33.6%
Adult % of Medi-Cal	14.6%	14.6%	14.6%	14.7%	14.7%	14.8%	14.9%	14.9%	15.0%	15.1%	15.1%		14.8%
SPD % of Medi-Cal	9.3%	9.2%	9.2%	9.2%	9.1%	9.1%	9.0%	8.9%	8.9%	8.9%	8.8%		9.0%
ACA OE % of Medi-Cal	34.9%	35.0%	35.0%	35.0%	35.1%	35.2%	35.6%	35.7%	35.8%	35.8%	36.0%		35.4%
Duals % of Medi-Cal	7.1%	7.1%	7.2%	7.2%	7.2%	7.2%	7.1%	7.1%	7.1%	7.1%	7.1%		7.1%
Medi-Cal Program % of Total	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.1%	98.1%	98.1%	98.1%	98.1%		98.0%
Group Care Program % of Total	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	1.9%	1.9%	1.9%	1.9%	1.9%		2.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**		**100.0%**

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

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

	Actual Jul-21	**Actual Aug-21**	**Actual Sep-21**	**Actual Oct-21**	**Actual Nov-21**	**Actual Dec-21**	**Actual Jan-22**	**Actual Feb-22**	**Actual Mar-22**	**Actual Apr-22**	**Actual May-22**	**Actual Jun-22**	**YTD Member Months**
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	53,189	53,441	53,246	53,081	53,438	52,288	57,046	51,053	51,767	51,662	51,910		582,121
Alameda Health System	58,045	57,812	58,060	58,049	58,073	58,590	58,927	60,699	60,974	61,442	61,693		652,364
	111,234	111,253	111,306	111,130	111,511	110,878	115,973	111,752	112,741	113,104	113,603		1,234,485
Delegated:													
CFMG	32,217	32,167	32,217	32,232	32,266	32,573	32,689	33,319	33,293	33,333	33,378		359,684
CHCN	104,433	105,113	106,050	106,808	107,583	109,059	109,878	114,264	115,125	116,169	117,163		1,211,645
Kaiser	42,207	42,674	43,059	43,425	43,791	44,218	44,633	45,117	45,628	46,135	46,614		487,501
Delegated Subtotal	178,857	179,954	181,326	182,465	183,640	185,850	187,200	192,700	194,046	195,637	197,155		2,058,830
Total	**290,091**	**291,207**	**292,632**	**293,595**	**295,151**	**296,728**	**303,173**	**304,452**	**306,787**	**308,741**	**310,758**		**3,293,315**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(24)	19	53	(176)	381	(633)	5,095	(4,221)	989	363	499		2,345
Delegated:													
CFMG	20	(50)	50	15	34	307	116	630	(26)	40	45		1,181
CHCN	1,094	680	937	758	775	1,476	819	4,386	861	1,044	994		13,824
Kaiser	447	467	385	366	366	427	415	484	511	507	479		4,854
Delegated Subtotal	1,561	1,097	1,372	1,139	1,175	2,210	1,350	5,500	1,346	1,591	1,518		19,859
Total	**1,537**	**1,116**	**1,425**	**963**	**1,556**	**1,577**	**6,445**	**1,279**	**2,335**	**1,954**	**2,017**		**22,204**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	38.3%	38.2%	38.0%	37.9%	37.8%	37.4%	38.3%	36.7%	36.7%	36.6%	36.6%		37.5%
Delegated:													
CFMG	11.1%	11.0%	11.0%	11.0%	10.9%	11.0%	10.8%	10.9%	10.9%	10.8%	10.7%		10.9%
CHCN	36.0%	36.1%	36.2%	36.4%	36.5%	36.8%	36.2%	37.5%	37.5%	37.6%	37.7%		36.8%
Kaiser	14.5%	14.7%	14.7%	14.8%	14.8%	14.9%	14.7%	14.8%	14.9%	14.9%	15.0%		14.8%
Delegated Subtotal	61.7%	61.8%	62.0%	62.1%	62.2%	62.6%	61.7%	63.3%	63.3%	63.4%	63.4%		62.5%
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%**

REPORT #9

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

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

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

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

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

	Variance Jul-21	Variance Aug-21	Variance Sep-21	Variance Oct-21	Variance Nov-21	Variance Dec-21	Variance Jan-22	Variance Feb-22	Variance Mar-22	Variance Apr-22	Variance May-22	Variance Jun-22	Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	123	162	(254)	952	2,228	3,505	4,817		11,533
Adult	0	0	0	0	193	394	1,184	1,855	2,912	3,925	4,689		15,152
SPD	0	0	0	0	25	12	166	455	844	1,114	(39)		2,577
ACA OE	0	0	0	0	289	670	4,110	5,708	7,739	9,578	5,330		33,424
Duals	0	0	0	0	(17)	(42)	339	651	967	1,278	1,551		4,727
Medi-Cal Program	0	0	0	0	613	1,196	5,545	9,621	14,690	19,400	16,348		67,413
Group Care Program	0	0	0	0	(37)	(29)	(21)	(28)	(2)	(24)	(44)		(185)
Total	**0**	**0**	**0**	**0**	**576**	**1,167**	**5,524**	**9,593**	**14,688**	**19,376**	**16,304**		**67,228**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted	0	0	0	0	(28)	(1,073)	3,524	341	2,355	3,734	1,461		10,314
Delegated:													
CFMG	0	0	0	0	(28)	217	(159)	790	1,079	1,431	1,662		4,992
CHCN	0	0	0	0	418	1,534	1,628	7,024	8,885	10,919	9,933		40,341
Kaiser	0	0	0	0	214	489	531	1,438	2,369	3,292	3,248		11,581
Delegated Subtotal	0	0	0	0	604	2,240	2,000	9,252	12,333	15,642	14,843		56,914
Total	**0**	**0**	**0**	**0**	**576**	**1,167**	**5,524**	**9,593**	**14,688**	**19,376**	**16,304**		**67,228**

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

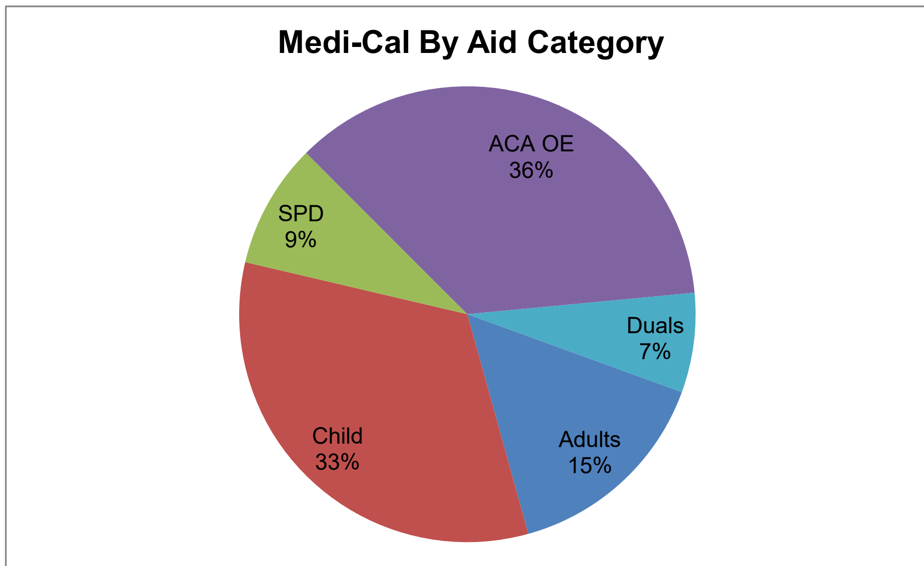
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$1,143,292	$1,816,326	$673,034	37.1%	PCP-Capitation	$12,229,158	$20,268,027	$8,038,869	39.7%
4,045,897	3,189,605	(856,292)	(26.8%)	PCP-Capitation - FQHC	42,429,147	33,727,085	(8,702,062)	(25.8%)
289,506	267,665	(21,841)	(8.2%)	Specialty-Capitation	3,123,270	3,039,528	(83,742)	(2.8%)
3,386,278	3,374,972	(11,306)	(0.3%)	Specialty-Capitation FQHC	35,216,407	35,208,793	(7,614)	0.0%
383,224	364,143	(19,081)	(5.2%)	Laboratory-Capitation	4,081,965	4,000,689	(81,276)	(2.0%)
932,001	883,362	(48,639)	(5.5%)	Transportation (Ambulance)-Cap	10,231,142	9,772,069	(459,073)	(4.7%)
226,033	214,844	(11,189)	(5.2%)	Vision Cap	2,407,857	2,362,367	(45,490)	(1.9%)
84,321	77,984	(6,337)	(8.1%)	CFMG Capitation	909,998	885,606	(24,392)	(2.8%)
170,384	168,537	(1,847)	(1.1%)	Anc IPA Admin Capitation FQHC	1,773,654	1,769,890	(3,764)	(0.2%)
10,657,508	10,167,609	(489,899)	(4.8%)	Kaiser Capitation	116,319,707	114,994,313	(1,325,394)	(1.2%)
769,562	758,914	(10,648)	(1.4%)	BHT Supplemental Expense	8,680,309	8,130,038	(550,271)	(6.8%)
0	0	0	0.0%	Hep-C Supplemental Expense	102,679	100,877	(1,802)	(1.8%)
367,898	477,803	109,905	23.0%	Maternity Supplemental Expense	3,643,919	4,632,557	988,638	21.3%
558,386	582,079	23,693	4.1%	DME - Cap	6,028,994	6,195,695	166,701	2.7%
23,014,289	**22,343,843**	**(670,446)**	**(3.0%)**	**5-TOTAL CAPITATED EXPENSES**	**247,178,206**	**245,087,534**	**(2,090,672)**	**(0.9%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
2,974,726	0	(2,974,726)	0.0%	IBNP-Inpatient Services	10,059,785	0	(10,059,785)	0.0%
89,243	0	(89,243)	0.0%	IBNP-Settlement (IP)	301,790	0	(301,790)	0.0%
237,978	0	(237,978)	0.0%	IBNP-Claims Fluctuation (IP)	804,778	0	(804,778)	0.0%
23,030,075	26,953,026	3,922,951	14.6%	Inpatient Hospitalization-FFS	261,129,494	294,263,169	33,133,675	11.3%
1,301,280	0	(1,301,280)	0.0%	IP OB - Mom & NB	13,407,363	0	(13,407,363)	0.0%
142,493	0	(142,493)	0.0%	IP Behavioral Health	2,493,377	0	(2,493,377)	0.0%
959,863	1,347,633	387,770	28.8%	IP - Long Term Care	11,874,749	9,166,869	(2,707,880)	(29.5%)
516,020	0	(516,020)	0.0%	IP - Facility Rehab FFS	8,912,581	0	(8,912,581)	0.0%
29,251,679	**28,300,659**	**(951,020)**	**(3.4%)**	**6-Inpatient Hospital & SNF FFS Expense**	**308,983,916**	**303,430,038**	**(5,553,878)**	**(1.8%)**
36,517	0	(36,517)	0.0%	IBNP-PCP	(102,635)	0	102,635	0.0%
1,095	0	(1,095)	0.0%	IBNP-Settlement (PCP)	(3,077)	0	3,077	0.0%
2,922	0	(2,922)	0.0%	IBNP-Claims Fluctuation (PCP)	(8,207)	0	8,207	0.0%
630	0	(630)	0.0%	Telemedicine FFS	9,450	0	(9,450)	0.0%
1,111,442	1,338,272	226,830	16.9%	Primary Care Non-Contracted FF	13,035,107	26,907,281	13,872,174	51.6%
56,498	81,614	25,116	30.8%	PCP FQHC FFS	561,719	567,903	6,184	1.1%
1,916,355	3,174,873	1,258,518	39.6%	Prop 56 Direct Payment Expenses	20,407,582	22,066,347	1,658,765	7.5%
13,705	0	(13,705)	0.0%	Prop 56 Hyde Direct Payment Expenses	67,234	0	(67,234)	0.0%
76,271	0	(76,271)	0.0%	Prop 56-Trauma Expense	830,791	0	(830,791)	0.0%
98,355	0	(98,355)	0.0%	Prop 56-Dev. Screening Exp.	1,088,972	0	(1,088,972)	0.0%
662,172	0	(662,172)	0.0%	Prop 56-Fam. Planning Exp.	7,085,894	0	(7,085,894)	0.0%
580,719	0	(580,719)	0.0%	Prop 56-Value Based Purchasing	6,150,591	0	(6,150,591)	0.0%
4,556,681	**4,594,759**	**38,078**	**0.8%**	**7-Primary Care Physician FFS Expense**	**49,123,420**	**49,541,531**	**418,111**	**0.8%**
159,567	0	(159,567)	0.0%	IBNP-Specialist	641,621	0	(641,621)	0.0%
2,489,787	4,750,011	2,260,224	47.6%	Specialty Care-FFS	26,891,213	51,319,983	24,428,770	47.6%
130,240	0	(130,240)	0.0%	Anesthesiology - FFS	1,413,478	0	(1,413,478)	0.0%
771,774	0	(771,774)	0.0%	Spec Rad Therapy - FFS	8,323,194	0	(8,323,194)	0.0%
109,203	0	(109,203)	0.0%	Obstetrics-FFS	1,233,266	0	(1,233,266)	0.0%
210,171	0	(210,171)	0.0%	Spec IP Surgery - FFS	2,872,758	0	(2,872,758)	0.0%
487,274	0	(487,274)	0.0%	Spec OP Surgery - FFS	5,657,903	0	(5,657,903)	0.0%
278,790	0	(278,790)	0.0%	Spec IP Physician	4,117,133	0	(4,117,133)	0.0%
39,288	5,047	(34,241)	(678.4%)	SCP FQHC FFS	469,453	34,644	(434,809)	(1,255.1%)
4,788	0	(4,788)	0.0%	IBNP-Settlement (SCP)	19,248	0	(19,248)	0.0%
12,767	0	(12,767)	0.0%	IBNP-Claims Fluctuation (SCP)	51,331	0	(51,331)	0.0%
4,693,649	**4,755,058**	**61,409**	**1.3%**	**8-Specialty Care Physician Expense**	**51,690,598**	**51,354,627**	**(335,971)**	**(0.7%)**
15,323	0	(15,323)	0.0%	IBNP-Ancillary	1,726,812	0	(1,726,812)	0.0%
461	0	(461)	0.0%	IBNP Settlement (ANC)	51,807	0	(51,807)	0.0%
1,225	0	(1,225)	0.0%	IBNP Claims Fluctuation (ANC)	138,143	0	(138,143)	0.0%
394,507	0	(394,507)	0.0%	Acupuncture/Biofeedback	4,753,092	0	(4,753,092)	0.0%
97,826	0	(97,826)	0.0%	Hearing Devices	1,061,570	0	(1,061,570)	0.0%
21,783	0	(21,783)	0.0%	Imaging/MRI/CT Global	346,024	0	(346,024)	0.0%
41,668	0	(41,668)	0.0%	Vision FFS	526,626	0	(526,626)	0.0%
11,145	0	(11,145)	0.0%	Family Planning	241,634	0	(241,634)	0.0%
744,140	0	(744,140)	0.0%	Laboratory-FFS	8,717,079	0	(8,717,079)	0.0%
78,132	0	(78,132)	0.0%	ANC Therapist	1,036,540	0	(1,036,540)	0.0%
0	0	0	0.0%	ANC Diagnostic Procedures	(166)	0	166	0.0%
255,150	0	(255,150)	0.0%	Transportation (Ambulance)-FFS	3,201,522	0	(3,201,522)	0.0%
176,938	0	(176,938)	0.0%	Transportation (Other)-FFS	1,443,531	0	(1,443,531)	0.0%
439,854	0	(439,854)	0.0%	Hospice	5,529,922	0	(5,529,922)	0.0%
766,109	0	(766,109)	0.0%	Home Health Services	7,168,949	0	(7,168,949)	0.0%
0	3,502,067	3,502,067	100.0%	Other Medical-FFS	0	41,937,378	41,937,378	100.0%

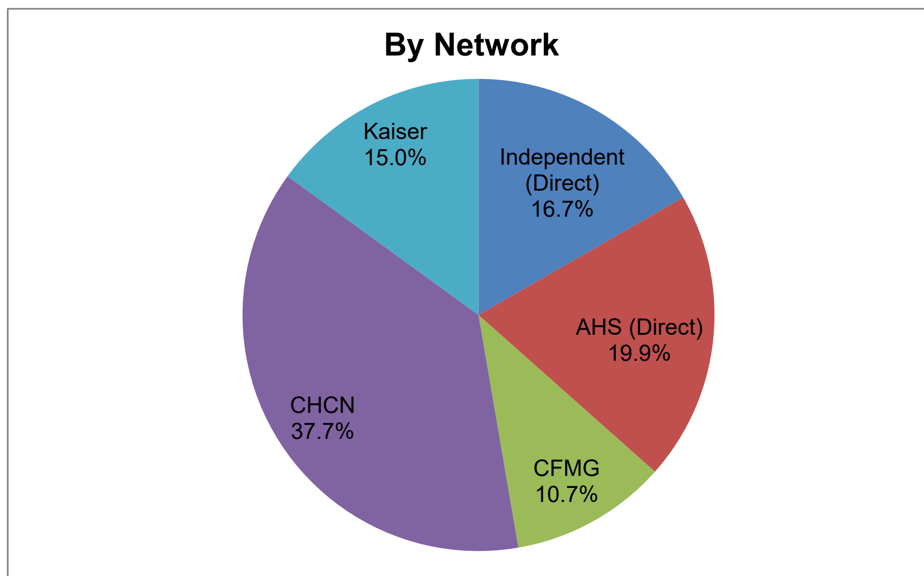
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 31, 2022

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
$393,991	$0	($393,991)	0.0%	HMS Medical Refunds	($13,571)	$0	$13,571	0.0%
397,195	0	(397,195)	0.0%	DME & Medical Supplies	5,104,194	0	(5,104,194)	0.0%
0	0	0	0.0%	Denials	167	0	(167)	0.0%
(70,675)	598,663	669,338	111.8%	GEMT Direct Payment Expense	5,414,708	4,102,748	(1,311,960)	(32.0%)
537,180	0	(537,180)	0.0%	Community Based Adult Services (CBAS)	5,068,760	0	(5,068,760)	0.0%
0	0	0	0.0%	COVID Vaccination Incentive	50,541	0	(50,541)	0.0%
858,509	729,105	(129,404)	(17.7%)	ECM Base FFS Ancillary	4,236,758	3,586,225	(650,533)	(18.1%)
2,195	9,999	7,804	78.0%	ECM Outreach FFS Ancillary	4,755	49,999	45,244	90.5%
399,732	398,608	(1,124)	(0.3%)	CS - Housing Deposits FFS Ancillary	1,994,163	1,993,039	(1,124)	(0.1%)
407,667	407,667	0	0.0%	CS - Housing Tenancy FFS Ancillary	2,038,335	2,038,335	0	0.0%
298,956	298,956	0	0.0%	CS - Housing Navigation Services FFS Ancillary	1,494,779	1,494,780	1	0.0%
241,313	241,312	(1)	0.0%	CS - Medical Respite FFS Ancillary	1,206,563	1,206,560	(3)	0.0%
230,081	230,081	0	0.0%	CS - Medically Tailored Meals FFS Ancillary	1,150,406	1,150,405	(1)	0.0%
35,244	35,244	0	0.0%	CS - Asthma Remediation FFS Ancillary	176,222	176,220	(2)	0.0%
0	0	0	0.0%	MOT- Wrap Around (Non Medical MOT Cost)	634	0	(634)	0.0%
6,775,650	**6,451,702**	**(323,949)**	**(5.0%)**	**9-Ancillary Medical Expense**	**63,870,499**	**57,735,689**	**(6,134,810)**	**(10.6%)**
246,156	0	(246,156)	0.0%	IBNP-Outpatient	1,216,758	0	(1,216,758)	0.0%
7,385	0	(7,385)	0.0%	IBNP Settlement (OP)	36,504	0	(36,504)	0.0%
19,692	0	(19,692)	0.0%	IBNP Claims Fluctuation (OP)	97,340	0	(97,340)	0.0%
1,284,550	8,276,250	6,991,700	84.5%	Out-Patient FFS	14,451,744	91,753,239	77,301,495	84.2%
1,116,716	0	(1,116,716)	0.0%	OP Ambul Surgery - FFS	14,429,619	0	(14,429,619)	0.0%
1,340,571	0	(1,340,571)	0.0%	OP Fac Imaging Services-FFS	12,676,238	0	(12,676,238)	0.0%
940,820	0	(940,820)	0.0%	Behav Health - FFS	17,059,144	0	(17,059,144)	0.0%
1,511,619	0	(1,511,619)	0.0%	Behavioral Health Therapy - FFS	6,020,558	0	(6,020,558)	0.0%
438,829	0	(438,829)	0.0%	OP Facility - Lab FFS	5,168,564	0	(5,168,564)	0.0%
123,852	0	(123,852)	0.0%	OP Facility - Cardio FFS	1,137,743	0	(1,137,743)	0.0%
42,049	0	(42,049)	0.0%	OP Facility - PT/OT/ST FFS	525,024	0	(525,024)	0.0%
1,553,295	0	(1,553,295)	0.0%	OP Facility - Dialysis FFS	18,376,841	0	(18,376,841)	0.0%
8,625,535	**8,276,250**	**(349,285)**	**(4.2%)**	**10-Outpatient Medical Expense Medical Expense**	**91,196,077**	**91,753,239**	**557,162**	**0.6%**
228,042	0	(228,042)	0.0%	IBNP-Emergency	1,683,308	0	(1,683,308)	0.0%
6,842	0	(6,842)	0.0%	IBNP Settlement (ER)	50,500	0	(50,500)	0.0%
18,245	0	(18,245)	0.0%	IBNP Claims Fluctuation (ER)	134,669	0	(134,669)	0.0%
545,059	0	(545,059)	0.0%	Special ER Physician-FFS	6,710,053	0	(6,710,053)	0.0%
3,622,017	4,379,328	757,311	17.3%	ER-Facility	41,409,190	48,867,597	7,458,407	15.3%
4,420,205	**4,379,328**	**(40,877)**	**(0.9%)**	**11-Emergency Expense**	**49,987,720**	**48,867,597**	**(1,120,123)**	**(2.3%)**
67,171	0	(67,171)	0.0%	IBNP-Pharmacy	535,879	0	(535,879)	0.0%
2,014	0	(2,014)	0.0%	IBNP Settlement (RX)	16,077	0	(16,077)	0.0%
5,374	0	(5,374)	0.0%	IBNP Claims Fluctuation (RX)	42,873	0	(42,873)	0.0%
(207,703)	371,748	579,451	155.9%	Pharmacy-FFS	72,113,406	71,153,106	(960,300)	(1.3%)
5,179,750	4,914,840	(264,910)	(5.4%)	Pharmacy- Non-PBM FFS-Other Anc	56,649,169	52,165,857	(4,483,312)	(8.6%)
(466)	0	466	0.0%	HMS RX Refunds	(752,334)	0	752,334	0.0%
0	(18,132)	(18,132)	100.0%	Pharmacy-Rebate	(3,425,129)	(3,518,816)	(93,687)	2.7%
5,046,141	**5,268,456**	**222,315**	**4.2%**	**12-Pharmacy Expense**	**125,179,942**	**119,800,147**	**(5,379,795)**	**(4.5%)**
63,369,540	**62,026,212**	**(1,343,329)**	**(2.2%)**	**13-TOTAL FFS MEDICAL EXPENSES**	**740,032,173**	**722,482,868**	**(17,549,304)**	**(2.4%)**
0	(47,157)	(47,157)	100.0%	Clinical Vacancy	0	(386,100)	(386,100)	100.0%
109,415	117,150	7,735	6.6%	Quality Analytics	880,718	984,067	103,349	10.5%
458,781	469,635	10,854	2.3%	Health Plan Services Department Total	4,485,003	5,297,242	812,239	15.3%
(771,179)	420,720	1,191,899	283.3%	Case & Disease Management Department Total	2,975,456	5,876,091	2,900,635	49.4%
2,089,280	236,796	(1,852,484)	(782.3%)	Medical Services Department Total	8,226,438	2,069,686	(6,156,751)	(297.5%)
361,795	753,843	392,048	52.0%	Quality Management Department Total	4,818,952	7,499,527	2,680,575	35.7%
60,843	123,570	62,727	50.8%	HCS Behavioral Health Department Total	394,965	719,295	324,330	45.1%
125,477	126,835	1,358	1.1%	Pharmacy Services Department Total	1,324,910	1,418,973	94,063	6.6%
109,240	54,189	(55,051)	(101.6%)	Regulatory Readiness Total	601,001	491,270	(109,731)	(22.3%)
2,543,652	**2,255,581**	**(288,071)**	**(12.8%)**	**14-Other Benefits & Services**	**23,707,443**	**23,970,051**	**262,609**	**1.1%**
				Reinsurance Expense				
(414,476)	(414,476)	(1)	0.0%	Reinsurance Recoveries	(6,417,712)	(5,049,755)	1,367,957	(27.1%)
565,387	552,634	(12,753)	(2.3%)	Stop-Loss Expense	6,046,334	5,957,094	(89,240)	(1.5%)
150,912	**138,158**	**(12,754)**	**(9.2%)**	**15-Reinsurance Expense**	**(371,378)**	**907,339**	**1,278,717**	**140.9%**
89,078,393	**86,763,794**	**(2,314,599)**	**(2.7%)**	**17-TOTAL MEDICAL EXPENSES**	**1,010,546,443**	**992,447,793**	**(18,098,650)**	**(1.8%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Current Membership by Network By Category of Aid							
Category of Aid	**May 2022**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	46,171	15%	9,108	9,371	742	18,510	8,440
Child	100,560	33%	7,588	9,145	30,443	35,055	18,329
SPD	26,958	9%	8,186	4,240	1,037	11,402	2,093
ACA OE	109,734	36%	16,504	35,716	1,156	41,859	14,499
Duals	21,527	7%	8,175	2,348	-	7,751	3,253
Medi-Cal	304,950		49,561	60,820	33,378	114,577	46,614
Group Care	5,808		2,349	873	-	2,586	-
Total	**310,758**	**100%**	**51,910**	**61,693**	**33,378**	**117,163**	**46,614**
Medi-Cal %	98.1%		95.5%	98.6%	100.0%	97.8%	100.0%
Group Care %	1.9%		4.5%	1.4%	0.0%	2.2%	0.0%
		Network Distribution	*16.7%*	*19.9%*	*10.7%*	*37.7%*	*15.0%*
			% Direct:	**37%**		**% Delegated:**	**63%**

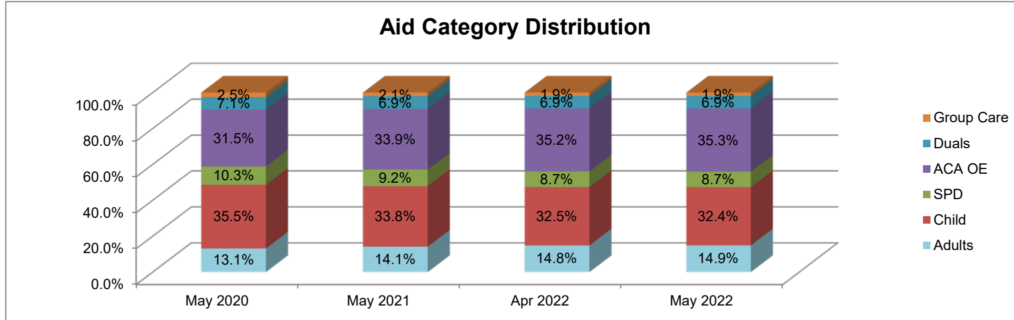




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

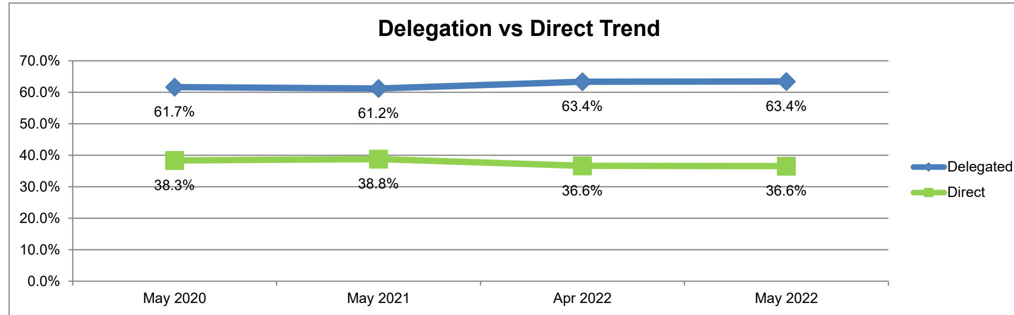
Category of Aid Trend

Category of Aid	Members May 2020	May 2021	Apr 2022	May 2022	% of Total (ie.Distribution) May 2020	May 2021	Apr 2022	May 2022	% Growth (Loss) May 2020 to May 2021	May 2021 to May 2022	Apr 2022 to May 2022
Adults	33,229	40,561	45,826	46,171	13.1%	14.1%	14.8%	14.9%	22.1%	13.8%	0.8%
Child	89,755	96,782	100,215	100,560	35.5%	33.8%	32.5%	32.4%	7.8%	3.9%	0.3%
SPD	25,985	26,289	26,848	26,958	10.3%	9.2%	8.7%	8.7%	1.2%	2.5%	0.4%
ACA OE	79,736	97,325	108,568	109,734	31.5%	33.9%	35.2%	35.3%	22.1%	12.8%	1.1%
Duals	17,971	19,851	21,456	21,527	7.1%	6.9%	6.9%	6.9%	10.5%	8.4%	0.3%
Medi-Cal Total	246,676	280,808	302,913	304,950	97.5%	97.9%	98.1%	98.1%	13.8%	8.6%	0.7%
Group Care	6,295	5,949	5,828	5,808	2.5%	2.1%	1.9%	1.9%	-5.5%	-2.4%	-0.3%
Total	**252,971**	**286,757**	**308,741**	**310,758**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**13.4%**	**8.4%**	**0.7%**



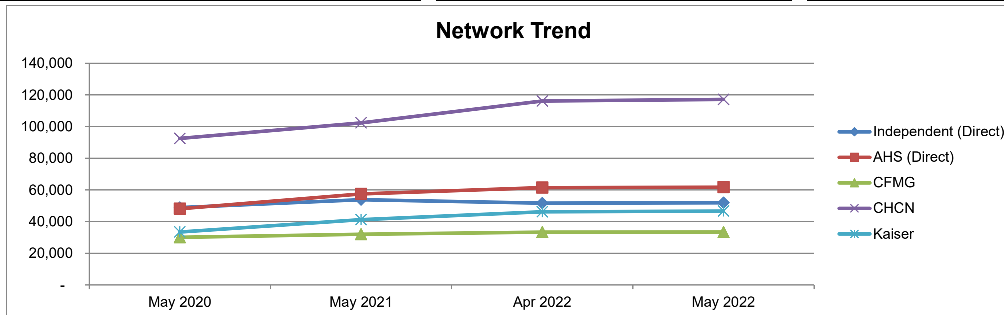
Delegation vs Direct Trend

Members	Members May 2020	May 2021	Apr 2022	May 2022	% of Total (ie.Distribution) May 2020	May 2021	Apr 2022	May 2022	% Growth (Loss) May 2020 to May 2021	May 2021 to May 2022	Apr 2022 to May 2022
Delegated	156,015	175,503	195,637	197,155	61.7%	61.2%	63.4%	63.4%	12.5%	12.3%	0.8%
Direct	96,956	111,254	113,104	113,603	38.3%	38.8%	36.6%	36.6%	14.7%	2.1%	0.4%
Total	**252,971**	**286,757**	**308,741**	**310,758**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**13.4%**	**8.4%**	**0.7%**



Network Trend

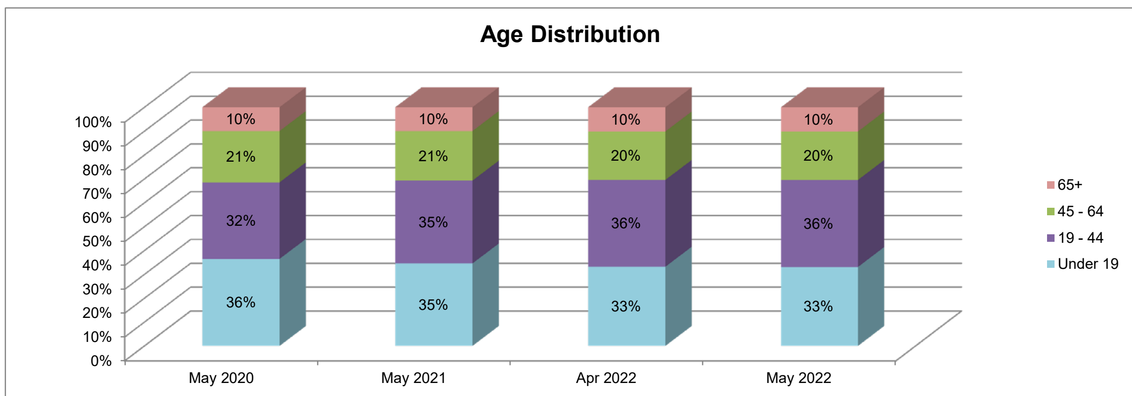
Network	Members May 2020	May 2021	Apr 2022	May 2022	% of Total (ie.Distribution) May 2020	May 2021	Apr 2022	May 2022	% Growth (Loss) May 2020 to May 2021	May 2021 to May 2022	Apr 2022 to May 2022
Independent (Direct)	48,857	53,817	51,662	51,910	19.3%	18.8%	16.7%	16.7%	10.2%	-3.5%	0.5%
AHS (Direct)	48,099	57,437	61,442	61,693	19.0%	20.0%	19.9%	19.9%	19.4%	7.4%	0.4%
CFMG	30,072	32,001	33,333	33,378	11.9%	11.2%	10.8%	10.7%	6.4%	4.3%	0.1%
CHCN	92,533	102,275	116,169	117,163	36.6%	35.7%	37.6%	37.7%	10.5%	14.6%	0.9%
Kaiser	33,410	41,227	46,135	46,614	13.2%	14.4%	14.9%	15.0%	23.4%	13.1%	1.0%
Total	**252,971**	**286,757**	**308,741**	**310,758**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**13.4%**	**8.4%**	**0.7%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

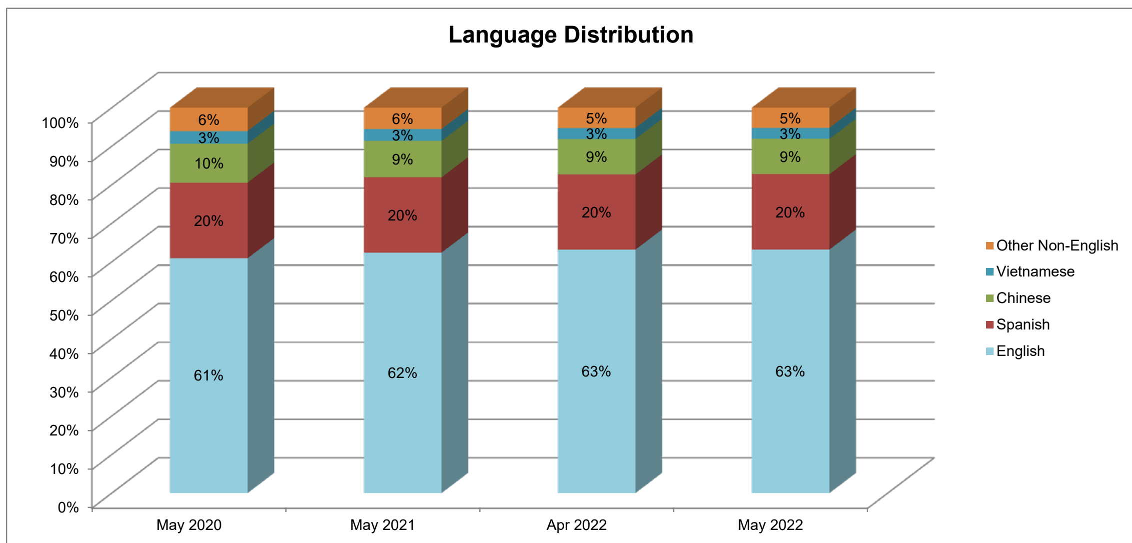
Age Category Trend

Age Category	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2020	May 2021	Apr 2022	May 2022	May 2020	May 2021	Apr 2022	May 2022	May 2020 to May 2021	May 2021 to May 2022	Apr 2022 to May 2022
Under 19	92,275	99,140	102,464	102,823	36%	35%	33%	33%	7%	4%	0%
19 - 44	81,146	99,528	112,308	113,325	32%	35%	36%	36%	23%	14%	1%
45 - 64	54,361	59,512	62,659	63,061	21%	21%	20%	20%	9%	6%	1%
65+	25,189	28,577	31,310	31,549	10%	10%	10%	10%	13%	10%	1%
Total	**252,971**	**286,757**	**308,741**	**310,758**	**100%**	**100%**	**100%**	**100%**	**13%**	**8%**	**1%**



Language Trend

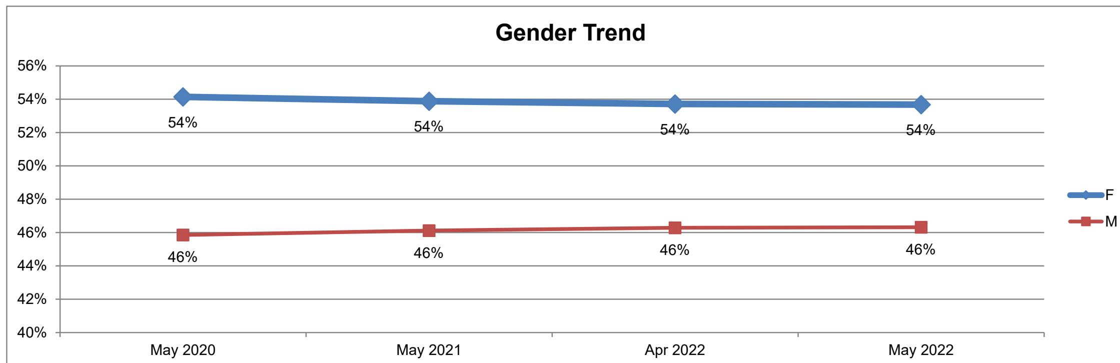
Language	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2020	May 2021	Apr 2022	May 2022	May 2020	May 2021	Apr 2022	May 2022	May 2020 to May 2021	May 2021 to May 2022	Apr 2022 to May 2022
English	154,121	178,901	194,983	196,309	61%	62%	63%	63%	16%	10%	1%
Spanish	49,663	56,029	60,230	60,778	20%	20%	20%	20%	13%	8%	1%
Chinese	25,538	27,121	28,433	28,583	10%	9%	9%	9%	6%	5%	1%
Vietnamese	8,336	8,787	8,863	8,868	3%	3%	3%	3%	5%	1%	0%
Other Non-English	15,313	15,919	16,232	16,220	6%	6%	5%	5%	4%	2%	0%
Total	**252,971**	**286,757**	**308,741**	**310,758**	**100%**	**100%**	**100%**	**100%**	**13%**	**8%**	**1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

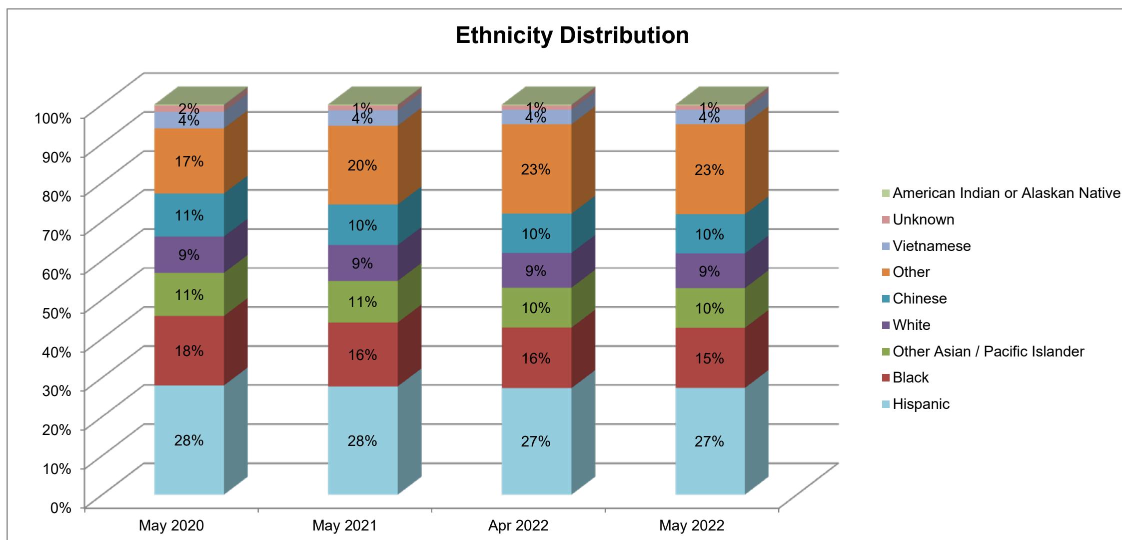
Gender Trend

Gender	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2020	May 2021	Apr 2022	May 2022	May 2020	May 2021	Apr 2022	May 2022	May 2020 to May 2021	May 2021 to May 2022	Apr 2022 to May 2022
F	136,969	154,516	165,836	166,816	54%	54%	54%	54%	13%	8%	1%
M	116,002	132,241	142,905	143,942	46%	46%	46%	46%	14%	9%	1%
Total	**252,971**	**286,757**	**308,741**	**310,758**	**100%**	**100%**	**100%**	**100%**	**13%**	**8%**	**1%**



Ethnicity Trend

Ethnicity	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2020	May 2021	Apr 2022	May 2022	May 2020	May 2021	Apr 2022	May 2022	May 2020 to May 2021	May 2021 to May 2022	Apr 2022 to May 2022
Hispanic	70,745	79,509	84,250	84,892	28%	28%	27%	27%	12%	7%	1%
Black	45,057	46,929	47,891	47,883	18%	16%	16%	15%	4%	2%	0%
Other Asian / Pacific Islander	27,943	30,597	31,590	31,631	11%	11%	10%	10%	9%	3%	0%
White	23,573	26,358	27,524	27,619	9%	9%	9%	9%	12%	5%	0%
Chinese	27,910	29,855	31,057	31,216	11%	10%	10%	10%	7%	5%	1%
Other	42,289	57,913	70,736	71,778	17%	20%	23%	23%	37%	24%	1%
Vietnamese	10,760	11,322	11,420	11,444	4%	4%	4%	4%	5%	1%	0%
Unknown	4,113	3,648	3,612	3,620	2%	1%	1%	1%	-11%	-1%	0%
American Indian or Alaskan Native	581	626	661	675	0%	0%	0%	0%	8%	8%	2%
Total	**252,971**	**286,757**	**308,741**	**310,758**	**100%**	**100%**	**100%**	**100%**	**13%**	**8%**	**1%**



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

Medi-Cal By City

City	May 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	119,841	39%	12,880	29,152	14,162	50,424	13,223
Hayward	47,469	16%	7,140	10,454	5,408	15,993	8,474
Fremont	27,689	9%	9,805	4,296	963	7,941	4,684
San Leandro	27,656	9%	4,445	4,158	3,460	10,474	5,119
Union City	12,750	4%	3,867	2,023	526	3,877	2,457
Alameda	11,683	4%	2,074	1,907	1,636	4,157	1,909
Berkeley	11,446	4%	1,545	1,695	1,313	5,121	1,772
Livermore	9,341	3%	1,040	746	1,886	3,956	1,713
Newark	7,057	2%	1,835	2,255	233	1,382	1,352
Castro Valley	7,628	3%	1,268	1,230	1,065	2,450	1,615
San Lorenzo	6,446	2%	846	1,100	724	2,403	1,373
Pleasanton	5,123	2%	979	425	509	2,305	905
Dublin	5,496	2%	991	447	681	2,325	1,052
Emeryville	2,078	1%	331	408	307	664	368
Albany	1,921	1%	269	216	363	674	399
Piedmont	369	0%	49	103	21	99	97
Sunol	59	0%	10	10	5	20	14
Antioch	31	0%	7	3	9	10	2
Other	867	0%	180	192	107	302	86
Total	**304,950**	**100%**	**49,561**	**60,820**	**33,378**	**114,577**	**46,614**

Group Care By City

City	May 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,915	33%	456	362	-	1,097	-
Hayward	656	11%	327	142	-	187	-
Fremont	617	11%	449	46	-	122	-
San Leandro	579	10%	221	93	-	265	-
Union City	315	5%	221	28	-	66	-
Alameda	279	5%	106	17	-	156	-
Berkeley	167	3%	47	10	-	110	-
Livermore	82	1%	28	1	-	53	-
Newark	146	3%	89	36	-	21	-
Castro Valley	186	3%	83	19	-	84	-
San Lorenzo	119	2%	48	15	-	56	-
Pleasanton	59	1%	23	3	-	33	-
Dublin	108	2%	36	11	-	61	-
Emeryville	34	1%	12	6	-	16	-
Albany	15	0%	6	1	-	8	-
Piedmont	14	0%	4	-	-	10	-
Sunol	-	0%	-	-	-	-	-
Antioch	28	0%	7	8	-	13	-
Other	489	8%	186	75	-	228	-
Total	**5,808**	**100%**	**2,349**	**873**	**-**	**2,586**	**-**

Total By City

City	May 2022	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	121,756	39%	13,336	29,514	14,162	51,521	13,223
Hayward	48,125	15%	7,467	10,596	5,408	16,180	8,474
Fremont	28,306	9%	10,254	4,342	963	8,063	4,684
San Leandro	28,235	9%	4,666	4,251	3,460	10,739	5,119
Union City	13,065	4%	4,088	2,051	526	3,943	2,457
Alameda	11,962	4%	2,180	1,924	1,636	4,313	1,909
Berkeley	11,613	4%	1,592	1,705	1,313	5,231	1,772
Livermore	9,423	3%	1,068	747	1,886	4,009	1,713
Newark	7,203	2%	1,924	2,291	233	1,403	1,352
Castro Valley	7,814	3%	1,351	1,249	1,065	2,534	1,615
San Lorenzo	6,565	2%	894	1,115	724	2,459	1,373
Pleasanton	5,182	2%	1,002	428	509	2,338	905
Dublin	5,604	2%	1,027	458	681	2,386	1,052
Emeryville	2,112	1%	343	414	307	680	368
Albany	1,936	1%	275	217	363	682	399
Piedmont	383	0%	53	103	21	109	97
Sunol	59	0%	10	10	5	20	14
Antioch	59	0%	14	11	9	23	2
Other	1,356	0%	366	267	107	530	86
Total	**310,758**	**100%**	**51,910**	**61,693**	**33,378**	**117,163**	**46,614**

Staff Report and Resolution

TO: Alameda Alliance for Health Board of Governors

FROM: Scott Coffin

DATE: July 8th, 2022

SUBJECT: At-Large Labor Seat (Regular #4) Member Nomination

RECOMMENDED ACTION

1. Adopt Resolution 2022-02 titled: "A Resolution of Alameda Alliance for Health Approving At-Large Labor Seat Nominee for Board of Governors Membership, and Recommending that the Alameda County Board of Supervisors Make an Appointment to the Board of Governors of Alameda Alliance for Health"

DISCUSSION

Due to the resignation of Nicholas Peraino, the Alameda Alliance for Health ("Alliance") Board of Governors has a vacancy of the At-Large Labor Seat (Regular #4). The Alliance Bylaws section 3.J.2 states that a vacant seat shall be filled for the unexpired term by an individual having the affiliation of their predecessor. Section 3.D.8 of the Bylaws sets forth the At-Large Labor Seat as a labor representative to be recommended by the Board. The Executive Committee of the Board has recommended Yeon Park, a labor union leader, from SEIU Local 1021, as the nominee for this vacant seat.

Resolution 2022-02 provides for the approval of Ms. Park as the At-Large Labor Seat nominee. If the resolution is passed and adopted by the Board of Governors, it will be sent to the Alameda County Board of Supervisors, who will vote on Ms. Park's appointment to the Board's At-Large Labor Seat.

FISCAL IMPACT

This action will not have a fiscal impact.

ATTACHMENTS

1. Resolution 2022-02

RESOLUTION NO. 2022-02

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

WHEREAS, The Alameda Alliance for Health ("Alliance") Board of Governors has a vacancy of the At-Large Labor Seat (Regular #4); and

WHEREAS, pursuant to Section 3.C of the Alliance Bylaws the Alliance Executive Committee recommends that the Alliance Board of Governors nominate Yeon Park to fill the vacant seat; and

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

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

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

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

SECTION 1. That the Alliance Board of Governors approves Yeon Park to fill the At-Large Labor Seat (Regular #4) on the Alliance Board of Governors, as created pursuant to Section 3.D.8 of the Alliance Bylaws.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors adopt a resolution by majority vote appointing Yeon Park as a member in the At-Large Labor Seat (Regular #4) of the Alliance Board of Governors.

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

PASSED AND ADOPTED by the Board at a meeting held on the 8th day of July 2022.

____
CHAIR, BOARD OF GOVERNORS

ATTEST:

____
Secretary

CalAIM Long Term Care Carve-In

Presented by the Integrated Planning, Health Care Services, and Operations Division Leadership Teams

Presented to the Alameda Alliance Board of Governors

July 8th, 2022

Agenda

ALAMEDA Alliance FOR HEALTH

Program Scope

Critical Path
- Provider Contracting & Credentialing
- Workflows/Process Requirements
- System Development & Configuration
- Staffing
- Cultural Competency
- Financial Forecast

Timeline

Risks & Mitigation

Discussion

Program Scope

Alameda Alliance for Health

- Long Term Care (LTC) is currently not the responsibility of Alameda Alliance
- AAH will be fully responsible for LTC Skilled Nursing Facility (SNF) and Custodial Care as of January 1st, 2023
  - Currently responsible for month of admit and month after
  - LTC Sub-acute, Intermediate Care Facilities (ICF) and Institutions for Mental Disease (IMD) will transition to MCPs no earlier than July 1st, 2023
- Transition coincides with two LTC Populations of Focus that go-live on January 1st, 2023
  - Adults Living in the Community at Risk for LTC Institutionalization
  - Nursing Facility Residents Transitioning to the Community

ALAMEDA Alliance FOR HEALTH

Critical Path

- **Provider Contracting & Credentialing**:
  - Continuity of Care is critical for all transitioning Members making contracting/credentialing an essential, large up-front effort
  - AAH currently contracts with 64 SNF facilities; contracts will be amended to include new requirements – in process
    - Likely that there are SNFs being utilized that are not currently contracted
  - Temporary letters of agreement will be executed with facilities if not contracted at time of transition; target date for contract execution is October 1st
  - De-identified data was received from DHCS on June 27th
    - 1,891 members currently with LTC Aid Codes
      - 1,675 Duals and 216 Non-Duals
    - Member-specific data expected from DHCS in November
      - Data will provide information on which facility each member resides in, and the implementation team will use this data to address any gaps in the SNF network
  - Also need to contract with SNF medical providers (SNFists) as well as other providers serving LTC members

Critical Path

Alameda Alliance for Health

- **Workflow & Process Design** Requirements:
  - Development of Business processes (Utilization & Case Management, Claims, Member & Provider Call Center, etc.) to support departmental and interdepartmental services for the LTC population
  - Create and/or update Policies and Procedures

- **System Development & Configurations**:
  - Developing interim and long-term solutions for authorization requests and claims processing
  - Proof of Concept testing for custom codes

Critical Path

- **Staffing & Recruitment**:
  - New LTC Department – starting with five (5) dedicated positions in Health Care Services; other departments will also have supporting positions (matrixed into Operations and LTC)
  - Estimated annual staffing costs of $1.5-$1.6M

ALAMEDA Alliance FOR HEALTH

Critical Path

- **Development of Cultural Competency** for Older Adults & Long-Term Care Patients:
  - **Member Focus**
    - Expand understanding of unique needs of Older Adults and developmentally & physically disabled LTC residents
    - Listening sessions will be scheduled with targeted stakeholders
    - Create a LTC Collaborative as part of the countywide CalAIM Stakeholder Committee to provide input from the community regarding the transition of this population to managed Medi-Cal
  - **Provider Focus**
    - LTC will be a Medi-Cal managed care benefit in Alameda County starting 1/1/2023:
      - We already work with many of the facility providers due to current SNF benefit (coverage for month of admit and month after)
      - Alameda Alliance will now be responsible to provide services and pay claims beyond month of and month after
      - Provider education and engagement required on benefit transition and timing, authorization request process, new coding requirements

Critical Path

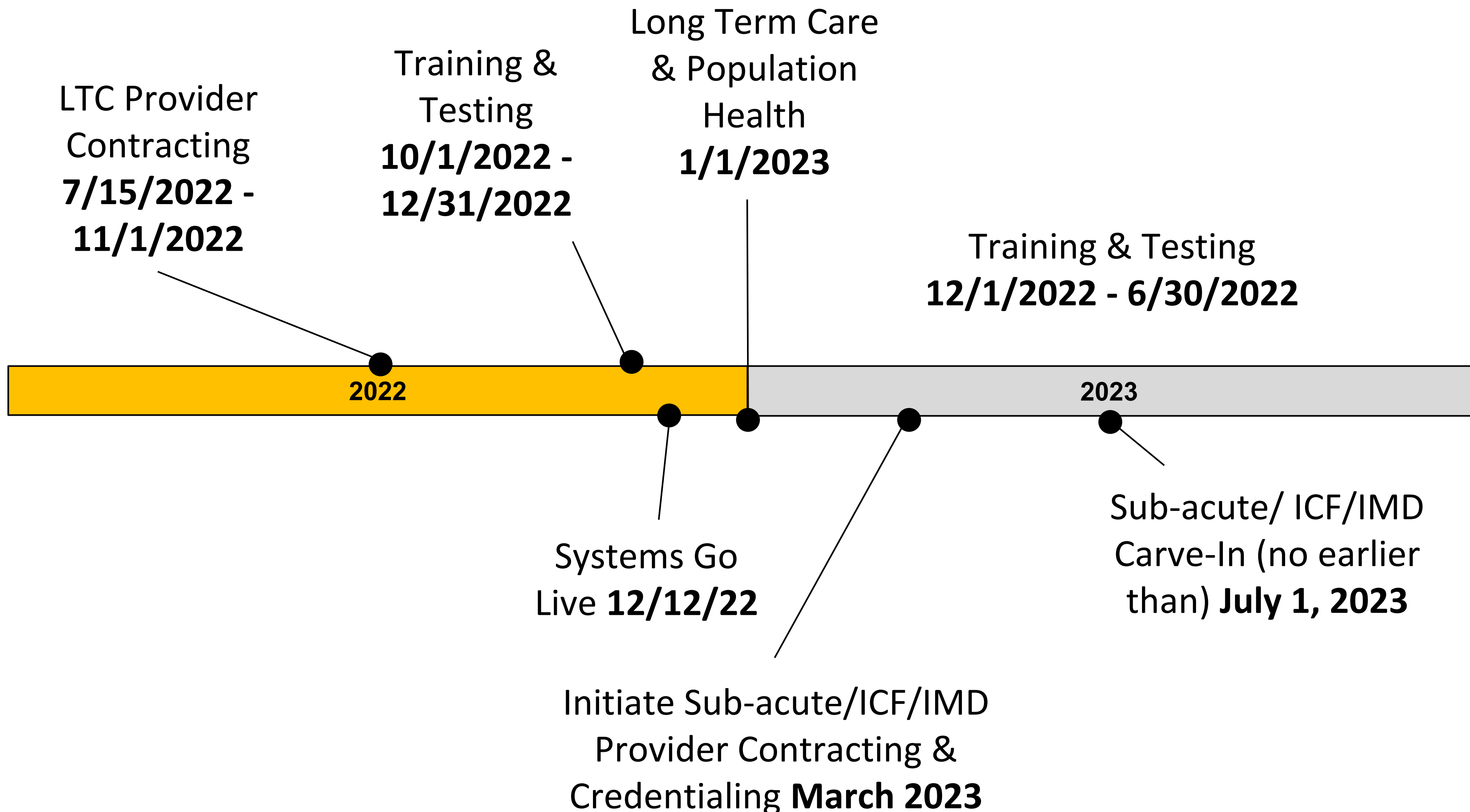
- **AAH Utilization and Clinical Impact**:
  - LTC population is largely unmanaged as it is handled by Fee-for-Service Medi-Cal
  - LTC transition to Managed Medi-Cal will:
    - Increase the number of members in acute care facilities
    - Increase the number and complexity of Transitions of Care
    - Increase the focus on quality of care, palliative care and end of life issues for some of our most ill members
    - Maintain Continuity of Care requirements & Member Rights.

Critical Path

- **Financial Forecast 2023**: Preliminary Budget
  - Enrollment: 300 LTC Medi-Cal Only Members and 1,200 LTC Duals
  - $79.3 million in revenue, $77.7 million in expense
  - Forecasted MLR 98%
  - DHCS has not established a risk corridor for LTC

CalAIM Long Term Care Carve-In

Implementation Phases in 2022 & 2023



Risks & Mitigation Plan

ALAMEDA Alliance FOR HEALTH

Area of Concern	Risk	Mitigation Plan
Contracting & Credentialing	≥64 Facilities requiring contract amendments and Providers Credentialing	Adding Contracting Specialist Consultants to work on Contracting
DHCS will not send identified Member data with facility location until November 2022	Potential delays in getting Members loaded into Systems to support care Potential to have members in non-contracted facilities	Using historical utilization and encounter data to try to predict location and volume Have strong LOA process in place for missed facilities
Staffing	5 dedicated positions to recruit, onboard and train	Recruitment firm hired to support LTC and other hiring efforts
Competing Priorities (CalAIM, Operations)	Human Resource & System Constraints	Monitor performance and adjust resource assignments

ALAMEDA Alliance FOR HEALTH

Questions?

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

Presented by the Integrated Planning, Health Care Services, and Operations Division Leadership Teams

Presented to the Alameda Alliance Board of Governors

July 8th, 2022

Agenda

ALAMEDA Alliance FOR HEALTH

Service Domains

Critical Path

- Contracting & Credentialing
- Workflows/Process Requirements
- System Development & Configuration
- Staffing

Risks & Mitigation

Discussion

Service Domains - “Lift & Shift”

ALAMEDA Alliance FOR HEALTH

1. **Care Transitions** – Workflow Process Development in Progress
2. **Utilization Management** – Workflow Process Development in Progress
3. **Quality Improvement** – Workflow Process Development in Progress
4. **Provider Network** – Contracting In Progress
5. **Credentialing** – In Progress
6. **Customer Service** – Workflow Process Development in Progress
7. **Claims Processing & Payment** – Workflow Process Development in Progress

Critical Path

- Contracting & Credentialing
  - Prioritized by volume; first wave of contracts being sent to Providers treating the most Members
- Workflow Design Requirements
  - In Progress
- System Development & Configurations
  - Requirements gathering in progress
- Staffing
  - In Progress (Posting positions and interviewing)

ALAMEDA Alliance FOR HEALTH

Staffing Update

Department	Total Staff to Hire	Hired	Percent Complete	Comments
Analytics	1	0	0%	Interviewing
Compliance & Legal	3	0	0%	
Finance	2	0	0%	
HCS	10	1	10%	Interviewing
IT				
Operations- Claims	4	0	0%	
Operations- Credentialing	2	0	0%	
Operations- Member Svcs	5	0	0%	1 position being graded 2 positions posted
Operations- Provider Svcs	6	0	0%	

ALAMEDA Alliance FOR HEALTH

Risks & Mitigation Plan

Area of Concern	Risk	Mitigation Plan
Contracting & Credentialing	200+ Facilities requiring contract amendments and Providers Credentialing	Adding Contracting Specialist Consultants to work on Contracting
Staffing	36 positions to recruit, onboard and train	Recruitment firm hired to support MH Insourcing and other hiring efforts
Competing Priorities	Resource & System Constraints	Monitor

Other Constraints

- Competing Priorities
  - CalAIM
    - → 2023 Populations of Focus (PoFs)
    - → LTC
  - Incentive Programs
    - – Behavioral Health Integration Incentive Program (BHIIP)
    - – CalAIM Incentive Payment Program (IPP)
    - – Housing and Homelessness Incentive Program (HHIP)
    - – Student Behavioral Health Incentive Program (SBHIP)
  - Operational Readiness for 2024 DHCS MCP Contract / RFP Single Plan
  - Audits
  - Performance Evaluations

ALAMEDA Alliance FOR HEALTH

Questions?

Operations

Matt Woodruff

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

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

Date: **July 8th, 2022**

Subject: **Operations Report**

Member Services

- 12-Month Trend Summary:
  - The Member Services Department received a twenty-one percent (21%) decrease in calls in June 2022, totaling 12,793 compared to 16,149 in June 2021. Call volume pre-pandemic in June 2019 was 13,740, which is seven percent (7%) higher than the current call volume.
  - The abandonment rate for June 2022 was thirteen percent (13%), compared to fifteen percent (15%) in June 2021.
  - The Department's service level was fifty-one percent (51%) in June 2022, compared to forty-four percent (44%) in June 2021. The Department continues to recruit to fill open positions. Service levels continue to be directly impacted due to staffing challenges (unplanned callouts related to personal or family illnesses with COVID-19). Training of customer call support vendor is ongoing to augment queue support.
  - The average talk time (ATT) was six minutes and fifty-three seconds (06:53) for June 2022 compared to six minutes and twenty-three seconds (06:23) for June 2021.
  - Member utilization of self-service phone options totaled one thousand thirty-five (1035) in June 2022, which includes seventy-seven (77) for the member automated eligibility IVR system. The Department continues to analyze IVR prompt utilization and employs member feedback to improve the member's experience and meet the ever-changing needs of our members.
  - The top five call reasons for June 2022 were: 1). Change of PCP, 2). Kaiser, 3) Eligibility/Enrollment, 4). Benefits, 5). Provider Network Information. The top five call reasons for June 2021 were: 1). Eligibility/Enrollment, 2). Change of PCP, 3). Kaiser, 4). Benefits, 5). Correspondence Question/Follow-Up.
  - The Department continues to service members via multiple non-contact communication channels (telephonic, email, web-based requests) while honoring the organization's policies. The Department responded to five hundred eighty-one (581) web-based requests (19% increase) in June 2022 compared to four hundred seventy-two (472) in June 2021. The top three

web reason requests for June 2022 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information.

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

Claims

- 12-Month Trend Summary:
    - The Claims Department received 173,269 claims in June 2022 compared to 136,687 in June 2021.
    - The Auto Adjudication was 84% in June 2022 compared to 72.6% in June 2021.
    - Claims compliance for the 30-day turn-around time was 97.8% in June 2022 compared to 93.7% in June 2021. The 45-day turn-around time was 99.9% in June 2022 compared to 99.9% in June 2021.
- Training:
    - Routine and new hire training is being conducted remotely by the Claims Trainer.
- Monthly Analysis:
    - In June, we received a total of 173,269 claims in the HEALTHsuite system. This represents an increase of 6.12% from June and is higher, by 36,582 claims, than the number of claims received in June 2021; the higher volume of received claims remains attributed to COVID-19, COBA implementation, and increased membership.
    - We received 86% of claims via EDI and 14% of claims via paper.
    - During June, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 84% for June.

Provider Services

- 12-Month Trend Summary:

- The Provider Services department's call volume in June 2022 was 5,215 calls compared to 5,588 calls in June 2021.
- Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our priority.
- The Provider Services department completed 185 calls/visits during June 2022.
- The Provider Services department answered 3,703 calls for June 2022 and made 573 outbound calls.

Credentialing

- 12-Month Trend Summary:
  - At the Peer Review and Credentialing (PRCC) meeting held on June 21st, 2022, there were fifteen (15) initial providers approved; two (2) primary care providers, seven (7) specialists, zero (0) ancillary provider, and six (6) midlevel providers. Additionally, forty-three (43) providers were re-credentialed at this meeting; thirteen (13) primary care providers, sixteen (16) specialists, one (1) ancillary provider, and thirteen (13) 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 June 2022, the Provider Dispute Resolution (PDR) team received 1573 PDRs versus 658 in June 2021. 922 Cases from University Healthcare.
  - The PDR team resolved 872 cases in June 2022 compared to 741 cases in June 2021.
  - In June 2022, the PDR team upheld 69% of cases versus 67% in June 2021.
  - The PDR team resolved 99.8% of cases within the compliance standard of 95% within 45 working days in June 2022 compared to 99.1% in June 2021.

- Monthly Analysis:
  - AAH received 1573 PDRs in June 2022. Nine hundred twenty-two (922) cases from University Healthcare.

- In June, 872 PDRs were resolved. Out of the 872 PDRs, 598 were upheld, and 274 were overturned.
- The overturn rate for PDRs was 31% which did not meet our goal of 25% or less.

Community Relations and Outreach

- 12-Month Trend Summary:
  - In Q4 2022, the Alliance completed 1,329-member orientation outreach calls and 396 member orientations by phone.
  - The C&O Department reached 396 people, 100% identified as Alliance members, compared to 531 individuals who identified as Alliance members in Q4 2021.
  - The C&O Department spent a total of $0 in donations, fees, and/or sponsorships, compared to $0 in Q4 2021.
  - The C&O Department reached members in 17 cities/unincorporated areas throughout Alameda County, Bay Area, and the U.S., compared to 24 locations in Q4 2021.

- Quarterly Analysis:
  - In Q4 2022, the C&O Department completed 1,329-member orientation outreach calls and 396 member orientations by phone.
  - Among the 396 people reached, 100% identified as Alliance members.
  - In Q4 2022, the C&O Department reached members in 17 locations throughout Alameda County, Bay Area, and the U.S.

- Monthly Analysis:
  - In June 2022, the C&O Department completed 445-member orientation outreach calls and 143 member orientations by phone, and 46 Alliance website inquiries.
  - Among the 143 people reached, 100% identified as Alliance members.
  - In June 2022, the C&O Department reached members in 14 locations throughout Alameda County, Bay Area, and the U.S.
  - Please see attached **Addendum A**.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	June 2022
Incoming Calls (R/V)	12,793
Abandoned Rate (R/V)	13%
Answered Calls (R/V)	11,071
Average Speed to Answer (ASA)	03:48
Calls Answered in 60 Seconds (R/V)	51%
Average Talk Time (ATT)	06:53
Outbound Calls	6,019

Top 5 Call Reasons (Medi-Cal and Group Care) June 2022
Change of PCP
Kaiser
Eligibility/Enrollment
Benefits
Provider Network

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

Claims Department
May 2022 Final and June 2022 Final

METRICS

Claims Compliance	May-22	Jun-22
90% of clean claims processed within 30 calendar days	98.7%	97.8%
95% of all claims processed within 45 working days	99.9%	99.9%

Claims Volume (Received)	May-22	Jun-22
Paper claims	22,061	23,748
EDI claims	141,211	149,521
Claim Volume Total	**163,272**	**173,269**

Percentage of Claims Volume by Submission Method	May-22	Jun-22
% Paper	13.51%	13.71%
% EDI	86.49%	86.29%

Claims Processed	May-22	Jun-22
HEALTHsuite Paid (original claims)	103,670	129,062
HEALTHsuite Denied (original claims)	47,209	59,474
HEALTHsuite Original Claims Sub-Total	**150,879**	**188,536**
HEALTHsuite Adjustments	1,470	1,191
HEALTHsuite Total	**152,349**	**189,727**

Claims Expense	May-22	Jun-22
Medical Claims Paid	$51,796,011	$59,796,097
Interest Paid	$26,542	$32,765

Auto Adjudication	May-22	Jun-22
Claims Auto Adjudicated	126,251	158,457
% Auto Adjudicated	83.7%	84.0%

Average Days from Receipt to Payment	May-22	Jun-22
HEALTHsuite	18	19

Pended Claim Age	May-22	Jun-22
0-29 calendar days		
HEALTHsuite	13,693	13,915
30-59 calendar days		
HEALTHsuite	383	208
Over 60 calendar days		
HEALTHsuite	4	1

Overall Denial Rate	May-22	Jun-22
Claims denied in HEALTHsuite	47,209	59,474
% Denied	31.0%	31.3%

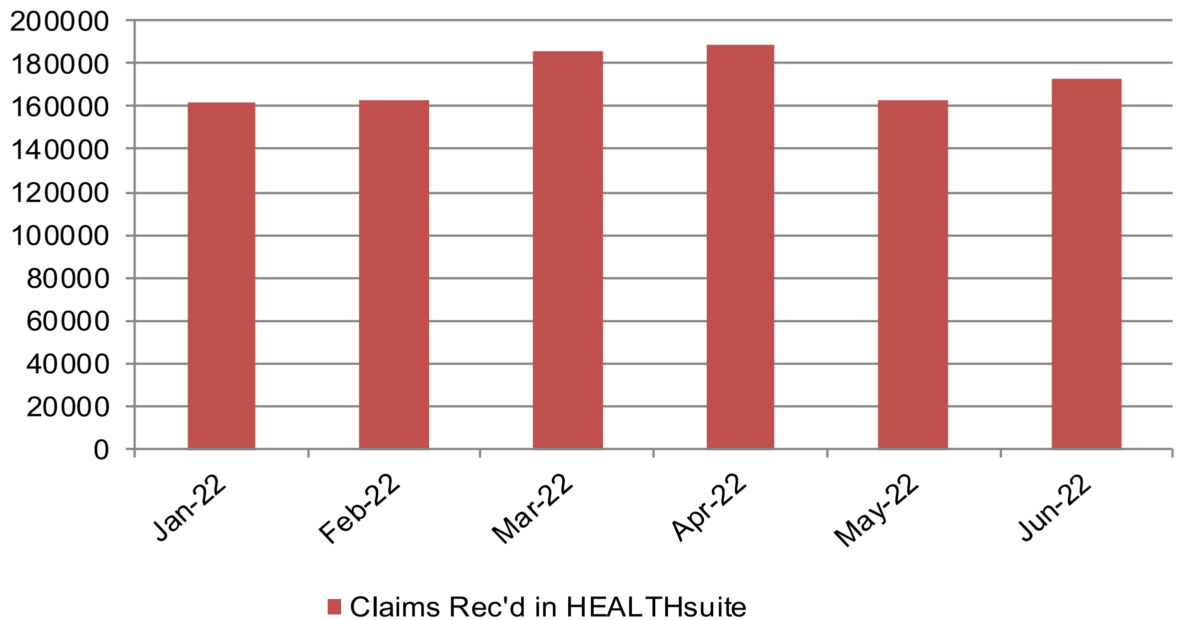
Claims Department
May 2022 Final and June 2022 Final

Jun-22

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	24%
No Benefits Found For Dates of Service	15%
Non-Covered Benefit for this Plan	12%
Duplicate Claim	10%
This is a Capitated Service	5%
% Total of all denials	**66%**

Claims Received By Month

Run Date	2/1/2022	3/1/2022	4/1/2022	5/1/2022	6/1/2022	7/1/2022
Claims Received Through	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**
Claims Rec'd in HEALTHsuite	162,201	162,433	185,738	189,172	163,272	173,269



Provider Relations Dashboard June 2022

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	4810	4334	6078	5767	5236	5215						
Abandoned Calls	626	586	2149	2219	1333	1512						
Answered Calls (PR)	4184	3748	3929	3548	3903	3703						
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	332	373	1067	1309	677	807						
Abandoned Calls (R/V)												
Answered Calls (R/V)	332	373	1067	1309	677	807						
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	624	680	664	640	677	573						
N/A												
Outbound Calls	624	680	664	640	677	573						
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	5766	5387	7809	7716	6590	6595						
Abandoned Calls	626	586	2149	2219	1333	1512						
Total Answered Incoming, R/V, Outbound Calls	5140	4801	5660	5497	5257	5083						

Provider Relations Dashboard June 2022

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	3.4%	4.2%	3.4%	3.0%	3.3%	3.4%						
Benefits	4.1%	3.4%	3.1%	3.8%	3.9%	3.1%						
Claims Inquiry	40.2%	41.5%	40.8%	48.8%	44.8%	47.8%						
Change of PCP	2.4%	4.0%	4.8%	4.1%	5.0%	4.2%						
Complaint/Grievance (includes PDR's)	4.9%	5.3%	4.8%	4.2%	3.8%	3.5%						
Contracts	0.5%	0.7%	0.8%	0.7%	1.1%	1.2%						
Correspondence Question/Followup	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%						
Demographic Change	0.1%	0.3%	0.0%	0.1%	0.0%	0.1%						
Eligibility - Call from Provider	25.3%	23.2%	22.6%	21.4%	23.2%	18.8%						
Exempt Grievance/ G&A	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%						
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Intrepreter Services Request	0.8%	0.4%	0.8%	0.7%	1.0%	0.8%						
Kaiser	0.0%	0.1%	0.1%	0.7%	0.1%	0.0%						
Member bill	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%						
Mystery Shopper Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Provider Portal Assistance	4.5%	5.4%	4.9%	3.9%	4.2%	4.0%						
Pharmacy	1.2%	0.3%	0.3%	0.3%	0.2%	0.1%						
Provider Network Info	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%						
Transferred Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
All Other Calls	12.3%	10.8%	13.4%	8.2%	9.2%	12.8%						
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	9	18	17	12	7	15						
Contracting/Credentialing	8	10	28	20	12	14						
Drop-ins	0	0	0	0	0	0						
JOM's	1	2	3	1	4	2						
New Provider Orientation	22	15	34	22	22	5						
Quarterly Visits	211	274	159	175	201	149						
UM Issues	2	4	2	1	2	0						
Total Field Visits	253	323	243	231	248	185	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS

Practitioners		AHP 408	PCP 352	SPEC 626	PCP/SPEC 15
AAH/AHS/CHCN Breakdown		AAH 408	AHS 161	CHCN 425	COMBINATION OF GROUPS 407
Facilities	**297**				

VENDOR SUMMARY
Credentialing Verification Organization, Symply CVO

	Number	**Average Calendar Days in Process**	**Goal - Business Days**	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	13	6	25	Y	Y
Recred Files in Process	6	37	25	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**19**				

CAQH Applications Processed in June 2022

Standard Providers and Allied Health	**Invoice not received**

June 2022 Peer Review and Credentialing Committee Approvals

Initial Credentialing	**Number**
PCP	2
SPEC	7
ANCILLARY	0
MIDLEVEL/AHP	6
	15
Recredentialing	
PCP	13
SPEC	16
ANCILLARY	1
MIDLEVEL/AHP	13
	43
TOTAL	**58**

June 2022 Facility Approvals

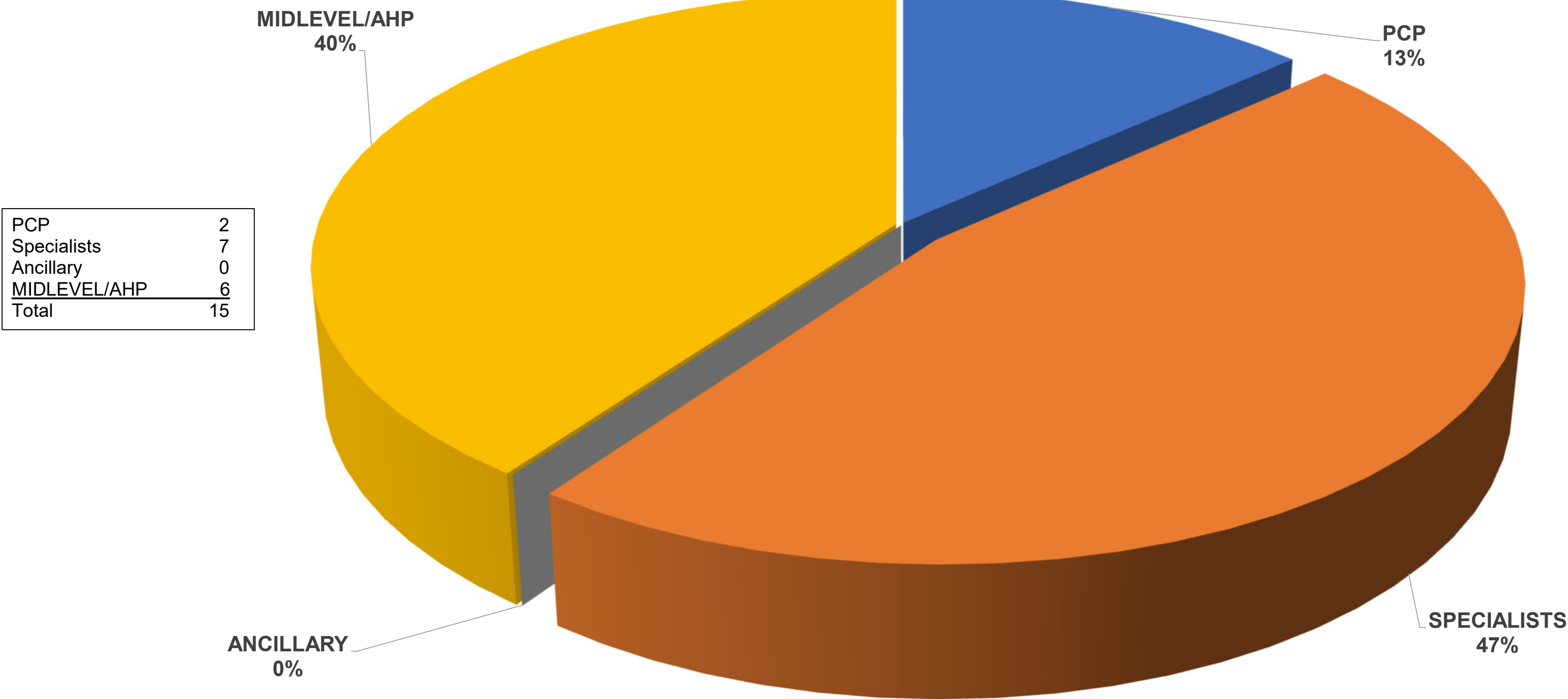
Initial Credentialing	2
Recredentialing	6
	8
Facility Files in Process	**30**

June 2022 Employee Metrics 4

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

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Agarwal	Sanjay	Specialist	6/21/2022	INITIAL
Allen	Emile	Specialist	6/21/2022	INITIAL
James	Jaison	Specialist	6/21/2022	INITIAL
Kelley	Kanwar	Specialist	6/21/2022	INITIAL
Kragie	Alexandria	Specialist	6/21/2022	INITIAL
Morais	Luisa	Allied Health	6/21/2022	INITIAL
Nemeth	Nicole	Specialist	6/21/2022	INITIAL
Saifulrahman	Najibulrahman	Primary Care Physician	6/21/2022	INITIAL
Schott	Katherine	Allied Health	6/21/2022	INITIAL
Sharma	Shashi	Primary Care Physician	6/21/2022	INITIAL
Souza	Magda	Allied Health	6/21/2022	INITIAL
Sun	Macy	Allied Health	6/21/2022	INITIAL
Tamplen	Matthew	Specialist	6/21/2022	INITIAL
Yang	Paige	Allied Health	6/21/2022	INITIAL
Yoo	Karam	Allied Health	6/21/2022	INITIAL
Bohman	Corey	Allied Health	6/21/2022	RECRED
Chan	Debbie	Allied Health	6/21/2022	RECRED
Cheng	Ernest	Specialist	6/21/2022	RECRED
Chica	Gabriela	Allied Health	6/21/2022	RECRED
Chin	Angela	Allied Health	6/21/2022	RECRED
Chu	Jason	Specialist	6/21/2022	RECRED
Cortez	Michelle	Allied Health	6/21/2022	RECRED
Duterte	Jason	Allied Health	6/21/2022	RECRED
Edelen	John	Specialist	6/21/2022	RECRED
Fisher	Mary	Primary Care Physician	6/21/2022	RECRED
Fong	Stewart	Primary Care Physician	6/21/2022	RECRED
Garcia	Jennie	Specialist	6/21/2022	RECRED
Ghosh	Dipankar	Primary Care Physician	6/21/2022	RECRED
Hsu	Mark	Specialist	6/21/2022	RECRED
Hyder	Shakir	Specialist	6/21/2022	RECRED
Ing	Dennis	Primary Care Physician	6/21/2022	RECRED
Jiang	Lei	Allied Health	6/21/2022	RECRED
Kane	Amy	Specialist	6/21/2022	RECRED
Kramer	Arin	Allied Health	6/21/2022	RECRED
Krosin	Michael	Specialist	6/21/2022	RECRED
Kudaravalli	Padmavathi	Primary Care Physician	6/21/2022	RECRED
Lee	Peter	Specialist	6/21/2022	RECRED
Lerner	Dimitry	Specialist	6/21/2022	RECRED
Longmuir	Nicola	Primary Care Physician	6/21/2022	RECRED
Lopez	Brenda	Allied Health	6/21/2022	RECRED
Lowery	William	Primary Care Physician and Specialist	6/21/2022	RECRED
Lunny	Peter	Specialist	6/21/2022	RECRED
Massen	Arkady	Primary Care Physician	6/21/2022	RECRED
McBride	Thomas	Primary Care Physician	6/21/2022	RECRED
Mehandru	Leena	Specialist	6/21/2022	RECRED
Murthy	Anjali	Specialist	6/21/2022	RECRED
Nguyen	Danielle	Primary Care Physician	6/21/2022	RECRED
Ruiz Iniguez	Norma	Allied Health	6/21/2022	RECRED
Shah	Swapnil	Specialist	6/21/2022	RECRED
Sharpe	Cynthia	Allied Health	6/21/2022	RECRED
Tran	Yen	Allied Health	6/21/2022	RECRED
Veeragandham	Ramesh	Specialist	6/21/2022	RECRED
Vu	Cuong	Primary Care Physician	6/21/2022	RECRED
Woo	Sandi	Allied Health	6/21/2022	RECRED
Yumena	Lucia	Specialist	6/21/2022	RECRED
Zafer	Sadaf	Primary Care Physician	6/21/2022	RECRED
Zhang	Lan	Primary Care Physician	6/21/2022	RECRED
Zhu	Baibing	Ancillary	6/21/2022	RECRED

JUNE PEER REVIEW AND CREDENTIALING INITIAL APPROVALS BY SPECIALTY



PCP	2
Specialists	7
Ancillary	0
MIDLEVEL/AHP	6
Total	15

Provider Dispute Resolution
May 2022 and June 2022

METRICS

PDR Compliance	May-22	Jun-22
# of PDRs Resolved	852	872
# Resolved Within 45 Working Days	836	870
% of PDRs Resolved Within 45 Working Days	98.1%	99.8%

PDRs Received	May-22	Jun-22
# of PDRs Received	737	1,573
PDR Volume Total	**737**	**1,573**

PDRs Resolved	May-22	Jun-22
# of PDRs Upheld	597	598
% of PDRs Upheld	70%	69%
# of PDRs Overturned	255	274
% of PDRs Overturned	30%	31%
Total # of PDRs Resolved	**852**	**872**

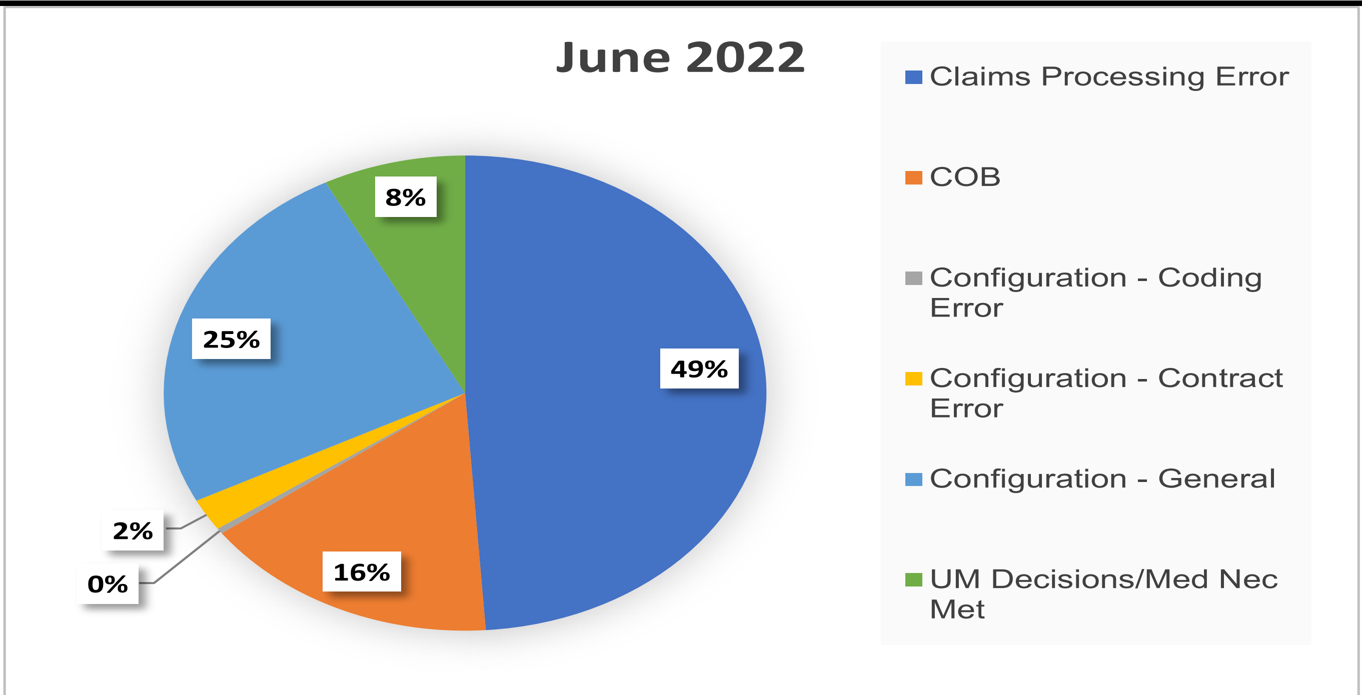
Average Turnaround Time	May-22	Jun-22
Average # of Days to Resolve PDRs	29	29
Oldest Unresolved PDR in Days	85	58

Unresolved PDR Age	May-22	Jun-22
0-45 Working Days	799	1,801
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**799**	**1,801**

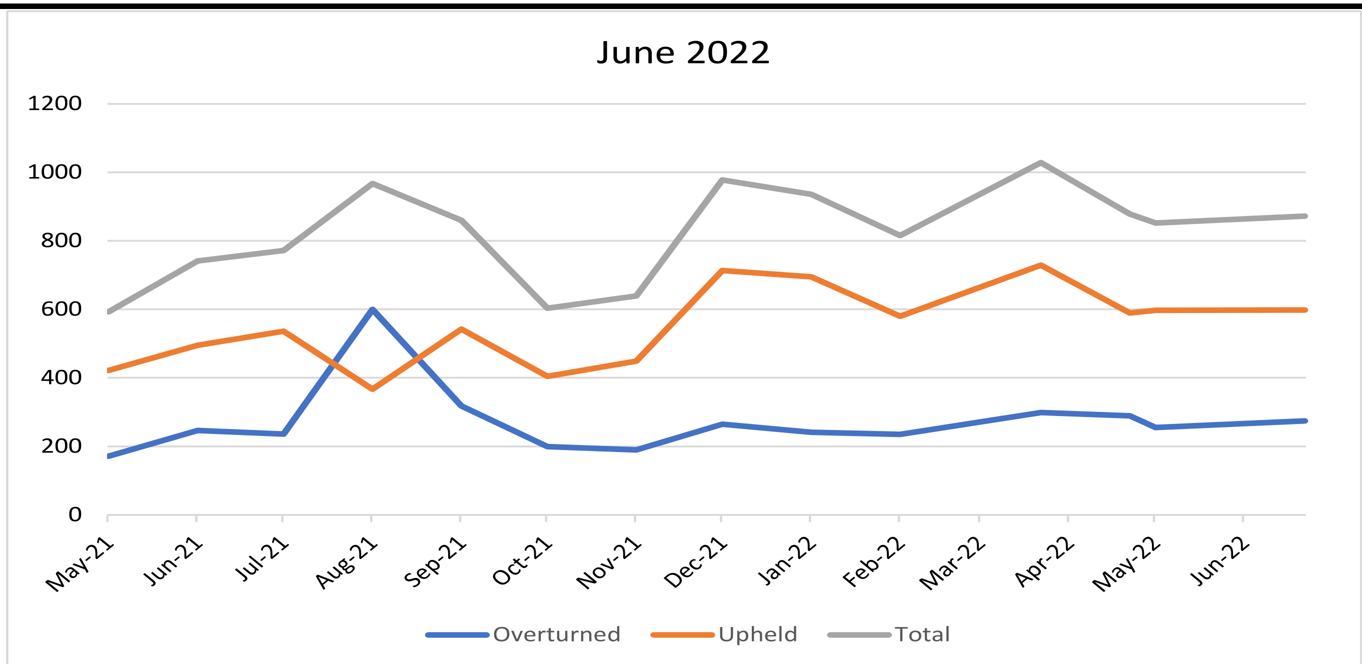
Provider Dispute Resolution
May 2022 and June 2022

Jun-22

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2021 - 2022 | 4TH QUARTER (Q4) OUTREACH REPORT

ALLIANCE IN THE COMMUNITY

FY 2020 - 2021 | 4TH QUARTER (Q4) OUTREACH REPORT

Between April 2022 and June 2022, the Alliance completed **1,329**-member orientation outreach calls and conducted **396** member orientations (**30%-member** participation rate). The Communications & Outreach (C&O) Department also completed **6** Service Requests, and **151** Website Inquires in Q4.

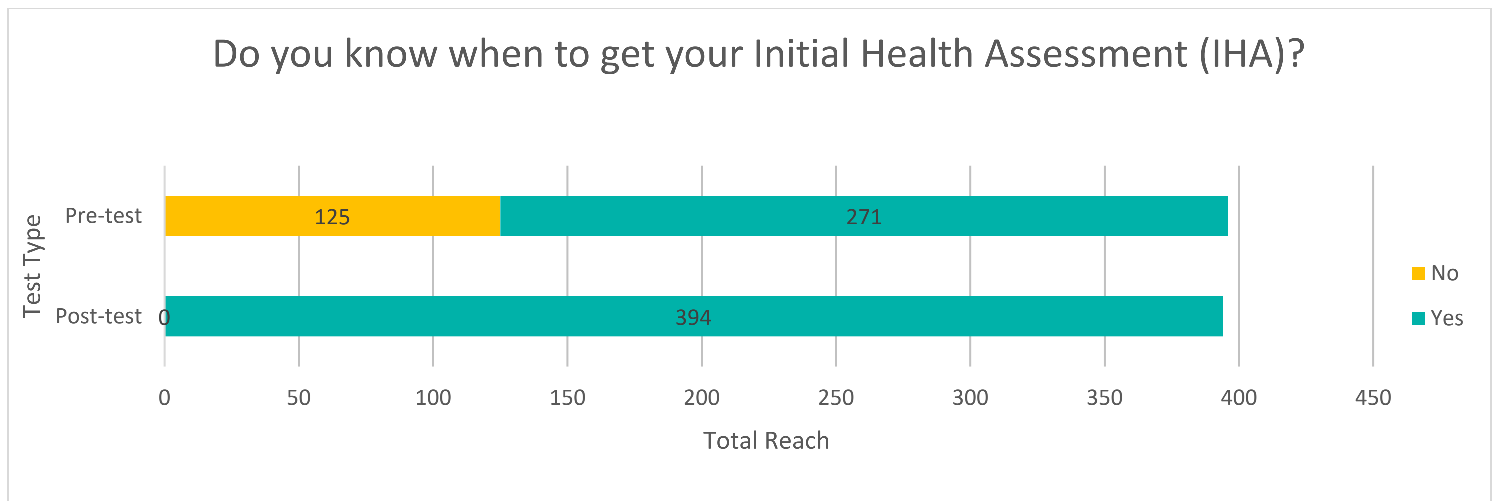
The C&O Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **25,294** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of June 30th, 2022, the Outreach Team completed **19,299**-member orientation outreach calls and conducted **5,469** member orientations (**28%-member** participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18th, 2020 through June 30th, 2022 – **5,469** members completed our MO program by phone.

After completing a MO **100%** of members who completed the post-test survey in Q4 FY 21-22 reported knowing when to get their IHA, compared to only **68.4%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 21-22\Q4\3. June**

ALLIANCE IN THE COMMUNITY

FY 2021 - 2022 | 4TH QUARTER (Q4) OUTREACH REPORT

Q4 FY 2021-2022 TOTALS

0	VIRTUAL COMMUNITY EVENTS	**0**	TOTAL REACHED AT VIRTUAL COMMUNITY EVENTS
0	MEMBER EDUCATION EVENTS	**0**	TOTAL REACHED AT MEMBER EDUCATION EVENTS
396	MEMBER ORIENTATIONS	**396**	TOTAL REACHED AT MEMBER ORIENTATIONS
0	MEETINGS/ PRESENTATIONS	**0**	TOTAL REACHED AT MEETINGS/PRESENTATIONS
0	TOTAL INITIATED/INVITED EVENTS	**396**	TOTAL MEMBERS REACHED AT EVENTS
396	TOTAL EVENTS	**396**	TOTAL REACHED AT ALL EVENTS

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

TOTAL REACH 17 CITIES

******Cities represent the mailing addresses for members who completed a Member Orientation by phone. The italicized cities are outside of Alameda County. The following cities had a <1% reach during Q4 2021: Elk Grove, Hermiston, and Martinez. The C&O Department started including these cities in the Q3 FY21 Outreach Report.*

$0

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

Compliance

Richard Golfin III

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

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

Date: **July 8th, 2022**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2022 DHCS Routine Medical Survey:
  - The 2022 DHCS Routine Medical Survey has concluded the on-site portion of the review process. The Plan has not received an update on audit status from the State since the Exit Conference held on April 13th, 2022. Preliminary Audit Findings are expected this coming Summer 2022.

- 2022 DMHC Routine Financial Examination:
  - On May 23rd, 2022, the DMHC sent notice to the Plan of the 2022 DMHC Routine Financial Examination beginning August 15th, 2022. The audit will review the Plan's fiscal and administrative affairs and activities through the quarter-ending March 31st, 2022. The audit will be conducted remotely and cover the following areas:
    - Affiliate and non-Affiliate Agreements
    - Management Assessment Questionnaires
    - Plan Financial Information
  - Staff are preparing the pre-audit documentation, which is due to the DMHC on July 15th, 2022.

- 2022 DMHC Behavioral Health Investigation [MHPAEA]:
  - In 2021, the DMHC began investigating full-service commercial health plans to evaluate and assess barriers providers experience in providing behavioral health services. The Audit is a review of Mental Health Parity at the Plan and excludes the Medi-Cal Line of Business. On May 9th, 2022, the Plan received notice that the DMHC will conduct interviews with the Plan and its delegate beginning September 5th, 2022. The review period for this audit is April 1st, 2020, through April 30th, 2022.
  - The submission included more than 1000-documents split into 142 Sections over 3-phases. On June 23rd, 2022, the Plan completed submission of Phase 1 & 2 of the pre-audit documentation. The Plan is expected to complete Phase 3 pre-audit submissions on or around July 5, 2022.

- 2022 NCQA Re-Accreditation Survey:
    - On February 24th, 2022, the Plan received confirmation from the National Committee of Quality Assurance (NCQA) of its 2022 Re-Accreditation Survey. The Audit began in early June 2022, with an on-site portion expected to last from July 25th, 2022, through July 26th, 2022. On June 29th, 2022, the Plan received initial observations and questions from the NCQA audit team. Staff are working through the list of 20 observations and developing its responses to provide a comprehensive assessment of our preparedness for the audit.
    - The Plan holds active accreditation for both its Medi-Cal and Commercial Lines of Business.

- 2021 DMHC Full Medical Survey:
    - The 2021 DMHC Routine Medical Survey, virtual audit took place from April 13th, 2021, through April 16th, 2021. On May 25th, 2022, the Plan received its 2021 Preliminary Audit Report and survey results. The preliminary report had a total of six (6) findings: three (3) in Grievances and Appeals; and three (3) in Prescription Drug Coverage. On June 15th, 2021, the Plan participated in an exit interview where the DMHC explained its findings and next steps. The Plan's response is due on July 9th, 2022.

Delegation Oversight Audit Activity Updates

- 2022 Kaiser Collaborative Plan Audit:
    - The 2022 Delegation Audit Season is underway with the next major audit expected to be Kaiser Foundation Health (Kaiser) Plan beginning in July 2022. The Kaiser Audit is a joint audit held in collaboration with Northern California Local Initiative Health Plans. The participating health plans are: Alameda Alliance for Health; Contra Costa Health Plan; Health Plan of San Joaquin; Health Plan of San Mateo; Partnership Health Plan; San Francisco Health Plan; and, Contra Costa Health Plan. The Lead Plan is the Health Plan of San Joaquin, who will be responsible for coordinating audit responses, audit reviews, and keeping participating plans on schedule during the various stages of the audit. The Preliminary Audit Report for the KFHP is expected by November 1st, 2022.

Compliance Activity Updates

- 2022 RFP Contract Award & Review:
    - On February 9th, 2022, the DHCS released Request for Proposal (RFP) #20-10029 soliciting submissions for the 2024 Contract for the provision of managed health care services to Medi-Cal beneficiaries. The contract award is expected in August 2022, with implementation to take place through December 31st, 2023.
    - On June 15th & 22nd, 2022, Staff attended DHCS's Operational Readiness kick-off meeting, which is primarily focused on pre-submission logistics and

process overview. Deliverable submissions will take place from August 12th, 2022, to July 31st, 2023, in three phases:

  - Phase 1 will take place from August 12th, 2022 – December 8th, 2022. Forty-two percent (42%) of the deliverables will be submitted during this period.
  - Phase 2 will take place from December 15th, 2022 – March 31st, 2023. Thirty-three percent (33%) of the deliverables will be submitted during this period.
  - Phase 3 will take place from April 20th, 2023 – July 31st, 2023. Twenty-five percent (25%) of the deliverables will be submitted during this period.

- Staff are preparing internal stakeholders and systems for the upcoming submissions. Project leads have been assigned and a comprehensive approach to the months-long submission is in development.

- Proposed Modifications to the HIPAA Privacy Rule:
  - In December 2020 the Office for Civil Rights (OCR) proposed modifications to the HIPAA Privacy Rule to Empower Individuals, Improve Coordinated Care and Reduce Regulatory Burdens. On June 22nd, 2022, the OCR announced that the new rules will be implemented in March 2023. Covered Entities will have 240-days, or until November 2023, to implement the new rules. The exact rule changes will be available at the time of publication.

- 2022 Corporate Compliance Training – Board of Governors & Staff:
  - In accordance with the Annual Anti-Fraud Plan filed with the DMHC in Q1 each year, and in compliance with requirements from the DHCS State Sponsored contract on Fraud, Waste and Abuse, the Plan maintains an annual training and education program to ensure understanding of all relevant laws, regulations, and internal policies covering relevant subject matter. The Board of Governors Corporate Compliance Training will be assigned on August 1st, 2022, all members of the Board will have ninety (90) days to complete the assigned training. The 2022 Annual training includes:

    - Health Insurance Portability and Accountability Act (HIPAA)
    - Fraud Waste and Abuse

  - The Corporate Compliance Training for Plan Staff is planned for mid-September 2022.

Compliance

Supporting Documents

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

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
				2022 APL/PL IMPLEMENTATION TRACKING LIST		
11	DMHC	22-009	3/16/2022	PROVIDER DIRECTORY ANNUAL FILING REQUIREMENTS	MEDI-CAL & GROUP CARE	California Health and Safety Code section 1367.27, subdivision (m), requires health care service plans to annually submit provider directory policies and procedures to the Department of Managed Health Care (Department).
12	DMHC	22-010	3/17/2022	GUIDANCE REGARDING AB 1184 - CONFIDENTIALITY OF MEDICAL INFORMATION	MEDI-CAL & GROUP CARE	On September 22, 2021, Governor Gavin Newsom signed AB 1184, which amends the Confidentiality of Medical Information Act to require plans to take specified steps to protect the confidentiality of a subscriber's or enrollee's medical information.
13	DHCS	22-003	3/17/2022	MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITY TO PROVIDE SERVICES TO MEMBERS WITH EATING DISORDERS	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with clarification and guidance regarding their responsibility to coordinate and provide medically necessary services for members who are diagnosed with feeding and eating disorders and are currently receiving Specialty Mental Health Services (SMHS) from a county Mental Health Plan (MHP). Corresponding guidance to MHPs is contained in Behavioral Health Information Notice (BHIN) 22-009.
14	DHCS	22-004	3/17/2022	STRATEGIC APPROACHES FOR USE BY MANAGED CARE PLANS TO MAXIMIZE CONTINUTIY OF COVERAGE AS NORMAL ELIGIBILITY AND ENROLLMENT OPERATIONS RESUME	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide instruction to Medi-Cal managed care health plans (MCPs) about strategies that must be used by MCPs in collaboration with counties to help ensure eligible beneficiaries retain coverage in Medi-Cal and ease transitions for individuals eligible for coverage through Covered California as the Department of Health Care Services (DHCS) prepares for the resumption of normal operations after the end of the COVID-19 Public Health Emergency (PHE).
15	DMHC	22-011	3/21/2022	NO SURPRISES ACT (NSA) GUIDANCE	GROUP CARE	Effective for plan years beginning on or after January 1, 2022, the NSA prohibits surprise balance billing, as specified, and establishes other consumer protections. To date, the federal government has issued four rulemaking packages, issued guidance, and established a dedicated web page, No Surprises to implement the NSA.
16	DMHC	22-012	3/24/2022	SECTION 1357.503 COMPLIANCE AND MEWA REGISTRATION	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to inform health care service plans (Plans) and association of employers defined as multiple employer welfare arrangement (MEWA) of the requirements of SB 255 (Portantino, Ch. 725, Stats. 2021) and SB 718 (Bates, Ch. 736, Stats. 2021), including California Health and Safety Code section 1357.503. This APL discusses the requirements of Section 1357.503, including requirements of Plans, registration of MEWAs, and other requirements.
17	DHCS	22-005	3/30/2022	NO WRONG DOOR FOR MENTAL HEALTH SERVICES POLICY	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCP) with guidance and clarification regarding the No Wrong Door for Mental Health Services policy. This policy ensures that members receive timely mental health services without delay regardless of the delivery system where they seek care and that members are able to maintain treatment relationships with trusted providers without interruption.
18	DMHC	22-013	4/6/2022	COMPLIANCE WITH SENATE BILL 368	GROUP CARE	On October 6, 2021, Governor Gavin Newsom signed Senate Bill (SB) 368. SB 368 requires individual or group health care service plan (health plans or plans) contracts, issued, amended, or renewed on or after July 1, 2022, to provide enrollees with their up-to-date accrual towards their annual deductible and out-of-pocket maximum for every month benefits were used until the accrual balances are met. SB 368 also requires plans to notify enrollees of their rights to such accrual information and the ability to opt in to receiving the accrual information electronically instead of via mail. Delegated entities with claims payment functions must also comply with the provisions of SB 368.
19	DHCS	22-006	4/8/2022	MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITIES FOR NON-SPECIALTY MENTAL HEALTH SERVICES	MEDI-CAL	The purpose of this All Plan Letter (APL) is to explain the responsibilities of Medi-Cal managed care health plans (MCPs) for the provision or arrangement of clinically appropriate and covered non-specialty mental health services (NSMHS) and the regulatory requirements for the Medicaid Mental Health Parity Final Rule (CMS-2333-F). This APL also delineates MCP responsibilities for referring to, and coordinating with, County Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS).
20	DMHC	22-014	4/25/2022	SENATE BILL 510 COVID-19 TESTING AND VACCINATION COVERAGE GUIDANCE	MEDI-CAL & GROUP CARE	SB 510 requires health care service plans (health plans) to cover, among other things, the costs associated with COVID-19 diagnostic and screening testing and immunization against COVID-19 without cost-sharing, prior authorization, utilization management, or in-network requirements.
21	DMHC	22-015	5/31/2022	FINANCIAL REPORTING REGULATION	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to notify health care service plans (health plans) about the recent amendments to the annual, quarterly, and monthly financial reporting requirements.

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
2022 APL/PL IMPLEMENTATION TRACKING LIST						
22	DHCS	22-007	5/5/2022	CALIFORNIA HOUSING AND HOMELESSNESS INCENTIVE PROGRAM	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCP) with guidance on the incentive payments linked to the Housing and Homelessness Incentive Program (HHIP) implemented by the California Department of Health Care Services (DHCS) in accordance with the Medi-Cal Home and CommunityBased Services (HCBS) Spending Plan.
23	DHCS	22-008	5/18/2022	NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION SERVICES AND RELATED TRAVEL EXPENSES	MEDI-CAL	This All Plan Letter (APL) provides Medi-Cal managed care health plans (MCPs) with guidance regarding Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. In addition, this APL clarifies MCP responsibilities regarding the coverage of transportation for pharmacy services with the implementation of Medi-Cal Rx, Medi-Cal enrollment requirements for transportation providers, as well as MCP coverage of transportation related travel expenses.
24	DMHC	22-016	6/10/2022	NATIONAL INFANT FORMULA SHORTAGE	GROUP CARE	To the extent a health plan covers enteral or specialty formula for its enrollees, plans must ensure prior authorization or utilization management requirements do not impede a provider's ability to change or modify an enrollee's formula, including when a physician must change the type, size or brand of formula based on availability. The DMHC encourages plans to treat such requests in an expeditious manner.
25	DHCS	22-009	6/13/2022	COVID-19 GUIDANCE FOR MEDI-CAL MANAGED CARE HEALTH PLANS	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide information to Medi-Cal managed care health plans (MCPs) on changes to federal and state requirements for COVID-19 testing, treatment, and prevention.
26	DMHC	22-017	6/14/2022	COVERAGE OF COVID-19 THERAPEUTICS	GROUP CARE	This APL concerns commercial health plan coverage of COVID-19 therapeutics, steps plans can take to encourage providers to use therapeutics, when appropriate, and directs plans to submit a description of how the plan is ensuring enrollees who need and are eligible for therapeutics have ready access to such treatment.
27	DHCS	22-010	6/22/2022	CANCER BIOMARKER TESTING	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide information to Medi-Cal managed care health plans (MCPs) about coverage requirements for cancer biomarker testing as required by Senate Bill (SB) 535 (Limón, Chapter 605, Statutes of 2021).
28	DHCS	22-011	6/23/2022	PROPOSITION 56 DIRECTED PAYMENTS FOR FAMILY PLANNING SERVICES	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed health care plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of specified family planning services with dates of service on or after July 1, 2019.

Health Care Services

Steve O'Brien, MD

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

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

Date: **July 8th, 2022**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

- The carve in of Major Organ Transplant/Bone Marrow Transplant (MOT/BMT) went live on 1/1/2022. So far 156 members are in various stages of the Transplant process, and the systems developed to coordinate care between UM, CM and the Centers of Excellence are working well. UCSF has 83% of the cases, Stanford 7%; and Out of Network 10%.

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

- CCS process enhancements are underway to integrate into the larger EPSDT strategy. Reports on shared members and workflows have been developed and are starting to be used to enhance the coordination of care between AAH and CCS on our mutual members under age 21. Further integration of the information on members who are enrolled with CCS into the TruCare system is in progress. There is progress on one hospital not currently paneled with CCS to become paneled, and AAH will continue to support that effort.

- The process to refer members to Tertiary/Quaternary (T/Q) centers for specialized care is being revised to ensure that members appropriate for this higher-level care receive it in the most appropriate setting. Prior authorization will be required for office visits and consultations to a T/Q center, (ex. UCSF, Stanford,) using a standard process reviewing medical appropriateness of referrals and transitions to T/Q centers. Go live for implementation is set for 9/1/22, after communication with all stakeholders.

- NCQA 2022: UM team had submitted documents that address the NCQA UM standards for submission to NCQA in June 2022. Submission was on June 6th, and there will be follow up with NCQA in the next week. Case file review will be at the end of July.

Denial Rate Type	April 2022	May 2022	June 2022
Overall Denial Rate	**4.3%**	**3.7%**	**3.4%**
Denial Rate Excluding Partial Denials	**3.7%**	**3.2%**	**3.0%**
Partial Denial Rate	**0.6%**	**0.5%**	**0.4%**

Line of Business	April 2022	May 2022	June 2022
Overall	**98%**	**98%**	**97%**
Medi-Cal	**98%**	**98%**	**97%**
IHSS	**99%**	**98%**	**98%**
Benchmark	***95%***	***95%***	***95%***

Utilization Management: Inpatient

- The IP department is re-evaluating the organization of the UM IP program to align with the carve in of Long-Term Care, close management of high-risk members, and to optimize departmental functioning. Areas under review are: Staffing and coverage, development of additional standard work, training/monitoring, and integration with AAH initiatives.

- IP Team implemented Unsafe Discharge and Administrative Day Review workflow, conducted staff training on inpatient admissions that meet criteria for review and standard practice for escalation to Medical Directors. This training has been extended to delegates to ensure alignment.

- Inpatient department continues to track COVID admissions: Covid admissions increased slightly in the month of May, and then declined into June. Overall, the rate continues to remain low, consistent with Alameda County data. There are also fewer Intensive Care days than in the earlier time periods and have a significantly shorter than average length of stay than previously.

- Weekly complex/long stay patient rounds continue with partner hospitals and CHCN with a goal of removing barriers to discharge. The focus of these rounds is on members with catastrophic injury or illness, longer lengths of stay, and patients with challenging barriers to placement. Opportunities are identified for referral to ECM, Community Supports, and Case Management for high risk members.

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

Inpatient Med-Surg Utilization Total All Aid Categories Actuals (excludes Maternity)			
Metric	**March 2022**	**April 2022**	**May 2022**
Authorized LOS	5.3	5.0	5.1
Admits/1,000	56.1	48.6	57.2
Days/1,000	289.9	245.0	293.0

Pharmacy

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

Decisions	Number of PAs Processed
Approved	18
Denied	33
Closed	26
Total	**77**

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

- Medications for are top ten categories for denials.

Rank	Drug Name	Common Use	Common Denial Reason
1	ADVAIR 250-50 DISKUS	Chronic obstructive pulmonary disease (COPD)	Criteria for approval not met
2	NUCALA 100 MG/ML SYRINGE	Asthma	Criteria for approval not met
3	REPATHA 140 MG/ML SURECLICK	Hyperlipidemia	Criteria for approval not met
4	WEGOVY 0.25 MG/0.5 ML PEN	Chronic weight management	Criteria for approval not met
5	TRETINOIN 0.025% CREAM	Acne	Criteria for approval not met
6	JANUVIA 50 MG TABLET	Diabetes	Criteria for approval not met
7	WEGOVY 1 MG/0.5 ML PEN	Chronic weight management	Criteria for approval not met
8	LANTUS SOLOSTAR 100 UNIT/ML	Diabetes mellitus	Criteria for approval not met
9	SCOPOLAMINE 1 MG/3 DAY PATCH	Nausea and vomiting associated with motion sickness	Criteria for approval not met
10	LIDOCAINE 5% PATCH	Pain	Criteria for approval not met

- The Alameda Alliance for Health (AAH) Pharmacy Department has successfully carried out Medi-Cal RX go-live as of 1/1/2022 and continues to serve its members with the same high standards of care.
  - As of June 27th, 2022, processed more than 59.22 million point-of-sale pharmacy paid claims with a sub second response time to participating pharmacies totaling more than $7.11 billion in payments.
  - Processed more than 212,416 prior authorizations. PA continues to decline (i.e., 2,518 per 6/24 weekly data).
  - Answered 288,962 calls and 100 percent of virtual hold calls and voicemails have been returned. Call volume continues to decline (i.e., 8,206 per 6/24 weekly data).
  - The most edits/PA/limitations have been removed/lifted.
    - We have closed submitted Medi-Cal PAs and informing doctor offices to submitted to Medi-Cal RX:

Month	Number of Total PA Closed
January 2022	169
February 2022	44
March 2022	31
April 2022	25
May 2022	7
June 2022	8

- The AAH Pharmacy Department is working with its Inpatient Department and Case Management Disease Management (CMDM) Department.
    - The AAH Pharmacy Department's TOC (Transition of Care) Program continues collaborating with the AAH Inpatient UM Department and Case Management Disease Management (CMDM) Department to help reduce the number of re-admissions after members are discharged from hospitals through education to the members as well as filling potential gaps between providers and their patients.
    - The inclusion criteria are members with heart failure, diabetes, sepsis and use of anti-coagulants.
    - We have had up to 10-11 cases/day.

- Pharmacy is leading initiatives on PAD focused internal and external partnership and biosimilar optimization.
    - AAH revised their single UM medication prior authorization (PA) list. This list is a list of drugs that will require PA before reimbursement. The list has gone thru P & T committee approval on June 21st, 2022.
    - AAH is working to transition the billing of continuous glucose monitors (CGM) for Type 1 Diabetic Members under Medi-Cal line of business to MediCal-Rx. This change will require providers to submit prescriptions to the pharmacy instead of our vendor partner. AAH workgroup identified 100 Type 1 Diabetic members and 40+ providers who may be impacted and is currently working on an outreach campaign to notify members and providers of this transition.

Case and Disease Management

- Population health-driven, disease-specific case management bundles (standard sets of actions developed to address the specific needs of members with significant diseases,) continue development. Current bundles are Heme-Onc, Major Organ Transplant (MOT) CM Bundle was deployed, and the volume continues to increase, (156 cases YTD.) The processes to support the members is working well across CM, UM, and the Centers of Excellence.

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

- Asthma Remediation Community Supports has been incorporated into the larger Disease Management program. Disease Management is a collaboration with AAH

Health Education to optimize and enhance the Diabetes and Asthma Disease Management programs.

- NCQA 2022: CM team had submitted documents that address the NCQA PHM standards for submission to NCQA in June 2022. Submission was on June 6th, and there will be follow up with NCQA in the next week.

Case Type	New Cases Opened in April 2022	Total Open Cases as of April 2022	New Cases Opened in May 2022	Total Open Cases as of May 2022
Care Coordination	270	590	264	556
Complex Case Management	16	45	21	60
Transitions of Care (TOC)	256	514	293	540
ECM	TBD	TBD	TBD	TBD

Enhanced Case Management and Community Supports Services

- Enhanced Case Management (ECM): ECM Providers are re-evaluting "grandfathered" members from HHP to see if they meet criteria for continued services through ECM or are ready for step down to other CM services by 6/30/2022.

- ACBH as an ECM provider launch is being postponed until 9/1/22 ensuring full readiness.

- Work with PPD team continues for next Populations of Focus (LTC to home; LTC diversion) to launch 01/01/23.

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

- Community Supports: CS services are focused on reducing unnecessary hospitalizations and ED visits. The six initial CS services launched on 1/1/2022 were:
    - Housing Navigation
    - Housing Deposits
    - Tenancy Sustaining Services

- Medical Respite
- Medically Tailored/Supportive meals
- Asthma Remediation

- CalAIM Community Supports (CS): The planned staff for the CS program have been hired and are refining the authorization processes for referrals, and for program tracking.

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

- Recipe for Health (R4H) is working toward becoming a Medically Supportive Food CS provider, with an anticipated launch on 9/1/22. AAH will provide bridge funding between July 1 to Aug 31 to ensure that the current program continues until launch.

Community Supports	Services Started in Jan 2022	Services Started in Feb 2022	Services Started in Mar 2022	Services Started in Apr 2022
Housing Navigation	8	10	14	0
Housing Deposits	0	1	3	34
Housing Tenancy	4	13	7	3
Asthma Remediation	1	5	6	5
Meals	24	16	30	14
Medical Respite	10	1	12	24

Grievances & Appeals

- All cases were resolved within the goal of 95% within regulatory timeframes.
  - During the month of May, the G&A Department received 104 complaints that were originally logged as expedited and de-expedited within the required timeframe.

- Total grievances resolved in June were 4.51 complaints per 1,000 members.

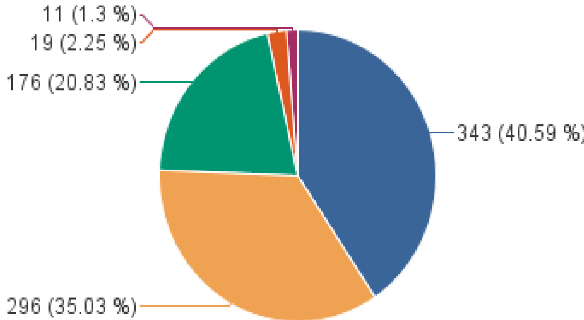
- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of June 2022; we did meet our goal at 20% overturn rate.

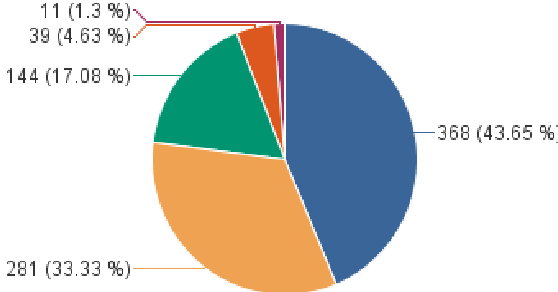
June 2022 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	512	30 Calendar Days	95% compliance within standard	498	97.2%	1.63
Expedited Grievance	1	72 Hours	95% compliance within standard	1	100.0%	0.00
Exempt Grievance	880	Next Business Day	95% compliance within standard	876	99.5%	2.80
Standard Appeal	20	30 Calendar Days	95% compliance within standard	20	100.0%	0.06
Expedited Appeal	0	72 Hours	95% compliance within standard	NA	NA	NA
Total Cases:	1,413		95% compliance within standard	1,395	98.7%	4.51

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

Quality

- Quality continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our aging report month to month goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records. As part of an effort to streamline the PQI review process, Quality of Access issues are now being reviewed by the Access & Availability team. PQI cases open > 120 days made up 1.3% of total cases for June which account for the same cases identified in May.
- Cases open for >120 days continues to be primarily related to delay in submission of medical records by specific providers and measures to close these 11 cases continue to be pursued. It was also noted that for cases open >90 days, there was a decrease of 2.38% from 4.63% in May to 2.25% in June. This was due in part to moving Access issues for review to the Access & Availability team.


PQI Aging Report as of 06/27/2022 N= 845
11 (1.3 %)
19 (2.25 %)
176 (20.83 %)
343 (40.59 %)
296 (35.03 %)
TAT_Bracket
1. <=30
2. >30<=60
3. >60<=90
4. >90<=120
5. >120


PQI Aging Report as of 05/31/2022 N= 843
11 (1.3 %)
39 (4.63 %)
144 (17.08 %)
368 (43.65 %)
281 (33.33 %)
TAT_Bracket
1. <=30
2. >30<=60
3. >60<=90
4. >90<=120
5. >120

Information Technology

Sasikumar Karaiyan

To: Alameda Alliance for Health Board of Governors

From: Sasi Karaiyan, Chief Information & Security Officer

Date: July 8th, 2022

Subject: Information Technology Report

Call Center System Availability

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

Office 365 Initiative

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

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

- WebEx meetings and Cisco Jabber chat has been successfully retired on July 1st, 2022. The entire enterprise is now fully transitioned to Microsoft Teams for chat and meetings.

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

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

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

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

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

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

Disaster Recovery and Business Continuity

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

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

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

- Replication design for all tier 1 applications is now in progress and expected to be completed by July 15th, 2022. This will be included in the run books for each application.

- The Disaster Recovery project is scheduled to complete before end of August 2022.

IT Security Program

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

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

    - **Key initiatives include:**

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

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

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

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

- Cyber Security is at 73% complete, M365 is at 83% complete, and Azure 73% and overall, 75% complete for high-severity items.

- Protecting shared cloud applications with Multi-Factor Authentication and Single Sign-On has been included in the overall project. The design modeling of current and future state of each cloud application has been completed and testing will begin July 15th.

- The Extended 24/7 Security Support project with Arctic Wolf has kicked-off and the initial portal configuration is now in progress.

Encounter Data

- In the month of June 2022, the Alliance submitted 135 encounter files to the Department of Health Care Services (DHCS) with a total of 262,497 encounters.

Enrollment

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

HealthSuite

- A total of 188,536 claims were processed in the month of June 2022 out of which 158,457 claims auto adjudicated. This sets the auto-adjudication rate for this period to 84.0%.

- The Alliance claims processing system HealthSuite was upgraded successfully. This upgrade had introduced new additional features such as: improved version of Service Modules to submit tickets, and also enabled audit capabilities to track all user edits.

TruCare

- A total of 12,469 authorizations were loaded and processed in the TruCare application.

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

- The authorization management application, TruCare was successfully upgraded to version 9.1 from version 8.1 on June 10th. This version has additional features and is also compatible with Milliman Care Guideline v25. We have not encountered any major defects since the application was upgraded a month ago.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of June 2022”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of June 2022”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal and Group Care Member enrollment in the month of June 2022

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
June	313,016	4,362	2,180	5,796	132	146

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 June 2022

Auto-Assignments	Member Count
Auto-assignments MC	1,549
Auto-assignments Expansion	1,401
Auto-assignments GC	31
PCP Changes (PCP Change Tool) Total	2,573

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of June 2022”.
- There were 12,469 authorizations processed into TruCare application.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

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

Transaction Type	Inbound EDI Auths	Errored	Total Auths Loaded in TruCare
EDI	4,004	377	3,933
Paper to EDI	3,102	2,086	1,173
Provider Portal	2,349	414	2,222
Manual Entry	N/A	N/A	1,500
Total			8,828

Key: EDI – Electronic Data Interchange

Web Portal Consumer Platform

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

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

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	6,432	3,366	164,216	353
MCAL	84,130	2,287	5,127	839
IHSS	3,117	82	190	22
AAH Staff	173	53	826	1
Total	**93,852**	**5,788**	**170,359**	**1,215**

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

Top 25 Pages Viewed		
Category	**Page Name**	**May - 22**
Provider	Member Eligibility	690,864
Provider	Claim Status	203,122
Provider - Authorizations	Auth Submit	8,060
Provider - Authorizations	Auth Search	3,286
Member My Care	Member Eligibility	2,598
Provider	Member Roster	1,920
Member Help Resources	Find a Doctor or Hospital	1,686
Member Help Resources	ID Card	1,590
Member Help Resources	Select or Change Your PCP	971
Member My Care	MC ID Card	906
Provider - Provider Directory	Provider Directory	791
Member My Care	My Claims Services	757
Member Help Resources	Request Kaiser as my Provider	515
Provider - Home	Forms	383
Member My Care	Authorization	361
Member My Care	My Pharmacy Medication Benefits	288
Provider - Provider Directory	Manual	259
Provider - Provider Directory	Instruction Guide	213
Member Help Resources	FAQs	208
Provider	Pharmacy	193
Member Help Resources	Authorizations Referrals	141
Member Help Resources	Forms Resources	135
Member My Care	Member Benefits Materials	131
Member Help Resources	Contact Us	118
Member My Care	Protected Health Information	93

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

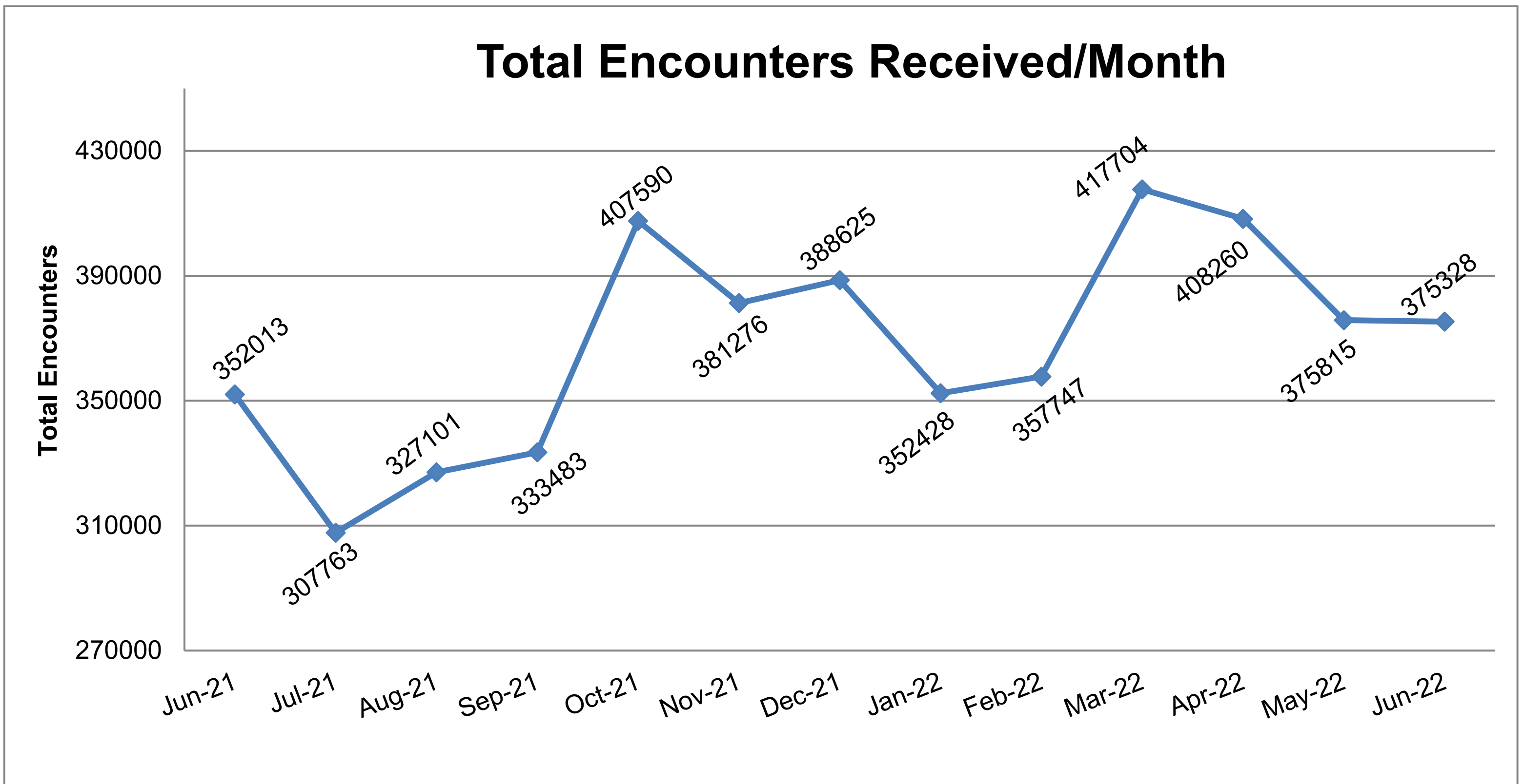
Member Portal Preferred Languages		
Member Group	**# of Individual User Accounts Accessed**	**Total Logins**
MCAL - English	2,287	5,127
MCAL - Spanish	-	-
MCAL - Vietnamese	-	-
MCAL - Tagalog	-	-
MCAL - Chinese	-	-
IHSS - English	82	190
IHSS - Spanish	-	-
IHSS - Vietnamese	-	-
IHSS - Tagalog	-	-
IHSS - Chinese	-	-
Total	**2,369**	**5,317**

Encounter Data from Trading Partners 2022

- **AHS**: June weekly files (5,486 records) were received on time.
- **BAC**: June monthly file (53 records) were received on time.
- **Beacon**: June weekly files (18,340 records) were received on time
- **CHCN**: June weekly files (67,339 records) were received on time.
- **CHME**: June monthly file (4,578 records) were received on time.
- **CFMG**: June weekly files (10,300 records) were received on time.
- **Docustream**: June monthly files (1,263 records) were received on time.
- **HCSA**: June monthly files (1,880 records) were received on time.
- **Magellan**: June monthly files (282,688 records) were received on time.
- **Kaiser**: June bi-weekly files (62,952 records) were received on time.
- **LogistiCare**: June weekly files (14,590 records) were received on time.
- **March Vision**: June monthly file (3,188 records) were received on time.
- **Quest Diagnostics**: June weekly files (12,058 records) were received on time.
- **Teladoc**: June monthly files (32 records) were received on time.

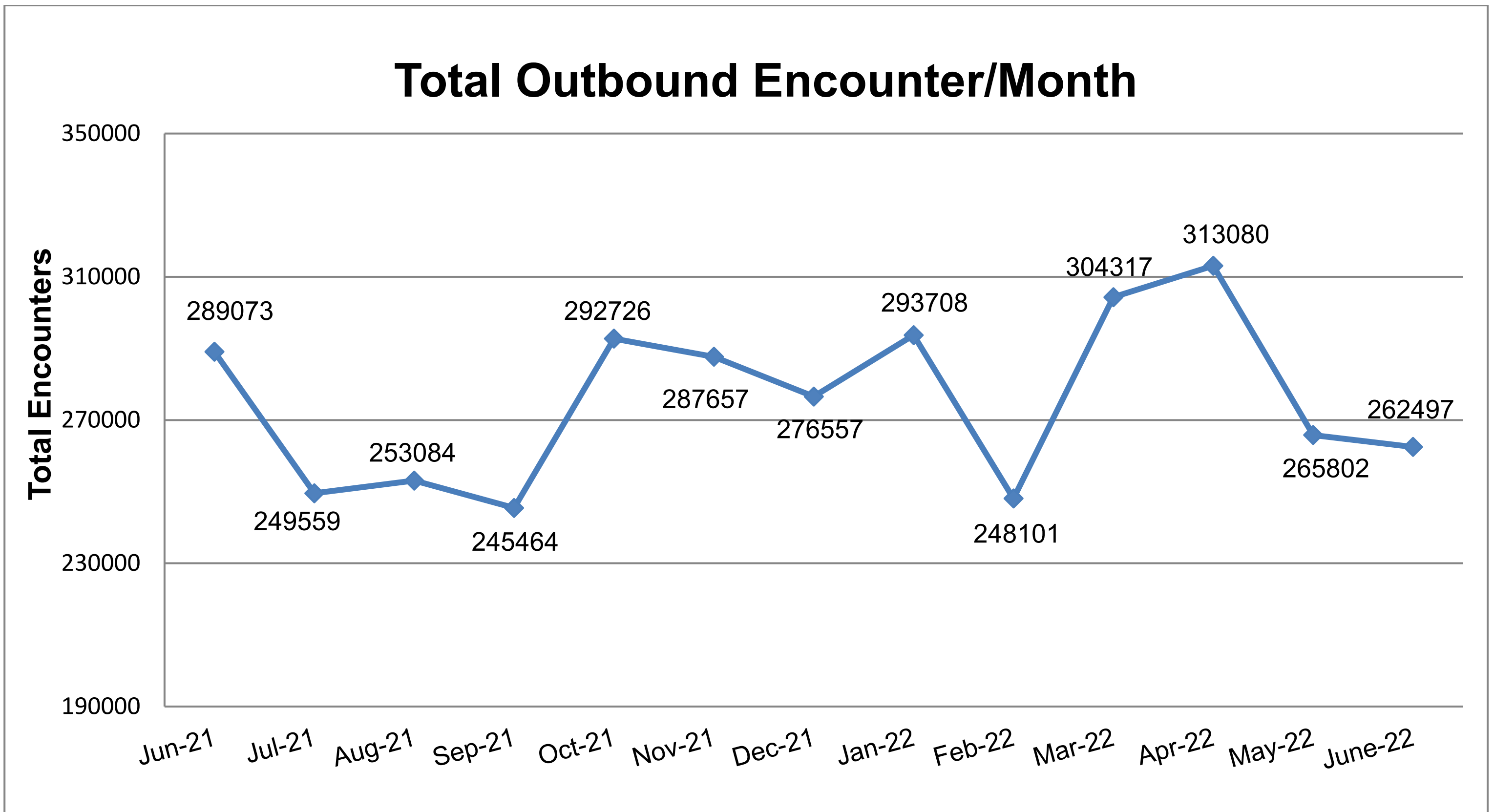
Trading Partner Medical Encounter Inbound Submission History

Trading Partners	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
HealthSuite	136687	133958	139079	159558	177483	167057	175441	162201	162433	185738	189172	163272	173269
AHS	10138	8913	7869	7640	10625	8791	9314	6944	5630	6215	7717	6105	5486
BAC									34	12	45	63	53
Beacon	17079	15236	13320	14618	13693	12456	14899	9796	10966	16088	14303	13796	18340
CHCN	82211	63905	80862	60227	71581	99117	73269	75302	77276	79363	74683	80340	67339
CHME	4700	4960	4926	5393	4814	5003	4908	9254	4706	4778	4955	4551	4578
Claimsnet	8129	9774	7712	9880	15598	11032	12410	8643	13228	13522	10943	14075	10300
Docustream	1218	1296	1568	1594	1474	1185	1586	1703	1304	2130	2220	1140	1263
HCSA										3630	2029	1824	1880
Kaiser	60081	39398	35165	44366	75112	38085	63939	46458	52179	68530	69174	51214	62952
Logisticare	15473	14415	17306	13803	16977	22403	17125	16536	16393	19841	16232	20299	14590
March Vision	3306	3303	3531	3297	3377	3584	3220	2872	1445	3559	3425	3345	3188
Quest	12979	12563	15746	13084	16841	12542	12494	12696	12121	14268	13330	15757	12058
Teladoc	12	42	17	23	15	21	20	23	32	30	32	34	32
Total	352013	307763	327101	333483	407590	381276	388625	352428	357747	417704	408260	375815	375328



Outbound Medical Encounter Submission

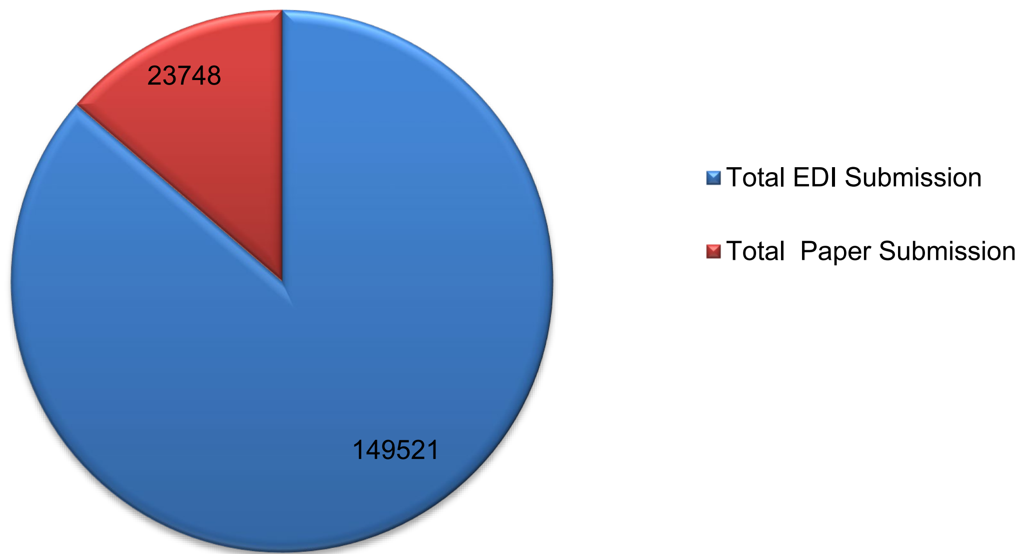
Trading Partners	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
HealthSuite	128980	85346	109070	83690	100925	114507	95489	139452	97141	103843	133252	93919	90605
AHS	9912	7163	9172	7476	10176	8541	7728	7943	5524	6142	6251	7156	5363
BAC									34	12	45	61	52
Beacon	11746	12684	10959	9355	11423	9969	12659	7566	8140	12332	11273	9221	9534
CHCN	58519	45338	46573	54958	49171	67383	49080	52531	44745	58795	49365	49911	51060
CHME	4586	4753	4820	5280	4587	4849	4691	4496	4585	4702	4686	4448	4470
Claimsnet	5993	5625	7335	7452	10829	7406	8465	6114	9917	9677	8100	8410	7985
Docustream	1016	1120	1273	1209	1094	981	1185	1176	66	72	14	3406	854
HCSA										3112	1810	1518	1719
Kaiser	38443	59215	33798	43779	73264	37473	63433	44248	51831	67559	67177	50894	62562
Logisticare	15178	14008	12751	17657	16231	19240	19787	16309	16242	19700	16123	19777	14677
March Vision	2624	2596	2665	2483	2608	2831	2490	2175	1072	2724	2575	2464	2392
Quest	12066	11711	14632	12102	12403	14457	11531	11676	8774	15620	12378	14602	11192
Teladoc	10	0	36	23	15	20	19	22	30	27	31	15	32
Total	289073	249559	253084	245464	292726	287657	276557	293708	248101	304317	313080	265802	262497



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
22-Jun	149521	23748	173269

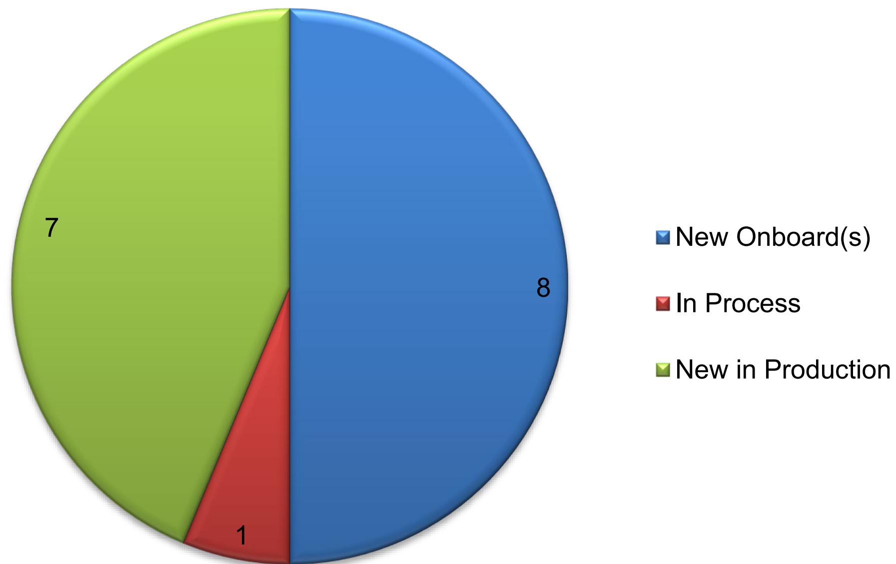
Key: EDI – Electronic Data Interchange

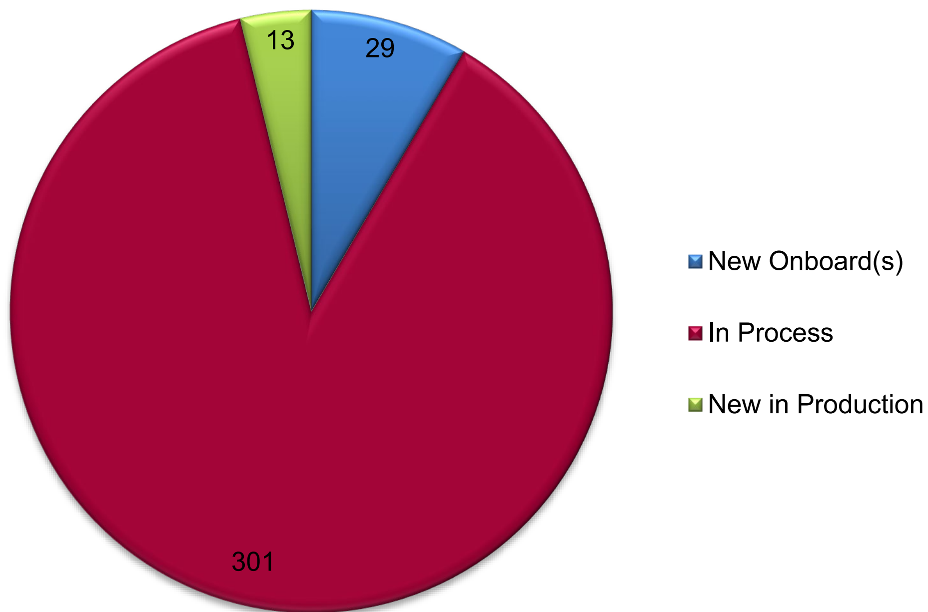


Onboarding EDI Providers - Updates

- June 2022 EDI Claims:
  - A total of 1346 new EDI submitters have been added since October 2015, with 7 added in June 2022.
  - The total number of EDI submitters is 2086 providers.
- June 2022 EDI Remittances (ERA):
  - A total of 442 new ERA receivers have been added since October 2015, with 13 added in June 2022.
  - The total number of ERA receivers is 469 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
Jul-21	30	3	27	1902	14	138	12	356
Aug-21	17	0	17	1919	47	178	7	363
Sep-21	21	1	20	1939	15	193	0	363
Oct-21	17	0	17	1956	30	205	18	381
Nov-21	14	0	14	1970	19	210	14	395
Dec-21	8	0	8	1978	18	223	5	400
Jan-22	29	1	28	2006	44	253	14	414
Feb-22	17	2	15	2021	20	258	15	429
Mar-22	36	0	36	2057	22	268	12	441
Apr-22	11	3	8	2065	19	275	12	453
May-22	17	3	14	2079	13	285	3	456
Jun-22	8	1	7	2086	29	301	13	469


837 EDI Submitters - June 2022
7
8
1
New Onboard(s)
In Process
New in Production


835 EDI Receivers - June 2022
13
29
301
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 June 2022.

File Type	Jun-22
837 I Files	23
837 P Files	112
Total Files	135

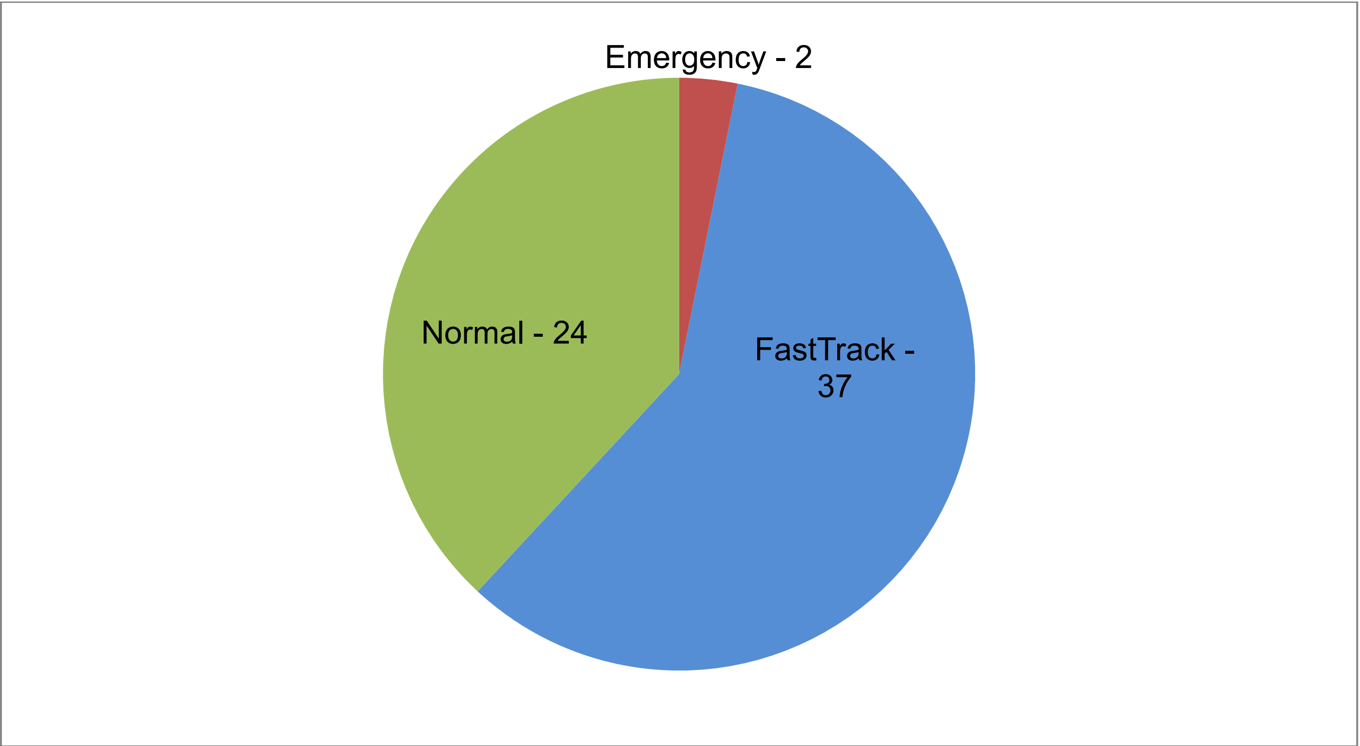
Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Jun-22	Target
Timeliness-% Within Lag Time – Institutional 0-90 days	96%	60%
Timeliness-% Within Lag Time – Institutional 0-180 days	99%	80%
Timeliness-% Within Lag Time – Professional 0-90 days	94%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

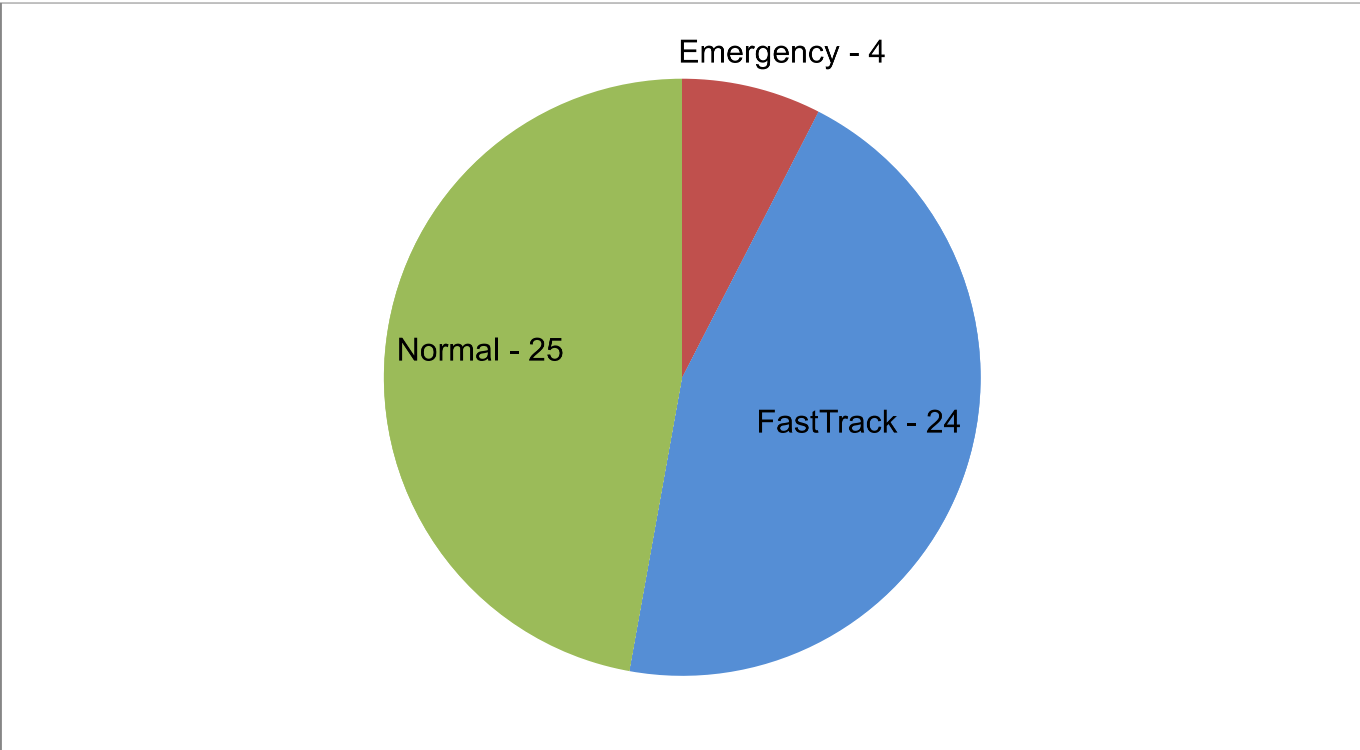
Change Management Key Performance Indicator (KPI)

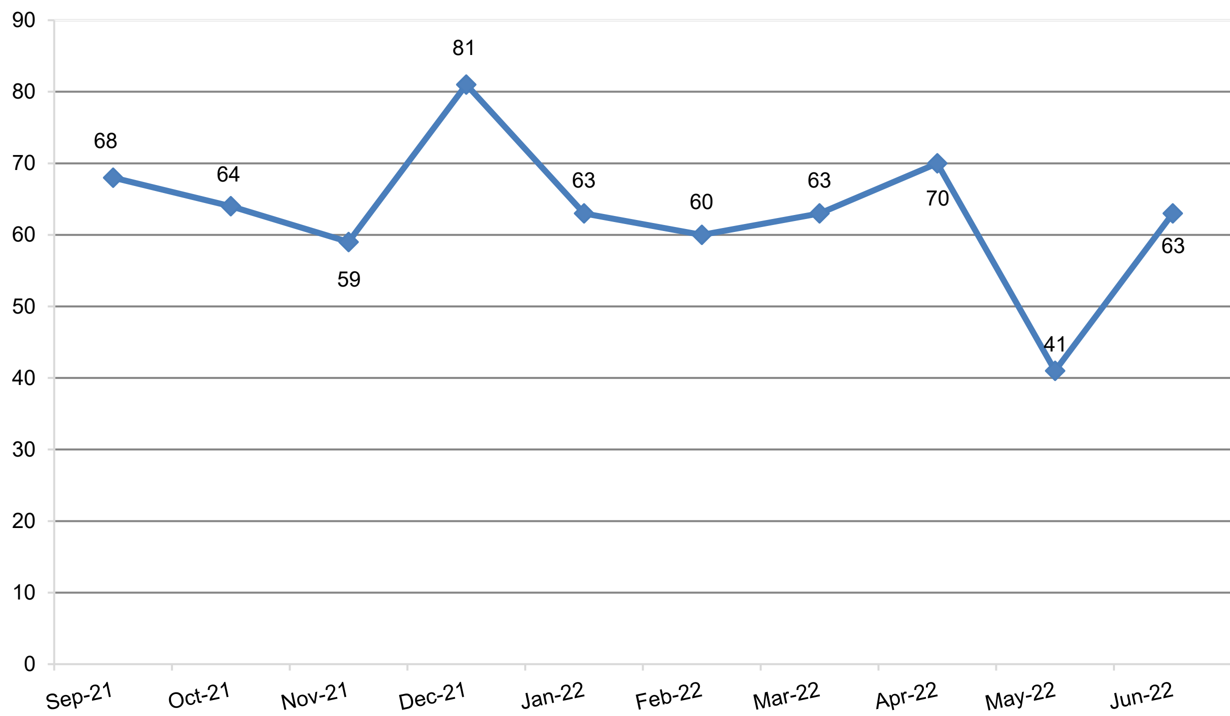
- Change Request Overall Summary in the month of June 2022 KPI:
  - 63 Changes Submitted.
  - 53 Changes Completed and Closed.
  - 125 Active Change Requests in pipeline.
  - 4 Change Request Cancelled or Rejected.

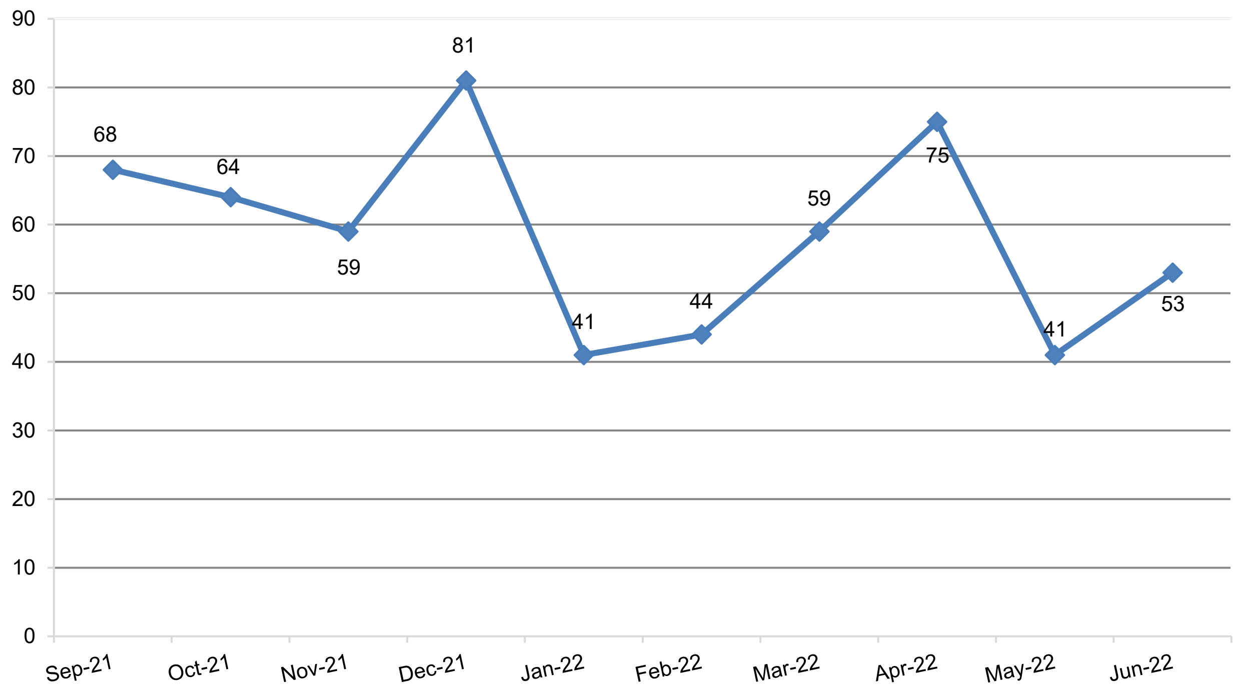
- 63 Change Requests Submitted/Logged in the month of June 2022



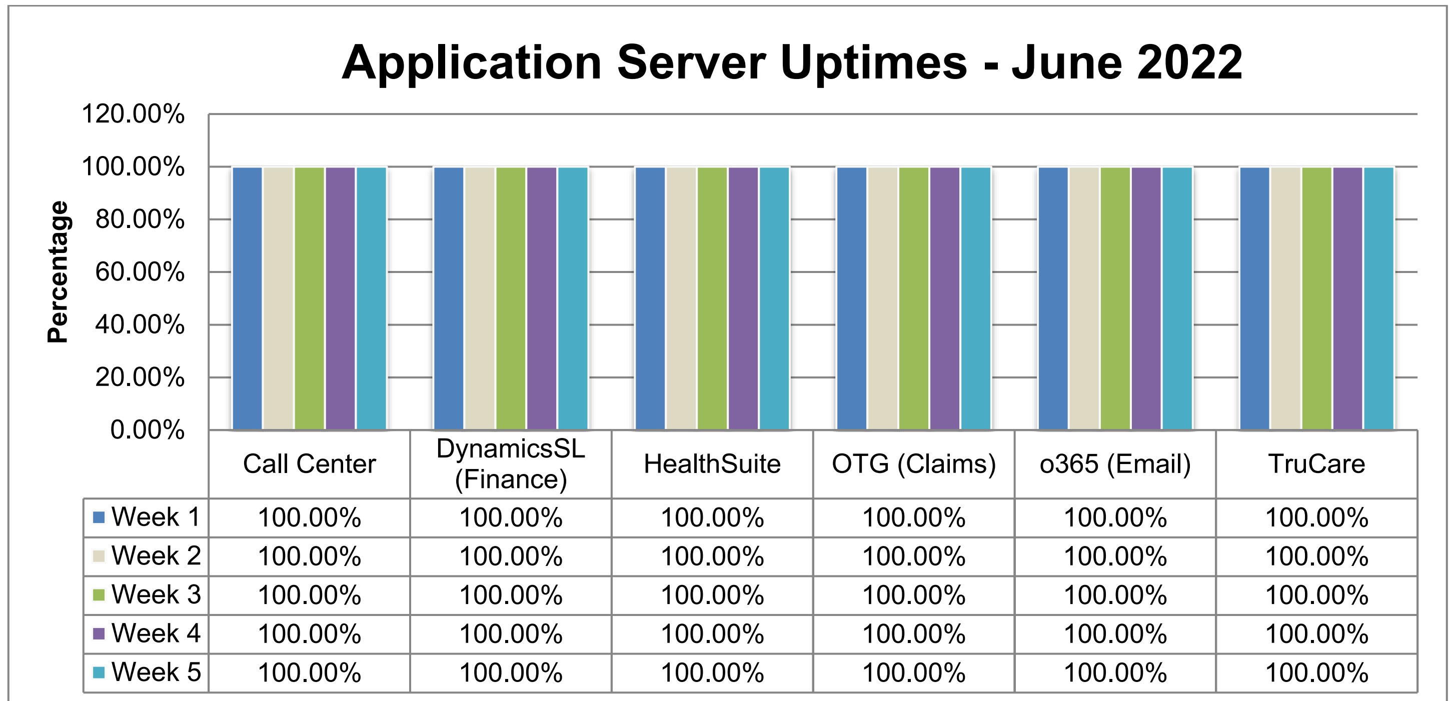
- 53 Change Requests Closed in the month of June 2022




Change Requests Submitted: Monthly Trend
90
80
70
60
50
40
30
20
10
0
68
64
59
81
63
60
63
70
41
63
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22


Change Requests Closed: Monthly Trend
90
80
70
60
50
40
30
20
10
0
68
64
59
81
41
44
59
75
41
53
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22

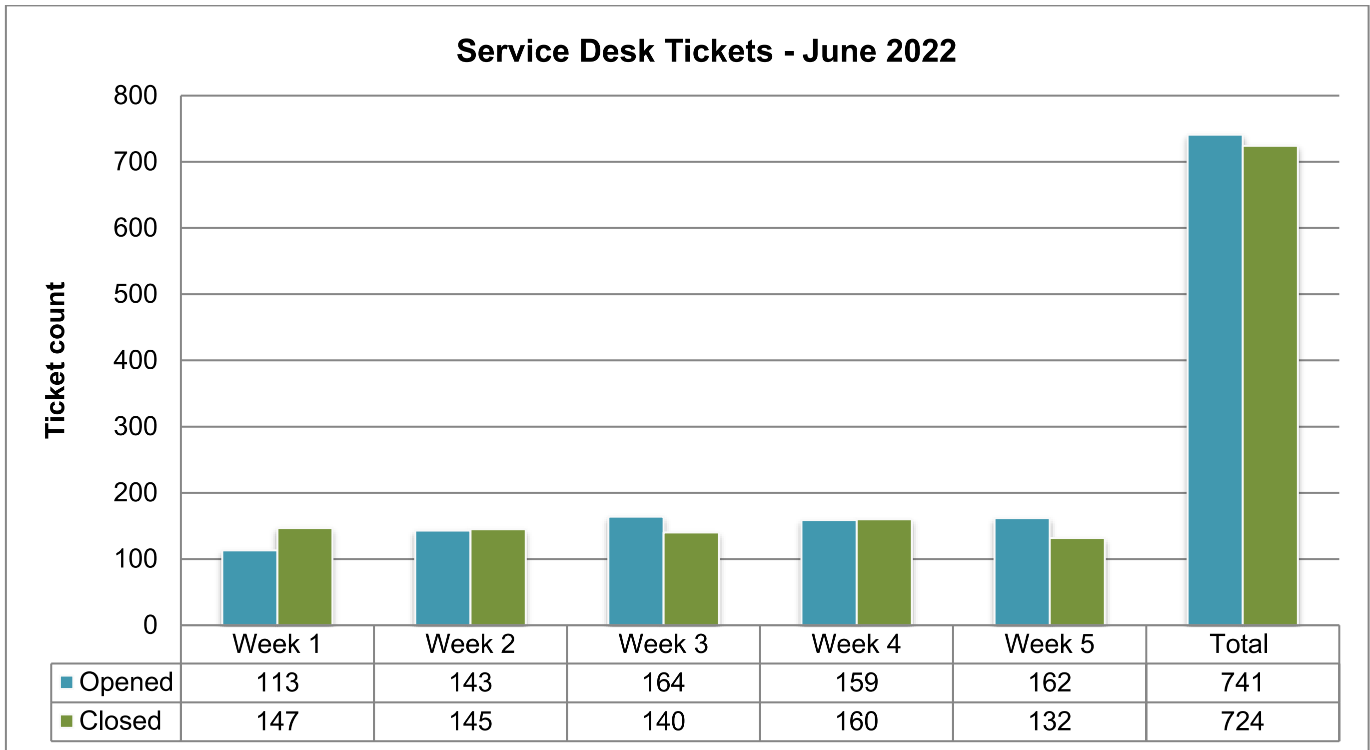
IT Stats: Infrastructure



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

- All mission critical applications are monitored and managed thoroughly.
- There were no outages experience in the month of June 2022.

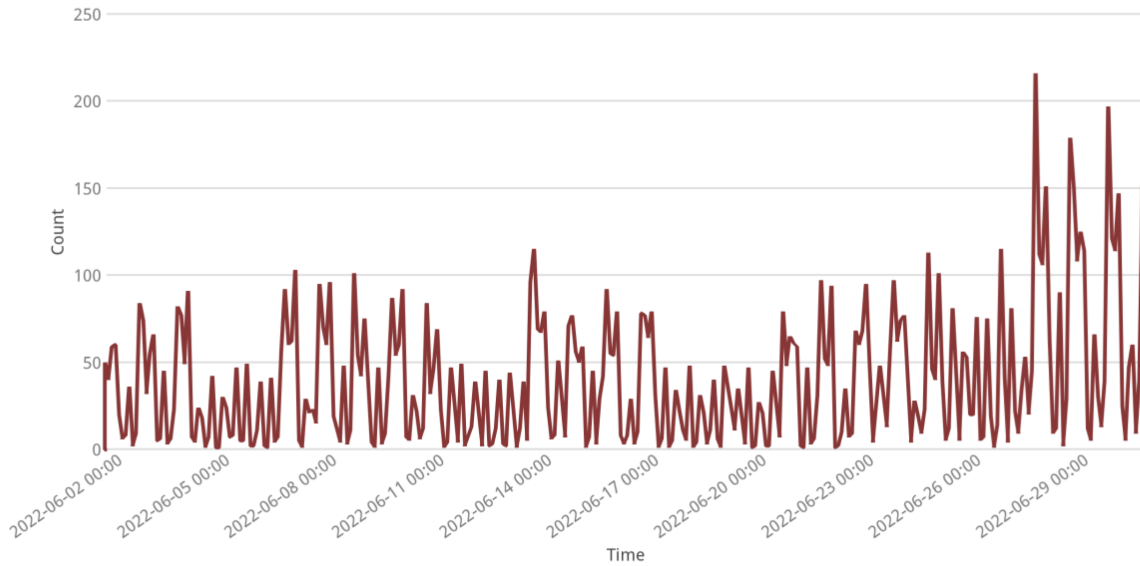
- 741 Service Desk tickets were opened in the month of June 2022, which is 17.5% higher than the previous month and 724 Service Desk tickets were closed, which is 18% higher than the previous month.



- The open ticket count for the month of June aligns with the previous 3-month average of 700.

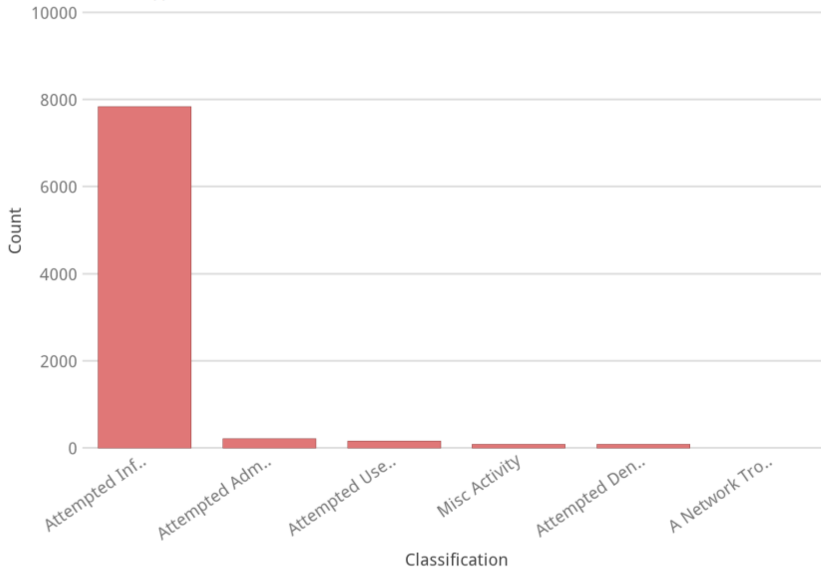
All Intrusion Events

Time Window: *2022-06-01 09:29:00 - 2022-06-30 09:29:00*



Dropped Intrusion Events

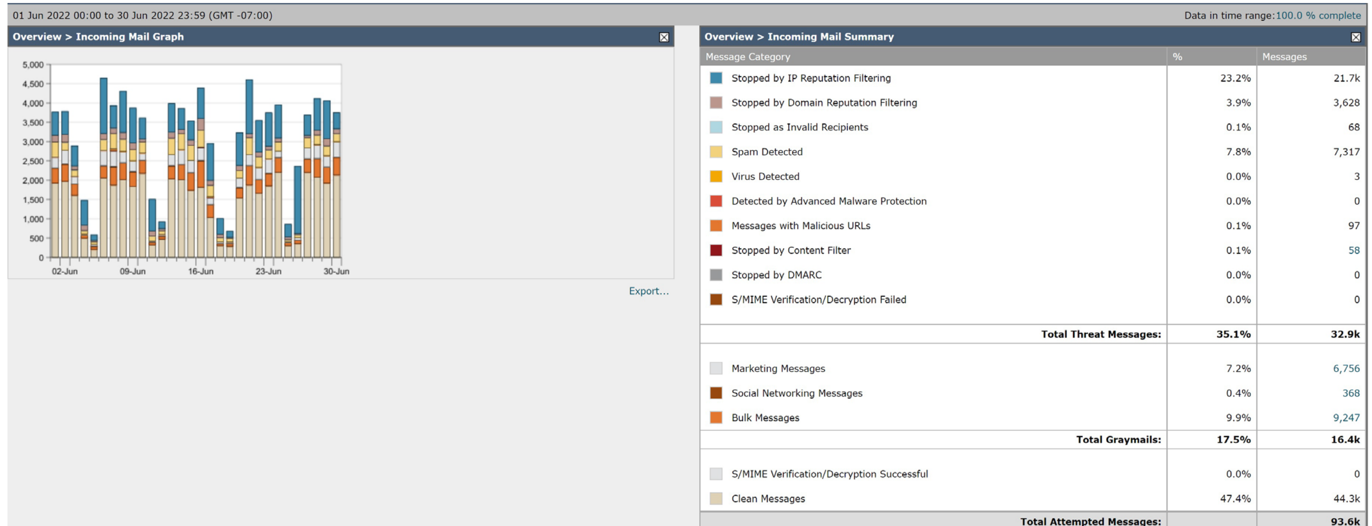
Time Window: *2022-06-01 09:30:00 - 2022-06-30 09:30:00*
Constraints: *Inline Result = dropped*



Classification	Count
Attempted Information Leak	7,839
Attempted Administrator Privilege Gain	215
Attempted User Privilege Gain	157
Misc Activity	88
Attempted Denial of Service	86
A Network Trojan was Detected	3

IronPort Email Security Gateways
Email Filters

MX4



01 Jun 2022 00:00 to 30 Jun 2022 23:59 (GMT -07:00) — Data in time range: 100.0 % complete

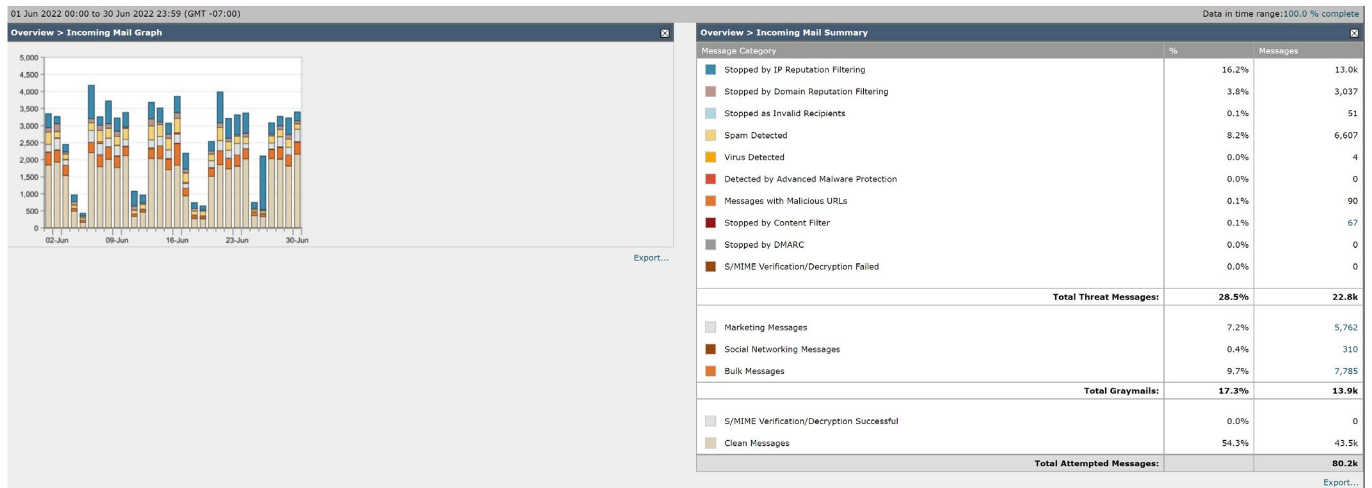
Overview > Incoming Mail Graph

Export...

Overview > Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	23.2%	21.7k
Stopped by Domain Reputation Filtering	3.9%	3,628
Stopped as Invalid Recipients	0.1%	68
Spam Detected	7.8%	7,317
Virus Detected	0.0%	3
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.1%	97
Stopped by Content Filter	0.1%	58
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**35.1%**	**32.9k**
Marketing Messages	7.2%	6,756
Social Networking Messages	0.4%	368
Bulk Messages	9.9%	9,247
Total Graymails:	**17.5%**	**16.4k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	47.4%	44.3k
Total Attempted Messages:		**93.6k**

MX9



01 Jun 2022 00:00 to 30 Jun 2022 23:59 (GMT -07:00) — Data in time range: 100.0 % complete

Overview > Incoming Mail Graph

Export...

Overview > Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	16.2%	13.0k
Stopped by Domain Reputation Filtering	3.8%	3,037
Stopped as Invalid Recipients	0.1%	51
Spam Detected	8.2%	6,607
Virus Detected	0.0%	4
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.1%	90
Stopped by Content Filter	0.1%	67
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**28.5%**	**22.8k**
Marketing Messages	7.2%	5,762
Social Networking Messages	0.4%	310
Bulk Messages	9.7%	7,785
Total Graymails:	**17.3%**	**13.9k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	54.3%	43.5k
Total Attempted Messages:		**80.2k**

Export...

Item / Date	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	***Jun-22***
Stopped By Reputation	78.8k	62.7k	43.1k	41.5k	24.3k	39.3k	69.7k	42.4k	329.9k	52.8k	36k	36k	***34.7k***
Invalid Recipients	1,982	742	185	132	82	92	153	185	69	389	117	100	***119***
Spam Detected	17.4k	27	12.8k	10.8k	5.6k	9,684	13.2k	10.3k	10.3k	15k	13.7k	13.8k	***13.9k***
Virus Detected	2	9	14	14	0	1	1	5	13	1	4	18	***18***
Advanced Malware	0	1	3	2	0	0	9	0	4	2	1	0	***0***
Malicious URLs	30	12	9	7	6	43	39	16	89	41	159	296	***187***
Content Filter	167	78	58	89	27	27	8	371	54	39	115	108	***125***
Marketing Messages	6,357	6,256	6,710	7,383	4,489	9,221	6,147	8,864	9,588	8,864	11.3k	10.7k	***12.5k***
Attempted Admin Privilege Gain	109	101	129	157	128	124	116	103	116	132	143	113	***215***
Attempted User Privilege Gain	0	3	7	6	6	13	49	117	663	789	401	549	***157***
Attempted Information Leak	38	15	32	3,700	7,782	9,376	13.7k	13.7k	5,813	5,192	5,207	5,924	***7,839***
Potential Corp Policy Violation	0	0	0	0	0	0	0	0	0	0	0	0	***0***
Network Scans Detected	0	0	0	0	0	0	0	0	0	0	0	0	***0***
Web Application Attack	3	1	0	0	0	0	0	0	1	0	0	0	***0***
Attempted Denial of Service	0	0	0	0	0	0	0	0	0	0	50	0	***86***
Misc. Attack	1,516	975	446	5,733	8,550	76	161	275	626	308	78	874	***88***

- All security activity data is based on the current month’s metrics as a percentage. This is compared to the previous three month’s average, except as noted.
- Email based metrics currently monitored have increased with a return to a reputation-based block for a total of 34.7k.
- Attempted information leaks detected and blocked at the firewall is at 7,839 for the month of June 2022.
- Network scans returned a value of 0, which is in line with previous month’s data.
- Attempted User Privilege Gain is slightly higher at 157 from a previous six-month average of 446.

Integrated Planning

Ruth Watson

To: Alameda Alliance for Health Board of Governors

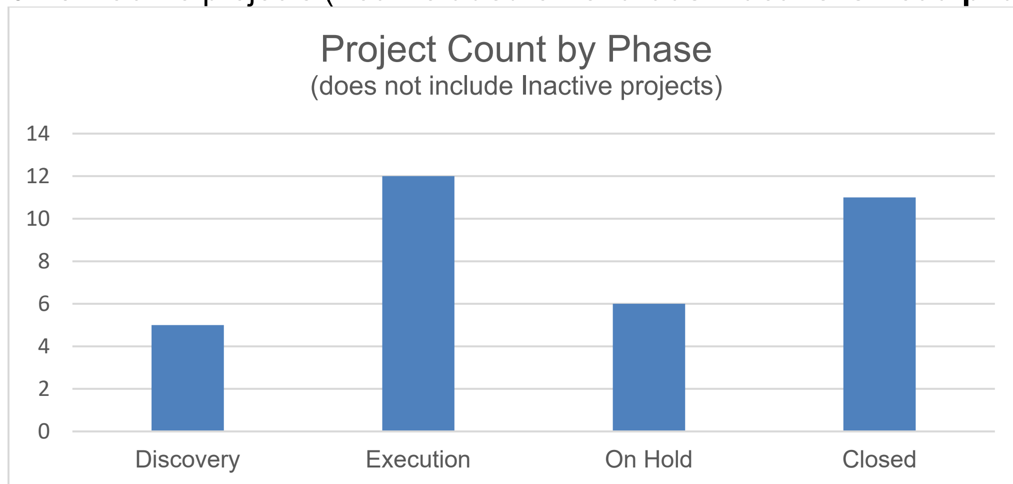
From: Ruth Watson, Chief of Integrated Planning

Date: July 8th, 2022

Subject: Integrated Planning Report

Project Management Office

- 42 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
  - 17 Active projects (discovery, initiation, planning, execution, warranty)
  - 6 On Hold projects
  - 11 Closed projects
  - 8 Inactive projects (**not included on chart as Inactive is not a phase**)



Integrated Planning

- CalAIM Initiatives – Enhanced Care Management (ECM) and Community Supports (CS):
  - Implementation of additional ECM PoFs effective January 2023 (2) and July 2023 (1).
    - Individuals Transitioning from Incarceration PoF, originally scheduled for implementation in January 2023, has been delayed by DHCS with no new implementation date.
    - Preparing Model of Care (MOC) Addendum templates for ECM and CS for the July 5th required submission.
    - Additional submissions for ECM and CS will be due September 1st
  - Adding Alameda County Behavioral Health (ACBH) as an ECM Provider effective July 1st.

- Adding Recipe 4 Health (R4H) as a Community Supports Provider for Medically Supportive Food/Meals/Medically Tailored Meals effective September 1st.
- Post-Implementation Activities – Work continues in two-week increments to complete identified activities.

- CalAIM Major Organ Transplants (MOT):
  - Submitted response to DHCS on January 7th regarding the Corrective Action Plan (CAP) received on December 10th, 2021 for lack of a certified MOT network; CAP will remain in place until AAH has an executed contract with a transplant program that is a Center of Excellence (COE) for adult kidney-pancreas transplants.
    - AAH only contracted with UCSF and Stanford for transplants and Stanford is not a COE for kidney-pancreas transplants.
    - Still waiting for DHCS to issue rate guidance so we can execute a formal contract with UCSF for kidney-pancreas transplants.

- Long Term Care (LTC) Carve-In – AAH will be responsible for all members residing in LTC facilities as of January 1st, 2023.
  - Does not include Intermediate Care Facilities and Institutions for Mental Disease (ICF and IMD) which will be implemented no earlier than July 1st, 2023.
  - Boilerplate contract, amendment and cover letter have been drafted and are in final review.
  - Communications
    - Member notification – pending templates from DHCS.
    - Provider notification – developing FAQs and call scripts.
  - Individual workstreams meetings continue.

- Population Health Management (PHM) Program – effective January 1st, 2023
  - MCP 2023 PHM Readiness Submission due in October.

- CalAIM Incentive Payment Program – three-year DHCS program to provide funding for the support of ECM and CS in the following areas:
  - 1) Delivery System Infrastructure
  - 2) ECM Provider Capacity Building
  - 3) Community Supports Provider Capacity Building and Community Supports Take-Up
  - Program Year 1 (PY1), Payment 1 of $7.4M (50% of PY1 funding) received from DHCS.
  - AAH has received ten (10) applications for IPP Funding to date.
    - $3.7M out of the $7.4M has been approved for distribution.
  - Application review still in progress.

Other Initiatives

- Mental Health (Mild to Moderate/Autism Spectrum Disorder) Insourcing – services currently performed by Beacon Health Options will be brought in-house as of November 1st, 2022.
  - Boilerplate contract and cover letter have been drafted and approved.
  - Contracts scheduled to be sent out week of July 5th and will be prioritized by provider volume.
  - Communications
    - Member notification – pending approval from DHCS.
    - Provider notification – developing FAQs and call scripts.
  - Individual workstreams meetings continue.
  - Deliverables, timelines, and risk will be assessment monthly.

- Behavioral Health Integration (BHI) Incentive Program – DHCS pilot program commenced January 1st, 2021 and continues through December 31st, 2022.
  - Received payment of $371,750 from DHCS on June 15th for Program Year 1, Quarter 4 milestones.

- Student Behavioral Health Incentive Program (SBHIP) – DHCS program commenced January 1st, 2022 and continues through December 31st, 2024:
  - Draft MOU for Alameda County Office of Education created and being reviewed.
  - Draft MOU for Health Care Services Agency (HCSA) for work being completed by the Center for Healthy Schools and Communities (CHSC) created and being reviewed.
  - Drafting MOUs for use with Local Education Agencies (LEAs).
  - Developed Needs Assessment allocation model.
  - Next Stakeholder meeting has been scheduled for August 25th.

- Housing and Homelessness Incentive Program (HHIP) – DHCS program commenced January 1st, 2022 and continues through December 31st, 2023.
  - Local Homelessness Plan (LHP) and supporting documents submitted to DHCS on June 30th.
  - Two (2) LHPs required – one for Alameda County and one for AAH
    - Countywide LHP completed in collaboration with HCSA, AAH and Anthem.
- DHCS released draft Investment Plan template for feedback.
  - Investment Plan is due to DHCS by August 31st

- Justice-Involved/Coordinated Re-Entry:
  - January 2023 implementation has been delayed by DHCS; awaiting additional program guidance.

- 2024 Managed Care Contract Operational Readiness:
  - DHCS held kick-off meeting on June 15th.
  - 245 deliverables due to DHCS in three (3) phases – 8/12/2022-12/8/2022, 12/15/2022-3/31/2023, 4/20/2023-7/31/2023.

Recruiting and Staffing

- Project Management Open position(s):
  - Recruitment to commence/continue for the following positions:
    - Manager, Project Management Office (PMO)
    - Senior Business Analyst
    - Project Manager – offer made and accepted

Integrated Planning

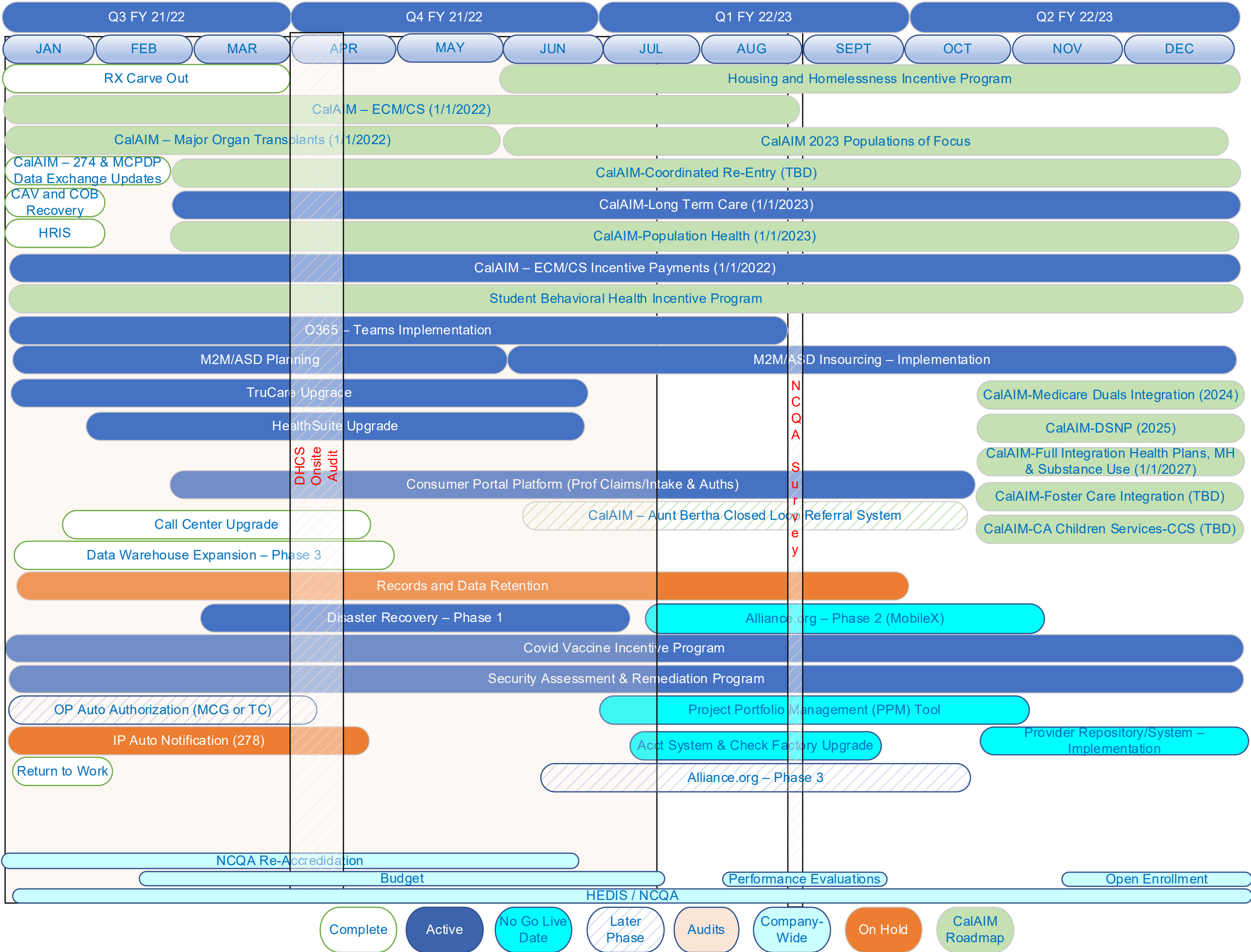
Supporting Documents

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 seven (7) specific populations of vulnerable and high-risk children and adults
    - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022.
    - Two (2) additional PoFs will become effective on January 1st, 2023.
    - Third PoF originally scheduled for January 1st has been delayed by DHCS until further notice.
    - One (1) PoF will become effective on July 1st, 2023.
  - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays.
    - Six (6) Community Supports were implemented on January 1st, 2022.
    - Two (2) additional CS services are targeted for implementation by January 1st, 2024.
  - Major Organ Transplants (MOT) – currently not within the scope of many Medi-Cal managed care plans (MCPs); carved into all MCPs effective January 1st, 2022.
    - Applicable to all adults as well as children if the transplant is not covered by California Children's Services
  - CalAIM Incentive Payment Program (IPP) – The CalAIM ECM and CS programs will require significant new investments in care management capabilities, ECM and CS infrastructure, information technology (IT) and data exchange, and workforce capacity across MCPs, city and county agencies, providers and other community-based organizations. CalAIM incentive payments are intended to:
    - Build appropriate and sustainable ECM and ILOS capacity
    - Drive MCP investment in necessary delivery system infrastructure
    - Incentivize MCP take-up of ILOS
    - Bridge current silos across physical and behavioral health care service delivery
    - Reduce health disparities and promote health equity
    - Achieve improvements in quality performance
  - Long Term Care - currently not within the scope of many Medi-Cal MCPs; will be carved into all MCPs effective January 1st, 2023.
    - ICF and IMD facilities will be implemented no earlier than July 1st, 2023.
  - Justice Involved/Coordinated Re-Entry – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release.

        - Originally scheduled for January 1st, 2023 but has now been delayed by DHCS with no new implementation date.
    - Population Health Management (PHM) – all Medi-Cal managed care plans will be required to develop and maintain a whole system, person-centered population health management strategy effective January 1st, 2023.
        - PHM is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes.
- Return to Work – assessment of current state work environment and recommendations for future configurations (remote/onsite/hybrid)
    - Current targeted date for returning to the office is July 5th, 2022.
- Project Portfolio Management (PPM) Tool – vendor demonstrations complete and tool selected; target implementation in FY 2022-23.
- Accounting & Enterprise Resource Planning (ERP) System Upgrade – upgrade current system to supported platform
- Student Behavioral Health Incentive Program (SBHIP) – program launched in January 2022 to support new investments in behavioral health services, infrastructure, information technology and data exchange, and workforce capacity for school-based and school-affiliated behavioral health providers. Incentive payments will be paid to Medi-Cal managed care plans (MCPs) to build infrastructure, partnerships and capacity, statewide, for school behavioral health services.
    - Meetings completed with Alameda County Office of Education (ACOE), Center for Healthy Schools and Communities (CHSC) and interested Local Education Agencies (LEAs) to begin work on Needs Assessment which will identify which of the fourteen (14) Targeted Interventions are a priority for Alameda County.
    - Needs Assessment and Project Plans for the selected Targeted Interventions are due to DHCS by December 31st, 2022.
- Housing and Homelessness Incentive Program (HHIP) – program launched in January 2022 and is part of the Home and Community-Based (HCBS) Spending Plan
    - Enables MCPs to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health
    - MCPs must collaborate with local homeless Continuums of Care (CoCs) and submit a Local Homelessness Plan (LHP) to be eligible for HHIP funding
        - LHP is due to DHCS by June 30th, 2022.
        - LHP is expected to be in alignment with local Homeless Housing, Assistance and Prevention (HHAP) grant application.
        - In counties with more than one MCP, MCPs need to work together to submit one LHP per county.
- 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.


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

Performance & Analytics

Tiffany Cheang

To: Alameda Alliance for Health Board of Governors

From: Tiffany Cheang, Chief Analytics Officer

Date: July 8th, 2022

Subject: Performance & Analytics Report

Member Cost Analysis

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

- For the Current reporting period, the top 9.1% of members account for 84.1% of total costs.

- In comparison, the Prior reporting period was lower at 8.1% of members accounting for 83.6% of total costs.

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

  - The SPD (non-duals) and ACA OE categories of aid saw no change to account for 60.7% of the members, with SPDs accounting for 27.1% and ACA OE's at 33.6%.
  - The percent of members with costs >= $30K slightly increased from 1.7% to 1.9%.
  - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.5%.
    - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 49.4%.

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

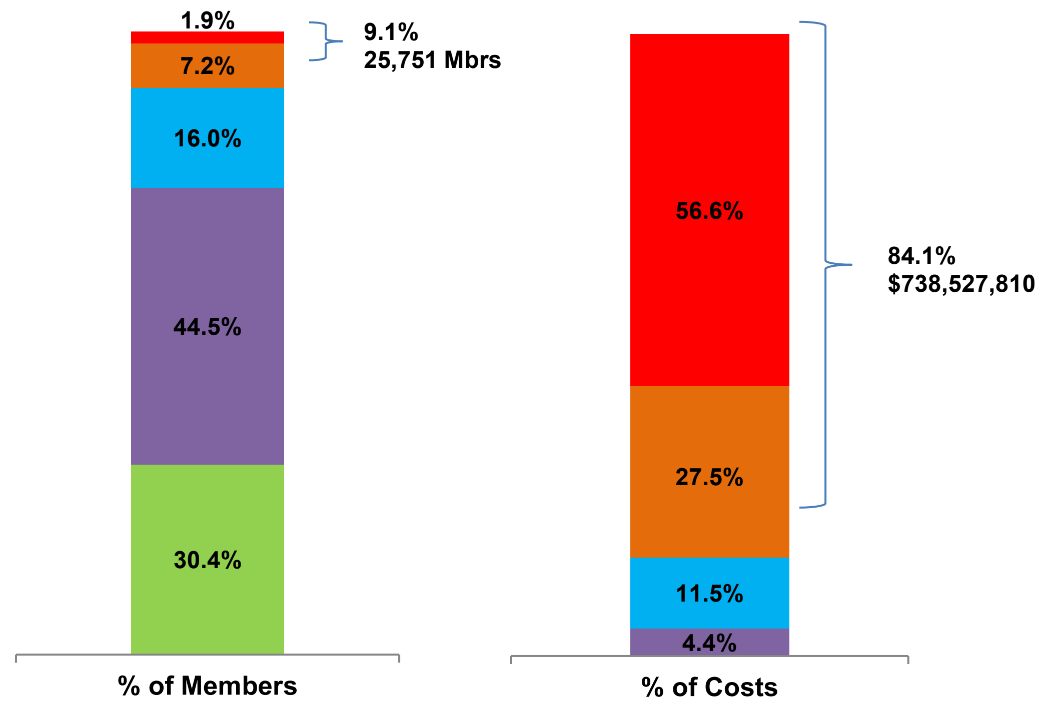
  - However, the age distribution of the top 9.1% is more concentrated in the 45-66-year-old category (40.0%) compared to the overall population (20.3%).

Performance & Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Apr 2021 - Mar 2022
Note: Data incomplete due to claims lag
Run Date: 06/29/2022

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	5,350	1.9%	$ 496,747,995	56.6%
$5K - $30K	20,401	7.2%	$ 241,779,814	27.5%
$1K - $5K	45,273	16.0%	$ 100,681,153	11.5%
< $1K	126,162	44.5%	$ 38,828,538	4.4%
$0	86,267	30.4%	$ -	0.0%
Totals	**283,453**	**100.0%**	**$ 878,037,500**	**100.0%**

Top 9.1% of Members = 84.1% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	1,278	0.5%	$ 278,729,287	31.7%
$75K to $100K	655	0.2%	$ 56,521,324	6.4%
$50K to $75K	1,316	0.5%	$ 80,719,226	9.2%
$40K to $50K	814	0.3%	$ 36,346,386	4.1%
$30K to $40K	1,287	0.5%	$ 44,431,772	5.1%
SubTotal	***5,350***	***1.9%***	***$ 496,747,995***	***56.6%***
$20K to $30K	2,680	0.9%	$ 65,154,556	7.4%
$10K to $20K	7,541	2.7%	$ 104,045,667	11.8%
$5K to $10K	10,180	3.6%	$ 72,579,592	8.3%
SubTotal	***20,401***	***7.2%***	***$ 241,779,814***	***27.5%***
Total	**25,751**	***9.1%***	**$ 738,527,810**	***84.1%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Mar 2022	260,724	$ 783,871,404
Dis-Enrolled During Year	22,729	$ 94,166,096
Totals	**283,453**	**$ 878,037,500**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
9.1% of Members = 84.1% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Apr 2021 - Mar 2022
Note: Data incomplete due to claims lag
Run Date: 06/29/2022

9.1% of Members = 84.1% of Costs
27.1% of members are SPDs and account for 32.7% of costs.
33.6% of members are ACA OE and account for 32.8% of costs.
6.8% of members disenrolled as of Mar 2022 and account for 12.5% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	140	593	733	2.9%
MCAL	MCAL - ADULT	601	3,659	4,260	17.0%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	218	1,632	1,850	7.4%
	MCAL - ACA OE	1,697	6,718	8,415	33.6%
	MCAL - SPD	1,869	4,914	6,783	27.1%
	MCAL - DUALS	109	1,226	1,335	5.3%
Not Eligible	Not Eligible	671	1,025	1,696	6.8%
Total		**5,305**	**19,767**	**25,072**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 9,958,538	$ 6,591,732	$ 16,550,270	2.3%
MCAL	MCAL - ADULT	$ 47,705,736	$ 42,653,616	$ 90,359,352	12.5%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 10,901,155	$ 19,006,774	$ 29,907,929	4.1%
	MCAL - ACA OE	$ 159,620,855	$ 77,495,484	$ 237,116,339	32.8%
	MCAL - SPD	$ 176,886,481	$ 59,689,677	$ 236,576,158	32.7%
	MCAL - DUALS	$ 7,843,014	$ 15,029,318	$ 22,872,333	3.2%
Not Eligible	Not Eligible	$ 77,522,159	$ 13,049,262	$ 90,571,421	12.5%
Total		**$ 490,437,939**	**$ 233,515,863**	**$ 723,953,802**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
36.4% of members are SPDs and account for 186.9% of costs.
31.7% of members are ACA OE and account for 170.6% of costs.
18.7% of members disenrolled as of Mar 2022 and account for 100.0% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	22	1.8%
MCAL	MCAL - ADULT	116	9.3%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	9	0.7%
	MCAL - ACA OE	398	31.7%
	MCAL - SPD	456	36.4%
	MCAL - DUALS	19	1.5%
Not Eligible	Not Eligible	234	18.7%
Total		**1,254**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 4,105,955	7.8%
MCAL	MCAL - ADULT	$ 22,997,462	43.5%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 1,621,735	3.1%
	MCAL - ACA OE	$ 90,089,323	170.6%
	MCAL - SPD	$ 98,692,012	186.9%
	MCAL - DUALS	$ 3,264,419	6.2%
Not Eligible	Not Eligible	$ 52,811,387	100.0%
Total		**$ 273,582,293**	**518.0%**

% of Total Costs By Service Type

				Breakout by Service Type/Location						
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	7%	0%	0%	9%	57%	1%	14%	6%	2%	7%
$75K to $100K	7%	0%	1%	13%	46%	3%	8%	5%	7%	13%
$50K to $75K	7%	0%	1%	12%	43%	4%	8%	7%	8%	13%
$40K to $50K	7%	1%	1%	13%	45%	7%	8%	6%	1%	15%
$30K to $40K	13%	1%	1%	11%	37%	13%	7%	6%	1%	17%
$20K to $30K	6%	2%	1%	14%	33%	10%	9%	7%	1%	18%
$10K to $20K	1%	0%	1%	15%	30%	6%	12%	9%	1%	15%
$5K to $10K	0%	0%	0%	16%	18%	8%	12%	15%	0%	17%
Total	**6%**	**0%**	**1%**	**12%**	**43%**	**5%**	**11%**	**7%**	**3%**	**12%**

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

Human Resources

Anastacia Swift

To: Alameda Alliance for Health Board of Governors

From: Anastacia Swift, Chief Human Resources Officer

Date: July 8th, 2022

Subject: Human Resources Report

Staffing

- As of July 1st, 2022, the Alliance had 375 full time employees and 1-part time employee.
- On July 1st, 2022, the Alliance had 74 open positions in which 12 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 62 positions open to date. The Alliance is actively recruiting for the remaining 62 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by department:

Department	Open Positions July 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	24	3	21
Operations	28	3	25
Healthcare Analytics	3	0	3
Information Technology	4	2	2
Finance	4	1	3
Regulatory Compliance	3	1	2
Human Resources	6	1	5
Integrated Planning	2	1	1
Total	74	12	62

- Our current recruitment rate is 18%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in June 2022 included:
  - 5 years:
    - Judith Foster (Member Services)
    - Karen Mejia (Member Services)
    - Brittany Nielsen (Healthcare Analytics)
  - 6 years:
    - Isabelle Liang (Member Services)
    - Sherry Roces (Utilization Management)
    - Snowvia Rodgers (Provider Relation)
  - 7 years:
    - Tiana Rivas (Provider Relation)
    - Latrice Allen (Claims)
    - Jeanette Murray (Executive)
  - 10 years:
    - Marcie Sperling-Bullock (Claims)
    - Thuan Le (Claims)
  - 11 years:
    - Eileen Ahn (Regulatory Readiness)
    - Elisea Toscano-Cochrane (Case & Disease Management)
  - 14 years:
    - Annie Wong (Healthcare Analytics)
  - 15 years:
    - Cindy Brazil (Quality Improvement)
  - 25 years:
    - Monina Malonzo-Rayo (Claims)
  - 26 years:
    - Angie Vaziri (Member Services)